

Beyond the Bondi Junction tragedy: Strategies to Address System Failures & Subsequent Dangers affecting Homeless, Itinerant & Alienated Individuals living with Complex Mental Health Disorders in NSW

To: NSW State Coroner, Her Honour, Magistrate Teresa O'Sullivan, Bondi Junction Inquest April-May 2025

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Overview:

Major investment and reform of NSW mental health services are urgently needed in response to the Bondi Junction tragedy of 13 April 2024. This is a major challenge for the NSW Government.

There have been overlapping and cumulative crises in NSW mental health services for some years. This culminated in 2024 in the Bondi Junction Tragedy which alerted the public to the serious system failures in the mental health system. This was compounded by the impending collapse of public health psychiatrist services in 2025. A NSW Coroner's Inquest is soon to investigate these related system failures, and what can we do to prevent their recurrence.

A chronology of events at the Bondi Junction tragedy indicates **at least 20 cumulative system failures and missed opportunities** [see **Box 1** pp 20-24].

How to avoid these tragedies has been evident for some time. So far there has been a lack of action by NSW Government Authorities to take the necessary coherent action, even after a year. It is possible that only recommendations of a Royal Commission may be able to generate and sustain effective solutions. But **why must we wait further for a long-drawn-out Royal Commission when we know what needs doing?** Some of the most rigorous studies which generated and replicated international evidence of the effectiveness of the methods recommended below, were completed in NSW for Australian conditions. NSW often led the way in Australia & internationally with this evidence base and subsequent reforms. Over recent years, these reforms have been eroded, diluted and underfunded by NSW Health and inadvertent neglect by successive governments.

What needs to be done?

A significant proportion of the roughly 20+% of homeless individuals who have severe psychiatric disorders, may develop a potential to cause harm to themselves and/or others.

They are often difficult to locate consistently as they have no fixed address. Itinerant wandering may be associated with transient, acute or long-term psychosis and loss of contact with, and support by, family and mental health services.

A '**Housing First**' approach is required to help such individuals promptly into normative, stable and secure housing, and associated support services in a locality with which they are familiar. This should often be done well-ahead of offering ongoing mental health services. A 'Housing First' approach is a priority for **Assertive Community Treatment (ACT) & Support Teams** (which are ongoing intensive 7/7 mobile-outreach home-visiting teams) to be able to establish regular contact with homeless or itinerant individuals who are contending with complex and severe mental health disorders.

Once the person has stable accommodation, it is easier to offer consistent continuity of care, while upholding their human rights and their sense of control. In this way, these teams can build trust to subsequently encourage engaging in specific treatment needs and assistance, when appropriate, with family reconnection and support. These ACT teams need to be available throughout NSW, including adaptations for rural, remote and first nations communities.

The NSW Government must urgently rectify [the cascading streams of budgetary erosion contributing to the continuing discriminatory depletion of existing mental health services in NSW](#). This has occurred as allocated mental health funding is (a) less than half the percentage of mental health's proportion of the measured health burden, and still decreasing (b) much less per-capita than other Australian jurisdictions, and even then, (c) too frequently allowed by NSW Health to be diverted by LHD's for non-mental health purposes.

It must ensure sustained funding both for stable and secure normative housing for homeless mentally ill individuals while maintaining an appropriate staffing density, stability, 24/7 day and night availability & mobility of assertive community mental health teams. The financing for this can be met by NSW introducing a levy on large businesses similar to that now in place in Victoria (2022). The NSW Mental Health Commission should be empowered to exercise its own independent statutory powers and delegations for investigation and discovery, to ensure that the NSW mental health budget is held separately and is spent squarely on mental health services on the ground.

Hopefully NSW Government will respond adequately to this sentinel warning event, with a major investment in NSW mental health services. If NSW Health and the Government can't lift their game, and soon, only a Royal Commission, with a Report like Victoria's in 2021, will be able to save NSW from its mental health service malaise, and from courting further such disasters.

So the two most essential requirements to effectively address these needs are:

- **Community based mental health services with mobile outreach Assertive Community Treatment and Support Teams (ACT's)** to consistently locate, reach, engage and support homeless individuals reliably where-ever they are. Such teams

can then provide a **continuity of practical care** and support while building trust to encourage engagement in meeting specific treatment needs. Continuity of personal care, including family support, education and reconnection, often requires a commitment to long-term care management, which entails resisting pressure to discharge and/or transfer completely to primary health, NGO or private care.

- These ACT teams can assist individuals into an adequate supply of **Dedicated, Normative, Stable and Secure, Social Housing** in a locality with which they are familiar, with a “**Housing First**” approach, developing engagement and trust, often before intensive ongoing clinical care is offered. This is a crucial need if the outreach teams are to identify, locate and maintain the vital continuity of care and support required by contending with complex mental health disorders¹, especially the psychoses, of which about 20% of homeless individuals suffer².

To meet these requirements NSW will need to:

Ensure guaranteed and sustained adequate funding both for stable and secure normative housing and maintaining an appropriate staffing density, stability, 7/7 day and evening availability & mobility of assertive community mental health teams. The financing for this can be met by NSW introducing a levy similar to that now in place in Victoria (2022) and Queensland (2023)³.

Determine that the NSW Mental Health Commission is a statutory authority with its own delegations and powers for independent monitoring, data access, inquiries & reporting to Parliament and the public, to ensure that the designated funding reaches such services reliably, and is retained for workforce & teamwork development, stability and sustainably.

Establish and implement nationally (and eventually Internationally) consistent and humane conventions and cross-border reciprocal arrangements to ensure the reciprocal alerting and communication between jurisdictional mental health services and authorities for purposes of monitoring, providing continuity of care or returning of individuals crossing borders while on Mental Health Act orders.

Establish and implement nationally more consistent and humane approaches to appraisal of danger and monitoring, relying on the most current appraisals of the evidence base, to derive the most effective balance between clinical, capacity and risk assessment methods, and interpersonal or technological monitoring, and least restrictive care consistent with safety and good quality care.

¹ **Complex and Severe Mental Health Disorders** (The ‘Quintuple Whammy’, Table 2 in Rosen A, Gill N, Salvador-Carulla, L, Current Opinion in Psychiatry, 2020) are often multi-faceted, and pervasive in many aspects of the person’s life [See Box 2, p25].

² Ayano, G., Tesfaw, G. & Shumet, S. The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis. *BMC Psychiatry* 19, 370 (2019). <https://doi.org/10.1186/s12888-019-2361-7>

³ <https://www.sro.vic.gov.au/news/mental-health-and-wellbeing-surcharge-has-commenced>
<https://qro.qld.gov.au/payroll-tax/mental-health-levy/>

Establish Guidelines for Cultural Safety, so that all these initiatives are delivered in “Two Ways”⁴ both technically (clinically and legally) and culturally, in parallel. They should be undertaken in consultation with affected service-users and families, (including First Nations, transcultural, gender- and neuro- diverse representatives), and the spectrum of service providers and agencies involved.

NOTE: These requirements aren’t necessarily for everybody contending with such disorders. In putting forward these requirements, it must be acknowledged that there is a significant proportion of individuals living with severe and/or complex mental health disorders who have found, over time, ways to adapt to living with the disorder in the community. Some have recovered sufficiently or completely, to live independently with or without the recommended interventions and service delivery systems which are detailed in this submission. They may be responsible and peaceful citizens with some becoming peer workers, coaches, guides or informal mentors to teach others how to retain their autonomy and human rights while accessing the mental health services they might need, on an ongoing basis or when required. There is now much more empirical research to support this, while others do better with continuing engagement with community rehabilitative facilities⁵.

The Core Problems

In relation to the recent Bondi Junction & Wakeley tragedies in NSW, it should be emphasized that most people living with complex mental health disorders are gentle and peaceful, and much more likely to be victims than perpetrators. The events in Bondi Junction on 13 April 2024 and in Wakeley, Western Sydney on 15 April 2024 are rarely perpetrated by individuals with complex and severe mental disorders and should not lead to the false conclusion that the majority of instances of mass violence are likely to be due to people living with psychiatric disorders. That would be untrue and most distressing to most people living with long-term or intermittent complex psychiatric disorders, who continue to live in the community as peaceful and responsible citizens. However, some of the roughly 20% of homeless individuals [NSW incomplete Street Count DCJ, Feb-March 2024, up 26% since 2023] and a considerably larger group with precarious or unstable housing who have a severe psychiatric disorder, may develop a potential to cause harm to others, especially if they have some combination of persecutory delusions, command hallucinations, a substantial drug and alcohol disorder, cognitive deficit and/or a severe personality disorder (associated with developmental trauma, e.g. family violence and/or neglect⁶) Intellectual Disabilities, Foetal Alcohol Syndrome (FAS)⁷, Brain Injury & other cognitive disorders, Trauma and Substance Abuse. Violence can also be associated in later life with depression,

⁴ Gayaa Dhuwi Declaration: Gayaa Dhuwi Australia 2015, based partly on the International Wharerata Declaration, 2010).

⁵ Harding, C, Recovery from Schizophrenia: Evidence, History and Hope, Oxford University Press, 2024;

Beels, C. C., The Invisible Village. In C. C. Beels & L. L. Bachrach (Eds.), *Survival strategies for public psychiatry* 1989, (pp. 27–40). San Francisco, CA: Jossey-Bass.

Rosen A, The Pathway from the Bondi Junction Disaster to the Invisible Village, TheMHS Conference, Canberra, 2024.

⁶ Bennett, M. (2024) *Childhood Stress, Trauma and Synapse Loss*, Springer Nature; Bennett, M., Lagopoulos, J (2018) *Stress, Trauma and Synaptic Plasticity* Springer Nature.

⁷ Streissguth A.P. et al, Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome and Fetal Alcohol Effects, *Developmental and Behavioral Pediatrics* Vol. 25, No. 4, August 2004

psychosis, poverty, isolation, unemployment, homelessness, police involvement, incarceration in institutions or prisons and danger to self or others.

Itinerant wandering may be associated with loss of family support and contact, transient, acute or long-term psychosis, dissociative states, epileptic, memory loss and other cognitive disorders. Individuals who are itinerant across borders may become so apparently aimlessly or may be making an intentional bid for new climes, company, imagined or sought opportunities, adventures or a different way of life, or in a quest to escape the constraints sought or applied by services, authorities or families concerned for their wellbeing, mental ill-health, safety, reputations or exhaustion of their resources. Some individuals are lost to contact by those who love or care for them, and to treatment, rehabilitation and support services, for extended periods or indefinitely in this way.

[See Box 1: Bondi Junction-An Avoidable Tragedy? pp 20-25]

Lack of consistent and easy access to age-appropriate early intervention in psychosis programs and to ongoing expert interdisciplinary continuity of care if and when needed are crucial. **A key aspect of such tragedies is that too often appropriate services for that individual's condition do not get organised and applied until they have already committed a serious crime or harm to self or others, while psychotic.** Either the severity or danger of their condition has not yet become apparent inside or outside the family, or the person may have lost contact with their family. It may not have been brought to the attention of services until then, or services may not have gained access to work with the person or family until then, or the service has been too under-resourced to be mobile or proactive enough to do its job properly.

Although most political extremists and demagogues do not have a psychiatric illness, extremist groups may sometimes attract and try to radicalize psychiatrically vulnerable, hyper-aroused individuals to exploit their suggestibility, persecutory thinking, anger management issues and compromised insight, to get them worked up to carry out conspiratorial and violent acts on behalf of these networks. With some differences in terms of circumstances and legitimate rights to privacy, freedom, and to possession, there appear to be some parallels between the overdue further development of consistent and reciprocal gun control laws, standards and conventions⁸, and exemplified by the recent gun 'collecting' 'displaced substitute' domestic violence murders in Floreat Park, Perth WA. As stated in that article, we must be mindful that: "Most violent individuals do not have mental illness, and most mass murderers do not have identifiable severe mental illness. Many have maladaptive personality configurations" ...often with a range of narcissistic, persecutory, or antisocial traits and/or controlling, tyrannical and even demagogic behaviours. While variants of the latter are overrepresented in the prison population, most live as ordinary citizens in the community, usually undetected unless or until they offend, unfettered, and without any systematic scrutiny by the law, and clearly outside the scope of involuntary mental health service legislation.

⁸ Dudley M, Rosen A, Alpers P, Peters R, The Port Arthur massacre and the National Firearms Agreement: 20 years on, what are the lessons? Med Journal Aust May 2016 doi: [10.5694/mja16.00293](https://doi.org/10.5694/mja16.00293)

We make this submission from the perspective of our lifetimes' practical work, research and advocacy in the mental health, brain and mind science areas. Our aim is to help relieve the perpetual or intermittent torment, vigilance and distress of both those living with a brain and mind disorder, as well as worries of and dangers to their families and friends, and individuals and families in the community who may suffer from the consequences of services not effectively ameliorating such cumulative risks. This must be balanced with human rights considerations for all the individuals, families and community members who may be involved.

The Evidence Based Solutions.

1. Community based mental health centres with mobile outreach home visiting Assertive Community Treatment and Support (ACT) teams for those with complex or severe mental health disorders

1.1 Specifications

- 1.1.1 Continuity of Care via expert & familiar mental health professionals (at least 50% of staffing) plus support and peer workers in the same team, and primary health care, working closely together.
- 1.1.2 **Close Communication** both ways between all agencies involved, not just downwards, eg. as support workers may be first to detect suicidality or potential danger to others.
- 1.1.3 **Coordination and clinical liaison with 24/7 accessible Community based Crisis teams** or equivalent in all parts of NSW, including remote community access eg MHEC (Mental Health Emergency Consultation) teams, to be responsive when ACT teams are off duty (e.g. over-night).
- 1.1.4 Provide and access unlocked local community based **residential respite facilities** as needed, as alternatives to acute locked hospital emergency facilities & involuntary admissions if possible, but as part of effective community care for many without necessitating hospital admission, thus ensuring rapid access to inpatient beds when needed. [See 2.2.2. Residential facilities].

1.2 Rationale:

Systematise a “one-stop-shop” or an “invisible village” of support, (after Beels C., pers. comm, 2023), rather than leaving the individual or family to try to navigate a maze of uncoordinated fragments of service. We need to develop these components into mental health-care ecosystems⁹, shifting the centre of gravity of Mental Health Services further from hospital-centric to more community-centred treatment and care, taking responsibility and accountability for delivering mental health services at both:

⁹ Rosen A, Gill N S, Salvador-Carulla L, The future of community psychiatry and community mental health services, Current Opinion in Psychiatry, 33: 4: 375-390, July 2020. doi: 10.1097/YCO.0000000000000620
<https://protect-au.mimecast.com/s/dt8tCL7EwMfRmg5O8lBzGyu?domain=journals.lww.com>

(a) the micro-level (eg. clinical, individual & family interventions, care and continuity of care for complex conditions, including family and group education, drop-in and home delivered support and networks) and...

(b) the macro-level (eg. preventive screening and education, early intervention, whole of community or catchment, proactive mental health & well-being services)¹⁰.

This wholistic consortium approach may ultimately enable a local or regional mental health service to consult, negotiate and work together on a unitary mental health service plan for that catchment area. This entails coordinating complementary roles with an explicit division of labour, and easy-to-operate interactive communication channels & IT systems, between public mental health, including secondary (LHD) and primary (PHN) mental health care, NDIS & NGO support & peer workers, Aboriginal Medical Service, Transcultural, RFDS, and private contractual & fee-for-service providers.

1.2.1. Assertive Community Treatment and Support (ACT) Teams: the most rigorous level of evidence for the effectiveness of these teams has been established and replicated internationally since the 1970's and in Australia since 1979¹¹ particularly with individuals and families contending with severe and treatment resistant mental disorders and co-occurring (eg substance use, physical, homelessness, forensic) conditions. In Australia, most of their staff are interdisciplinary clinicians including a psychiatrist and registrar, but more often now they include vocational, housing, physical care and substance use specialist staff and peer workers.¹² ACT teams usually operate with a limited ratio of 10:1 service-users to each staff member, on a 7 day basis, with day and afternoon/evening shifts. They are only patchily applied and not consistently available in NSW, even in urban, suburban and regional centre catchments.

1.2.2. Ensuring ongoing Family support. Offer and provide continuity of support. education, evidence-based family intervention and care for affected Families, no matter what: each team or service should have a member carrying the portfolio and designated role as a highly skilled family work practitioner/coordinator/trainer. ACT teams should include a family specialist or train all their clinicians to provide such family services. These were clear expectations and rateable indicators of the Area Integrated Mental Health Service (AIMHS) Standards for NSW Health¹³ which set a global precedent as fully Integrated Community & Hospital MHS Standards and subsequently led to the development of the Australian National MHS Standards. The AIMHS Family Intervention Standard includes:

¹⁰ Byrne P & Rosen A, *Early Intervention in Psychiatry: EI of Nearly Everything*, Blackwell-Wiley, Oxford, 2014.

¹¹ Hoult J, Rosen A, Teesson M, Hambridge J, Chapman C./ Issakidis C et al, 1980's-90's.

¹² Killapsy H, Rosen A & Harvey C, 2024, *Case Management & Assertive Community Treatment*, Chapter in *Oxford Textbook of Community Mental Health*, 3rd edition, Thornicroft G, Szmukler G, Mueser K, Drake R, eds. Oxford UP, Oxford, forthcoming, 2024.; Teesson M, PhD Thesis, UNSW, Sydney, 1995: "An evaluation of mental health service delivery in an inner city area". *Trove Books, National Library of Australia.*; Hoult J, Rosen A & Reynolds I, 1984, *Community Orientated Treatment Compared to Psychiatric Hospital Orientated Treatment*, [RCT] *Social Science in Medicine*, 18, 11, 1005 - 1010. Sanderson K, Issakidis C, Johnson S, Teesson M, Buhrich N, "Cost-effectiveness of intensive case management for people with SMI" Research Report, UNSW, 1996.

¹³ Rosen A, Miller V & Parker G, 1992 *AIMHS Standards: Area Integrated Mental Health Service Standards*, Chatswood, N.S.W. : NSW Department of Health, Area Integrated Mental Health Services Standards Project, [https://catalogue.nla.gov.au/Search/Home?lookfor=author:%22Rosen,%20Alan,%20MB.BS.\(W.A.\),%20F.R.A.N.Z.C.P%22&i-knowwhatimean=1](https://catalogue.nla.gov.au/Search/Home?lookfor=author:%22Rosen,%20Alan,%20MB.BS.(W.A.),%20F.R.A.N.Z.C.P%22&i-knowwhatimean=1)

For Service Users without families:

- reconnecting with their families at their own pace
- grieving loss with families
- connecting with proxy & adult foster families eg host family schemes

For Families without a cooperative Service-user:

- who will not cooperate with mental health services
- who will not see or cannot get along with them
- providing access to a full range of family interventions and support.

1.2.3.-1.2.12: Concerns Related to mobile Assertive Community Team provision.

1.2.3. Alternatives to avoidable Police & Court charges and/or entering Corrections system:

- 1.2.3.1. **Pacer teams**, comprising Policing and a Community Mental Health professional, trained and rostered to do community assessments and interventions together, mainly in circumstances deemed potentially dangerous. Pacer teams can potentially improve both outcomes and the police culture and attitudes to working with individuals with severe mental disorders, probably more so if a rostered police officer is co-located with placements in an urban mental health team, learning more nuanced responses from a more reflective rather than from the more instrumental police culture. Police could learn to understand their culture, commitment and their mission (as in Vancouver BC since 1970's) rather than only vice-versa. Some police spokespeople otherwise will continue to complain that responding to mentally ill individuals and their families is not what they signed up for. Pacer teams and arrangements are reputedly in danger of having their systems dismantled and/or their funding cut in NSW and ACT¹⁴.
- 1.2.3.2. **Forensic Assertive Community Teams** for individuals on parole or recent release from the NSW Corrections system, for intensive mobile follow-up and full stabilization with or without Forensic Community Treatment Orders (CTO's), before handing over to local catchment teams for long-term continuity of care with or without civil CTO's, as necessary. Evidence has recently emerged that the greatest vulnerability to death of prisoners occurs in the initial days following release, mainly due to suicides, drug overdoses, and cardiac emergencies. Professor Paul Mullens, as Clinical lead of Victorian Justice Mental Health, often stated that internationally, forensic mental health applications of Assertive Community Treatment Teams provided the best evidence and advertisements for its effectiveness.
- 1.2.3.3. **Address the significant proportion of Domestic Violence**, including coercive control, injuring and killing of women, children and elderly family members, contributed to by undiagnosed, untreated or undertreated episodes of severe mental health disorders¹⁵. So more effective Pacer systems and systematic

¹⁴ Rose T, McLeod C, NSW Police could ditch mental health response program, The Guardian, 21 Sept 23

¹⁵ Peek-Asa C, Zwerling C, Young T, Stromquist AM, Burmeister LF, Merchant JA (2005) [A population based study of reporting patterns and characteristics of men who abuse their female partners](#). Inj Prev.11(3):180-5

mental health trainings of police and other 1st responders re how to work together with mental health teams, are essential. Address the need for inexpensive/equitable & rapid access to mental health services. Ensure a **Coordinated and Effective Domestic Violence Response** by police, ambulance, social services, child protection, mental health and housing services.

1.2.4. **Challenge “the antithesis” of continuity of care:** Resist health administrations pressuring depleted or overloaded ACT teams to transfer or discharge individuals with severe mental disorders prematurely (eg without stabilization on oral Clozapine and/or intramuscular medication and without continuing drug & alcohol and physical rehabilitation).

1.2.5. **Try to avoid Involuntary Orders whenever possible** by reaching out and working hard on establishing and sustaining ongoing interpersonal engagement, the practical benefit of continuity of care (eg help to settle in stable housing) and trust throughout the therapeutic encounter. **If unavoidable, make judicious use of Community Treatment Orders (CTO’s)** without using them as a “kangaroo court” to officiously control lives. Humane & dutiful community care coordinators often feel obliged to apply for CTO’s to be able to retain clientele who need continuity of care in their team, when they are under administrative pressure to discharge prematurely to GP’s. etc. *A well-functioning ACT/AOT team may intake more clientele on CTO’s but will work steadily towards developing a long-term therapeutic alliance on a voluntary basis, lowering the proportion of individuals on CTO’s overall, well before transfer to a less intensive mental health care team.*

1.2.6. **General practitioners and/or private psychiatrists** and their clinic staff may be able to negotiate and provide a more acceptable basis for ongoing personalized and trusted care, which will ensure continuity of care and specific medication by the interdisciplinary treatment team, as designated by any formal order under the Mental Health Act. They can provide diligent continuity of engagement and care on this basis, especially if the individual or her family can afford their fees and/or longer appointments, and can reliably turn up for appointments, or less frequently if the practitioner can arrange for them to be bulk billed. However, on occasion, these clinicians take it upon themselves to prioritize the person’s privacy and personal preference to come off medication over all other concerns. They may exclude the family on their patient’s instructions, and not take their calls, on the grounds of “confidentiality”. They may comply with their patient’s wishes to reduce or cease regular medication, if only to preserve their therapeutic relationship, or on the sometimes ultimately futile grounds that they can retain the therapeutic relationship purely by psychotherapy or sheer power of personality. They may then find that their patient gradually loses all insight into their condition, drifts away from them, family and friends and all clinical & support services, and has an acute episode. Some of these practitioners may refuse to take calls from distressed family, fellow clinicians or caregivers, and may be reluctant to schedule this person for a short period of involuntary care, if need be, as these requests could disrupt their set appointments and/or do not suit their psycho-therapeutic mode of relating. Perhaps these are matters of clinical re-education bridging across the public-private divide, requiring public mental health services to be better trained and/or resourced to be more immediately responsive to fee-for-service practitioners needing to make an urgent referral. Meanwhile, organisations of all clinical professionals and professional registration

bodies need to attend to their code of ethics regarding professional responsibilities and accountability in several of these circumstances.

1.2.7. Address Co-Occurring Disorders with Drugs & Alcohol strategy-pull out stops on both simultaneously. **Apply a concurrent co-occurring disorders strategy** for severe & long-term mental illness with alcohol and other drug disorders, provided simultaneously by expert psychiatric and drug and alcohol specialists in the same team, and by rapid access to intensive residential drug & alcohol detoxification and rehabilitation facilities. The so-called “dual disorder” often exists less in the individual, and more in the treatment systems’ complete separation or lack of coordination and integration of both approaches.

1.2.8. Addressing Severe or Complex Developmental and Secondary Trauma which may exacerbate both complex psychiatric disorders and physical harm. Innovations with growing evidence which may markedly impact on functional relapse and recidivism, including Eye Movement Desensitization & Reprocessing, Dialectical Behaviour Therapy, Neurofeedback based on neuroplasticity which may persist well into adulthood, for developmental and secondary traumas as part of an array of other bio/psycho/social approaches¹⁶.

1.2.9. Special culturally safe and appropriate proxies for assertive mental health continuity of care & social housing arrangements for regional, rural/remote, First Nations and transcultural populations [e.g.’s Aboriginal community controlled residential facilities, and restore internationally acknowledged and externally validated tertiary cross-regional rural crisis teams with residential respite facilities, with ongoing community based mental health farm-based recovery services and work cooperative options, such as the Satellite Housing Integrated Support Service (SHIPS), based in Orange NSW (Fanning P, pers comm, 2024)¹⁷. We also need to establish and network in rural & remote regions, congenial Aboriginal Community-Controlled, culturally-safe residential & counselling facilities for **co-occurring severe mental illness and drug and alcohol detoxification and residential rehabilitation**.

1.2.10. We should restore and re-establish specialized day centres, living skills centres or clubhouses, as “communities of identity”, which breathe life into the “invisible village” model of care (Beels C, 1989; Rosen A, 2024) [see Footnote 5, page 4] through communal networking, cooperative and individual work options and reciprocal caring. Since the advent of NDIS individualized packages of care, for which we advocated, unfortunately many group programs and day centres have been downgraded or closed. We need both to provide both personal control and empowerment and a relational network, with opportunities to work, to

¹⁶ Gurr R, Report: A Tipping Point for Developmental Trauma Treatment? Neuroscience developments leading to more specific treatments of Trauma.,15.12.22 TAMHSS <https://transformingmentalhealth.org.au>

P McGorry et al, Orygen, Hype Program, [CBT, DBT, CAT, etc], Bennett M, Childhood Stress & Trauma, Springer, 2024.

¹⁷ Fanning P, pers comm, 2024: Re SHIPS program: These were key components of a comprehensive epidemiologically-based rural mental health service that served thousands of severely mentally ill individuals, many with co-occurring drug & alcohol and personality disorders, in central and western NSW for 35 years. SHIPS provided an alternative to hospitalization with a 24- hour clinician staffed crisis response and core house, with respite beds and temporary care as a gazetted health care agency with staffed satellite homesteads for residential rehabilitation in nearby farmlands including vocational opportunities. Referrals were taken from across NSW. Several commissions of inquiry which reviewed this service model recommended it be replicated in other regions. It was then administratively defunded and closed down a few years ago, after nationally and internationally acclaimed decades of cost-effective outcomes. The SHIPS model should be revamped and widely disseminated in rural NSW.

form a complete evidence-based spectrum of community-based continuity- of-care programs for individuals with long-term complex psychiatric disabilities. [see footnote 5.]

1.2.11. Access for young people with first episode psychoses an Early Intervention for Psychosis team and protocols, for 12–30-year-olds, and increasingly for other disorders, phases of care and age groups and their families [see footnote 10.]

1.2.12. Addressing physical illness: appoint a team member to be coordinator of all physical health monitoring, and each person’s care coordinator working in partnership with the person’s chosen or appointed general practitioner.

1.2.13. Addressing practical needs -all social determinants of health, including housing, income support, sustenance, occupation, social life, education, training & career development.
[See **Box 2. P24**].

1.2.14. Upholding Human Rights: our services and staff should encourage individual choices and engagement with Indigenous community-controlled organisations¹⁸.

2. Stable secure and normative housing

2.1 Specifications:

2.1.1 Ensuring Stable Supported & Normative Housing where-ever possible and “Housing First” strategies in conjunction with assertive outreach clinical & support workers. This entails:

2.1.2 A “Housing First” strategy in stable socially supported housing together with mobile Assertive Community Treatment team continuity of care for individuals who need it, Eg Habilis (in NSW) and the Haven projects (in Victoria and NSW), although some mentally ill homeless people prefer not to live close to others living with mental disorders, as they may wish to be more independent or idiosyncratic in lifestyle, with support on tap as needed.

2.1.3 A spectrum of normative and well supported social housing, respite and inpatient rehabilitation accommodation should always be available, as locally as possible, as needed. eg consolidating and combining HASI (Housing & Support Initiative), PCLi (Program for Community Living Initiative for Individuals stuck in hospitals for many months or years), and Extended Inpatient Stabilization or closely monitored medication (eg Clozapine) induction as necessary¹⁹, NDIS funded supported independent living (SIL) group residences.

2.1.4. Provide unlocked & 24/7 staffed local **community residential respite facilities** (eg PARC’s in Victoria) as alternatives to acute locked hospital emergency facilities & involuntary

¹⁸ Mezzina R, Rosen A, Amering M, Javed A, The Practice of Freedom: Human Rights and the Global Mental Health Agenda, Ch 30 in A. Javed, K.N. Fountoulakis (eds.), *Advances in Psychiatry*, Springer International Publishing AG, part of Springer Nature, 2019. https://doi.org/10.1007/978-3-319-70554-5_30

¹⁹Killaspy H, & Burns N, RANZCP/WAPR Section of Psychiatric Rehabilitation, webinar, Sydney, 27 February, 2024.

admissions if possible, with transition to effective community care for the majority, while ensuring rapid access to inpatient beds when needed.

2.2 Rationale:

2.2.1 The Evidence:

2.2.1.1. Teesson M, Hambridge J 1992 63:2:119-127 *Psychiatric Quarterly* and Teesson M, PhD Thesis, UNSW, Sydney, 1995: "An evaluation of mental health service delivery in an inner-city area". *Trove Books, National Library of Australia*, Sanderson K, Issakidis C, Johnson S, Teesson M, Buhrich N, "Cost-effectiveness of intensive case management for people with SMI" Research Report, UNSW, 1996, on the Inner-City Sydney Assertive Community Treatment and Care teams: Once placed with a regular roof over their head & practically supported, homeless people with mental disorders trusted the care coordinator and home visiting team to sort out DSP income, support services, and then treatment & care, resulting in less hospitalizations, more stable housing tenure and higher social functioning levels.

2.2.1.2. Much later this strategy later emerged as the internationally recognised evidence base on "Housing First" initiatives. Notably, "Chez Soi", Canada ---the worldwide largest "Housing First" Plus Assertive Outreach teams RCT sponsored by the Mental Health Commission of Canada [Latimer EA et al, *Psychiatric Services J*, Oct 2020, 1;71(10):1020-1030, doi: 10.1176/appi.ps.202000029; Aubry T, Nelson G, Tsemberis S, *Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the At Home-Chez soi Demonstration Project*, *CanJPsychiatry* 2015;60 (11):467-474]

Learning: Helping homeless people into stable addresses (even harder now there is so much competition for rentals) locates them for care, and may be needed before individuals will trust service providers sufficiently to allow their further engagement in treatment and care.

2.2.2. Where possible, provide **unlocked local short-term residential respite facilities** as alternatives to acute locked hospital emergency facilities & involuntary admissions as much as possible. Reluctant service users are more likely to approach such voluntary units than hospital emergency depts and locked inpatient units when in crisis. Whereas in Victoria they are provided by government in every Health area, in NSW these are only provided consistently in larger regional country centres. [e.g. Victorian PARC centres: Brophy L, et al, *A longitudinal study of the impacts of a stay in a Prevention and Recovery Care service in Victoria, Australia*, *ANZJP*, 2024, 58:7;615-626.]

2.2.3. **Itinerant individuals with severe mental disorders.** Some people with long-term psychiatric disorders chafe under perceived infringements or restrictions on their human rights, and will understandably do almost anything to escape what they perceive as the control of clinicians, services or their families over their lives. Having experienced persecutory delusions, they may become both homeless and itinerant, trying to relocate interstate, or even overseas, trying to disappear from the view and influence of both families and authorities. The unofficial diagnosis of "**Itinerant Psychosis**" could be poignantly coined for these individuals. Australia-wide cross-border arrangements to address this need could include consideration of a nationally connected electronic medical record system with alerts to such service usage, one such unit saying that "the buck stops here" and balancing their human rights against their need for treatment and care, rather than allowing them the

doubtful dignity of “dying with your rights on”²⁰. The full Human Rights of these individuals also need to be honoured, preserved or restored as soon as possible, in balance with safety, health and wellbeing considerations [see also footnote 18].

2.2.4. Try hard to not work alone. This is difficult when your team is underfunded and depleted of staffing. It is crucial for community mental health workers to determine with your team when it may be unsafe to do home visits alone and knowing when to ask to be accompanied by a team-member, peer-worker and/or police, e.g. by a **Pacer team** (mobile police response accompanied by a rostered mental health Crisis Team member). The principle we try to convey is that *“it is a skill, not a failure to know when to ask for help”*. While we value independently minded self-starters demonstrating initiative in community mental health teams, we discourage “lone rangers”. Teamwork entails sharing complexity dilemmas and frustrations, how to prevent or grieve losses of service-users via disengagement while still in dire need, or loss of life, and celebrating achievements, by regular team reviews of the needs of all active clientele and their families. Both clinical supervision and pastoral care, including mentorship and communities of practice, need to be provided on consistently for all mental health workers, at least on a team basis.

2.2.5. Work hard at continuity of engagement, as long as needed, and try hard not to get sacked, while trying to honour their human rights, even if that engagement has to be established by regularly home visiting rough sleepers in harbourside caves and car parks under shopping centres, and retrieving plausible but also vulnerable service-users mid-psychosis from international airports, which our teams have had to do, though such hot pursuit must be tempered by the importance of being mindful of rights [see footnote 18].

3 Ensuring guaranteed and sustained adequate funding and workforce

3.1. Specifications:

3.1.1. Sustained and adequate funding for the mental health support outlined in this submission can be obtained with a Levy like that in Victoria (preferably) and/or possibly Queensland. (see also 3.2.2 next page).

3.1.2. Take firm and sustainable steps to protect both the proceeds of this levy plus the current NSW mental health budget and expenditure. See mechanisms in rationale below. Alternatively, explore mechanisms to separate and relocate the NSW Mental Health Service budget under the NSW Mental Health Minister and arm’s length monitoring of expenditure/acquittals via the NSW Mental Health Commission.

3.1.3 There is a pressing need for the **NSW Mental Health Service Commission to have full statutory powers and delegations** (see 4. below) to oversee the integrity of the mental health budget and its expenditure as well as continual analytical assessment of the success of programs and their modification in the light of emerging evidence of new discoveries impacting on the amelioration of mental illness.

20, Treffert D.A., 1973 "Dying with their rights on". Am J Psychiatry 1973 Sep;130(9):1041. PMID: 4727765. DOI: [10.1176/ajp.130.9.1041](https://doi.org/10.1176/ajp.130.9.1041)

3.1.4 **Hold the NDIS to account** by direct negotiations between the Commonwealth & NSW Governments to directly fund **normative social housing** for Mental Health NDIS recipients, and to provide the **support worker/ peer worker component** of Assertive Community Treatment & Support teams (that is 50% of positions in each team)²¹.

3.2. Rationale:

3.2.1. There is a diminishing proportion of the NSW Health budget and expenditure allocated for Mental Health treatment. The mental health proportion of NSW Health Burden is still increasing to more than 15% while the mental health allocated proportion of Health Budget has been heading downwards towards “7-8% at best”²². [NSW Health has supplied unsubstantiated but more favourable figures for the NSW Mental Health Commission Annual Report 2024 at variance with the above, but indicates that the proportion of NSW Health budget has been diminishing from 14% to 11% over the last 5 years]. Over the period 2010-11 to 2020-21, official total health spending in NSW increased by 35.5% but only by 22.4% for mental health specifically. In other words, mental health's official share of total health spending in NSW declined by just under 9.7% over the same period.

3.2.2. Sustained adequate funding for the mental health initiatives outlined in this submission may be achieved by a dedicated Levy as in Victoria with the Mental Health and Wellbeing Surcharge that applies to employers with annual wages exceeding \$10 million. The surcharge is 0.5% of wages above \$10 million and an additional 0.5% on wages over \$100 million. Alternatively, there has been a Queensland Levy which targetted large employers with more than \$10 million in taxable wages. This levy was set at 0.25% for wages above \$10 million and an additional 0.5% for wages over \$100 million, so it has raised less per employer than the Victorian Levy. In Victoria this Levy is expected to raise about \$1 billion in the current financial year²³. An equivalent levy in NSW would raise \$1.3-4 billion annually.

3.2.3. **Take firm and sustainable steps to protect both the proceeds of the NSW MHS levy plus the current NSW mental health budget and expenditure.**

A rational agenda of budgetary reform could flow, as follows:

3.2.3.1. To **ensure protection of the current mental health service budget and the proceeds of the NSW MHS Levy**, the NSW Government will need to revive the operating account for mental health services for the Mental Health Program. This will provide a separate Mental Health financial operating system for budgeting cashflow and auditing. It should be removed from the general financial operating system of the LHD's.

²¹ Gurr R, Rosen A, Fanning P and Salvador Carulla L, Invited Response to Exposure Draft Productivity Inquiry into Mental Health Services, 2021].

²² Harvey S, CE, Chief Scientist, Black Dog Institute, ABC RN 14 April 2025.

https://url.au.m.mimecastprotect.com/s/T_8aCOMKzVTNBLV1ocEuaOs?domain=readnow.isentia.com

²³ <https://www.pitcher.com.au/insights/victorian-state-budget-2023-24-payroll-tax/>

3.2.3.2. The NSW Government should commit to undertaking a **comprehensive independent review and reform** of the **entire governance and funding models for MHS in NSW**, which are not fit for purpose in any respect.

This will include:

- a) an **independent statewide forensic audit of the previous 3 years**, to identify how much of the MH cash allocated to the LHDs is actually being spent annually on front-line clinical services, and identify then what happens to the rest: this may include the diversion, especially at LHD level to non-mh purposes of the proceeds of unfilled mental health clinical positions, depletion of interdisciplinary teams, and involuntary contributions to generic managerial positions. [eg. MH budget contributions to district overhead costs, efficiency savings, recruitment freezes (so resultant savings get redirected to non-mental health purposes) and contributions to shared clinical and non-MH administrative positions. Often these 'contributions' are budgeted for at the start of the financial years and the cash is progressively redirected].
- b) **The NSW Mental Health Services budget, governance, commissioning and operations will be separated from NSW Health and relocated in a Mental Health Executive Directorate (MHED) under the NSW Minister for Mental Health.**
- c) **Remove the discretion of CEO's of LHD's, under their Performance Agreements, to divert MHS budgets for other purposes, as part of their powers to manage overall budgets, and enforce a guarantee that mental health budgets will be ringfenced within LHDs.** The Minister and MHED will be in full control of these block funded budgets and allocations to each LHD MHS, in accordance with NSW MHS policy. Subsequently, full delegations for budget and expenditure will be allocated to the Director of Mental Health Services in each LHD, where mental health operations should be functionally integrated with the LHD's clinical activities.

3.2.3.3. Alternatively, explore other mechanisms to prevent diversion of NSW mental health funds for Non-Mental Health purposes e.g. transfer the mental health service budget, commissioning of regional mhs programs and projects and ensure rigorous monitoring via the NSW Mental Health Commission, which the Government of Western Australia has opted to do since 2010, or via The Primary Health Networks (PHN's), as is presently being done between the PHN's and both full clinical and support services managed by a number of NGO's eg Headspace Youth (hYEPP) Early Intervention in Psychosis Program teams, in most Australian states and territories.

4. Determining that the NSW Mental Health Commission is a statutory authority with its own delegations.

4.1. The NSW Government needs to transform the NSW Mental Health Commission into an arm's-length statutory authority with its own delegations, to act as a system manager/ inspector-general function for NSW Mental Health Services. Without this, any additional funding from a new levy also risks being siphoned off for other projects and programs of the NSW Health Ministry. The core roles of the Commission should include :

4.1.1. to monitor and protect allocated funding from informal diversion, and to ensure that actual base expenditure by NSW Health on mental health services (before any levy for special purposes) is commensurate with the measured extent and growth in the proportion

of NSW health burden due to psychiatric disorders and the public demand for adequate mental health services²⁴.

4.1.2. to encourage and ensure effective leadership, governance and to promote equitable growth and development of these services, in accordance with the growth in population, prevalence of mental disorders, clinical presentations and demand for services.

5. NSW Government should prompt the Commissioning of Cross-Jurisdictional Studies and develop Nationally consistent Conventions and Standards to address variations and lapses within and between jurisdictions:

a) in humane, reciprocal and systematically applied cross-border arrangements, for border-crossings of individuals living with complex disorders while on Mental Health Act orders, and:

b) for an effective and balanced combination of risk assessment, clinical assessment, measurement, personal and technical monitoring methods, by commissioning expert studies (including clinical, legal, academic, lived experience & family expertise), recommendations from Inquiries, in consultation with combined forums of Australian Mental Health Review Tribunals, Offices of Chief Psychiatrists, and Mental Health Commissions in all jurisdictions.

5.1. Establish and implement Nationally (binationally and ultimately Internationally) consistent standards, conventions and/or cross-border reciprocal arrangements to ensure alignment of secure communication systems between jurisdictional mental health services and authorities for purposes of reciprocal confidential clinical and medico-legal information sharing, alerting and cooperation, monitoring, providing continuity of care or returning individuals crossing borders while still on Mental Health Act orders. These arrangements are presently patchy and piecemeal, negotiated between some states and territories but not others, affecting individuals on either or both civil and forensic orders, and are not consistently applied. NSW has established different cross-border agreements with Victoria, South Australia, Queensland & ACT but not as yet with other jurisdictions. Despite some being in place since 2003, they are not well understood, not deployed routinely and are rarely employed to continue to facilitate treatment on a CTO in NSW or in the 'other state'²⁵.

5.2. Establish and implement Nationally (Binationally and ultimately Internationally) consistent approaches to monitoring and judicious balancing of capacity, danger to self and others, and least restrictive safe and effective care, relying on both the current evidence base and expert appraisals, (Ryan C et al ,2010)[see footnote 26]. Violence risk assessment is likely to shift from cross-sectional prediction to ongoing clinical monitoring, using technology such as the analysis of social media and even telemetry reporting, physiological markers of intoxication and abnormal mood states. Extent of intrusion needs to be weighed against effectiveness in decreasing violence. Ethically, “any new methods should not only be assessed by their predictive ability, but also by reliable evidence that

²⁴ See <https://www.croakey.org/mental-health-commissions-could-achieve-so-much-more-and-here-are-some-ways-forward/> <https://url.au.m.mimecastprotect.com/s/kEgxC3QNPBi7pnWOOsg5-qj?domain=croakey.org/>

²⁵ Barnett, M. "Developing National Civil Commitment Laws for the Mentally Ill" UWSLawRw 3; (2012) 16(1) University of Western Sydney Law Review 18

they can actually reduce violence, and that any reduction is not at an unacceptable cost to an already disadvantaged section of society”²⁶.

5.3. A Possible Template for Cultural Safety

We recommend that all these initiatives should be developed in “Two Ways”²⁷ both technically (clinically and legally) and culturally, both with First Nations and Transcultural individuals with severe psychiatric disorders. They should be undertaken in consultation with affected service-users and families, (including First Nations, transcultural, gender- and neuro- diverse representatives), and the spectrum of service providers and agencies involved. They should be undertaken with due care for the safety and security, privacy, human rights, and prevention from shaming, stigma and discrimination of affected individuals and families, without unnecessarily restricting connections between affected individuals, their families and friends, their occupations and life interests.

An important precedent of working “Two Ways” or “Two Worlds” are the existing provisions in the Western Australian and the preamble of the Northern Territories Mental Health Acts. That is, before placing an Aboriginal & Torres Strait Islander person on an involuntary mental health treatment order, an assessment by an Aboriginal Healer or Aboriginal Mental Health Worker/Professional should be sought, to ascertain if there is a more culturally appropriate and equally safe voluntary alternative arrangement. Such Cultural Safety provisions in law are applied unevenly as yet in WA & NT, and are absent from laws in other Australian jurisdictions. They are yet to be established as a national standard in methods of Risk Assessment of Violence and Re-offending, in laws determining imprisoning or otherwise of non-violent /non-predatory Indigenous offenders, and in the interface with Immigration Detention. This type of approach is more likely to contribute to and encourage the meeting of UN Human Rights requirements by allow and then passing inspections of facilities subject to OPCAT²⁸ provisions (eg Asylum Seeker Detention Facilities, Locked Psychiatric Inpatient Units & Forensic/Prison Mental Health Incarceration Facilities). Australia and particularly Queensland and NSW are still in breach of their obligations to comply with allowing and facilitating UN inspections, for blocking such access when UN inspectors had come to Australia for that specific purpose²⁹.

²⁶ Large M, Nielssen O, The limitations and future of violence risk assessment, Perspective, World Psychiatry 16:1: 25-26 - February 2017; Ryan C, Nielssen O, Paton M and Large M, Clinical decisions in psychiatry should not be based on risk assessment, Australasian Psychiatry, 18:5, October 2010, doi: 10.3109/10398562.2010.50781

²⁷ Gayaa Dhuwi Declaration: Gayaa Dhuwi Australia 2015, based partly on the International Wharerata Declaration, 2010).

²⁸ Optional Protocol to the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (OPCAT).

²⁹ Ouliaris C, Gill N, Castan M. Sundram S, OPCAT: How an international treaty regarding torture is relevant to the Australian mental health system, Australian & New Zealand Journal of Psychiatry 1–6, 2024.

Submitted by:

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Dedication

To the families and friends of those who died, and survivors who were injured and traumatized by the Bondi Junction Tragedy of 13 April 24, for their caring and compassion for the distress of all others affected, including first responders, families, bystanders and communities involved, amidst their grieving, including the Cauchi family.

Acknowledging the work being undertaken by:

- a) The Agency for Clinical Innovation (ACI)³⁰ which works with clinicians, consumers and system leaders to design and implement new ways to deliver healthcare in NSW and which is currently and belatedly engaged in a Rapid Redesign process in response to the current NSW mental health system crises.
- b) the NSW Housing and Mental Health Agreement 2022³¹, recognising that housing and mental health are closely related, we urgently need a commitment by NSW Government to a bold long overdue investment in consistent statewide evidence-based service delivery systems to ensure continuity of care.

Acknowledging the highly valued input and support by:

Distinguished Professor Maree Teesson AC, Director of the Matilda Centre, University of Sydney, Director of the NHMRC Centre of Research Excellence in Prevention and Early Intervention in Mental

30 <https://aci.health.nsw.gov.au/>

31 <https://www.health.nsw.gov.au/mentalhealth/Pages/housing-and-mental-health-agreement.aspx>

Illness and Substance Use (PREMISE), Chair of Australia's Mental Health Think Tank and Chair of the Million Minds Mental Health Research Mission Expert Advisory Panel and a Former National Mental Health Commissioner (2018-2021).

Ms. Maria Bisogni, Deputy President, Mental Health Review Tribunal of NSW.

Professor Carolyn Quadrio, former Clinical Director, NSW Forensic/Corrections Mental Health.

Professor Geoff Gallup, AC, Graduate School of Government, University of Sydney.

Professor Emeritus Carol Bower AC, Telethon Institute of Child Health Research, WA.

Professor Helen Killaspy, Former Chair, Rehabilitation Psychiatry, Royal College of Psychiatrists UK.

Dr Paul Fanning, Formerly Director of Rural & Remote MHS Research, Newcastle University, former National Advisor, Mental Health, St Vincents de Paul Association.

Associate Professor Roger Gurr AM, Chair STARTTS (Transcultural Torture & Trauma), Headspace Early Intervention in Psychosis Unit, Director & Consultant Psychiatrist.

Assoc Prof Michael Dudley AM, Adolescent Psychiatry UNSW.

Mr Thomas Brideson, former CEO Gaayaa Dhuwi Australia & former Co-Chair, National Taskforce on MHS Workforce, Commonwealth Department of Health.

Professor Helen Milroy, AM, Professor of Child & Adolescent Psychiatry, University of WA, Chair, Gaayaa Dhuwi Australia.

Mr Douglas Holmes, Project Manager, Supercro (NGO).

Professor Patrick McGorry, AO, Orygen Youth MHS, University of Melbourne, Victoria.

Assoc Prof Peter McGeorge, QSO, (recently deceased), formerly Clinical Director, Program for Community Living initiative (PCLi) & of St Vincents Hospital & Community MHS, Sydney.

Conjoint Professor Jackie Curtis, Executive Director of Mindgardens Neuroscience Network & Translational Research Centre incorporating NEURA, Black Dog Institute, UNSW.

Professor Luis Salvador-Carulla, Professor of Mental Health, Deputy Director of the Health Research Institute, University of Canberra,

Professor Ian Hickie, AO, Co-Director, Health & Policy, Brain & Mind Centre, Univ of Sydney.

Dr Warren Kealy-Bateman, Clinical Director Dubbo and Regions, Western NSW LHD, NSW Health. Immediate past Board member & Chair of Practice, Policy and Partnerships, RANZCP.

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Dr Jacqueline Huber, Senior Staff Specialist, & Head of Emergency Psychiatry, St Vincent's Hospital, Sydney, Chair, Australian Emergency Psychiatry Network,

Dr Neeraj Gill, Professor of Adult Psychiatry, School of Medicine and Dentistry, Griffith University, Snr Consultant Psychiatrist & Clinical Lead MHS, Griffith University-Gold Coast HHS, Qld, Professor, Public Mental Health Policy Unit, University of Canberra, ACT.

Dr Louise Nash, Director of Training in Psychiatry, Brain & Mind Centre, University of Sydney, Clinical Director, Kimberley WA MHS.

Dr Neil Jeyasingham, former Clinical Director, Consultant Adult & Aged Care Psychiatrist, Far West NSW MHS.

Ms Vivienne Miller, Psychiatric Occupational Therapist, Founding Executive Director, The Mental Health Services (TheMHS) Conference & Learning Network of ANZ.

Box 1:

Bondi Junction-An Avoidable Tragedy? A Chronology of Potential System Failures

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[Timeline Sequence, highlighting Probable Discontinuities of Care, combining accounts of Dr Peggy Dwyer, SC, Assisting Coroner, Directions Hearing 12 Nov 24, Opening Statement 28 April 25, Witness Statements, and detailed media reports, News.com.au, SMH, The Guardian, SBS News, ABC News on-line, 9News, 14 April 2024-23 May 2025].

[Note: Some inaccuracies may be due to lack of direct access to the evidence before the Coroner's Inquest, and allowances should be made for opportunities missed due to J.C.'s ability to present rationally, even when deluded and disorganised, at least for interactions of limited duration].

Re Mr Joel Cauchi:

1984: born and brought up in Toowoomba Queensland. Australia

2001: First diagnosed & treated for schizophrenia, aged 17, in his home-town of Toowoomba, Queensland.

2012: Transferred to the care of a private psychiatrist and a GP.

From 2012 until February 2020, he saw a private psychiatrist. Mr JC was on medication from December 2011, namely Clozapine and Abilify, but it was gradually reduced over time until it was stopped entirely in June 2019. By then, at JC's request, he had negotiated with his general practitioner to gradually come off all his anti-psychosis medication. He remained engaged with that private psychiatrist until February 2020.

"From early 2020 to 13 April 2024, there was no particular treatment directed at Mr Cauchi's mental health, and the evidence suggests a deterioration in his mental health over that time." Subsequently he started drifting around Queensland, especially the Gold Coast.

2021: January: commenced application for a gun license. Deemed eligible by GP and Queensland Police [9News, 28 April 2025].

2022 onwards: JC had moved around the Brisbane suburbs of Kangaroo Point and Carina, then back to his family's residence – understood to be in Rockville, near Toowoomba – over the past few years [news.com.au,17 April 2024].

2023 (early): In January, 2023 JC called Toowoomba police, accusing his father of stealing his knives, which he collected. But the court was told that his father told officers that Cauchi was a long-term "schizophrenic", he was no longer medicated and they were worried about his mental state, and the possibility of self-harm, leading his father to confiscate the knives, "for safekeeping". Cauchi called Queensland police a month later, complaining that his father had again "stolen" his knives, prompting police to mediate between them and then enter a "Be On Lookout" (BOLA) flag in their system, by email, [News.com.au, 12 Nov 24], which should have prompted a reply and further check or referral by a Police-Mental Health Liaison Unit. No response nor follow-up from initiating police.

2023: (Later): He left his home state and had drifted over several months to living homeless in inner Sydney, estranged from his caring family except for an occasional brief text message home. He was found by NSW Police living underneath the Maroubra Beach

Pavilion on 21 Dec 23 after a report of concern by the public. He was searched because they found his record of contact with Queensland police over knives, but none were found on him. He may have kept them in a rented self-storage unit nearby.

After some months without hearing from him, his parents, now in their 70's were relieved to receive a short text message "Mum, I just want to show you how beautiful Coogee Beach [is]," along with a video selfie of himself there. "They had no idea they said, that their son, who had suffered with schizophrenia for all of his adult life, was teetering on the edge".[news.com.au, 17 April, 2024].

2024 (Early): "In the months prior to April 2024, and while Mr Cauchi remained homeless with some limited engagement from community charity organisations who were primarily focused on giving food, the evidence..(of)..police regarding Mr Cauchi's mental health suggests that he'd continued to deteriorate" [Dr.P.D.,12.11.24].

2024: 13 April. At a popular upmarket shopping mall in Bondi Junction, Sydney, Australia, a man murdered 6 people, and injured 10, attacking them with a recently professionally sharpened knife, seemingly at random, except that he appeared to selectively choose mainly women as his victims, one who was trying to protect her baby from further injury, then passing the injured baby in her arms to a stranger before this young mother succumbed and died. The perpetrator was then confronted, shot and killed by a lone policewoman. No alarm was sounded inside the centre until a minute after Cauchi had been shot. He was identified as Mr. Joel Cauchi, aged 40. He was well known to Police, especially in Queensland, but had no criminal record.

His family members were distraught and "devastated" but were most understanding about and "had no issue" with the police action in these circumstances [ABC News 14 April 2024].

2024: 16 April, SBS News: **Lack of ensured Continuity of Care.** Professor Anthony Harris, University of Sydney, said some aspects of JC's situation could reflect the lack of resources in the mental health system in general. He said it's possible for schizophrenia to be well managed so people can work and live happy lives. "The fact that we see things like (the Bondi Junction attack) happen, reflects a system which has allowed this gentleman to drop out of regular care and to lose contact with both family, community and a mental health system that should have been able to support him". Harris said the lack of resources meant the focus in the system was on treating the most unwell and responding to crises, rather than on keeping people well. "There are very few other illnesses in our community where the most unwell people are left to fend for themselves in the community. "Mostly, if someone is severely unwell they receive a high level of care. Unfortunately for many people with mental illness, our most severely unwell people are left in disorganised states in the community with mental illness, our most

severely unwell people are left in disorganised states in the community with very few resources. This needs to change."

2024: 18 April. ABC News: **Systemic Failures:** Dr Harry McConnell, of Griffith University, a leading Queensland neuropsychiatrist, stated that there was a potential "missed opportunity" and a "systemic failure" by Queensland authorities to link JC with crucial treatment, considering his mental health history and his interactions with Queensland Police [ABC News on-line, 18 April 2024]. Some further public knifings and cautionary evacuations following threats of knifings in other public facilities ensued (eg in an Adelaide Shopping Mall).

Implications & Conclusions from Chronology:

1, Overall Context:

- *"The community is invested in understanding the events of that day and in finding out if there are lessons to learn from this tragedy that may prevent similar attacks or improve the emergency response to them in a way that saves lives."*
- *"... I pause to note that events like the one at Bondi Junction are extremely rare; many thousands of people in our community live with a mental illness like schizophrenia and they are not a threat to others. The team assisting is conscious of the need to avoid, stigmatising those living with a mental illness. On the other hand, harm caused by a small minority of persons expressing psychosis can occasionally be catastrophic - as it was in this case. And every effort will be made to identify areas to improve the care available to those persons for their sake, for the sake of their families and for the sake of the broader community."*

-Dr P Dwyer, Coronial Inquest, Directions Hearing, 12 Nov 24.

2. Twenty Possible Missed Opportunities and/or System Failures

- a) Premature transfer from Public to Private MHS & GP for ongoing Clinical Management, possibly and commonly under pressure of work, chronic underfunding, depleted staffing, excessive "caseloads", and/or administrative demands to discharge and transfer care whenever possible (to be investigated further).
- b) Private Psychiatrist and GP complying with his request to reduce and then cease psychotropic medications.
- c) Private Psychiatrist & GP losing contact with JC & apparently not alerting public mhs to his continuing needs.
- d) Possible failure to consult family over cessation of medication, and discharge from psychiatric care, or to take family concerns seriously enough while he was still within their reach?
- e) Private sector possibly did not seek a review with the local public mhs for more intensive/assertive continuity of care with social housing and a co-produced recovery plan, before or when he stopped attending his private sector and/or GP.
- f) Possibly lack of consideration or assessment or 2nd opinion for need for involuntary care of some kind, e.g. for an community treatment order.

- g) Queensland Police mediation re JC's father's concerns re potentially dangerous collection of knives, issuing "please follow up" notification or "BOLA" flag to police-mental health liaison unit, by email, but with no reply, no apparent further attempt to ensure a response, and no further monitoring or action taken by police on basis of either. Queensland Police concede at Inquest that this was a missed opportunity.
- h) J.C. was apprehended or came to attention of Queensland police on several other occasions, they were aware of his history of severe mental illness and when questioned at least on one of these occasions, J.C. told them that he was no longer on medication, yet they apparently took no action.
- i) Dr Dwyer related how J.C. had visited a Brisbane GP in January 2021 for a report to get a gun licence. He claimed he was interested in firing a pistol at a local gun range but did not want to purchase a firearm. In that single consultation, the doctor found Cauchi was a "fit and proper" person and recommended that Queensland police grant the licence, While the force sent over a "statement of eligibility", no further steps to get a proper licence were taken by Mr. Cauchi. "That is very, very fortunate," Dr Dwyer understated to the Coroner's Inquest. Why was this application not cross-referenced with his history of severe mental disorder, known to the Queensland Police, and his preoccupation with military weapons & hunting knives? So rather than being approved and declared by the GP and Police eligible to apply for a license, shouldn't his application have resulted in a system alert or mental health re-assessment? Are the relevant Police and Health gun ownership regulations and the advice in the relevant RANZCP Position Statement accurate, adequate and up-to-date?
- j) possible lack of consideration or legal pretext or mechanism for a forensic mental health assessment re risk of harm to others and self, associated with his collection of knives & military paraphernalia & preoccupations.
- k) Possible lack of engagement and involvement of a mental health worker, homeless mental illness team or peer workers or NGO's in engaging Mr JC in either or both Queensland and NSW. e.g. in a 1-1 interview, assertive community home care or a social support day program leading to reconnection with mental health services.
- l) Lack of action by NSW Police when checking on him under the Maroubra Beach Pavillion, once aware of his police history in Queensland, to both suggest and make a referral to a homeless mental illness service, which possibly could have re-engaged him.
- m) Lack of notification of his moving to NSW under any provision of the Cross-Border Agreement between Queensland and NSW, though he was obviously at risk, possibly because he was not on involuntary treatment under the Mental Health Act, he was not being actively tracked, he probably did not actively seek care or disclose full details of his past history.
- n) Unclear extent of formal responsibility to report, and/or possible lack of curiosity of Knife Sharpening operator, to inquire as to the customer's purpose, regarding why a person who may appear to be dishevelled, homeless or otherwise deteriorating in social function, may be seeking to sharpen his collection of large knives just before this tragic incident? Raises question for legislators of how can assault-weapon capable knife sales be monitored, regulated and/or effectively limited?
- o) Possible need to upgrade training and safety equipment of security guards in large shopping malls and the capacity of management to have them patrol in pairs and cover each other when on toilet or meal breaks from video surveillance.

- p) Elimination of delays in alarm systems, back-to-base emergency alerts, emergency responses and provision of back-up by and for police and paramedics.
- q) Enhancing or sometimes having to insist on providing Continuity of Care must be consistent with facilitating the person's Human Rights, not infringing on autonomy and choice unnecessarily, but explicitly in balance with protecting personal, family, communal and public health safety and rights.
- r) It is likely that neither Queensland nor NSW Police ever found cause to examine his phone at all or fully during any of their apprehensions or questionings of him. Dr Dwyer described the 40-year-old's web browsing history before the attack (presumably discovered post-mortem), as "distressing". "Mr Cauchi was preoccupied with weapons, with violence and with mass killing," she told the NSW Coroners Court on 28 April 2025.
- s) not taking his substantial THC/Cannabis habit into account as a continuing precipitant of severe episodes or deepening of a likely longterm ongoing or intermittent condition of severe psychosis.
- t) Inappropriate psychiatric diagnosis by his private psychiatrist of extended first episode or early psychosis, as an operative clinical framework, when there had been ample evidence and corroboration available of:
- a history of ongoing or intermittent active psychosis for many years,
 - with active symptoms likely to have been allayed or successfully minimized by substantial doses of anti-psychosis medications for many of those years, while he still took them,
 - with substance precipitation of episodes or severity, and
 - with a probable active but milder family history in a 1st degree relative
 - and J.C.'s ability to cover over active psychiatric symptoms.

3. Other factors yet to be determined

Insufficient information to determine other factors, eg extent of drug and/or alcohol involvement, planning or collusion with others, motives based on perceived and/or actual harms.

4. Longterm Outcome:

Apart from the lives cut short, the trauma, losses and grief caused to up to 100 members of at least 16 families, including the perpetrator's family, and well over 1000 shoppers, staff, bystanders, and first responders, the disturbing impact on the sense of safety of the Australian community has been considerable. Meanwhile, at least several hundred thousands to more than a million Australian individuals and family members who contend every day with ongoing complex, severe and persistent or recurrent psychiatric disorders with quiet determination, caring and grace as peaceful citizens, have been tarred yet again with the familiar indelible brushstrokes of intense fear, stigma, avoidance and discrimination.

Of these approximately 230,500 of Australian individuals living with severe mental illnesses and their families are currently estimated to have substantially unmet critical needs, [Productivity Commission Report, 2019], Unmet Needs for Severe Mental Illness = 154,000, now exceeded by a further 76,000, so total estimate is 230,000. [Commonwealth Health & Disability Report on Unmet Needs for Psychosocial Supports

to Health Ministers & Statement of Australian Health Ministers, 16 August 2024, + Weekend Australian, Natasha Robinson, Health Editor, 17-18 Aug 24, p1,10]. NSW proportion of this estimate = 80,000+. At least a similar number can be expected to have vastly deficient or absent clinical engagement with needed specialized acute, intermittent and/or ongoing mental health care.

20+% of Homeless people have a complex and severe psychiatric disorder. NSW Department of Community Justice incomplete NSW Street Count = 2100 in Mar 2024, increased by 26% since 2023, and 2200 over 23 days in Feb 2025 and 415 towns and suburbs, a further increase of 8%. It does not include Unstable & Precarious accommodation (eg. boats, shacks, sheds, vehicles, squatting, couch surfing, undetected itinerant) and is therefore a considerable underestimate.

So, for example, if uncounted instability of housing is up to an additional 3x+ of NSW Street Sleeping Count, NSW has an estimated range of 440-1720 individuals who contend with Severe & Complex Mental Disorder in NSW plus are homeless or in unstable housing and/or itinerant. This number appears to be growing rapidly in the context of the cost-of-living and housing crises in NSW and increasing depletion and disorganisation of NSW Mental Health Services.

Box 2:

Dealing with Complex Mental Health Disorders: A Quintuple Whammy.

Dealing with Complex Mental Health Disorders entails applying a multi-modal in-person approach, squarely addressing ALL the 5 key components of Complex & Severe Psychiatric Illnesses and Disability (Rosen, Gill, Salvador-Carulla, 2020 (see footnote 9) which are:

- 1.** a complex, severe +/- long-term psychiatric disorder e.g. schizophrenia +/- a severe mood disorder +/- an enduring severe personality disorder, +/- marked functional limitations, including poor self-care and disorganisation.
- 2.** co-occurring Drug & Alcohol disorders.
- 3.** co-occurring Physical disorders &/or cognitive disabilities such as intellectual disability, brain damage, foetal alcohol syndrome, with vulnerability to grooming and exploitation, anger management problems etc.
- 4.** living an isolated, marginalized, alienated &/or stigmatized & socially excluded existence: e.g. young people, Indigenous, remote & alienated from mainstream society, long-term psychiatric disability, incarcerated, involvement with police and corrections system, refugees or asylum seekers.
- 5.** multiple deprivations/ social determinants of illness, including living itinerant lives with unstable housing & income: homelessness & poverty; unemployment; & lack of regular access to social support, health and social services.

