WITNESS STATEMENT OF DR AINSLIE SENZ

I, Ainslie Lynea Senz, Director and Staff Specialist (Emergency Physician) at Footscray Hospital, of Gordon St, Footscray, Victoria, say as follows:

1 I am authorised by Western Health to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background

Please outline your relevant background including qualifications, experience and provide a copy of your current CV.

3 I am an emergency physician. My qualifications are:

(a) Bachelor of Medicine/Bachelor of Surgery – University of Queensland, Brisbane, 2002;

(b) Graduate Diploma in Nutrition and Dietetics – Queensland University of Technology, Brisbane, 1996; and

(c) Bachelor of Biomedical Science – Griffith University, Brisbane, 1994.

4 I have the following registration and memberships:

(a) Fellow, Australasian College of Emergency Medicine;

(b) Specialist Registration, Australian Health Practitioners Registration Agency; and

(c) Professional Indemnity, MDA National.

5 I was previously registered with General Medical Council, UK in 2005 and Medical Board of Northern Territory in 2008.

6 Attached to this statement and marked 'ALS-1 is a copy of my current Curriculum Vitae.

Please describe your current role and your responsibilities, specifically your role as Director of the Department of Emergency Medicine at Footscray Hospital, Western Health.

7 I am the director of the Department of Emergency Medicine **(Footscray ED)** at Footscray Hospital.

8 I am also an emergency physician, and in that role have experience dealing directly with patients. I have worked in an alcohol and drug role, and now hold the portfolio of occupational violence in the Emergency Department at Western Health. This portfolio has a strong connection with mental health.

Please describe the chief functions of the Department of Emergency Medicine at Footscray Hospital (the Footscray ED) and the population that it services.

9 The Footscray ED comprises 25 cubicles and an adjacent 12 bed Emergency Observation Unit. In addition to these areas there are rooms for the isolation of infectious diseases, minor procedures and a fast-track with 3 chairs.

10 Mental health services are provided at the Footscray ED through Werribee-Mercy. Mental health staff report to Werribee-Mercy. There is no autonomous mental health service in the hospital. The mental health staff at Sunshine Hospital report to North-West Mental Health. The effect is that mental health staff at two related and closely located hospitals are reporting through two different health systems.

11 Until 2017, there were no formal communication structures in place between the health services. During 2017 a liaison role was developed – the formal title for that role was Service Development & Operations Manager – Mental Health. The objective of this role was to provide liaison and dialogue between Western Health and the mental health services (Werribee-Mercy and North-West Mental Health). The person in that role was charged with opening and maintaining lines of communication between the health services and addressing system issues, particularly those around access. Access is key because it concerns assessment of patients and getting patients to the destination they need to be in in a timely manner.

12 There were limitations on what the liaison role could achieve and the position has been vacant for several months. However, having someone in the role does make a difference.

13 By way of introduction, in the mental health context, Footscray ED is staffed by allied health staff (including psychologists) and by Emergency Mental Health **(EMH)** staff employed by Werribee-Mercy. One person per shift is responsible for acute mental health assessment in the emergency

14 In my view, Western Health needs to own its own mental health service. This would bring with it an accountability for performance. One of the challenges I face in my role is accountability across the interface between Footscray ED and mental health services. The management of Footscray ED and the mental health services are supposed to meet monthly. This was successful whilst someone held the liaison role, but whilst vacant and without direct accountability, it is difficult to facilitate attendance with any consistency. The EMH staff working within Footscray ED work reasonably well alongside us, but if

there are any issues, this needs to be escalated to their off-site manager rather than directly managed. Interaction has been improved recently through the allocation of desk space at Footscray ED, but unfortunately this position has also been vacant recently. Staff retention in management positions appears to be a huge issue in the mental health space.

15 There has been an increase in presentations to the Footscray ED in general which has impacted access to emergency services. As well as naturally increased demand, society and the community have changed the purpose for which they use emergency departments in general and the community uses emergency departments for non-urgent issues. These changes have occurred in the context of changes to health awareness, changed access to GPs and other services, health literacy and urgency. There is an immediacy in society which has moved into the health system – we expect to have everything available and done now. Footscray ED offers a one stop shop whereas access to treatment through a GP requires an appointment, referrals and more appointments. People factor this in when they choose to use the Footscray ED.

16 We see many consumers presenting with drug and alcohol issues, often co-existing with mental health issues. The term 'dual diagnosis' is used in this context. Dual diagnosis describes a person experiencing both mental health issues and drug and/or alcohol misuse. I expect the demand for consumers with drug and alcohol issues to increase since there is an upwards trend in general in the community. Whilst alcohol is the most commonly abused drug, "Ice" is a particular problem with mental health as its harmful effects are more immediate and it has a significant relationship with psychosis. Many mental health patients self-medicate with drugs and alcohol.

17 We also see young people in need of mental health care. This care is provided through Orygen for patients between the ages of 15 and 24. These young people usually have significant social disadvantage and have experienced significant trauma, both psychologically and physically, in childhood. They need slightly different services to adults. The opportunity to make a difference when treating these young people is very high with the potential to change their trajectory and make a genuine difference to their lives.

Briefly, how is the Footscray ED funded?

18 In simple terms, Footscray ED is allocated a pool of funds based on current activity and projections. The funding is not based on the complexity of patient needs which is a real issue in mental health. The funding model will consider how patients present in the Footscray ED, in particular those who arrive by ambulance, and admission rates.

19 In addition to regular funding, we receive temporary grants from the Department of Health and Human Services **(DHHS)** for certain items. Recent examples are to improve offload of ambulances and also improve winter performance. Winter of 2017 was severe with poor performance in responding to the increase in patient numbers. The funding was provided to enable us to implement measures to improve future performance.

Running an Footscray ED

Presentations to Footscray ED:

(a) How many patients present at the Footscray ED annually, and what proportion of them present with mental health related conditions?

20 Approximately 40,000 patients present to Footscray ED each year. It is very difficult to say how many present with mental health related conditions because data searches rely on the final diagnosis, which might be different to the condition described at presentation. For example, if someone presents with lacerations to their wrist, the diagnosis may be entered as laceration, and the self-harm component may not be captured in the data search.

21 There is also a real issue around how you define mental health related conditions and how you capture the data in Footscray ED. This means that numbers are not always accurate. Amongst other things, there are different definitions used for mental health presentations.

22 My best estimate is that the proportion of patients presenting with mental health related conditions is 5% of the total, but it could be higher.

23 Attached to this statement and marked 'ALS-2 is a copy of a document providing Data Collection information, data around Mental Health Presentations and data around Mental Health Waiting Times compared with all Footscray ED patients.

(b) Generally speaking, with what kinds of mental health related conditions and in what kinds of circumstances do patients present at the Footscray ED?

24 We see patients presenting with the full range of mental health conditions at Footscray ED and within a broad range of severity, including:

(a) Exacerbations of chronic mental health conditions, commonly due to alcohol/drug use and non-compliance with treatment.

(b) Self-harm, including suicidal ideation. These range from simple lacerations to life-threatening overdoses and injuries, and a high proportion have underlying personality disorders or depression.

(c) Acute mental health issues due to drugs (usually psychosis) and alcohol (usually depressive states).

(d) Chronic conditions, such as anxiety and depression, schizophrenia, bipolar disorder and personality disorders, complicating other health parameters and illness.

(e) Social or situational crises, as the primary problem or the trigger for above.

25 Some of these cohorts, in particular the patients with personality disorders, exhibit very challenging behaviours, which can include verbal and physical abuse. These patients can be difficult to manage for staff, and cause distress for other patients and visitors. Unfortunately, some are also high users of the ED service, and some may require plans to guide management when they present.

26 Footscray ED is not the best place for people with acute or chronic mental health conditions. The department is old, small and confined and all patients are required to be managed in a highly visible and stimulating environment. Currently there are no behavioural assessment rooms or low stimulus rooms, although the former is planned for a build starting next month through a DHHS grant.

27 Patients presenting with acute mental health conditions in the context of alcohol and drugs are a very difficult group to manage. Mental health assessments are not valid if the patient is under the influence of alcohol/drugs, and so assessment must be delayed until the patient is "sober". Unfortunately, the definition of "sober" is variable, and the delay in assessment also means delays in decisions, plans and treatments. So the patient, and the ED, are just waiting. Sometimes, and mainly with alcohol, the condition will improve as the drugs wear off, however in my experience, most other patients do not make a full recovery within a few hours. So the wait can be unproductive, which frustrates both ED and the patient, and can lead to escalating behaviours.

(c) What proportion of patients presenting with mental health-related conditions have been sent or referred by a medical practitioner or a mental health-related service?

28 Most referrals from a mental health service will be for patients who have breached the conditions of, or been placed on, an involuntary treatment order. In other words, they are being referred for admission because they are not safe in the community. There are very few referred by GPs.

At Footscray ED, how are people presenting with mental health problems triaged?

29 Patients are triaged according to risk:

(a) A high risk patient is someone who has seriously self-harmed or who is acutely psychotic. Due to demand and resources, mental health staff will see medium to high risk patients.

(b) Low risk patients are not suicidal and are not self-harming, but might be suffering a situational crisis and are struggling with the question of where to go for help. Low risk patients are not seen by mental health staff. Low risk patients are usually referred back to the community, with a potential risk if not assisted.

(c) Moderate risk patients fall between high and low risk – they include, for example, a patient suffering from chronic schizophrenia who has failed to take their medication but is not acutely psychotic and has no features of harming self or others.

30 When someone presents to triage with no evident harm, that person provides an explanation to the triage nurse about why they are there. The triage nurse will use the standard category triage system to work out how urgent it is to see the patient:

(a) Rating 1: immediately life-threatening conditions: critical injury or cardiac arrest;

(b) Rating 2: imminently life-threatening conditions: critical illness, very severe pain, have serious chest pains, difficulty in breathing or severe fractures;

(c) Rating 3: potentially life-threatening conditions: severe illness, bleeding heavily from cuts, have major fractures, dehydrated;

(d) Rating 4: potentially serious conditions: less severe symptoms or injuries, such as foreign body in the eye, sprained ankle, migraine or ear ache; and

(e) Rating 5: less urgent conditions: minor illnesses or symptoms, rashes, minor aches and pains.

31 This triage system is supplemented by a mental health triage, which ranks risk of danger to self or others, from immediate risk to no risk, and allocates a supervision requirement. The mental health triage tool is available at: https://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-mh.

32 The triage nurse will apply both the emergency triage system and the mental health triage tool when the patient first presents. The assessment centres on urgency, not on severity.

33 Despite clear risk assessment at triage, referral to mental health staff is not part of triage process and most patients need to be seen by a doctor before referral for a mental health assessment. However, for many patients it is obvious on arrival that they need a mental health assessment, and whilst review by a doctor is required, it is not necessarily required first. The two processes can happen in parallel, or in reverse, depending on the

presentation. Patients presenting with lacerations for example, can have a mental health assessment made before or after the laceration is treated.

34 The hesitancy to see patients proactively is based on managing a finite resource and ensuring there is no other coexisting issue which may impair the assessment or require ongoing management in hospital for a non-mental-health reason. This is commonly called 'medically clearance'. There is no clear definition, but in practice it means that the mental health assessment is delayed until there is nothing ongoing which might distract from or affect the assessment. For example, if someone is intoxicated, then they are unable to be assessed. However, patients can require ongoing treatment without impairing their ability to be assessed. For example, a patient receiving treatment for a paracetamol overdose is still able to be assessed.

35 There are complexities around treating mental health patients. In some cases, where the patient presents with intoxication or drug abuse, an early mental health assessment is either inappropriate or pointless. In these cases, a delay in the assessment is appropriate. There are, however, other cases where early mental health assessment would be useful. An example of this is where the patient presents with an overdose of paracetamol. The treatment for this overdose is a 24 hour infusion. The patient is not strictly 'medically cleared' until after the infusion, however they are sitting in bed during the treatment and could undergo a mental health assessment during that time.

36 Another complexity is that if a patient requires admission to hospital for a non-mental-health issue, for example a serious laceration requiring surgery, the responsibility of the mental health assessment falls to another team of staff in the hospital, and providing an assessment in ED is not seen to be an appropriate use of the resource. Unfortunately, this other team provides an in-hours service only, meaning that the initial mental health assessment can be delayed.

37 As a result, my role is first to sort out the initial medical assessment and treatment, and then request an assessment by the mental health workers. This is part of the difference of not owning our own mental health service. For other specialities, I am empowered to make the decision about admission, whereas for mental health it is a request for assessment and they decide on admission.

38 As doctors, we do what we can to help patients presenting with mental health conditions. We can refer them to a social worker or provide them with a card for a 24 hour helpline. There is a care-coordinator in the Footscray ED between 7 am and 9 pm each day (but not at night). Care-coordinators are multi-disciplinary so that social work services can be provided by anyone in the team. During the night doctors and nurses provide information about helplines.

What are the average wait times for people presenting with mental health problems between triage and being seen by a clinician? If there are measures for wait times that are more informative than "averages", please also discuss those.

39 The Footscray ED is assessed on the National Emergency Access Target **(NEAT)** compliance rate. This is the proportion of patients admitted or discharged from the Footscray ED within 4 hours of presentation. The key element against which Footscray ED performance is assessed is timeliness.

40 Our current target for mental health patients is 8 hours, whereas the target for all other patients is 4 hours. A breach occurs at 24 hours, which commences on arrival. 24 hours is too long for any patient to wait in an ED, but unfortunately it is not uncommon for mental health patients to wait longer than 24 hours for a mental health bed. Our longest stay is 5 days, which was totally unacceptable to everyone involved but it happened.

41 There was an earlier practice of transferring patients to our ED short stay ward while they were waiting for a bed. This made their bed in ED available, and provided a nicer ward environment for the wait. It also had the additional effect of stopping the clock and preventing breaches. This created problems because we utilise each short stay beds for 2-3 patients a day. Furthermore, many mental health patients requiring admission had behaviours which made it unsafe for them and other patients to be in the less visible environment. A decision was made not to continue the practice.

42 In my view, the maximum length of stay in ED for all patients, both medical and mental health, should be 12 hours not 24 hours, although even 12 hours poses challenges for care. In 12 hours, patients have been 'handed over' twice as shifts end. As a consequence, knowledge and continuity are lost.

Once a patient has been triaged what are the pathways for treatment thereafter (e.g. admission, discharge, referral to another service)?

43 Some patients self-present at Footscray ED, but most arrive by ambulance or with the police. Those who self-present are usually less unwell. Those who present by ambulance or with the police are more likely to be very unwell and can have significant behaviours of concern.

44 If the police bring a patient to the Footscray ED against their will, the police will usually have relied on s 351 of the *Mental Health Act 2014* (Vic). Not all patients presented under s 351 will be admitted or have a continuation of assessment order. There are largely three options for us:

(a) There are serious mental health concerns AND the patient does not have capacity to make their own decisions, the patient can be admitted involuntarily

under a temporary assessment order. This is not common, as it does require meeting the criteria of lack of capacity.

(b) There are serious mental health concerns AND the patient has capacity to make their own decisions and is agreeable to assessment, the patient can be admitted voluntarily for further assessment.

(c) There are no serious mental health concerns AND the patient has capacity, the patient can be discharged. For some patients the situation leading to the police attendance will resolve.

45 As above, there are some patients who are brought in by the police who will stay voluntarily for an assessment. Often these patients have presented because of a suicidal attempt and they see the opportunity to get help. Occasionally the patient may be agreeable to stay voluntarily, but we would be concerned if they changed their mind and left. Technically they cannot be made involuntary as they are agreeing to stay voluntarily, but it is a grey zone, managed on a case-by-case basis depending on how impulsive the patient might be. In some circumstances I will say to a patient that if they choose to go and I have a sufficient level of concern about their mental health and associated risks, I can exercise my authority to make them stay or have them returned if they abscond.

46 Patients occasionally abscond and require police to bring them back. Staff are not permitted to go after a patient to bring them back to hospital due to concerns for staff safety. This used to be common practice, however has changed recently influenced by occupational health and safety legislation and hospital policy.

47 Patients presenting at Footscray ED can be referred to community services on discharge, usually mental health case workers. I am not an expert in this area, but can make the following comments:

(a) Chronic mental health patients may have case workers assigned to them to help them stay well.

(b) The Crisis Assessment and Treatment Team **(CATT)** works in the community to try to help people manage crises in the community – CATT can refer patients back to the Footscray ED

(c) The Police, Ambulance and Clinical Early Response team **(PACER)** respond to acute crises.

48 There are criteria which a patient must meet in order to be eligible for the support of a community case worker. Many people with chronic mental health conditions do not meet the criteria. There are many other people who never seek community help and are not assessed at all. These people, including many suffering from chronic depression and

anxiety, are still managed by their GP. They are under-represented in those supported by case workers.

49 One of the roles of PACER is to divert patients around the Footscray ED to an inpatient unit, but where there are no inpatient beds available, the patient is diverted back to the Footscray ED. There are some differences between Footscray Hospital and Sunshine Hospital with management of patients under the care of PACER. Sunshine Hospital has acute psychiatric beds on site, under the management of North-West Mental Health. The Footscray campus has acute psychiatric beds for youth only, managed by Orygen.

50 Access to a psychiatric bed through the Footscray ED is through the mental health staff and considers an assessment of risk. For example, patients who are unwell with acute psychosis, high-risk suicidality, and severe depression, will require a bed. The mental health staff in the Footscray ED will review the patient and then talk to their 'bed managers' about securing a bed. The bed managers are part of Werribee-Mercy Health and are located offsite.

51 For patients other than those presenting with mental health issues (meaning surgical or medical patients), I can make the decision that the patient needs a bed. I do this in my role as treating doctor and Western Health policy gives the senior ED doctor the authority to make the decision about admission. If the inpatient team disagrees with the decision to admit, they must personally assess the patient and organise the ongoing plan. Once my decision is made, the bed manager at the hospital sees my decision on the computer system and finds a bed. It is normal that there will be a wait for a bed, but the bed manager is regularly in ED updating the situation. During the waiting period, inpatient doctors will see the patient and start treatment. If ongoing care is required, they provide this. I am required to be responsible for care of the patient who is physically in the ED, but after referral, I do this in conjunction with the inpatient teams,

52 The situation for mental health patients is quite different for two reasons. Firstly, the beds are managed offsite and I do not have authority to make a decision to admit a patient even if it is obvious. I also do not have any dialogue with the bed manager for the mental health service and it is all coordinated through the mental health staff. Secondly, unlike other specialities, patients awaiting a mental health admission are not reviewed by psychiatric medical staff whilst they wait in the Footscray ED. Up until recently, there has been no dedicated psychiatry cover to ED. A new part-time role was created, however has been variably filled since commencement, and the predominant responsibilities are to a ward service. Even now, reviews will only occur if triggered by legislative requirement to review the temporary assessment order within 24 hours.

53 The current system at Footscray means that most mental health patients (except those who are at the most severe end) are kept in a 'holding pattern' – there is nothing

therapeutic about the Footscray ED for mental health patients. These patients do not improve in the Footscray ED, and potentially get worse. They simply wait until a bed becomes available. There is no counselling or psychiatric intervention.

54 There is also no clinical oversight similar to what is provided to medical and surgical patients. The only treatment provided is medications, prescribed by ED staff. ED staff are tasked with providing all the care, in many cases in very difficult circumstances, without assistance, for many, many hours. On occasion, and when we have been having particularly complex patient, I have tried to speak directly to the psychiatrist, but this is uncommon and not well received. Part of this is because the psychiatrist has many other responsibilities, and ED is only a small component of what is a part-time role. The fact this role has been variably filled over recent times makes it even harder to generate consistent practices around this.

55 There are also limited options when these patients deteriorate in the Footscray ED. Again, this is different to medical and surgical patients who have been seen by an inpatient doctor and are receiving treatment. The most common deterioration in this group is around behaviours, usually related to long-waits. ED staff are trained to de-escalate and manage behavioural crises, but unlike any other deteriorating patient, we do so without psychiatric input. If necessary, and especially when the patient is involuntary and/or a risk to themselves of others, we may be required to restrain the patient, either mechanically or chemically or both. This decision is not made lightly. If the patient is a voluntary patient, we will let them go.

56 It is not appropriate that there is little assistance provided by the psychiatry service in the ongoing management of patients in the ED, especially when we are being required to restrain patients, appropriately, but against their will. All that happens in this case is that the psychiatrist is notified, as this is a requirement by law.

For the purposes of managing people who present with mental health related conditions, how does Footscray ED connect with other parts of the mental health system?

57 All connections are via the Emergency Mental Health Staff and the Service Planning and Operations Manager role, which is currently vacant.

58 There are also monthly meetings, which are variably attended.

What does discharge planning involve?

59 Discharge planning for patients who present to Footscray ED for mental health conditions is complex. Some may be referred to a case worker or other community service. Others are given the phone number for services. If the patient has social issues, for example, is homeless, we provide assistance through social workers. If the patient has drug and

alcohol issues, we have someone in the Footscray ED with expertise in these issues who helps refer the patient to a specialist service. I do not know what happens to patients who are assessed in the Footscray ED but are not admitted. We do not track their path through the mental health service outside of the hospital, but issues of homelessness, drug and alcohol use and chronic illness mean that many may not follow through with discharge plans.

What options are available to the discharge staff member if the patient is homeless?

60 Where there is a real need, we keep patients suffering homelessness in the Footscray ED overnight; we do not discharge them. People need to be safe to leave, and have a place to go to, preferably with someone, to be discharged home. People who don't meet these criteria will stay overnight until services can be provided or the situation changes. Intoxication is an example of a situation which would change.

What are the challenges and complexities of triaging and treating patients who present to Footscray EDs with mental health related conditions, in relation to:

(a) The adequacy of resources:

61 Access to acute mental health beds is poor. This due to demand, capacity and outflow (or discharge). My role does not include addressing these issues, but it does appear that there is a capacity issue, and I am aware that even when capacity is being created, there are difficulties staffing the increased capacity. The delays to a mental health bed leads to longer stays in ED. This reduces the space available in ED to see new patients. This is a problem because people constantly present to ED. If we don't have space to see them, then we can't do our job in a timely fashion. This impacts on the parameters by which we are measured and the quality and timeliness of care that we can provide to other patients.

62 Patients with mental health presentations generally wait longer to be seen in the Footscray ED unless they are acute and need immediate attention. The reason for this is multi-factorial and includes stigma related to mental health, confidence of junior medical staff, and perceived likelihood of making a difference to these patients. In addition, frequent presenters, especially those with a management plan, require a senior doctor. There are fewer senior doctors, and so this creates delays.

63 All patients can be required to wait, however patients unwell with acute mental health issues are less likely to understand what is happening and why there is a wait. Certain mental health conditions, for example, paranoia, may worsen the situation, and some patients have a reduced capacity to moderate feelings. As a result, patients can become distressed and can be unpredictable, and even angry and violent.

64 A comparison of wait time for medical and surgical patients and mental health patients is revealing. However, mental health data from Footscray ED is influenced by what the patient has said at triage.

65 Once seen, it is not uncommon to find what appeared to be a simple problem on arrival becomes more complex. This contributes to reluctance by junior medical staff, and longer times to find solutions.

(b) The suitability of the physical environment;

66 Physical environment is important in mental health services. Footscray EDs are designed for immediate and short-term care – they are not designed for ongoing care. The needs of an environment which is conducive to mental health are not suitable for a high-turnover and dynamic workplace such as Footscray ED. Emergency Departments are designed to facilitate patient flow. High patient flow is very busy and stimulating, and is often inconsistent with the needs of patients with mental health issues.

67 Whether we should create a suitable environment is a good question. I would prefer to create community services that support outpatient care, and reduce the number of patients requiring an acute ED presentation. I would also like to create a health system that minimises the time patients spend in the ED. That would be better than accommodating the various needs of each different patient group whilst they spend too long in the ED.

68 Western Health is currently in the process of building a crisis hub at Sunshine Hospital. The crisis hub will feature short-stay beds where patients can stay overnight and will be utilised to provide short-term management for patients experiencing serious mental health or addiction issues who would have previously presented to the ED at Sunshine Hospital

69 Many people who present at the Footscray ED would be better served by community based, ambulatory care. This is the idea behind the crisis hub model, but another model would be to provide more community services not located at an ED. The co-location with ED is ideal for early follow-up of patients after acute presentation, but is also likely to increase ED's role in the management of chronic mental health problems.

If, in your experience, the demands on Footscray ED to triage and treat people presenting with mental health related conditions is not met by adequate resources:

(a) What unmet needs are the most critical?

70 In my opinion, the following needs are not being met:

(a) Needs of the low-acuity patients. They are not supported by community services and are not supported by the services we provide. For me, an ED presentation needs to add value to a patient's situation. That could be a diagnosis, but also reassurance, education, and symptom relief. I do not feel we are adding value for low acuity patients, and it is unrealistic for current ED staff to provide what are typically time and resource intensive interventions.

(b) Patients requiring admission are not being managed well in the ED. As described, they are in a holding pattern awaiting a bed for much longer than any other group of patients.

(c) Currently Western Health is not receiving an adequate service from the mental health services assigned to them.

(d) Community needs are not being met. If they were, patients requiring non-urgent care could have that provided in the community and not need ED. And patients requiring inpatient care could access a bed in a timely manner. And this does not include those patients who never seek care but probably should.

(b) What are the causes of unmet need?

71 The causes of these needs are:

(a) Lack of resources in the community to prevent need for ED presentation; and

(b) Lack of resources in ED to provide assessment of low-acuity patients.

(c) Lack of psychiatric engagement in ED, in part due to the lack of ownership of the mental health service

(d) Poor access to mental health beds - capacity and turnover issue

(e) Lack of ownership of the mental health service

In the framework for evaluating the performance of the Footscray ED:

(a) Do the evaluation methods reflect the complexity of mental health care?

72 The evaluation framework for Footscray EDs is all about time. We do not like this because it reduces the evaluation to an efficiency quotient rather than a quality quotient. I accept that there is a quality piece within efficiency; if you take too long to do something, you are probably not providing quality care, but this does not consider complexity.

73 A challenge for me is that I am not accountable for mental health patients, but I am still held to metrics for waiting periods in the Footscray ED. NEAT requires that a patient must be moved to wherever their destination should be within four hours (with a target of

meeting that metric for 81% of patients). The Footscray ED mental health team is also fairly powerless – they can ring and ask if a bed is ready, but have little power to create the bed. In some circumstances, we predict there will be a 24-hour breach. A 24-hour breach in medical or surgical care will attract a detailed investigation; breaches in mental health care are not evaluated with the same rigour, and there is an understanding that they will occur. We maintain records of breaches of the 24-hour rule. Unfortunately, patients can also wait several days. I am aware of a mental health patient waiting five days in our ED.

(b) How could they be improved?

74 It is difficult to identify what evaluation method would best suit the complexity of mental health care. The evaluation should take into account the number of people who receive a mental health assessment and the timeliness of that and the number of people who achieve an inpatient bed. Other measures might include:

(a) Re-presentation rates (although I am not aware of this data being collated);

(b) Footscray ED diversion rates (through the CATT and PACER); and

(c) Admission avoidance.

75 We are highly measured now, so I would not want to see additional measures imposed on mental health staff. One of the difficulties is that while we are measured on all sorts of things, the problem is at a systems level.

76 If the system is all working perfectly, setting targets is sensible and appropriate. In fact, the 4-hour target works reasonably well for most patients when the whole system, including access to beds, is working.

77 Targets or key performance indicators should include the timeliness of the medical and the psychiatric assessment for all consumers. This would require engagement between the Footscray ED and the psychiatric service.

Mental health system and reform

Are there ways in which you think the demand on Footscray EDs to triage and treat patients presenting with mental health related problems is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

78 All presentations to Footscray ED are increasing at a rate of ~ 5%. This is above population growth. As presentations grow, pressure on the system grows. The hospital is constantly working to optimise the system to accommodate the increased demand, but the valve is always the ED, with impact on waiting times and efficiency.

79 Drug and alcohol use in the population is growing. This impacts on acute and chronic mental health conditions and may lead to increasing proportion of mental health presentations.

80 Reliance on ED as a provider of care for the community is increasing. This is multi-factorial and due to public expectations and available community resources.

81 Otherwise at a big-picture level:

(a) Rebuild of Sunshine ED will increase ED capacity and provide a Behavioural Assessment Unit and Crisis Hub. This may change presentation trends.

(b) Build of new Footscray Hospital (2025) will increase ED capacity and provide a Crisis Hub.

What key changes and reforms do you consider would improve the ability of the mental health system to respond to people who are currently presenting at Footscray EDs with mental health related conditions:

(a) in relation to the resources and facilities available to hospital Footscray EDs;

82 Western Health needs to have its own mental health service with its own mental health beds, rather than outsource to different mental health services with beds across multiple different sites. This would improve oversight, accountability, and systems.

83 Additional capacity with the ED to manage mental health presentations is also required. These patients pose different challenges and this complexity needs to be reflected in space and resources, including staff. Crisis Hubs and Behavioural Assessment Units are two strategies to assist with this. The New Footscray Hospital ED will have an area with a combined function.

84 Additional Mental Health bed capacity in required, whoever runs them. It is clear there are not enough inpatient beds in the system.

(b) in relation to services outside of hospital Footscray EDs, with which Footscray EDs connect or should connect?

85 We need improved resources for patients to be managed in the community, reducing need for ED presentations.

86 If Western Health had its own mental health service and its own mental health beds, there would be less reliance on external providers. Having said that, even in this situation, there should still be strong links with CATT and PACER and other community services.

87 Again, additional Mental Health bed capacity is needed, whoever runs them.

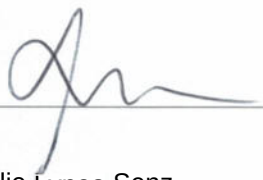
Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

88 The Royal Commission can raise awareness about increasing impact of mental health issues in the community, and make a big step to breaking down barriers. Employers, in particular, need to understand mental health, and insurers need to relax restrictions imposed on mental health conditions which, unlike any other medical issue, are often enforced without an assessment of severity. Proactive care should be commended; there should be no stigma attached and no adverse consequences. Whilst this will not change Footscray ED, a recommendation around stigma and prohibiting discrimination would be very powerful for resources in the community.

89 Most of the possible solutions for reform are significantly resource intensive and have ramifications for other areas. In the Footscray ED environment, prioritising mental health patients, for example by creating a specialised mental health area, has potential, but mandating without appropriate infrastructure and resources could impact on the service provided for other patient groups. It can also continue to falsely promote Emergency Departments and hospitals as the solution.

90 From my perspective, length of stay in emergency departments should be a high priority for mental health patients. These patients should have shorter, not longer, targets than other patients when considering how unsuitable and non-therapeutic the ED environment is. Changing the target would provide a clear mandate to improve and prioritise care of this patient group, but again needs the resources to achieve it. Otherwise we could have the same situation as now, where patients stay more than 24 hours even though they are not supposed to.

91 There is also a real need to provide more services in the community to maintain health and reduce the need for both urgent and non-urgent presentations to the emergency departments.

sign here ▶ 

print name Ainslie Lynea Senz

date 9.07.19

Royal Commission into Victoria's Mental Health System

ATTACHMENT ALS-1

This is the attachment marked 'ALS-1' referred to in the witness statement of Ainslie Lynea Senz dated 9 July 2019.

~CURRICULUM VITAE~

Dr Ainslie Lynea Senz
B. Biomed.Sc.; Grad Dip Nutr Diet; MBBS; FACEM

Current Position (May 2017 to current)

Director and Staff Specialist (Emergency Physician)
Department of Emergency Medicine, Footscray Hospital, Western Health

Director

- Responsible for overall management of the department encompassing accountability in the areas of:
  - Administration, including rostering, recruitment, finance, staff safety and complaints management;
  - Performance, relating to both national emergency access targets (NEAT) and including but not limited to other reportable key performance indicators such as time-to-treat, did-not-wait, and ambulance offload;
  - Quality, including the maintenance of standards of patient care through guidelines, policies, education and training, and incident review processes, as well as the improvement of quality through quality improvement framework and activities.
  - Future planning, most notably with respect to the New Footscray Hospital planned for 2025.
- Inter-disciplinary and hospital-wide collaboration through Divisional Heads of Unit meetings and hospital-wide quality initiatives
- Representative of the Emergency Department and Western Health in general

Emergency Physician

- Clinical responsibilities when on the floor include the delivery of quality patient care through the
  - Supervision of junior medical and nursing staff
  - Attention to emergency department flow
  - Direct provision of patient care
  - Collaboration with other hospital specialties and disciplines
  - Identification of risk and initiation of mitigation strategies.

- Non-clinical responsibilities in addition to Director role:
  - Occupational Violence
    Chair, Emergency Department (ED) Occupational Violence and Aggression (OVA) Working Group, a multi-disciplinary group working together to reduce occupational violence in the ED through
    - Development and implementation of an innovative violence screening tool for all patients
    - Education
    - Funding initiatives through Violence Prevention Funding project

    Member of the Hospital OVA Committee
  - Quality Improvement
    Development and implementation of various QI initiatives, including the new Trauma Guideline
  - Education and Training for medical students, nursing and junior medical staff.

Registration and Membership

Australasian College of Emergency Medicine No. 03563
Fellow

Specialist Registration No. 954592
Australian Health Practitioners Registration Agency

Professional Indemnity No. 7422
MDA National

Previous Registrations
General Medical Council, UK (2005)
Medical Board of Northern Territory (2008)

Education and Training

Bachelor of Medicine/Bachelor of Surgery
University of Queensland, Brisbane, Queensland, Australia. 2002

Graduate Diploma in Nutrition and Dietetics
Queensland University of Technology, Brisbane, Queensland, Australia. 1996

Bachelor of Biomedical Science
Griffith University, Brisbane, Queensland, Australia. 1994

Honours

- Safe Care Award, Best Care Forum, Western Health, 2018
- Occupational Health and Safety Individual Staff Achievement Award, 2016
- Food Technology Association of Queensland Award, Queensland University of Technology, 1996
- Bachelor of Biomedical Science Medal, Griffith University, 1994
- Academic Scholarship, Griffith University, 1992-1994

Presentations

Presentations
- IHI BMJ International Quality and Safety in Health Care Forum, Melbourne, November 2018
- Research Week, Western Health, Melbourne, October 2018
- Best Care, Western Health, Melbourne, September 2018
- Grand Rounds, Western Health, Melbourne, June 2018
- Worksafe Health and Safety Month, Melbourne, October 2017

Courses and Conferences

Leadership & Management
- RACMA Leadership for Clinicians, Adelaide, 2019 (ongoing)
- RACMA Professional Development Workshop, Management for Clinicians, Melbourne, 2016
- Project Management Course, Melbourne, 2016
- Balancing NEAT and NEST, Sydney, 2014
- Professional Development for Registrars Program, 2010

Clinical & Quality
- IHI BMJ International Quality and Safety in Health Care Forum, Melbourne, November 2018
- EMCORE, Fiji, October 2018
- International Forum on Quality and Safety in Health Care, Kuala Lumpur, August 2017
- Emergency Medicine & Acute Care Course, Center for Medical Education, New York 2016
- ACEM Autumn Symposium, Brisbane, 2016
- ACEM Annual Scientific Meeting, Brisbane, 2015
- ICEM Conference, Hong Kong 2014, including Pre-Conference Workshop
- Ultrasound for Emergency Physicians, UTS, Melbourne, 2013
- ACEM Annual Scientific Meeting, Hobart, 2012
- ACEM Autumn Symposium, Brisbane, 2011
- Advanced Paediatric Life Support (APLS) Instructor Course, 2011
- ACEM Advanced Paediatrics Emergency Medicine Course, 2010
- Early Management of Severe Trauma (EMST), 2009
- ACEM Autumn Symposium, Brisbane, 2008
- Advanced Paediatric Life Support (APLS), 2008

Occupational Violence/Alcohol and Drugs
- VAILA Conference, Melbourne, 2016
- Hospital Safety and Security Conference, Sydney, April 2017

Previous Employment: Medical

November 2012 to May 2017	Staff Specialist Departments of Emergency Medicine

Western Health
Footscray and Sunshine Hospitals

Melbourne, Victoria

Two general emergency departments servicing a large catchment area in the western suburbs of Melbourne. Both hospitals have acute care services including intensive care units and acute cardiac catheterisation facilities, and Sunshine Hospital provides obstetric care. Annual attendances at Sunshine and Footscray Emergency Departments are nearly 70000 and 40000 respectively with a high admission rate and broad case-mix. Both include an Emergency Observation Unit.

Direct Clinical Activities

- Responsibility for timely quality patient care, junior doctor supervision, and department flow whilst having an individual patient load.
- Associated communication, documentation and liaison responsibilities both within and external to the Emergency Department.

Clinical Support Activities

- Department wide Quality Improvement Activities
    - Sunshine Emergency Department Planning Days
    - ICU Working Party
    - Emergency Clinical Care Network (ECCN) Project: Reducing Unscheduled Return Visits
    - Footscray Strategic Planning – Clinical Care Stream Lead

- Interdisciplinary Guideline development
    - Sedation of Agitated Patients
    - Discharge Analgesia Policy (in development)

- Patient Information Handout Development and Redesign
    - Internal Discharge Analgesia Information
    - Internal Chest pain and Abdominal Pain Discharge Information
    - Victorian DHS Emergency Department Information Handouts

- Education & Training
    - Registrar & Junior Doctor Teaching and Development
        - ACEM Mentorship Role 2014 ongoing
        - Formal presentations during teaching schedule
        - Fellowship Teaching when required
        - Intern and House Officer Assessment Coordinator
        - Formal teaching sessions
    - Medical Students
        - Project supervision and report assessment
        - Medical Student Teaching Programme Coordinator
        - Bedside teaching and tutorials

Representation & Leadership

- ED Occupational Violence and Aggression Working Party, Chair
    - Stakeholders from various hospital departments working together to reduce occupational violence in ED
    - Education sessions for nursing staff regarding occupational violence
    - Development of management plans
    - Development of new Behaviours of Concern chart in response to WorkSafe investigation
    - Facilitation of Violence Prevention Funding project
- Positive Workplace Advisory Committee
    - Participation in medical leadership team designed to implement initiatives at WH to sustain a more positive workplace
- In-depth Case Review Group, December 2016
- Judge for Best Care Forum, March 2017
- Judge for Inspire Awards, May 2017

December 2015 to May 2017	Alcohol and Other Drugs (AOD) Emergency Physician Departments of Emergency Medicine
Western Health Footscray and Sunshine Hospitals **Melbourne, Victoria**	Interdisciplinary role involved in quality improvement activities addressing the management of patients with alcohol and other drug issues in the emergency department. Self-directed position focussed on identifying opportunities for change and improvements. Activities within the following domains: • Education o Regular Nursing and Medical Staff education sessions o Presentation at hospital-wide AOD week o Occupational Violence Education o Plans to design online learning packages for continuity & coverage • Guideline Development o Sedation in the Acute Behavioural Disturbance o Analgesia in the ED (in progress) o Hospital Discharge Analgesia Policy (in progress) • Research/Quality Improvement Audits and Projects o AOD screening rates of ED patients o Behavioural Assessment Room (BAR) Use Staff Survey o Disposition of Toxicology Patients after prolonged resus stay o Code Grey analysis (planned prospective audit into Code Grey Triggers) o Audit of sedation practices after implementation of Sedation Guideline • Liaison and Collaboration o Addiction Medicine o AOD Clinicians o Psychiatry o Anaesthetics

August 2012 to October 2012	Staff Specialist, Part time Department of Emergency Medicine
Royal Brisbane & Womens' Hospital Brisbane, Queensland	A large tertiary adult hospital and tertiary trauma centre with a busy Emergency Department seeing over 70000 patients per year. Occasional shift cover for Royal Children's Hospital, a tertiary paediatric hospital co-located on the same campus but independent of the adults hospital.

August 2012 to October 2012	Staff Specialist, Casual Paediatric Emergency Medicine
The Mater Children's Hospital, Brisbane	One of two tertiary referral paediatric hospitals in Queensland with a wide range of presentations including trauma and cardiothoracic surgery. Quality

January 2007 to August 2012	Emergency Registrar
Royal Brisbane & Womens' Hospital, The Prince Charles Hospital & Mater Children's Hospital Brisbane, Queensland **Alice Springs Hospital**	Five and half years advanced training in Emergency, Anaesthesia, Intensive Care, and Paediatrics according to College Guidelines, including 6 months as a Paediatric ED Fellow and Senior Registrar in ICU.

January 2006 to July 2006	Principal House Officer Department of Emergency Medicine
Royal Brisbane & Womens' Hospital Brisbane, Queensland	Relatively independent clinical work with occasional registrar duties as required and able, but minimal supervisory duties. Participation in teaching at registrar level.

January 2003 to January 2006	Intern and Resident Medical Officer
Royal Brisbane & Womens' Hospital Brisbane, Queensland	Intern: General Medicine, Emergency, Psychiatry, General Surgery (secondment to Hervey Bay Hospital), Obstetrics and Gynaecology Junior House Officer: Emergency Medicine, Vascular Surgery, Dermatology, Rural Relieving (Augathella, Weipa and Kingaroy Hospitals)
Various Hospitals in England	Senior House Officer: Bone Marrow Transplant, Cardiology, Emergency Queen Elizabeth Hospital, Gateshead, England (Aug – Sep 2004) General and Vascular Surgery in a County Hospital in North East England. Ward, clinic, theatre and on call responsibilities. Short term locums (Sept – Dec 2004) Short term locum work in various hospitals across England as a Senior House Officer in both medical and surgical disciplines. University Hospital North Durham, Durham, England (Dec 2004–April 2005) County Hospital in North East England. Responsible for managing a small general medical ward in liaison with individual consultants.

Publications

Senz A and Nunnink L, Review Article: Inotropes and Vasopressor Use in the Emergency Department. Emergency Medicine Australasia October 2009; 21(5): 342-51.

Platts D, Shekar K, Senz A and Thomson B, Massive bilateral pulmonary emboli, paradoxical embolus and the knot of life. European Heart Journal (online August 22, 2012).

Clinical and Procedural Skill Competencies

- Airway management and adjuncts, intubation and LMA, cricothyroidotomy (animal and simulation), percutaneous tracheostomy, extubation
- Assist, non-invasive and invasive ventilation techniques, needle decompression and ICC insertion
- Insertion of arterial, and central lines and dialysis catheters with ultrasound, intraosseous line insertion, pericardiocentesis
- Procedural sedation and rapid sequence induction
- Fracture manipulation, plastering, suturing, nerve blocks
- Use of Ultrasound for line insertion, FAST, simple early pregnancy, abdominal and cardiovascular assessment.

Employment: Non-Medical

Dietitian-Nutritionist

- Department of Nutrition and Food Services, Princess Alexandra Hospital (PAH), Brisbane, Queensland. June 1996 – January 1999.
- Domiciliary and Allied Health Ambulatory Rehabilitation Team (DAART). Jan 1997.
- Project Manager, Department of Nutrition and Food Services, PAH. July 1998 – Jan 1999.
- Office Manager, Department of Nutrition and Food Services, PAH. Nov 1997 – Jan 1998.

Royal Commission into Victoria's Mental Health System

ATTACHMENT ALS-2

This is the attachment marked 'ALS-2' referred to in the witness statement of Ainslie Lynea Senz dated 9 July 2019.

Further information for Royal Commission

Data collection

The data search used to identify mental health presentations searches for both diagnosis and triage symptoms codes as follows:

- ICD diagnosis code starting with F (which are the neurology/mental health/ substance use diagnoses) BUT excluding those starting with F0 which are dementia or delirium diagnoses
- ICD diagnosis code starting with T4 which are the substance use poisonings
- ICD diagnosis code Z91.5 (an old code for suicide risk)
- Diagnosis description containing POISON but excluding FOOD
- Diagnosis description containing SUICIDE
- Diagnosis description containing MENTAL
- Triage symptom codes such as Mental State or Paed Suicide Risk or Poisoning/Overdose or Section 351
- Triage description containing "351"
- Injury Intention being "Intentional"
- Seen by EMH clinician

This data search is used for the below discussion, unless otherwise indicated. As mentioned, this will not capture all presentations. For example, a patient may present with a laceration to the wrist. If the final diagnosis is 'laceration' as opposed to 'self-harm', and the injury data is incomplete or does not indicate intentional harm, this will not be captured by this search. I have no other immediately available way to retrospectively capture more accurate data.

Mental Health Presentations

Using the above search, mental health presentations comprise approximately 5-7% of the annual presentations, but this could potentially be higher. Of these between 15 and 25% are admitted, although this rate is falling.

Using a different data source from January 2018 – May 2019, of these

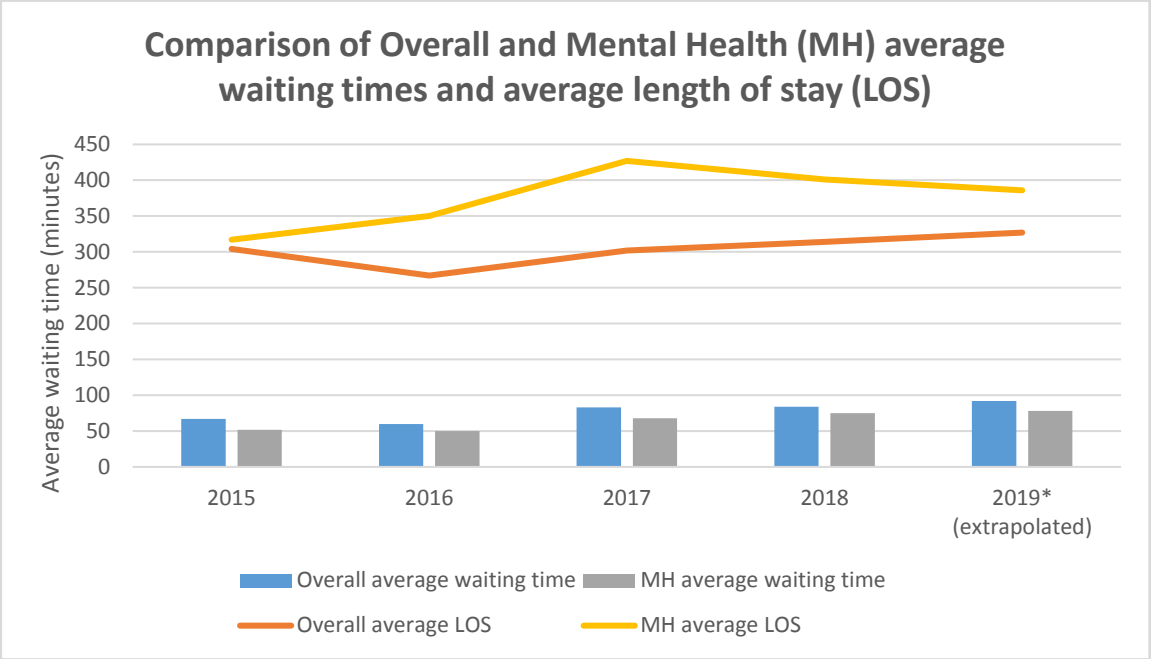
- 0 to 5% of presentations are referred by PACER.
- Up to 25% of patients present via Police under a Section 351.

Year	Total ED Presentations	MH presentations (%)	MH Admissions (% of presentations)
2015	36500	5%	25%
2016	38107	7%	26%
2017	39718	6%	19%
2018	41447	6%	17%
2019* (extrapolated)	42321	5%	17%

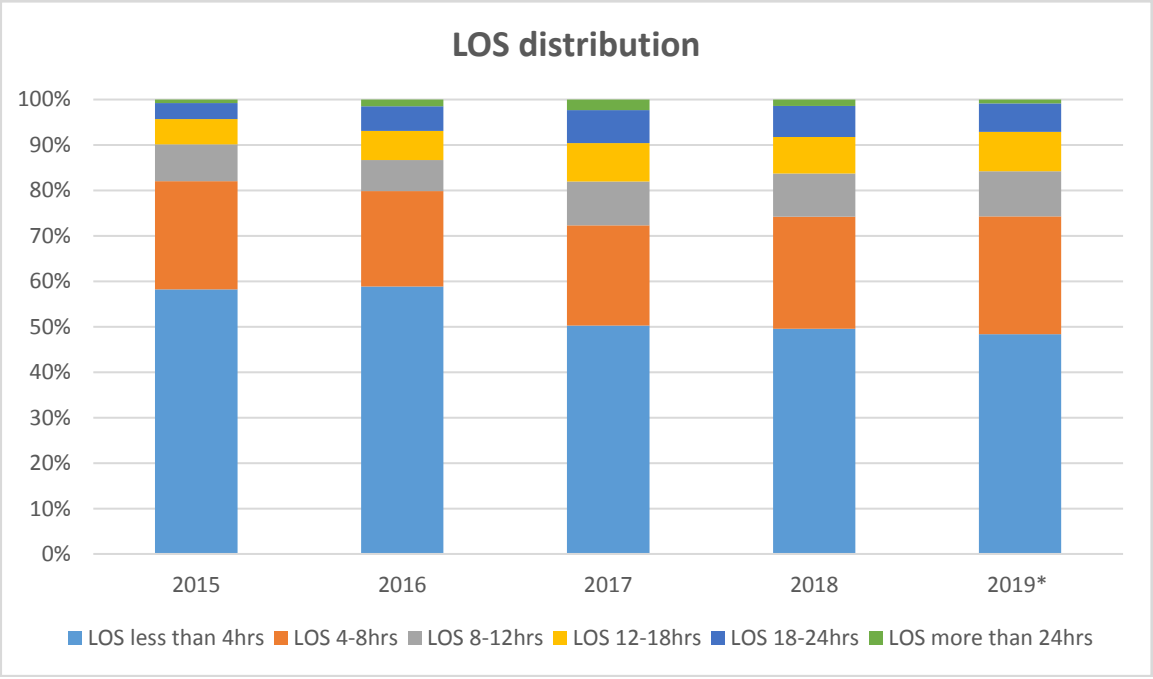
*Please note all 2019 data has been extrapolated to 12 months.

Mental Health Waiting Times compared with All ED patients

Mental health patients wait less time on average than the overall population of patients presenting to ED. This wait is increasing along with other demands for ED services (see graph below). The average length of stay (LOS) is greater for mental health patients than the general ED population.



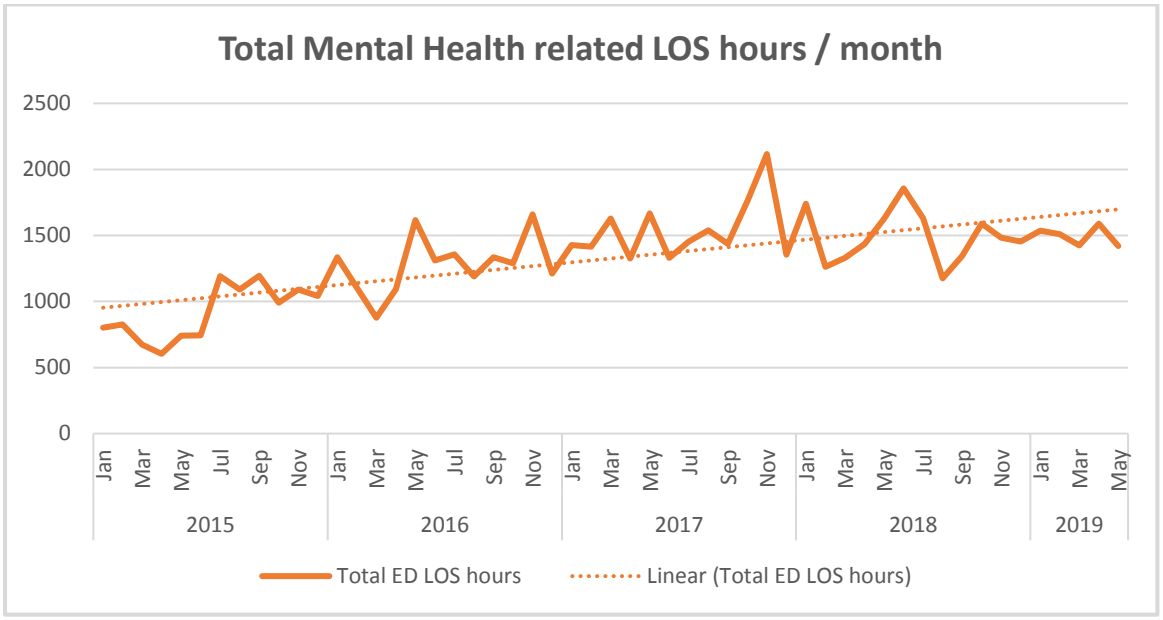
For all mental health patients, approximately half of mental health patients awaiting a mental health inpatient bed stay longer than 4 hours in ED, and nearly 20% stay longer than 12 hours.



TOTAL ED Length of Stay Hours

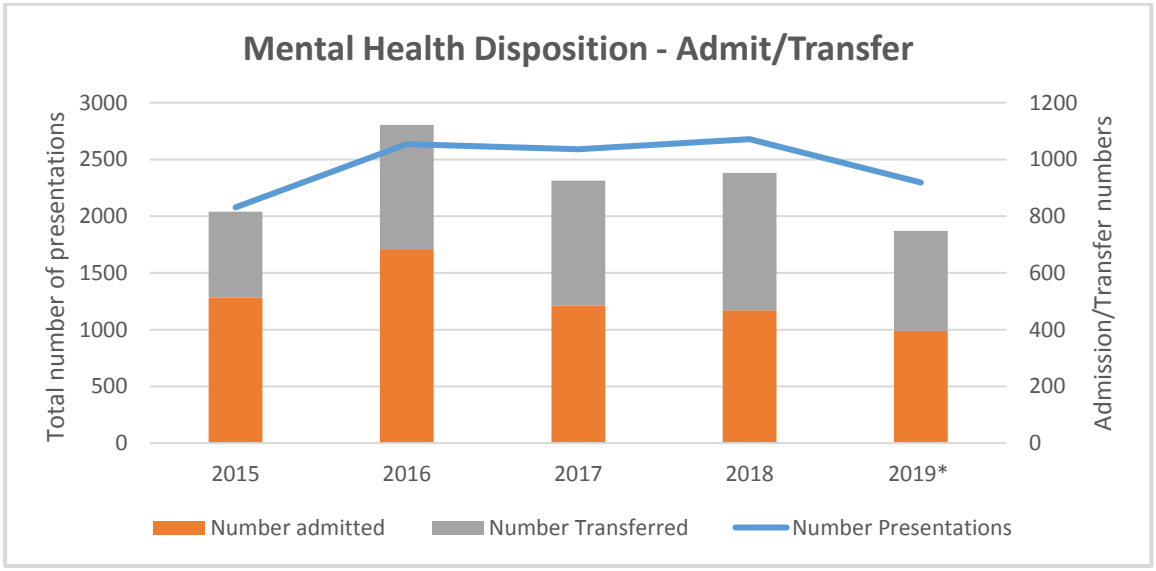
This graph shows the increase in the total number of hours spent by mental health patients in ED per month. This is influenced by

- number of patients presenting
- waiting time for ED assessment
- waiting time for EMH (mental health) assessment
- waiting times for inpatient beds
- other patient factors eg sobering from intoxicated state, and
- social factors such as homelessness.



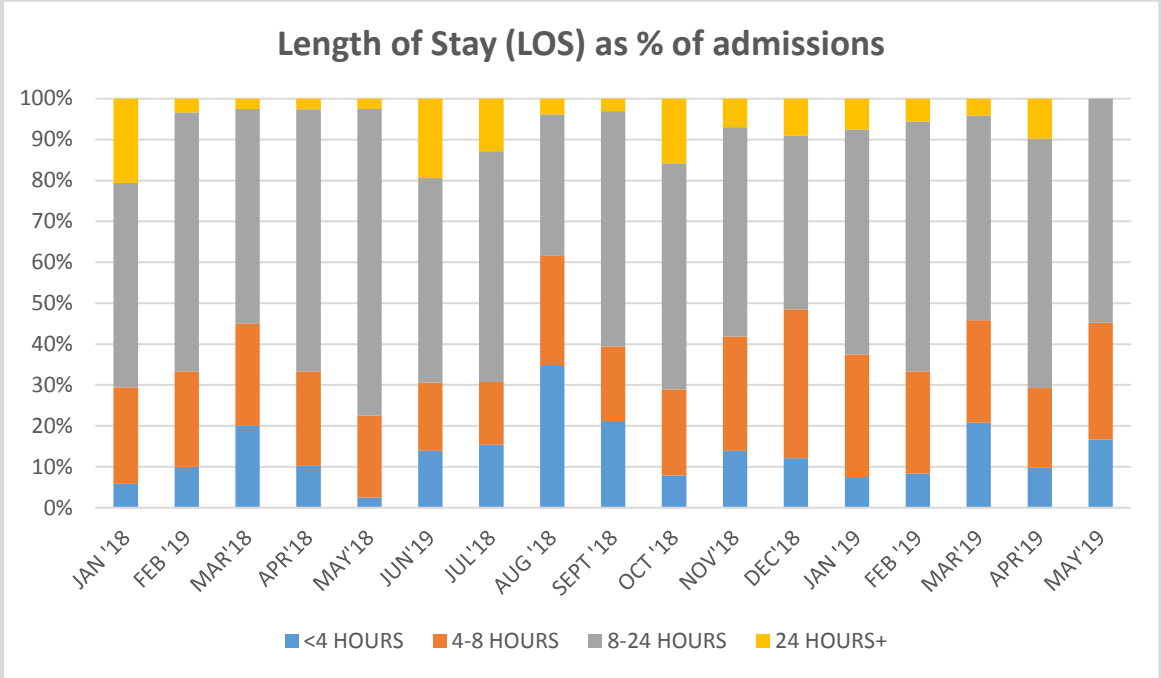
Mental Health Admission Rates

As mentioned above, the admission/transfer rate is reducing with time. The reasons may be slightly reduced overall numbers, reduced overall acuity/severity, better community services, or more difficult access to inpatient beds changing admission practices. Please note that these terms are essentially interchangeable since, without mental health beds at Western Health, ALL patients will need a transfer for admission under a different facility.



Mental Health Length of Stay when awaiting an inpatient bed

Using data specific to those patients who are admitted (only collected since January 2018), the majority stay more than 8 hours, and between 5 and 20% stay longer than 24 hours.



24 hour breach data

On average between 2 and 3 patients per month stay in ED longer than 24 hours, however sometimes this is much greater at more than 5 and even more than 10 per month.