Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR SIKA TURNER

I, Sika Turner, Discipline Senior, Adult Mental Health at Monash Health, of 246 Clayton Road, Clayton, in the State of Victoria, say as follows:

1 I am authorised by Monash Health (**Monash**) in respect of its service known as Psychology and Specialist Services 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 CV.

3 I completed my undergraduate qualifications in psychology at The University of Oxford in 1996. In 2002 I completed a post-graduate doctorate in clinical psychology at The University of Melbourne in 2002. I have been registered as a clinical psychologist since 2002. I am also approved as a Clinical Psychology supervisor and hold AHPRA endorsement in clinical psychology. I have worked in a variety of public and private settings since then.

4 Attached to this statement and marked 'ST-1 is a copy of my curriculum vitae.

Please describe your current role and your responsibilities, specifically your role as senior clinical psychologist in the Agile Psychological Medicine Clinic at Monash Health

5 My current role is Discipline Senior, Adult Mental Health in the Mental Health Program at Monash Health. This encompasses clinical work at the Agile Psychological Medicine Clinic (**aPM Clinic)**, in addition to professional leadership and supervision of psychologists (including students on placement at Monash Health). I have held this role since 2018.

6 Prior to this role, I held a purely clinical position as a senior clinical psychologist with the aPM Clinic.

What services does the Clinic provide?

7 The ethos of the aPM clinic is to provide up-front treatment to people in a manner that is genuinely responsive to their needs, that values the therapeutic relationship and relates to them as an individual.

8 The aPM Clinic provides treatment to people who present in a situational crisis, usually with suicidality and an underlying mental health condition such as mood disturbance, trauma or personality phenomena. These people present to emergency departments or make contact by phone with the Psychiatric Triage Service (**PTS**).

9 The aPM Clinic operates Monday to Friday. When a person presents to an emergency department, an Emergency Crisis Assessment and Treatment Team (**ECATT**) clinician sees the person, conducts an assessment and (if appropriate) books them an appointment at the aPM Clinic by directly accessing the aPM Clinic's online diary.

10 When a call is made to the PTS (either by the person or someone on their behalf), they are triaged during the phone call and once again, booked directly into the aPM calendar

11 Persons referred to the aPM Clinic are seen within 72 hours. We manage our diary very deliberately so that people can get in within 72 hours. Having the 72 hour upper limit also allows for people who present on a Friday to be seen on a Monday. Our objective at the aPM Clinic is to connect the person to a named therapist and provide biopsychosocial treatment as soon as they present, meaning when people first come in with their crisis. This is in contrast to what usually happens.

12 We do not aim to solely manage people and risk management is not our primary focus, although it is part of the individualised treatment if necessary. We work collaboratively with the person, not just the risk. We are driven by the idea that providing treatment is the key to resolving risk, rather than merely managing risk. We work on a joint formulation with the person and together we identity the goals of therapy. We then use evidence-based treatments and feedback-informed treatment to work on those goals together. Our use of feedback-informed treatment means we get feedback from the client after each session on whether we are meeting, through the process of therapy, the agreed goals. We adapt our treatment on the basis of the feedback from the client as to what is working and what is not.

13 For people with a situational crisis, we would usually see them for four sessions at the aPM Clinic. A situational crisis might include loss of a job, breakdown in a relationship, but is usually accompanied by an underlying mental health issue. People presenting with a situational crisis to public healthcare are often not well resourced to help themselves through the crisis and we work with them to help them mobilise resources.

14 Other people who use our service will have around ten sessions, typically for high prevalence mood disorders.

15 The third option is a 12 session program. This is a specialist option for people with Post Traumatic Stress Disorder (**PTSD**). We see a number of trauma presentations and there seems to be an increasing awareness that trauma might be linked to later mental health issues.

16 In all our agile clinical services, the number of sessions is not set in stone – we are conceptualised as a short-term service, but we try work from the agreed treatment goals we have formulated with the person and evaluate whether this is working in an ongoing way. If our evidence-based treatments have not worked, we assist the person in finding alternative options.

17 Working directly from goals that have been identified jointly between clinician and client is not a guarantee for a successful outcome, but we are aiming at building a person's agency and maximising recovery, and from this point of view, we do not want treatment to be something that is done to a person. Our ethos is that it is a joint and collaborative process.

Who receives the Clinic's services? What are the criteria for accessing the Clinic's services? How are consumers referred to the Clinic or how do they otherwise seek its services? Must they come from any particular geographic location?

18 The aPM Clinic accepts all persons over 18 years. There are no catchment restrictions; our ethos is we see people from out of the area if they are booked in. We simply aim to give people the treatment they need.

19 We generally try to minimise exclusion criteria because a lot of resources in the mental health system seem to be about keeping people out rather than getting them help when they need it. I see this as the result of ongoing underfunding and services being stretched. We see people with high prevalence disorders, however if someone is booked in with us and they have a psychotic illness, we will see them. Many of our clients have drug and alcohol issues and we see many people with personality disorders.

20 People are booked directly into our diaries by PTS or ECATT if the clinicians believe the person could benefit from a psychological treatment. Often GPs or other private practitioners call PTS looking for this sort of specialist therapeutic service

Does the Clinic assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of the Clinic's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

21 aPM assists people affected by mental illness with all degrees of severity and complexity, although mainly those with high prevalence mental illnesses. We also help them to navigate the system and to identify where their other needs can be met.

22 Our clients will all have had contact with either the PTS or the emergency department and many have also had (or will have) contact with CATT. Some clients might get referred by the aPM Clinic to IPUs (Inpatient units) or CCTs (continuing care team), occasionally to PARCS, WRC (Eating disorders service) or the Pain Clinic or other specialised service. Even though we refer clients to other services, we would almost always see them for several sessions before we make the referral – that is, we never turn anyone away if they are booked in our diary and attend the appointment.

23 People who need to be seen immediately will typically not end up in our diaries. If it turns out that someone does need an admission or an escalation of services, we would arrange that.

How does the Clinic interact with other parts of the mental health system?

24 Bookings can be made directly by PTS staff and staff within ECATT into the calendar for aPM. Access is therefore relatively easy. After the initial appointment with the person, we then communicate back to either PTS or ECATT what our plan is. Our analyses actually indicate that the number of people who could benefit from our service hugely outnumbers the actual referrals we receive. I think this might be because people are coming in through a system that largely thinks about risk mitigation and management and keeping people out so the system is not flooded, rather than what treatment needs people have

25 Attached to this statement and marked 'ST-2' is a copy of a figure which shows the number of people who presented to ED and PTS at Monash Health in 2018. As an example of my point, only 337 people were mobilised from PTS into aPM, even though 95% of their 13,000 callers reported suicidality

Briefly, how are the Clinic's services funded?

26 The aPM Clinic is funded from community mental health money. The funding is activity-based. aPM is not funded using Medicare item numbers so there is no 10 session limit.

27 We offer a permanent service which was established after a prototype that was approved but not funded. aPM Clinic has just received some additional funding for an expansion.

From the perspective of consumers seeking or likely to seek the Clinic's assistance, to what extent are the Clinic's services publicly funded?

28 aPM's services are completely publicly funded.

Servicing demand

In your experience, in relation to the needs for clinical psychological services:

Is supply keeping up with demand? What gaps have you observed?

29 It is difficult to recruit to senior psychology positions (level 3 and above), which is probably explained by the fact that psychologists in private practice are better paid than those in public mental health. In addition, working in a biomedical and risk management model, psychological services have been significantly reduced in tertiary mental health services. Some psychologists are employed in generic mental health roles (eg case management), where their skills are not utilised or valued.

30 If the 'bottleneck' which I described in paragraph 24 above is addressed, demand will substantially increase beyond current capacity in our aPM clinics. Our team have modelled this demand and can provide the data to the Royal Commission if required.

If there is unmet need, what needs are the most critical?

31 Triaging people on the basis of clinical need and potential to benefit from treatment, rather than risk, is critical.

32 The research shows that we are not good at assessing risk, that is, we are not able to reliably predict suicide from the risk factors [eg Chan et al 2016]. In spite of this, we use risk assessments as the main access point to services and as a system, we continue to think that we can predict suicide and we focus many of our efforts on doing that. The cost of this is that we do not provide mental health services to some people who have a lot of distress because they do not express the right type of risk or enough of it. Another cost is that by focusing on risk, we often do not spend enough time on understanding the person and providing them with appropriate treatment. Risk does need to be taken into account, but at the aPM Clinic we do not deal only with risk – we try to work on the underlying issues the person is dealing with. There is a lot of activity in the system focused on risk, but sometimes the amount of activity can obfuscate an absence of genuine evidence-based treatment.

What are the key drivers of unmet need?

33 The fact that we use risk as the 'admission ticket' into mental health services means that many people who need services do not have access to them. I have been in the situation of helping family members of those requiring services with what to say in order to elicit services, even where these services are badly needed.

What kinds of impact does unmet need have on people who might otherwise receive treatment?

34 It is very hard to get psychological treatment service that has any continuity to it and is easily accessed, both in the public health system but also sometimes in private health. This has the biggest impact on people with complex or severe depressive disorders (where there is no urgent risk), severe anxiety, PTSD and other trauma-related issues or personality disorders (and often all of these go together), who are not getting evidenced-based treatment.

35 It often seems as if decisions around session numbers are financial or service-based and not based on the needs of the client (using a one-size-fits-all approach).

36 The impact is that clients often have snippets of services where there are a lot of assessments and working out where to send people and not enough actual treatment.

37 Ultimately when people attempt to get help and do not get any, or they get insufficient help or the wrong kind of help, they may end up worse than before they tried to get help.

In your experience, is there effective collaboration between different parts of the mental health system? If not, in what ways is it not effective?

38 Collaboration between different parts of the mental health system is an issue needing urgent attention. It is patchy and area-dependent. Services are often siloed and is it often unnecessarily difficult to refer between them with multiple gatekeeping in between services. If I want to refer someone to another part of the mental health service, I fill out a form and (often) follow this with a phone call. If the referral is accepted (and many times they are not), the client usually has to wait before the referral is processed and is then assessed again by the new service. The new service might not accept the client in spite of my referral. If the client is not accepted, then I go back to the drawing board to find another suitable service and the referral process is repeated. This process may repeat several times before a service is located.

39 I see part of my role as navigating the system for people and with people. Many of the services are so hard to access that there is little chance of someone in a significant crisis managing that by themselves.

40 There is no distinction between an internal referral (for example, to another Monash Health service) and a referral to an external service in terms of how easy they are to do. The names of external services change frequently and the roles those services play in the mental health system also change, particularly since the introduction of the NDIS. The services are always evolving and even from within the system it is hard to stay on top of the changes.

41 I do not know what generates the constant change, but there is a lack of co-ordination across the system and a lack of a unifying 'model of care' within the system and clear understanding of the contributions of the component parts. A model of care identifies treatments offered and in response to what and how it helps (based on data). The newer services usually have models of care, but we lack consistency, co-ordination of treatment and a clear strategy for recovery.

42 We know that each time we 'hand over' from one service to another, we risk losing people (both through suicide risk and by disengagement with the service), and clients tell us that they hate telling their stories over and over again. Yet, we typically follow the 'intake model' each time a person presents to a service, even if the referral has come from within the same health network. The rationale behind this is that every service insists on its own right to make decisions about which clients to accept and which not to accept, driven by that fact that resources are so scarce Related services do not trust the assessment and judgment of referring services. This often leads to people being in the system for lengthy periods of time with multiple hand-overs and multiple intake assessments without getting any actual evidence-based treatment.

43 In short, there is a lot of activity, but very little to no actual treatment. The consequences of this can be tragic, which we have been able to track for a number of people with our activity analyses.

44 The other great difficulty I have with this system as a psychologist is that research reliably shows that the therapeutic relationship is one of the most powerful tools we have in the work we do with people. And yet our clients are often seen by ten or eleven different people. When we shift people around without letting them establish a therapeutic relationship with someone, we throw away one of the most valuable tools we have.

What are the barriers to people receiving access to psychology services from a systems perspective?

45 There are a number of barriers to people receiving access to psychology services. These are:

(a) People cannot readily access teams offering psychological services at the time when they are most open to them (which is when they really want something to change in their life). Access in the current system is limited to those with acute needs and those who meet the risk profile.

(b) Psychological services are not considered a 'first line treatment' in many parts of the mental health system. This is in spite of the evidence which shows that psychological treatment works. This reflects a broader tendency to disregard data, in favour of service as usual.

In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

46 The short answer is that the mental health system is crisis driven. Crisis is the main access point to getting treatment in the public mental health system. What this means is that we often manage the crisis rather than giving treatment.

47 The focus of the service becomes about how to keep a person safe, but it does not deal with, for example, the underlying depression. We know that we can treat people while they are in crisis (not just manage the crisis). The system should be designed to facilitate this as soon as possible after people first present. We know from our agile clinic data, that when this is done, not only do people show meaningful and significant improvements, they are also less likely to present again to the mental health system. People frequently re-presenting is a big problem in mental health and the response of having KPIs around reducing re-presentations without trying to understand why people are re-presenting and providing them with adequate treatment is simply insufficient.

48 Risk assessments drive a lot of the service delivery in mental health. Persons seeking mental health services are judged on their level of risk. This judgment will dictate whether they access the services or are denied the services. There is obviously a need to respond to risk, however I am not convinced that it should be the main access criterion. The reasons for this are:

(a) We deny access to people with very complex and long-standing problems if there is little to no risk, which could include people with long standing depression, anxiety and trauma.

(b) We respond unhelpfully to people with chronically high risk and end up causing iatrogenic damage.

(c) We are not very good at assessing risk and even though we know that, we continue to base access to our systems on risk assessment. There is clear and consistent data to support a change in practice.

(d) We often turn people away because they are not 'risky enough'. We know that this hugely increases hopelessness and demoralisation.

(e) On the other hand, some people become very good at navigating the risk currency and we tend to give them a diagnosis of borderline personality disorder which may give them entry to services (often with the empathy removed because the 'system' has run out of compassion). The aPM Clinic receives a lot of referrals for people in this category.

49 PTS turns away a large number of people who ring. Whilst we review cases where there is an adverse outcome for a consumer, we do not review people who have asked for access to services but have been turned away – this is a big 'unknown' in mental health care.

If a person has a chronic mental illness but is not 'in crisis', where do they go for immediate support?

50 If the system has served the chronically ill person well, they will have ongoing services set up in their life. These services will be include their GP, community groups, perhaps an external support worker or a private practitioner. When the system has not worked well, the person with chronic mental illness may not receive any treatment until there is a crisis and then may only get crisis management

Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services?

51 The "missing middle" is a side effect of using risk as currency within the mental health system. The aPM Clinic can cover the "missing middle".

52 Over the years I have seen some people in my private practice who would fall into this "missing middle". The difficulty is that the Medicare funded 10 sessions of psychological services is inadequate for some people. If you know the system, you can advocate for people to be seen by specialist mental health services, but this involves an element of 'coaching' (helping them articulate their needs in a particular way). This skews the system towards risk responsiveness only.

53 In aPM we often get people who are already using private psychology services. We tend to see these people at the end of the year when they have run out of Medicare funded sessions or when the private psychologist feels that the person could benefit from specialist treatment of some kind.

How does the complexity of the mental health system (variability between geographical areas, overlaps/duplications between different levels of government, and gaps) impact

on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

54 The mental health system is often extremely confusing for consumers. Having had some time out of the public health system and then having returned to it, I have personal experience of re-learning how to navigate it. Many of us working in the public mental health service do not know what other parts of the system offer so it must be very difficult for people trying to access help.

55 I spend a lot of my time at aPM ringing services with my clients and asking questions on their behalf to help them navigate the system. Too often we leave people to navigate this system themselves

Mental health system and reform

Are there ways in which you think the demand for services of the kind offered by the Clinic is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

56 Demand for services at aPM will increase if everyone who needed our services was given a referral. This would result in increases in demand.

57 Within aPM Clinic we know that rates of anxiety and depression are rising, and yet the 'bottleneck' remains. We need to unblock this so that we can ease access to specialised treatment and move away from management of crises.

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

58 My view is that the key issues with the current mental health system focus on:

(a) Ease of access to treatment when and where people need it;

(b) Use of data and routinely-gathered, structured feedback from clients to guide service development and delivery;

(c) Keeping our eyes on the prize at all times – quality of life and recovery for consumers (which involves listening to what that means for each individual)

(d) Having adequate facilities to support our services.

What do you think are the critical elements of a well-functioning mental health system?

59 The critical elements of a well-functioning mental health system are:

(a) Rigorous and ongoing examinations of what we are doing and whether it works: *Measure what you value, not value what you measure*.

(b) The availability of treatment for people when and where they need it.

(c) The availability of both specialist and general services with easy pathways between them.

(d) Capacity to easily step care up or step care down, depending on the needs of the client (without having to go through 'gates' to access the next level of service).

(e) Valuing the therapeutic relationship.

(f) Looking after the workforce, including the opportunity for their ongoing professional development which is consistent with the outcomes we are working towards.

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

Access to treatment and services

60 Access to treatment and services could be improved by reducing the number of 'intakes' and commencing service delivery earlier, by using digital strategies to help people use the services effectively and by grouping services together geographically (according to the needs of the population).

61 We should also ask people for feedback. Data across therapy studies show that if a person shows no significant improvement early on in the treatment they are not likely to improve with that clinician. We should be monitoring this session-by-session to ensure that improvements are happening. Similarly, we know, that if a person does not feel connected with the clinician trying to help them, they are less likely to improve. There are simple and effective ways of getting this feedback and these questions should be asked across the board in a systematic way.

Navigating the mental health system

62 Navigation of the mental health system could be improved by:

(a) Improving websites for public health – they often have so little information on them that the perceived goal is to keep people away rather than encourage them to use the services;

(b) Creating clear, easily accessible documentation around different services and making this easily available;

(c) Implementing digital solutions;

(d) Clarifying acronyms and not having services change so frequently; and

(e) Removing barriers, including re-assessment at each level of service.

Getting help to people when they first need it

63 This can be improved by offering genuine treatment immediately at entry points into the system

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

64 The key messages for me are:

(a) Value outcome over activity;

(b) Value the relationship over transactions;

(c) Move away from risk mitigation to a focus on people's needs (listening to people);

(d) Insist on evidence-based specialist treatment; and

(e) Work on the workforce, which must be skilled in providing evidence-based treatment and safe in dealing with risk.

sign here ▶ _____

print name Dr Sika Turner

date 8 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT ST-1

This is the attachment marked 'ST-1' referred to in the witness statement of Dr Sika Turner dated 8 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

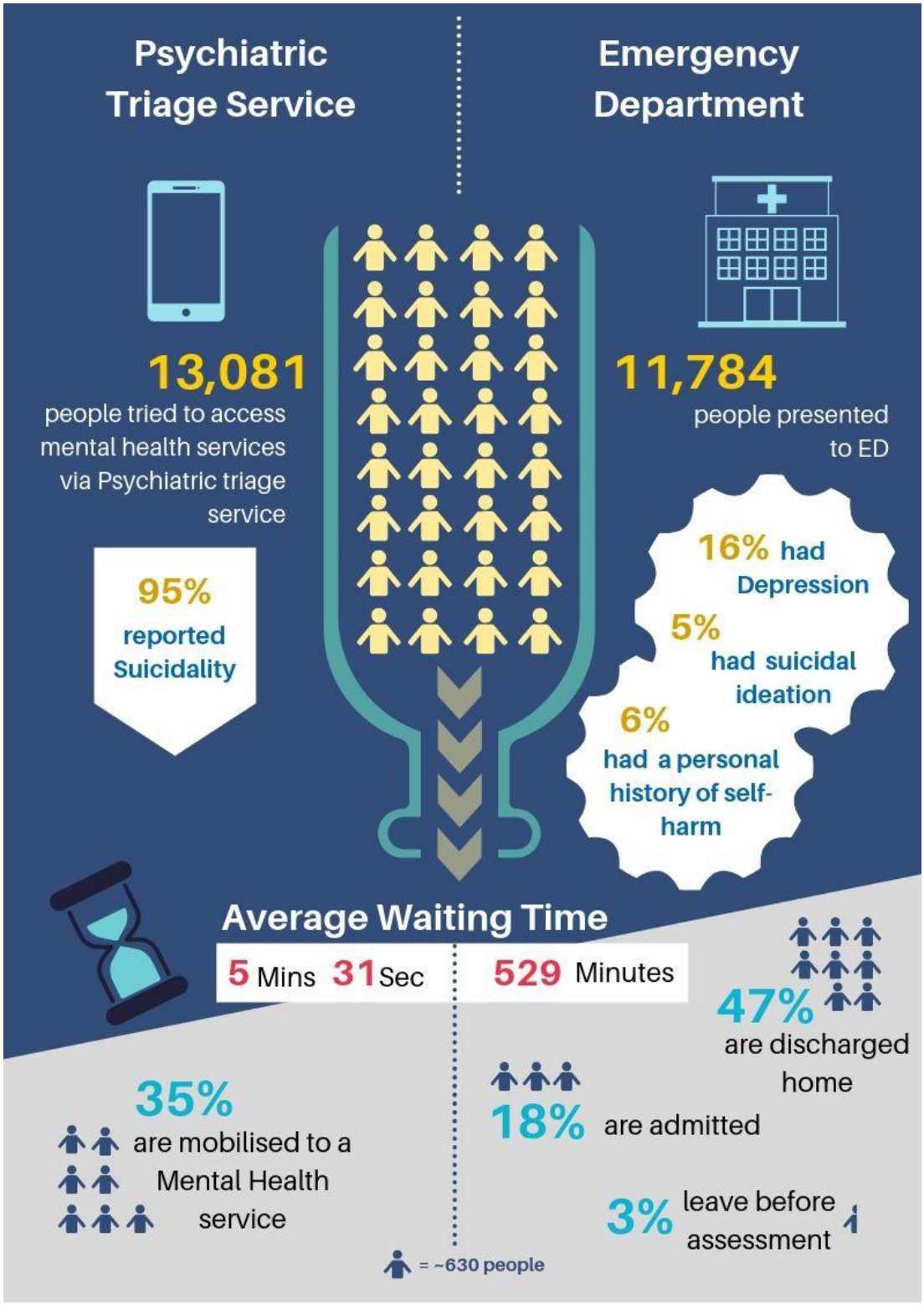
Dietitian-Nutritionist

- 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 ST-2

This is the attachment marked 'ST-2' referred to in the witness statement of Dr Sika Turner dated 8 July 2019.


Psychiatric Triage Service
Emergency Department
13,081
people tried to access mental health services via Psychiatric triage service
11,784
people presented to ED
95% reported Suicidality
16% had Depression
5% had suicidal ideation
6% had a personal history of self-harm
Average Waiting Time
5 Mins 31 Sec
529 Minutes
47% are discharged home
35% are mobilised to a Mental Health service
18% are admitted
3% leave before assessment
= ~630 people