Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF MICHAEL SILVA

I, Michael Silva,[1] say as follows:

1 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.

2 I make this statement in my personal capacity, and not on behalf of my employer.

Professional background

3 I am currently working as a carer peer worker within the dual diagnosis team at a public health service. This is a new role for me, and draws directly from my lived experience as a carer. My role has a dual purpose. First, I am responsible for liaising with and facilitating discussions between people who have lived experience within the mental health system, as either a consumer or a carer, and the dual-diagnosis clinicians within the health service. Second, I am responsible for administering a carer support fund.

4 I've been in the mental health service for about 15 years. Prior to coming to my current employer, I worked for a non-clinical community based outreach service in the suburbs of Melbourne.

Personal story

5 I am a carer for my brother, Alan. Alan has a dual diagnosis of bipolar disorder (with psychotic episodes) and addiction to alcohol and other drugs.

6 Alan is 55 years old, and his first episode of illness was when he was 21. He "celebrated" his 21st birthday at Larundel Psychiatric Hospital (**Larundel**), which was the psychiatric institution at Bundoora. That was our family's first exposure to an explosive and acute situation with Alan.

7 Our family originated from Sri Lanka. There are six of us siblings: three from my mother's first marriage (including me) and three from my mother's second marriage, one of whom is Alan. Each of us, at some point in our lives, has had to be there for Alan for various reasons. Our mother, who is now aged 78, is no longer able to care for Alan as she used

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[1] The names and details of the witness and others referred to in this statement have been changed to protect their identity.

to. My sister Ann and I have been sharing this caring role, but due to the COVID-19 restrictions I have not seen Alan recently. Instead we keep in touch over the phone.

8 Since leaving hospital this year, Alan has stayed with our mother. As I discuss below, Alan is abstaining from alcohol and drugs and is very stable emotionally. His physical health continues to be precarious. I feel mum is enjoying her time with him. I also get the same feeling from him that he is making up for those difficult and lost years and is enjoying her company. My sister and I are on ‘standby’ if Alan deteriorates in any way.

Alan’s early years in the mental health system

9 When Alan was 19, he would be a frequent visitor to the area mental health service or to the case manager at the mental health clinic. He was put on his first Community Treatment Order (**CTO**) when he was around 21 years old. Alan would abscond and the Crisis Assessment and Treatment Team (**CAT Team**) would bring him back to the ward. He had no insight into his illness. He had episodes of psychosis. For example, during Alan’s first episode when he was 21, he was found running down the freeway, trying to outrun cars. That was Alan’s first major episode.

10 In his 20s, Alan’s manic stage was quite frequent, maybe once a year. There was a bit of a forewarning, because the first thing Alan used to do when he was becoming unwell was shave his head. Then he would change the way he dressed. For us that was a little tell-tale sign. We would then be prepared as a family to watch him like a hawk. But there was very little we could do, because he could become very secretive and turn aggressive if he perceived the family were being intrusive.

11 At that time, Alan was living at home with my mum. I was also living at home during Alan’s first five to six years of illness; then I got married and moved out. I just lived around the corner, so Alan visited me frequently, usually just for someone to give him some emotional support, to try to calm him down. I was working with adults who had an intellectual disability, and in particular people who were providing us (the sector) with challenges in terms of their adaptive behaviour. I often viewed Alan as a client with the challenge of trying to find a solution for working with him. In 2003 I moved across to a psychosocial mental health program and became aware of the constraints that people work under and how clinical case managers are doing their best with Alan to try to convince him to co-operate. But co-operation was difficult when Alan didn’t have any insight into his illness. So, that became our life for a while.

12 There was a domino effect. It would start with Alan, and then my mother would become unwell herself, due to the stresses that she had. Then it would come through to me, even though I was not living at the family home by then. Alan would turn up at my home without

warning. One morning I was leaving for work at 6:30am and I opened the door to find Alan doing push-ups on my front doorstep. It was a sign of him being mentally unwell.

Alan and our family dynamics

13 When Alan is managing his illness, he's just like any other person—very articulate. Alan is quite reclusive and super-secretive at times. Alan is probably the one who has been affected the most by some dysfunctional family dynamics. It's unfortunate; he is probably the one who has suffered. We all recognise that he has had difficulty in coping with his father, and that he found alcohol and drugs as a way to help him cope.

14 Alan's father died about five years ago, and Alan had some unfinished business with him. Alan became very reclusive and had only limited contact with the family after his father died.

15 Next thing we knew, Alan was in a private hospital. He was found to have blocked arteries, an enlarged heart, a damaged liver and kidney failure. He ended up being moved between hospitals before he found a hospital and a surgeon who was prepared to operate on him. Alan's situation was precarious, and the odds were against him. Alan went through one of two five-hour operations to insert two stents into each artery. This became the turning point for Alan, to come out of the depths of his illness.

16 If Alan needs to be admitted for his mental health, he'll go through the private system. The last time he was admitted through the public system was about 15 years ago. We had to wait and wait and wait in the emergency department. Alan had just had some road rage incident, and had almost flattened somebody in a fight. I had to sit with him and slowly coax him to come with me. Then we waited for about an hour and a half. It's the funniest thing: when the clinicians come, Alan is a different person. He's putting on airs and graces. So I tripped him up and I said, "Tell them what you told me about the incident you had with the guy." He'd start talking about it, and then he dropped his guard and the demons came up. The CAT Team thought Alan was unwell and needed to be admitted. Alan just did a runner, and the police were called. But at least it was good that we could hand him over in that instance.

17 We were scared for what Alan was going to do next. We were scared about what he would do not to us, but to the outside world, and how they would respond to him. We didn't know who we could rely on. That's why we switched him over to private health. For Alan, it hasn't been better, but from a carer's perspective, it has. I could take him to his appointments, and if he was making a fuss, I could say, "It's either a consultant psychiatrist at a private hospital, or it's a CTO with the CAT Team."

18 Alan is a bigger bloke than me. He's a very strong, very powerful, man. As a family, you're coping with someone who, in the case of Alan, is incredibly strong and incredibly dangerous when he is unwell. Not that he means to be, but he's paranoid. As a carer, you're using every ounce of survival instinct not to get hurt yourself as you try to keep him safe.

19 There is a lot of responsibility on the carers. My mother was not coping herself. For her, Alan's situation was a tragedy. My mother received some support from a program called Carers Offering Peers Early Support (**COPES**). For some people, COPES is helpful. For my mother, for the amount of time that she needed, it was as if she needed to go to a retreat and sit with someone and talk endlessly. It's like peeling back layers, the years of this trauma.

20 Alan is reflective about what he has put the family through. I have to reassure him that we are not here to judge him. We understand where he's coming from. When he reflects on what he has put the family through, I say, "You don't need to apologise to anyone." These are his unfortunate circumstances.

Alan's most recent hospital admission and our family's support for Alan

21 Just before Christmas 2019, Alan was in hospital and it was quite dire. The hospital let Alan have a day release so he could come home at Christmas. When he came home, we were all mindful about our own alcohol consumption around Alan, both because of his addiction and because he was abstaining. He said, "Don't worry about it. Just do as you do." We only had a glass of wine; that was the extent of our alcohol consumption.

22 Nowadays, Alan basically has to abstain from alcohol and drugs. Alan has also stopped smoking. He also has to watch the amount of fluid he takes in, because his heart is not strong enough to pump the blood to his vital organs. Alan has to concentrate on getting as well as he can be; his situation is very precarious. It's like walking on a tightrope. This is where he is now, but he was on the brink just before Christmas. It must have been willpower from himself and the medical team that was around him, just to pull him back.

23 Alan was only discharged from hospital in late February 2020. The hospital is going to have a palliative care team coming in and checking in on Alan, because they can't say whether he might die this week or in 10 years' time. The palliative care team recently had a meeting with my sister, Ann. Ann has come from interstate and spent three months here to help manage Alan's treatment. She's put everything on hold to do that. She's a mover and a shaker: she gets things done. I think Alan appreciates the effort she puts in.

24 Ann rang me up recently to say that she was going back interstate, and that she was going to put me as contact person for the palliative care team. Alan's other siblings aren't always readily available. So that's what I'm here for. The main thing is that Alan trusts me. He might not always agree with me, but he'll come back at the end of the day and acknowledge the help. When the chips are down, the family just comes around, and even the ones who don't agree with him always have to come in. You need to be there, because if one person is not there, that can get into Alan's head. You don't have to agree, just be supportive in that moment.

25 Alan has his own home which is not far from where my mum and I each live—it's a very nice little unit that his dad bought him. He has private health insurance and he's looked after. Although Alan has his own home, he has chosen to live with mum for the foreseeable future.

26 Since his most recent hospital admission, something has changed about Alan's understanding of his responsibility. There is a sense of how some of his actions have impacted on his mum, and we just hope that he lives as long as he possibly can. It's like someone's spun Alan around 180 degrees. It's scary for him. He has joined in a circle of friends who are of the same mindset. Many of them visited Alan in hospital, thinking that it would be the last time they were going to see him. Some of them were openly emotional. They cannot believe he came through.

27 I've got a feeling that this time Alan's understanding is genuine. He has had difficulty with the truth at times. But now there's a sense of responsibility, and a sense of gratitude for the family. Everyone has come in to help. We were taking time off work—work is a secondary thing at the moment. I'd take two or three days off, just so I could visit him every morning and evening. His other brothers would come when they could. It's good because Alan says, "I've run my own race; it's time to die now. I'm now paying the price." He thinks that his physical illness is his penance, that it is the price he has to pay. But it's not his fault.

28 Alan is genuinely remorseful for what he sees as his "selfish" behaviour, having pushed the family away on several occasions for months or even years at a time. But the family has always been there when he has reached out.

29 There's usually a reason why people take that pathway of drugs and alcohol. People may not necessarily use drugs as a means of dealing with their emotions. Many people have used alcohol and illicit drugs to have a good time and have incidentally discovered that during the euphoric stage their emotional pain is absent.

30 I cope with stress. I just go and exercise. Fortunately I don't have to do much, I can just go and run. I also have my partner who's a carer herself. She's very insightful, and we talk and support each other. Some people use alcohol to calm themselves down. But the problem is when the use becomes a dependency and it slowly creeps up on you.

Experience with the mental health system in the context of a dual diagnosis

Communication, connection and the added challenges of a dual diagnosis

31 Early on, Alan's dual diagnosis meant that it was difficult for him to receive support. For example, we were once trying to give an explanation of Alan's dual diagnosis to a CAT Team. Their response was, "We're not concerned about what the cause is. We just deal with the symptoms." That became difficult for us. We were trying to explain that his drug taking was because of an environmental factor, and the drug taking then brought on psychosis. How do you work with someone like that? We didn't know at the time. We know now that Alan needs massive amounts of therapeutic work. Whether he's willing to do that, of course, is another question.

32 In general, there were some people who said, "No, this is clinical mental health. We're not worried about anything else." When we heard that, we felt helpless. He was in a system that's quite rigid, but also inconsistent. You can talk to one person, and they may appear to be empathic, and then you might come the next day and you're seeing someone else who may not have the same perspective. That was very frustrating, both for us and for Alan. We couldn't share some of the nuances about how to work around him. For example, when Alan had psychosis, if anyone looked at him the wrong way, you would need to talk to him and slowly bring him around. There was one case manager who worked with Alan for a number of years who understood that. That case manager had to walk a fine line with keeping Alan engaged.

33 Another difficulty for us as Alan's family was trying to get a connection with the nursing staff. Alan has been at a private hospital, but he was for a little time at a public hospital as well. In the medical area, there seem to be nursing staff who connected with him. That meant that we could have a continuity of dialogue. They knew what Alan was like. They could joke with him. They knew how to work with him. Whereas, if you're frightened of someone, you're more likely to use the rule book. And then of course, that becomes a barrier. The rule book is the barrier for Alan, anyway.

34 Sometimes Alan would fail to meet his CTO conditions and he would be subsequently hospitalised. There have been some issues with how our family members have responded to this. My mother would get on the phone and chew the case manager's ear off because she believed the case manager wasn't being proactive enough. The case

manager did listen to us, but of course at that moment in time he's got to work with someone who is not his son or family. It was a juggling match.

35 For us as Alan's family, it was a question of how we could have an open and honest dialogue. Sometimes this was difficult when we needed to call the CAT Team for Alan; there was an anxiety about the call, because we knew that this was going to become a full-blown episode for him. We thought, "How do you impress on these people that this issue is imminent?" They want to see evidence in every sign, but these are subtle things that we know as a family, which are difficult to impart.

36 Alan also had the Mobile Support and Treatment Service (**MST**) supporting him from time to time. From a family perspective, we would have liked to have had some kind of dialogue with MST. I know there's the issue of privacy, but we didn't know what was going on, and that became difficult for us.

37 I did try once to have an open and honest dialogue with Alan's support team. I made a concerted effort and arranged a meeting. About 10 or 15 years ago, Alan had become unwell (although not bad enough at that moment in time to have him hospitalised). As a family, we felt our concerns were not being listened to, so we arranged a meeting at the area mental health clinic with most if not all of Alan's support team. It was like a care team meeting.

38 Our perception was that the care team had become complacent. They seemed to have accepted that this was going to be Alan's lot in life—in and out of hospital and case management. They wanted to discharge him from case management and had not conversed with the family. They just tried to massage my ego, telling me what they thought I wanted to hear. They'd say, "Oh, yes, we'll do this." But there was no follow-up; it was hard to get. We didn't know who we could talk to—who do we contact?

39 There seems to be a feeling of anonymity amongst staff at some of these services. This might be because of the constant change of staff within CAT Teams and MSTs. Now, people working at mental health services are generally more accountable if they say they will do something.

Interpersonal connections and compassion are key

40 The facilitation of treatment for dual diagnosis is about attitude and connection. If people are in crisis, they're never going to take a top–down approach. There has to be something within what you're offering that is inviting to that person to even come and have a look. People who are using drugs may be pre-contemplative, which means they're not even thinking of stopping their use of drugs. There is something you need to do even before

any discussion about harm minimisation or the negative effects that drugs can have on a person's health. Even before you do that, you have to have a connection. That's where a lot of the work needs to be done.

41 Clinicians need to try to look at everyone as a separate case, as an individual, and not just as part of their caseload for the day. Especially having worked in mental health myself, I know that people can tell whether you're genuine or not, whether there's compassion there. You really need to have a real factor of compassion. People are hurting. They don't normally become long-time users because of their own choice. There's something there that they need to take to block something out.

42 There are lots of skills that individual clinicians and psychiatrists have. Compassion is what needs to be worked on in this area. Compassion goes a long way. It helps you get a foot in the door—more than a foot. You're invited into that person's life and you can start a dialogue.

The importance of language and validation

43 If I was to strip it bare, one of the biggest challenges of engaging with the mental health system is to do with language: the clinical language versus the layperson's language and how those two sometimes don't quite translate. The layperson's language may be quite emotive and charged at times. The message is still there, but the people on the receiving end (the clinicians) may not quite be in tune with the circumstances at that time. It feels virtually impossible to articulate yourself and converse on a level which leaves you feeling content that you have been heard.

44 From my perspective, it's about the language and trying to articulate myself, as well as I could, knowing that, even though I work in mental health, sometimes I didn't quite know the clinical dialogue. It was often difficult to impress on someone: "This is what's happening; this is quite serious."

45 Validation is important. I say this both from my experience working in community mental health, and from talking to other carers. When a person presents quite unwell, for example they are angry, the easiest way to take the heat off is to validate. I've found that, in the clinical setting, sometimes the validation of whatever they're experiencing is lacking. For these people, it's real. A dismissive or patronising attitude from a clinician doesn't serve in the long term.

46 At work recently I read a draft of a clinical guide to responding to patients who are exhibiting aggressive or threatening behaviour.[2] I was reading through it with some of the carer and consumer advisors I work alongside, and one of the things I noticed was that it said nothing about validating how a person is feeling. If someone is presenting to you and they're really angry, it goes a long way if you validate how that person is feeling at the time. The language has to change; the approach has to change. It was something that we fed back to Better Safer Care Victoria. I have not yet received a response from them.

Response during crises

47 When my brother first had his episode in around 1986 or 1987, we, as a family, suspected that he had been taking illicit drugs. We tried to articulate that to the CAT Team at the time. We were in crisis. His mental state on the night was explosive and irrational; he had a lot of paranoia. We, as carers to Alan, felt kind of inadequate trying to articulate this. We were told, "This is what the outcome is when someone is meddling in drugs." We just felt powerless to portray the urgency of the situation that we were facing as a family across to a person over the end of the phone.

48 We felt that the mention of his use of illicit substances affected how people responded to the crisis. It was a situation of, "Well, this is not really our domain. This is a drug and alcohol issue." For the very first time in our family, we were faced with someone who was seriously mentally unwell. He was putting holes in the wall. Alan's first episode was a very frightening episode for us.

49 Over the years, our main dealings were with the CAT Team. Once the CAT Team got to be aware of Alan's history, we thought that this might give us an easier passage for getting help from someone, whom we could then inform that we were going through another episode of illness. However, we often felt that it wasn't getting easier to get help; it was almost as if we had to retell everything again to the team. Even though they had quite a bit of historical evidence, we had to try to justify their intervention. Without trying to demonise him, we had to say, "This is bloody urgent." That was the most frustrating part. Each subsequent episode was almost like the first episode again. We had to articulate again and again and again.

50 We found that the only way to get a response was by constantly ringing. We didn't wish to make it any worse for Alan, or to articulate anything more than what we were seeing and being presented with. However, if we didn't get a phone call back from the CAT Team in half an hour, we were on the phone again, constantly ringing, and eventually we would

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[2] The draft has since been published: Better Safer Care Victoria, 'Caring for People Displaying Acute Behavioural Disturbance' <https://www.bettersafercare.vic.gov.au/resources/clinical-guidance/emergency-care/acute-behavioural-disturbance> [accessed 1 June 2020].

get a response. With Alan it was as if we were walking on eggshells until he was finally admitted to hospital on each occasion.

Integrated treatment

51 We have never had an experience in the public mental health system of Alan being treated in an integrated way with respect to his dual diagnosis. Alan has eventually moved over to the private health sector, but even in the private health sector it's still only mental health and not integrated treatment. The psychiatrists will only see you for your mental health issues. The psychiatrist may say that you should not take the drugs or smoke marijuana, but that is about the extent of the integration.

52 Alan in himself did not have the insight that his drug taking was causing the reaction. If there was ever going to be a time when his drug taking could have been challenged and worked on, it would have been when he was under a CTO within the public system.

53 Going into the private system, Alan has more choice about who he sees. I guess he had two main motivations in moving across to the private system. First, I think that he felt more empowered to discuss his issues with the psychiatrist and that he found the visits to the psychiatrist therapeutic. Secondly, he did not want to be put on a CTO and be subject to compulsory treatment. I have no recollection of the dual diagnosis factor ever being discussed amongst us as a family in terms of the treatment options.

54 I think integrated treatment would give the family, us, something that we could work within. Alan is very averse to clinicians, but he tends to listen to his family, and especially to me. From time to time, he will take on board things that I might pass over to him, and we have long conversations in isolation from any mental health intervention. I just let him talk about his drugs. For me, his drug taking was a symptom of something else, and so I would try to look at it from that viewpoint, and try to discuss it with him. For him, the pain was too great. I feel that someone in a clinical role with training in dual diagnosis may have resonated with Alan. It's about trying to speak the right language with him. When you're working with someone like my brother, or I guess with everyone who's in the system, you have to find that resonance. I think treatment from someone with the right training and skills would have made quite a large difference to him at the time.

55 I've been in my role for a short time. What I've heard is that families receive mixed responses when seeking help for their loved one. Most of the time, if the person is presenting alcohol-affected, or if there is alcohol on their breath, then carers have a hard time convincing mental health care workers that the person also has a mental illness. If you go to the emergency department, and the most obvious thing to that person behind

the desk is that they can smell alcohol, then you must be drunk. They're making assumptions; they're not listening to you.

Community Treatment Orders

56 Since his first episode, Alan has been on about three to four CTOs. The main condition of the CTO is for Alan to turn up fortnightly to the clinic or to be available for the MST when they visit to dispense medication. The CTO did nothing to prevent Alan from taking his marijuana and other drugs. As a family, our understanding at the time was that Alan continued to use illicit drugs such as marijuana while on a CTO, although he probably would have concealed this from his case manager. We were not privy to the outcomes of the contact with Alan's case manager or the MSTs.

A future mental health system

Combining the mental health and alcohol and other drug sectors

57 Ideally, the alcohol and other drug (**AoD**) sector and the mental health sector would be more closely aligned. Having worked in mental health, I have observed that a lot of our clients had drug use capabilities and were taking drugs. In saying this, I am speaking from a non-clinical perspective, drawing on my experience as a support worker and team leader within a mental health service. In these roles I was providing outreach for people living in the community whose primary diagnosis was a mental health issue, but a lot of whom were also using drugs.

58 In community based psychosocial mental health, our training and workshops touched on illicit drug use and on collaboration between the AoD and mental health sectors. AoD and mental health services were two separate services, funded separately. Our training focused on identifying clients who had AoD use and (with consent) referring them on to an AoD service.

59 There needs to be some way of ensuring that the person's treatment goes hand in hand. That was something that I found was quite fractured in my work for the non-clinical outreach service in the suburbs of Melbourne. There was no protocol for sharing a client who had a dual diagnosis. For example, our caseload did not take into consideration the complexities of working with a client who had a dual diagnosis, and that meant our workload often prevented us from forming closer working relationships with the AoD sector.

60 Our own professional experience at the non-clinical outreach service was that it was hard to get a continuity of dialogue with the AoD team. They have different systems and different reporting mechanisms. Those differences meant that we didn't have the will or

the capacity at a policy level to work together, even though in theory that's what we should have been doing.

61 Beyond having mental health and AoD services work together, there would also be benefit in having some mental health clinicians being trained in AoD issues, and vice versa. You have to be duly qualified yourself if you want to work with people who have a dual diagnosis. In the ideal world, there would be the one person, who understands both sides of the coin, working with a dual-diagnosis client. It would be far more productive and efficient. It would provide continuity of support for that person.

Helping carers seek information and support for themselves and their loved ones

62 A person's first presentation is always the one that makes the most impact on the family. Our family wasn't aware of any program like COPES, which offers support to carers, being around when Alan had his first episode.

63 The initial question is, "Where does a carer, who is presented in that time of crisis with an emergency, turn for support?" I know there is the police, or a CAT Team. But after that, what other support mechanisms can they be made aware of? It's about information, and the best way for carers to find different types of support. It can be improved. Unless you've been a carer for a long time, as we have, you won't be aware of the different systems. When we first had our episode with Alan, we really didn't know much. We were at the mercy of the system.

64 My family found out in time that Alan could go into a respite home just to give the family a break. We came by that by chance. We were talking to someone who said, "There are some houses near the clinic that he could access to give the family a bit of a break," and that's where Alan went. He was happy to stay there, and we were glad that he went, just to give us a break. We still went and visited him, just to make sure he was okay. I'm sure he was glad to have somewhere where he could be separated from us for a while too.

Carers from different cultural backgrounds

65 We're from Sri Lanka, and from a cultural perspective, we are quite mildly spoken people. We don't force our way into people; we don't demand. We just take things at face value; we don't tend to challenge as much as maybe someone from a different culture would. Carers from different cultural backgrounds can act and behave very differently. Some people say, "Well, this is my lot in life."

66 The squeaky wheel gets the oil. If you don't bang your fist on the table, if you're more passive and say, "Okay, we'll try and cope with this," then you stretch until breaking point, and then something goes wrong, and that's when you find out you could have gone on

another path. In our family, we tend to accept it and say, “This is it, at the moment.” But I do know other families who have been more proactive. To be proactive, there’s a degree of confidence you need to have. You need to have a good network, so you have other people who know things. If you can go into a meeting with clinicians confident, sometimes that can help your cause as a carer.

Giving carers knowledge and confidence

67 Support services could help promote that confidence in carers. They could provide workshops that explain to carers, “This is what you will come up against. These are maybe some of the hurdles. Here are some possible responses. Here is the terminology. Here are some other pathways.” Knowledge is power. Being well equipped with knowledge helps to keep the scales in balance. Sometimes the scales are tipped a little bit in favour of the clinicians, because of their knowledge and their confidence. They know the system. On the other side of the scales are people from all walks of life who are not quite sure of what is the right thing to do.

68 Once someone told me, in relation to Alan’s treatment, “We’re not so much worried about what caused the drug taking. We’re just going to treat the symptoms.” When you hear that expressed in a very decisive tone, you feel like, “Okay, I won’t interfere. Maybe I *am* barking up the wrong tree. Maybe they *are* right. Let them do it; they’re the experts.” However, if you strip it bare, it’s about why this person in the first place ever wanted to take these mind-altering drugs. What was behind that? Then you start working on that, in the setting that you’re presented with at that time.

Dated: 22 June 2020