Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF TRACEY LEE MORGAN

I, Tracey Lee Morgan, Acting Community Services Manager at Casey Area Mental Health Service of 62-70 Kangan Drive, Berwick, in the State of Victoria, say as follows:

1 I am authorised by Monash Health (**Monash**) in respect of its service known as Casey Area Mental Health Service 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, relevant experience and provide a copy of your current CV.

3 I hold a Bachelor of Nursing – Psychiatric from Deakin University (Burwood) which I completed in 1992.

4 I have worked with Monash Health since completing my degree.

5 I have held the following positions with Monash Health from 1992 to present:

(a) Clinician, Banksia Ward, Monash Health, Banksia Ward, Dandenong Psychiatric Service (1992-1994);

(b) Team Leader, Inpatient Group Program, Dandenong Area Mental Health Service (1994 -1996);

(c) Clinician Dandenong Crisis Assessment and Treatment Team (**CATT**), Monash Health (1996 - 1999);

(d) Senior Clinician, Casey Crisis Assessment Team (**CAT**) and Enhanced Crisis Assessment Team (**ECAT**), Monash Health, Dandenong Hospital (1999 - 2013);

(e) Senior Clinician, Casey CAT and ECAT Team, Monash Health, Casey Hospital (1999 - 2013);

(f) Acting Team Manager, Casey Acute Community Intervention Service (**ACIS**) (CATT / ECATT, Narre Warren A and E PARCS, Narre Warren MHaPs), Monash Health, Casey Hospital (2013 - 2015);

(g) Team Manager, Casey ACIS (CATT/ECTT/ Narre Warren A AND E PARCS/ CASEY MHaPS), Monash Health, Casey Hospital (2015 - 2017);

(h) Acting Operational Manager, Casey Area Mental Health Service, (2017 - November 2018);

(i) Acting Community Services Manager, Casey Area Mental Health Service (November 2018 – February 2019) and

(j) Community Mental Health Services Manager, Casey Area Mental Health Service (February 2019-current).

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

Please describe your current role and your responsibilities, specifically your role at the Enhanced Crisis Assessment and Treatment Team at Casey Hospital.

7 I am the Community Mental Health Services Manager of the Casey Area Mental Health Service. I have held this role since November 2018 but, as noted above, have been employed by Monash Health since 1992.

8 As part of my role, I support staff to transition to a new operational structure for the Mental Health Program at Monash Health and assist with the ongoing planning and coordination of community based services while continuing to be involved in the daily operational and management tasks for the Casey Area Mental Health Service.

9 I also currently oversee:

(a) two continuing care teams, these are the longer term case management team and two CAT teams;

(b) the Psychological Triage Service (**PTS**), a 24 hour, seven day a week triage phone service; and

(c) one adult and one extended Prevention and Recovery Care (**PARC**) services.

10 Until a month ago I was directly overseeing the Emergency Department (**ED**) but someone else has now taken that role.

Enhanced Crisis Assessment and Treatment Team

What is the Enhanced Crisis Assessment and Treatment Team at the Casey Hospital in Berwick? (ECAT) What are its aims? What services does it provide?

11 The ECAT team is based in the ED and provides a clinical mental health service. The clinicians provide mental health assessment, direction, management advice and treatment to patients who present with a mental health crisis or other presenting patients

where there are mental health issues identified. Referrals are made to this team by ED staff for assessment of each patient and for a determination of how they should be treated.

12 The ECAT team works 24 hours per day, seven days a week. During daytime hours (8.30 am to 5 pm), there is a consultant psychiatrist available for consultation. There is also a registrar and at times a medical officer. Casey has a "2 + 2 + 1" model of resourcing, meaning two ECAT clinicians on duty from 8.15 am to 4.45 pm ("morning"), two ECAT clinicians from 1.45 pm to 10.15 pm ("evening") and 1 ECAT clinician from 10 pm to 8.30 am (overnight). There is a doctor on call if needed and a consultant psychiatrist on call available by phone after hours.

13 When you arrive in the morning at the ED, there are always patients who have presented within the previous 24 hour period. These are patients who may not have been discharged because they were assessed as at risk or very unwell and for whom there is no mental health bed available. Some patients needing mental health services might be there because they also have medical issues (requiring for example, treatment for an overdose or substance use) and others may have been sedated to reduce agitation or distress. These clients require review and organization of the required treatment, be that admission to an inpatient bed or community follow up. There are also new presentations who start arriving from around 11 am. New patients continue to present during the day and into the evening (including overnight). There is a growing need for mental health services and waiting times are increasing. Clients can wait in the ED for up to 24 hours for a mental health bed.

14 There are some services which cannot be accessed overnight so patients have to wait in the ED until the morning. This includes patients who are homeless and need safe accommodation in the community. Where a patient has no safe accommodation, a mental health assessment is conducted. If the patient does not need treatment or admission, we keep them in the ED until accommodation somewhere is found or they are able to be linked to a crisis accommodation service.

15 Many of these patients are facing difficult psycho-social circumstances such as family break downs. They may be suffering from a relationship breakdown and sometimes have experienced domestic violence which precludes them from returning home. We have staff in the ED on the phones trying to find a place for people in the community. It is difficult for patients to engage with a psychologist or other supports through community services if they do not have a safe place to live.

Who can use ECAT? What are the criteria for people affected by mental illness to use ECAT? Must they come from any particular geographic location?

16 The needs of patients who can use ECAT services has changed over the years. When I was first working with ECAT over ten years ago, I saw more patients with depression and psychosis, but now we see patients with a wider range of mental health issues. Not every patient presenting with a mental health crisis will need to be hospitalised; there are a number of community services which we can suggest to patients. ECAT does not turn anyone away, we see patients of all ages from very young to elderly. There is no exclusion if there is a clear mental health component.

17 We do not specifically consider geographical boundaries when we see a patient for assessment. I have heard of other client experiences where people are diverted to a particular ED which is closer to where they live, but not where the client is located at the time. They might also be diverted so as to access a specialist service or so they can be connected to a relevant community based service. In arranging ongoing follow up post assessment sometimes I will call the CAT team for a specific area if a person has presented at our ED, but lives in another area.

How does ECAT link to other parts of the mental health system?

18 There are two ECAT teams based at Casey which are accessible both via the ED or the community.

19 Patients who come in with a mental health crisis can been seen in the ED, but treated in the community (for example, through psychological counselling and short term support). I can access diaries electronically throughout the night and arrange this community support through a clinic. An appointment is usually available within 24 hours. This system works for people who present in crisis, but who are seeking help rather than acting on suicidal ideation or thoughts of self-harm. I need to be satisfied that the risks associated with the patient are manageable. If I am unable to make an appointment for community services, I liaise with the CAT team for support for the patient.

20 Monash Health also has continuing care teams which offer longer term care, usually appointments every two weeks. We do not usually directly refer to them from the ED because the patients presenting are in crisis.

21 There are also non-government organisations to whom we can refer patients. These include the Way Back program and The Hospital Outreach Post-suicidal Engagement (**HOPE**) program. The Way Back program is Commonwealth funded and provides non-clinical support to consumers for up to 3 months. The program is designed to assist consumers to navigate their way back to work or through Centrelink or through accommodation or other social issues. The HOPE program is State funded and also

provides non-clinical assistance which can include finding housing and employment, or referral to a range of support services, such education and training, legal support, Centrelink, drug and alcohol or relationship and family services.

22 A further source of support to mental health patients is through their local General Practitioner with a referral to a psychologist or private psychiatrist. This is not an easy option for patients because it can be hard to find a psychologist who will bulk bill and many people we see cannot afford to pay the ongoing costs of a private psychologist. It is also often difficult for people coping with mental health issues to secure after hours appointments (which impacts their ability to work).

23 Most of our patients present in crisis. Some who feel they are in a crisis do not satisfy the objective criteria for access to crisis support services.

24 We also have a Police, Ambulance and Clinical Early Response (**PACER**) system in place at Monash. This involves a clinician working directly with the police. They are based at the police station during their shift and also sit in the cars with the police officer between 3 pm and 11 pm and provide a secondary response to the police. The clinician is a CAT clinician who can make a mental health assessment on the spot to alleviate the need for a person to attend the ED. When the clinician is in the car, they hear the radio calls and can often identify a mental health issue which might not be obvious to the police. CAT clinicians working with the police help teach the police more about mental health issues. The PACER model is a very effective model, but its efficiency depends on the proactivity of the clinicians. The clinicians in this role also provide some phone advice to police and clients and can refer directly to a CAT team or an inpatient unit.

25 We have noticed that the presence of a CAT clinician with the police has had a direct impact on the likelihood of the police needing to apprehend a person pursuant to section 351 of the *Mental Health Act 2014* (Vic) (**the Act**). Under this section of the Act the police have the power to apprehend a person if satisfied that the person *appears to have mental illness and because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person.*

How does the service make clinical decisions?

26 Clinical decisions are largely based on risk assessment. For each patient who presents to the ED, we assess their mental state against a Guidelines for Risk Assessment document. This is then used to form part of the discussion with the consultant when the patient is eventually seen. The biggest driver in assessing whether someone should be admitted to hospital or treated in the community is their risk to themselves and to other people, especially family members. Admission is necessary where there is a risk of suicide or a high risk of self-harm or harm to others. The behaviour of a patient shows

their risk. The question we ask is whether we can keep the patient safe at home. If the answer is no, then we look to admission.

27 Another reason to admit a patient is where the family members are exhausted and community support is not enough.

28 There is a cohort of people who will not engage with community options and the risks associated with these patients can escalate. This includes people who:

(a) have poor insight into their illness or need for treatment;

(b) are aware that they are unwell but do not wish to be treated; and

(c) as part of their illness symptoms, believe that the help being offered is intended to cause them harm.

There clients might not attend appointments or may not respond to attempts to engage them with either GPs or public mental health services. They may also have aggressive behaviours which present a safety concern for clinicians and for their family members. Some of these clients are living in unstable or changing accommodation. The lack of stable housing and reliable phone contact increases the potential for these clients to miss treatment or miss home visits from community services which would support their treatment.

What is the demand for the service? What are the waiting times?

29 Demand is much higher than resources in the mental health space. There are limitations on physically available space and time and on human resources. Beds are in short supply for mental health patients and there are long waits. It is very rare for me to come into the ED in the morning and not find people waiting for a mental health bed in the ED.

30 We have a 25 bed mental health ward at Casey and have access to an additional 5 bed ward within the hospital for patients who are less acute. Within Monash Health, we have a bed access unit which co-ordinates all beds across our health services at Casey/Dandenong/Monash. There are two acute units at Dandenong (adult and youth). Monash has one adult ward called P-block. We use beds across the whole network. Casey ED also has a short stay unit where mental health patients can stay, but they cannot be placed in this unit if they are at risk. The staffing level in the short stay unit is lower than in other areas of the ED.

31 The ED environment is not helpful for patients who present in crisis or who are exhibiting mental illness, particularly if the patient is depressed or paranoid. The ED is busy, constantly lit (including through the night), noisy and somewhat chaotic. A client presenting with a mental health issue can be scared and become distressed by what they see and hear while they are waiting. Most patients are unable to sleep in the ED. The

ED is also a high pressure environment and mental health presentations are not always well understood.

32 The ED environment is also not conducive to making an early assessment of mental health. For example, at Casey we do not have dedicated mental health cubicles within the ED. There can be long waiting times for patients to be moved to a cubicle and there is no other private space to consult with clients while they wait.

33 Dandenong Hospital has a separate interview room for mental health patients. Monash Hospital is currently is being re-designed which will positively impact on the environment for mental health patients.

What are the criteria that ECAT applies for assessing whether patients should be admitted to hospital?

34 Patients presenting at the ED, including mental health patients, are triaged by a nurse. All patients are triaged using the National Emergency Access Target (**NEAT**), but there is also a separate mental health triage tool. All mental health assessments are carried out by the ECAT clinician.

35 Clients will also have an allocated ED doctor for their ED stay. The doctor may not be directly involved during the mental health assessment. It takes 1.5 hours to take a full medical and psychiatric history. We have patients presenting frequently throughout each day. There is no shortcut; we do spend a full 1.5 hours with each patient. When needed, we try to bring on additional staff to assist but even if this is not possible, we do not shorten the time spent with a patient. Sometimes the CAT team staff from the community come into the ED to assist. It is hard to predict the cycles, meaning it is hard to know when we will have more presentations and therefore require additional staff.

36 Patients are also triaged through PTS when patients or their carers or family ring PTS. Sometimes GPs or private psychiatrists refer patients to the PTS or call on their behalf. We need greater resources as PTS is constantly busy and service needs of callers have become more complex. At the same time, PTS resources have not increased; there is only one phone number per health service which is used for a variety of purposes. There is work that can be done using that one number to help clients, carers and other referrers to get to the part of the service more effectively without long waits. Where you live dictates which number you should use to gain access to your local mental health service.

37 The PTS number is handed out to many patients, but not everyone needs a mental health triage service or access into the mental health service. Many people who call the number are looking for counselling (and there are other lines with that support). There is a disconnect between what the phone service provides and who rings it. We need to make it easier for people to find and access the services they need.

38 PTS is staffed by mental health clinicians. Anyone can call the number. I would like to see technology used to divert people from that general phone line to the service they need. This would require a direct link through the phone number to another service. We know that there are increasing waiting times on the phone line; we have had reports of this in the past. I do not know if there are issues with the phone line dropping out.

What treatment is available for people who do not meet the criteria for admission? Does ECAT encounter consumers who don't meet the criteria for either hospital admission or community-based treatment? If so, what help is available for them?

39 Patients who do not meet the criteria for admission can be referred to the CAT team for community support or referred to a psychologist. Most of our patients present in crisis and some feel they are in crisis although they do not satisfy the objective criteria.

40 There are also other community services available to someone who is in crisis but who does not qualify for admission to a mental health ward, but these are hard to find. The service providers in the community tend to change every few years and so you need to know where to look for them. There is no one reliable place to look for these services. Some services are provided by churches, for example, Uniting Health. Others are set up to provide family support services.

41 We also manage an Adult Prevention and Recovery unit (**PARC**) at Narre Warren (North not South). It is 100% occupied almost all of the time (except Easter and Christmas when people tend to prefer being at home) and usually at 80% capacity. There is often a waiting list. PARC takes referrals from the hospital wards (where patients are referred to as 'step downs'), but patients can refer themselves and GPs/private psychiatrists/psychologists also use the service. Staying at PARC is voluntary; ours is run in partnership with Mind Australia. We try to be flexible about goals for patients within PARC. PARC is often used for step downs because of the pressure on staff to move patients from hospital beds.

42 One of the complicating factors in treating patients suffering from mental illness is that medication prescribed for patients might take up to two weeks to work. This means that the average nine day stay in the E Ward Inpatient Unit is not enough to assess whether medication is successfully treating the patient. PARC performance is not tied to KPIs of any kind; but occupancy need is directly linked to hospital demands. A place in PARC is viewed as an alternative to a bed in a hospital; if someone in the ED needs a bed in a mental health ward, then someone else occupying a bed needs to be moved to another service or discharged.

43 There are large gaps for people trying to get help within the mental health service before they or someone they are caring for reaches crisis point.

44 Another gap is the people 'quietly bubbling' along in the community; they have mental health conditions, but are not doing anything risky. Those are the clients we knew of before when they were receiving ongoing care through the continuing care teams. Now those teams are under too much pressure and move patients through the system. They are also the people who will not be picked up through NDIS as they will not necessarily apply themselves for assistance, they do not have an advocate and they will not be identified until they present at the ED very unwell. They are often included in the homelessness statistics because they do not function well enough to find and stay in secure and safe accommodation. We do not have the ability to link these patients into the mental health system and offer them other services before they reach a crisis. This is because of demand for mental health services.

Are there pressures on ECAT's ability to perform as intended? If so, what are they?

45 The primary pressures on the ECAT's ability to perform as intended stem from the infrastructure challenges I have discussed earlier in this statement, from the limited resources and capacity in the mental health service and from the growing demand from consumers with increasingly complex mental health needs.

46 Stress in the ED also impacts on ECAT's ability to perform. The ED is a stressful place and the physical environment in the ED contributes to the pressure on staff – including the lack of a dedicated mental health cubicle or interview room where the patient can be asked personal questions about their health. It is simply not appropriate to discuss suicide for example other than in a confidential environment.

47 Further, ambulance workers are under pressure and become frustrated because they have to wait in the ED with patients until the patients are seen.

The mental health trial scale is founded on 4 key principles

(a) Access: Specialist mental health services should be accessible 24 hours a day, 7 days a week, and should proactively inform their communities about how to access triage points.

(b) Responsiveness: People who request help from specialist mental health services should have their mental health needs assessed by a clinician. People should then be offered appropriate advice, and if necessary, further assessment, treatment, and/or referral to other services.

(c) Consistency: Consumers, carers and referring professionals should be confident that their request for help will receive a similar response irrespective of their location or the individual clinician dealing with the request. Services should ensure that staffing arrangements maximise the

consistency of triage service delivery, and that the triage role is clearly articulated and understood within the organisation.

(d) Accountability: Services should have a high standard of documentation for triage and intake decisions and outcomes.

What changes to the system do you think would help ECAT (and similar services, if you can say) to better meet those objectives?

48 I would like to see a better connection between mental health and related services. Specialist programs are set up and funded, but they are not 'under the same umbrella' so they are disconnected from other mainline services. A website would help people with questions work out how they access the service and where they should go. The issue is about educating people; a GP might hand out a phone number for a service which no longer provides the service the patient needs, but if people knew who to call before they found themselves in crisis, this would make the system more effective. Co-located services would also be an excellent improvement. This would allow, for example, a maternal health nurse to connect a patient to a counsellor in the same building.

49 There also remains stigma around mental health and we need to work with mainstream services staff to raise their understanding of mental health issues. We have an educational program in the ED for nursing staff and medical teams. At Casey, individual staff such as the director of the ED has a history as a Psychiatric Registrar so is mental health aware and tries to support changes in views and perceptions. It is the unintended messages given to mental health presentations which are unhelpful and perpetuate the stigma.

50 Overall, the mental health system is under stress and it is a stressful environment to work in. Mainstream health staff find frequent repeat presentations frustrating. Patients who re-present are often suicidal and staff in the ED do not understand, for example, why someone is presenting with a laceration to their wrist, but with no intention to suicide. There is usually a history of trauma and distress behind these presentations and the lacerations are the coping mechanism for the patient, but these patients are not easily treated and managed. Staff struggle with providing support to these patients in crisis and in an environment that can both verbally and nonverbally communicate its frustration and stigma. Infrastructure changes and further education would help combat these pressures.

sign here ▸ 

print name Tracey Lee Morgan

date 8/7/19

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TLM-1

This is the attachment marked 'TLM-1' referred to in the witness statement of Tracey Lee Morgan dated 8 July 2019.

Tracey Morgan

Objectives

To continue to work within the Casey Area of Monash Health in providing excellent and collaborative support and care to clients, families and carers in need of mental health support.
I am also hoping to continue to consolidate management and leadership skills as well as the having the opportunity to assist in the review, planning and development of future community based mental health services within Monash Health

Education

Bachelor of Nursing – Psychiatric, Deakin University (Burwood)
(1992)

Experience

Acting Community Services Manager – Casey Area Mental Health Service
Nov 2018 – current

During this period I have been involved in supporting staff in transition to a new operational structure for the Mental Health Program at Monash Health while continuing to be involved in the daily operational and management tasks for the Casey Area Mental Health Service

Acting Operational Manager – Casey Area Mental Health Service
2017-Nov 2018

During this period I acted in the position of operational manager for the Casey Area. Responsibilities involved support and operational oversight of teams within the Casey Area. I was involved in supporting team managers and staff to minimize barriers that reduced barriers for clients moving between treatment areas, daily problem solving around issues and financial and operational planning and management.
During this period I was involved with Victoria Police around focus groups and development of the Victoria Police Electronic Referral service which is now provided by Monash Health services to Victoria Police statewide. I was also involved in the team reviewing and

redesigning the model of care for the TSU which sought to provide a more recovery focused program.
I was also involved in providing short term cover for the Operational Director Role when required as well as participating in the Operational Executive on Call After Hours roster.

Team Manager – Casey ACIS(CATT/ECTT/ Narre Warren A AND E PARCS/ CASEY MHaPS)
2015-2017
Monash Health (Casey Hospital)

Having previously acted in this position I was the successful applicant for the permanent position. Responsibilities involved the daily operational management of the acute community based services including regular meetings with both site and mental health team management to provide a collaborative response to service demand. Growing numbers of clients presenting to Casey emergency department saw clients spending extended periods of time in ED awaiting inpatient beds. This period saw the trial of the original Mental Health Hospital in the Home program which was extended to become an ongoing feature of the program.
This role also saw me providing short term cover for the Operational Manager Role when required.

Acting Team Manager – Casey ACIS (CATT/ECATT, Narre Warren A and E PARCS, Narre Warren MHaPs) 2013 - 2015
Monash Health (Casey Hospital)

Previous experience acting in the position of Team Manager for Casey ACIS. Responsibilities included the daily operational management of the Casey CATT and ECATT services including liaison with ED staff, site management, inpatient units and mental health executive around resource management, bed management, and monitoring the provision of quality and timely acute community based psychiatric care for clients living within the Casey Cardinia catchment area.

I have also had the opportunity to be involved in the planning, development and implementation of the Narre Warren MHaPs team previously known as PACER. Originally funded in partnership with South East Medicare Local and following subsequent involvement with Department of Health review, this team has received recurrent state government funding. Team management sees ongoing liaison and consultation with Victoria Police in partnership to provide on-site, responsive mental health assessment to clients presenting to Victoria Police in crisis who appear to have mental health issues and may otherwise have been transported to an Emergency Department.

During this period as acting team manager I was also involved in the final stages of planning and opening of the Narre Warren Acute and Extended PARCS units. These units are run in partnership with MIND Australia providing a community based residential rehabilitation program. The model instituted sees strong collaboration between clinical and recovery based staff working together to provide a seamless service to clients, their carers and extended community based treatment teams. The units will saw their 5th anniversary in April of 2018 and regularly receive requests from treating teams both within Victoria and interstate interested in viewing the model of care provided. I presented this model of care at the TheMHS conference in Perth 2014 around the set up and opening of the PARCS units in partnership the MIND manager

Senior Clinician Casey CAT and ECAT Team – 1999-2013, Monash Health (Casey Hospital)

Whilst working in this position I was working in the leadership group as a senior clinician providing acute community based treatment as an alternative to hospitalization for clients living in the Casey Cardinia Catchment area. I also worked on a number of projects including the provision of intensive acute treatment through the ISG program, and the early development and trial of PACER from Moorabbin Police Station.

Senior Clinician Casey CAT and ECAT Team – 1999-2013, Monash Health (Dandenong Hospital)

This position saw me based in the Dandenong Emergency Department providing acute assessment and treatment planning for clients presenting with mental health issues. During this time I was involved in the bed management working party, focusing on the development and implementation of a collaborative model involving planning, liaison and access planning for inpatient mental health beds. The success of this program on implementation saw me involved as part of a small team from Monash Health invited by the Department of Health to provide education sessions to other Area Mental Health services in metropolitan and rural Victoria around both the work done in planning and implementing the model as well as the positive impact on overall acute bed flow, inpatient unit environment and timely responses to clients in the emergency department

Clinician Dandenong CATT – 1996 -1999 Monash Health

In this position I joined the Dandenong CAT Team – providing acute assessment and treatment to clients presenting with a mental health issue in the communities of Dandenong,

Casey and Cardinia. This team initially worked in a consolidated model of care with clinicians providing both acute treatment and management to a case load of adult clients. I demonstrated a capacity to engage clients in strong therapeutic relationships and provided well organized care as well as contributing to an enthusiastic team environment. I was also involved in a trial program providing a 6 week psychoeducation program to local GP surgeries.

Team Leader, Inpatient Group Program 1994 – 1996

This position saw me work collaboratively in a multidisciplinary team providing an inpatient group program focused on psychoeducation, recovery based skill development and relaxation activities.

Clinician Banksia Ward 1992 – 1994 Monash Health – Banksia Ward, Dandenong Psychiatric Service

This was my first position having completed my University Degree allowing for consolidation of skills and further development of organizational and leadership skills.

Skills

- Organizational Skills
- Interpersonal skills
- Clinical Leadership