

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Monday, 8 July 2019 at 10.00am

(Day 5)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Fiona Batten
Ms Georgina Coghlan

1 MS NICHOLS: Commissioners, over the next four days we
2 will be examining a number of important parts of the mental
3 health system and asking how people access services from
4 the system and how they navigate between parts of the
5 system.

6
7 We will be asking whether supply is keeping up with
8 demand; where there are unmet needs, what are the most
9 critical of those needs; what are the pressures on the
10 system; and what are the consequences of unmet need.

11
12 A number of witnesses from whom we will be hearing
13 have been in the system for a very considerable period of
14 time and we're asking them to reflect and share their
15 wisdom with us about the extent to which the system does or
16 does not now embody the important principles that it was
17 intended to embody following de-institutionalisation.

18
19 We, of course, ask them also how the system should and
20 can be different and we are most grateful for people giving
21 up their time to come and give evidence and also to prepare
22 some very detailed and lengthy statements.

23
24 Today, we'll be hearing from Professor Simon Stafrace
25 who's Program Director of Mental Health and Addiction at
26 The Alfred; from Associate Professor Ruth Vine who was at
27 the relevant time Executive Director of NorthWestern Mental
28 Health; from Erica Williams, who is a 22-year-old woman who
29 has lived experience of dealing with the mental health
30 system; and from Dr Neil Coventry who is Victoria's Chief
31 Psychiatrist.

32
33 You will hear over the next four days quite a bit of
34 evidence from people that addresses the same questions, and
35 there's a reason for that, and that is that we wanted to
36 be, although not absolutely comprehensive because of time
37 pressures, but as comprehensive as we possibly could about
38 asking about the status of the system and the pressures on
39 it.

40
41 You will see some quite striking similarities, as I
42 mentioned in my opening statement, about the evidence given
43 by consumers, workers and managers who have the highest
44 levels of responsibility for the system.

45
46 I won't summarise the themes of the evidence because I
47 did that in my opening statement and we are short of time.

1 Each day before we start, we'll give you a short summary in
2 relation to each of the witnesses we'll be hearing from
3 that day.

4
5 And, without further delay, I'm going to ask the court
6 operators to show a short video that the Royal Commission
7 has prepared about this subject.

8
9 (Video played.)

10
11 The first witness today is Professor Simon Stafrace, I
12 call him now to give evidence.

13
14 **<SIMON PETER STAFRACE, affirmed and examined: [10.09am]**

15
16 MS NICHOLS: Q. Yes, Professor Stafrace, are you the
17 Director of the Mental Health and Addiction Program at The
18 Alfred?

19 A. Yes. The title, by the way, is Associate Professor.

20
21 Q. I beg your pardon.

22 A. That's all right.

23
24 Q. I've been promoting you for some time now.

25 A. That's all right.

26
27 Q. Have you been the Director of that program since 2006?

28 A. Yes, I have.

29
30 Q. Was it previously known as Psychiatry?

31 A. Alfred Psychiatry, that's correct.

32
33 Q. Have you got responsibility for the delivery of
34 services across 12 locations across southern Metropolitan
35 Melbourne?

36 A. Yes, I do.

37
38 Q. Before I ask you about those, have you prepared a
39 witness statement which deals with your experiences in your
40 professional role and deals with the questions we've asked
41 you to answer?

42 A. Yes, I have.

43
44 Q. Commissioners, you've received a statement fairly
45 recently which is essentially the current statement, but
46 there have been some minor amendments to cross-referencing
47 and the like and I will tender the final version of the

1 statement that we've received this morning.
2 [WIT.0001.0040.0001]
3

4 Can I ask you briefly about The Alfred Mental Health
5 and Addiction Service: do its programs include infant,
6 child, youth, adult, liaison, emergency and aged care
7 mental health services?

8 A. Yes, they do.
9

10 Q. Also a research centre managed in partnership with
11 Monash University?

12 A. Yes, it did does.
13

14 Q. Does your network include seven clinics, two hospitals
15 and three residential units?

16 A. Last time I counted, yes.
17

18 Q. Do you also have a series of partnerships with
19 community providers including Launch Housing, Wellways,
20 Odyssey, Headspace and South East Melbourne Primary
21 Healthcare Network?

22 A. Yes, we do.
23

24 Q. Is your adult community mental health service based in
25 a clinic in St Kilda Road?

26 A. Yes, it is.
27

28 Q. Does that service deal with the needs of adults
29 between the ages of 25 and 64 living in the inner south of
30 Melbourne?

31 A. Yes, it does.
32

33 Q. In relation to that service, can I ask you about the
34 continuing care teams. Can you tell the Commissioners what
35 they do?

36 A. Sure. So, we have two community mental health sites,
37 but one of them is about to relocate to the St Kilda Road
38 site; just to be clear, that's happening in about
39 three weeks' time.
40

41 The St Kilda Road Clinic has within it the research
42 centre plus three, and soon to be six, continuing care
43 teams, a Homeless Outreach Psychiatry Service and a Mobile
44 Support and Treatment Team. It also has a Navigations
45 Team, so a team that's called the Navigations Team that
46 incorporates the functions of intake, primary mental health
47 consultations and short-term care and transitions.

1
2 Q. Can I get you to elaborate a little bit on the
3 Navigations Service so we can understand what it does and
4 what its parts are, perhaps starting with its intake role?

5 A. So, just to perhaps put it in some context. There has
6 been an increase in funding over the last two
7 financial years, and in response to that we undertook a
8 service planning activity.

9
10 One of the results, one of the outcomes of that
11 service planning was that a decision was made to set up
12 what was called the Navigations Team, and the Navigations
13 Team would include intake, primary mental health
14 consultations and short-term treatment and transitions.

15
16 The transitions component really was a recognition of
17 the fact that we had a significant number of patients who
18 were sitting on case lists that could be managed in the
19 primary care setting, but really needed a fair bit of
20 support in order to make that transition, and it was a
21 process that would take 6 to 12 months and we felt that we
22 needed additional focus and emphasis upon that task.

23
24 Q. So, what are they transitioning from and to?

25 A. They're transitioning from - essentially, what we're
26 trying to do is set up an arrangement whereby GPs and other
27 community services can provide sustainable and ongoing care
28 for people with complex needs that may be not urgent but
29 are still quite complex, secondary to what are severe
30 mental illnesses, albeit chronic mental illnesses.

31
32 Q. How does the Transitions Team provide that support and
33 does it provide it directly to GPs or to the consumers
34 themselves?

35 A. They work with a combination of the consumers and GPs.
36 So, it might involve something like, for example, going and
37 helping the consumer make appointments with GPs, perhaps
38 attending an appointment or two; making sure that
39 information is passed over, trying to understand what some
40 of the barriers to continuing care might look like in that
41 setting and working with the client in order to overcome
42 some of those barriers. It's a slow process.

43
44 Q. And that service has been in existence since 2018?

45 A. Since 2018, yes.

46
47 Q. And that is a service that you've been able to

1 introduce because you understood it was needed and you
2 received funding for it?

3 A. Well, we received funding and we decided this was one
4 of the activities that we would use that funding for. And
5 I have to emphasise, you know, this idea came out of a
6 team-based, service-based planning process, so there were
7 lots of people who contributed to this, including consumers
8 and carers who were consulted in the planning process.

9

10 Q. As far as you're aware, do similar services exist
11 across the state?

12 A. I'm sure they exist, but you know, I suspect in a
13 different form. There are many different ways in which
14 these tasks can be undertaken.

15

16 Q. Returning to your adult community mental health
17 services, does that part of the service include community
18 residential mental health services?

19 A. Yes.

20

21 Q. Does that include a community care unit and a
22 prevention and recovery unit, otherwise known as a PARC?

23 A. Yes, it does.

24

25 Q. Just to be clear, can you tell the Commissioners what
26 consumers Alfred Mental Health doesn't serve, leaving to
27 one side your general primary care service dealing with
28 young people?

29 A. So, I tried to sort of explain in the submission that,
30 essentially the focus is very much on people with severe
31 mental illnesses with urgent need and alternatively with
32 those patients who may have been in that position and they
33 are at risk of having those needs emerge once again.

34

35 And so, the kinds of people that the service does not
36 routinely look after are those people I think that have
37 been referred to in conversations about the so-called
38 missing middle, which I'm happy to talk at some length
39 about.

40

41 I put together - you know, like, in preparing for
42 today we've been looking at quite a bit of our data and one
43 of the things that becomes very clear, is that, at the
44 emergency end we deal with everybody who walks through the
45 door. So, if somebody rings up triage, if somebody walks
46 into the emergency department and has a need, that need is
47 dealt with. The question then is, how is it dealt with and

1 for how long?

2

3 What you will see is that, as you move from the
4 emergency, into the CAT Team, onto the inpatient unit and
5 then out into the community, is that the case mix, the
6 diagnostic mix of people who are in each of these services
7 will change and you will see that a lot of people whose
8 diagnoses - in fact, what you will see in the data, and you
9 will see it in the submission, is that the proportion of
10 people with schizophrenia will increase as you move through
11 each of those layers, so that in the community people with
12 schizophrenia account for around 80 per cent of the case
13 mix in those settings. But at the front-end, in the
14 emergency department, it would seem that they account for
15 around 10 per cent.

16

17 Q. We'll return to this question a bit later, thank you.
18 We have asked you, in the context of these services that
19 the Alfred provides, on the basis of your experience there,
20 whether supply is keeping up with demand.

21 A. Yep.

22

23 Q. You've given us a quite sophisticated analysis of all
24 of the inputs to that in your statement. We won't go
25 through all of the parts of that, but making the assumption
26 that supply is acute inpatient care for patients who are
27 severely ill and at imminent and high risk of harm to
28 themselves and others, and also includes community-based
29 services that are able to provide early intervention or
30 short-term therapies or continuing care for patients with
31 non-urgent but complex needs: with that assumption, you
32 have identified that demand is increasing, and can I ask
33 you to elaborate on what you say about the trends in
34 demand?

35 A. Look, one of the points that I've tried to make is
36 that, there are very different stories that emerge when you
37 take a sort of an operational view on the one hand and when
38 you look at this from the perspective of a patient and a
39 family. I think both parties would say that supply is not
40 keeping up with demand, but would have very different ways
41 of communicating that and understanding that.

42

43 I think for families and carers, and for certainly
44 patients who talk to us and tell us about these things, the
45 situation is at times quite dire because the experience of
46 mental illness is one that extends over a long period of
47 time and the support that we provide for the majority of

1 people - the majority of the 5,000 people that come to us
2 each year is episodic; in fact, it's even briefer than
3 episodic.
4

5 But from our perspective, I suppose from an
6 operational perspective, the service has been designed and
7 resourced in order to focus primarily upon people with
8 urgent, complex and needs with high risks attached to them.
9 And so, even in that regard I think it would be fair to say
10 that we are struggling and the analysis that I presented in
11 the submission was really a focus on that perspective: to
12 what extent are we able to meet the demand of patients who
13 have severe problems that are urgent and that are
14 associated with high risks, and even there we are
15 struggling.
16

17 The evidence for that is that the numbers of people
18 with mental and behavioural disorders who are presenting to
19 the emergency department go up by about 5 per cent per
20 year. Our services are seeing around 15 per cent more
21 people per year - there's a reason for that disparity which
22 I'm happy to go into. Our bed numbers are static. The
23 access to our long-term beds, secure extended care beds,
24 community care unit beds is static, that hasn't changed in
25 about 15 to 20 years.
26

27 And what we're seeing is that, you know, people are
28 spending - we've done a lot of work to try and keep the
29 amount of time that people wait in the emergency department
30 to a minimum, but even that is beginning to creep up again
31 now, and we are seeing fewer patients being admitted
32 directly from the community; in other words, bypassing the
33 emergency department because there's often not a bed
34 available when they need it, and we're seeing more people
35 coming into our service via the medical units which means
36 that there is this interim step that is taking place in
37 order to get people into a bed somewhere at some point.
38

39 So all of that I think taken together is evidence
40 that, even when it comes to operationally dealing with
41 acute demand, we are struggling on a day-to-day basis.
42

43 Q. You mentioned wait times; do you want to elaborate on
44 what you say about how wait times are performing?

45 A. Wait times have been a bit of a focus of the work that
46 we've done at The Alfred for a bunch of reasons, one of
47 which is that the Commonwealth introduced national

1 emergency access targets back in 2012. That came on the
2 back of evidence that people who spend a long period of
3 time in ED tend to do worse if they spend more than a set
4 amount of time.

5
6 It also stemmed from, I think, an experience that we
7 had working day-to-day in that environment, that people
8 with mental health problems found the emergency department
9 setting very challenging and very difficult. And so, the
10 organisation has resourced a fairly sophisticated redesign
11 process and also resourced a mental health team within that
12 setting.

13
14 We've seen our performance on 8-hour and 4-hour
15 targets, which is the amount of time that people spend in
16 ED before either going into a bed or alternatively being
17 sent home; that performance has been very good insofar as
18 it's met state targets, but we've seen that beginning to
19 deteriorate over the last two or three quarters because,
20 you know, the numbers keep going up and we are continuing
21 to struggle because we're not getting any more beds.

22
23 Q. Is lack of capacity in community services contributing
24 to the pressure on emergency services?

25 A. Yes, it does. So, the system is all interconnected,
26 at least big parts of it are interconnected, and so, you
27 can trace the difficulties that our clients are
28 experiencing through from the lack of secure long-term
29 extended care beds, through to the absence of subacute and
30 non-acute shorter-term community care, through to community
31 services, and by that I mean sophisticated community
32 services that can deliver a range of treatment options, you
33 know, all the way to the way in which emergency demand is
34 handled sort of at the front-end in the emergency
35 department.

36
37 Q. Can I ask you about discharge rates. You've observed
38 in your statement that the number of discharges per month
39 remained high. And, acknowledging that each patient's
40 journey is different and there will be many factors that
41 influence when and in what circumstances a patient is
42 discharged, is discharging people as soon as you reasonably
43 can one way of managing demand pressure?

44 A. It's one way, that's right. And I think in my
45 submission I tried to make the point that, the questions
46 about when to discharge patients are complex, they require
47 the input of the patient, the input of the family; they

1 require a consideration of what the immediate risks are; a
2 consideration of what the client's housing situation is; a
3 consideration of the vulnerabilities that the client is
4 being exposed to in terms of drug and alcohol use, in terms
5 of homelessness, in terms of psychological vulnerabilities.
6

7 And so, taking all of that into account, yes,
8 sometimes we find that we're in a situation where we
9 think - in fact, we arrange with the patient and the family
10 that the discharge date will be in, say, seven days' time
11 or five days' time, and we find ourselves with people with
12 very urgent needs in the emergency departments who need to
13 be admitted there and then and we may look at ways of
14 curtailing another individual's admission in order to
15 accommodate that. That is not an uncommon process.
16

17 Q. What happens in those circumstances, where you feel
18 the pressure to discharge someone when you otherwise might
19 have kept them in?

20 A. Again, I mean, you know, we would not do that if we
21 thought that the patient was at imminent risk, and so,
22 you'll see from the data that I provided that in fact it's
23 not uncommon at The Alfred that we would admit somebody
24 with a mental health problem out of the emergency
25 department into a medical bed, for example, in order to
26 await their pending a transfer over into psychiatry. It's
27 important to make that point.
28

29 But, you know, I think when you take this from a
30 family perspective, if you're looking after a loved one
31 with a serious mental illness and - I'm hoping that's not
32 my phone.
33

34 Q. Wait for a minute.

35 A. But if you're looking after a loved one with a serious
36 mental illness, there are all sorts of processes that one
37 has to go through, including making psychological
38 adjustments, coping with your own grief, having to rally
39 resources in order to get care into place - that's assuming
40 there's a family in place.
41

42 For others, we look after patients - about
43 20-25 per cent of our patients come to us of no fixed
44 address, and so, finding housing is a major challenge for
45 us. And, in a situation where you've got the - I think it
46 was the Anglicare rental affordability survey which showed
47 that, if you're on a Centrelink allowance, if you're on a

1 Newstart allowance, there is no single person accommodation
2 that is affordable to you in the private rental market, so
3 these are all struggles that we have to deal with in making
4 some of these decisions.

5
6 So, when we do make decisions to discharge people
7 earlier, it is trying to take all of these issues into
8 account, and sometimes the outcomes are less than ideal.

9
10 Q. What do you do when you're faced with a person who has
11 no place to live?

12 A. Well, our social workers work really hard. They work
13 really hard, they ring around homeless shelters, they ring
14 around crisis housing providers. For many of the crisis
15 housing providers the way things work is, you've got to
16 turn up on the day when you're ready to find accommodation,
17 they will not take advance bookings, and so, this is really
18 problematic when you're trying to coordinate the clinical
19 care of somebody with complex needs and their housing
20 requirements at the same time, and so, yeah, it's a very
21 difficult, time-consuming and ultimately unrewarding for
22 everybody - you know, not the least of which is the patient
23 and anybody who cares about the patient.

24
25 Q. You said in your statement that:

26
27 "The decision about when to discharge a
28 patient can be exceptionally difficult when
29 it's driven by factors other than the
30 patient's recovery and the readiness of the
31 patient and family to return home."

32
33 What are you referring to when you say "driven by
34 other factors"?

35 A. Driven by demand pressures, specifically.

36
37 Q. Yes.

38 A. Yep.

39
40 Q. Alright. In relation to non-hospital-based services,
41 what's your opinion in relation to whether the mental
42 health system is providing the things it was intended to
43 provide?

44 A. If I remember correctly, the way I interpreted that
45 was in relation to community services. I think that, when
46 you look at the language of the framework documents in the
47 1990s and then the way in which in fact services were

1 resourced, there is this disparity between the rhetoric and
2 in fact the reality that emerged out of that process.

3
4 And so, I think one of the difficulties we've had
5 within the public mental health system is this notion that
6 continuing care should be open to all, to everybody who has
7 mental health problems, and I think that in reality has not
8 been the case because the focus has been very much, as I've
9 sort of suggested in talking about the diagnostic case mix
10 of the clientele, that the focus was very much on people
11 with chronic psychotic illnesses requiring ongoing
12 monitoring and coordination of care.

13
14 And so, if you haven't had an illness that has placed
15 you within that category, and in particular placed you at
16 risk of having an urgent need that would place you at
17 higher risk in the future, the system - Victoria's public
18 mental health system I think has actively sought in many
19 parts of the state, not everywhere, but in many parts of
20 the state has actively sought to transfer that
21 responsibility to the first two levels that were shown on
22 the video: the primary system and the consulting system,
23 and that system, I think, isn't particularly well set up in
24 order to manage all of the needs of the community under
25 those circumstances.

26
27 Q. And so, you've identified, I think, three groups of
28 patients who are not being adequately supported. The first
29 one is patients at risk of or recovering from an episode of
30 clinical deterioration and hospitalisation who require
31 intensive community support; in other words, step up, step
32 down community treatment options.

33 A. So that was a comment about the system as a whole and
34 I think - you know, I've always been a fairly - I've always
35 been very convinced by the evidence about the effectiveness
36 of assertive community treatment models and I believe that
37 they serve a really important function. They're
38 particularly effective in engaging the hard to engage and
39 engaging people with very complex psycho-social needs as
40 well as complex clinical needs as well, and I don't think
41 that model has been well looked after within Victoria's
42 mental health system over the past 25 years.

43
44 Many services have walked away from that model of
45 care, it is expensive to run, and the consequence then is
46 that there are no structural responses to that kind of
47 complexity. And the notion that clinicians within any one

1 team can simply change models of care according to the
2 needs of the client, I think, is optimistic. I think that
3 there is obviously flexibility, but I think where you have
4 groups of patients with such disparate needs I think there
5 is benefit in having different models of care that are set
6 up in order to meet those needs.

7
8 And so, within the assertive community treatment
9 framework you need to have more frequent contact, you need
10 to have exposure to multidisciplinary clinicians,
11 clinicians from multiple disciplines. You need to be able
12 to focus on issues like housing, you've got to support
13 families and you've got to do it in a way that's fairly
14 intensive and that requires a lot of engagement and
15 contact.

16
17 And so, it's important to have models that are
18 resourced, and partly what that means is having a lower
19 caseload so that you can spend more time with patients and
20 their families in order to achieve those kinds of outcomes.

21
22 So I think as a consequence there is a bit of a gap in
23 our system in that regard. I've been particularly drawn
24 towards models of intensive, even brief intensive care
25 models, in order to help cover the period post-discharge
26 and obviously cover people who are at risk of being
27 admitted as well.

28
29 Not everybody needs ongoing assertive community
30 treatment, but I think we also need to have the flexibility
31 to be able to provide it in short amounts, and part of that
32 will depend upon caseloads. Insofar as the capacity of
33 clinicians who are doing more general work to make those
34 adjustments, they need to have caseloads that are a little
35 bit manageable.

36
37 It hasn't been uncommon, just to conclude, it hasn't
38 been uncommon for case managers in many services to have
39 caseloads of 30 or 40 clients, and the capacity to shift
40 from what is very general outpatient-based care into a
41 model of care that is intensive, provides in-reach into the
42 home, connects many different parts in order to help people
43 with complex needs, the capacity to do that is almost
44 non-existent under those circumstances.

45
46 Q. So, what sort of caseloads would you be needing to
47 have in order to provide that sort of assertive and

1 intensive community-based care?
2 A. I mean, it depends. It can be as low as eight to 10.
3 I think that within a generalist team caseloads between 15
4 and 20 will allow some degree of flexibility for different
5 phases of care. So, we've only been able to achieve those
6 numbers since 2017, since we had a bit of an uplift in
7 funding since 2017. So, prior to that it was very common
8 for people to be sitting on caseloads of 25 to 35.

9

10 Q. So when your caseload is significantly reduced, just
11 to give us an idea, what difference does that make in
12 relation to the kind of care practitioners are able to
13 provide?

14 A. Well, I think we're still exploring that to be quite
15 honest with you because it's been such a long time since
16 we've been able to do that. And when I say it's been a
17 long time, for many of the clinicians who are in the
18 system, they've never known a system to provide them with
19 that kind of time, and so, this touches a little bit upon
20 the workforce issues: that there is a real need for us to
21 continue to support the workforce to develop the
22 competencies and the skills required to deliver specific
23 evidence-based interventions right across the board.

24

25 But, you know, when you've got a caseload of 15, you
26 might have time to provide some structured psychological
27 therapies, you'll have time to get to know the individual,
28 to get to know their story, to get to know their families,
29 to spend time with them and their families, for example.
30 You might have time to engage with the client.

31

32 You know, many of our clients have had negative
33 experiences with the system and, you know, mistrust is an
34 issue that can only be overcome with respect and with
35 people's problems being taken seriously, and so, these are
36 all of the things that you can do when you have more time.

37

38 Q. To ask the question from a different perspective: what
39 sort of pressures occur when caseloads are too high?

40 A. Oh, when caseloads are too high, clients get short -
41 well, clients get short appointments, they get less
42 frequent appointments, there's more work that's done on the
43 telephone. The families may never see a case manager under
44 those circumstances.

45

46 You know, we've had caseloads up to 35-40 at times and
47 under those circumstances you're really dealing with the

1 most clinical of tasks and putting out - essentially
2 dealing with the emergency. So, when you've got a caseload
3 of 40 patients, for example, you might have ten, 20
4 experiencing acute episodes of illness, or at least early
5 warning signs of that, and that can take up your entire
6 week. And so, those people who are not acutely ill may not
7 necessarily hear from their case manager for two, three,
8 four weeks, or more sometimes.

9
10 Our data has told us about all of these phenomena over
11 the years. We've had small groups of patients receiving
12 contact for very - you know, very infrequent contact. The
13 work that needs to be done in order to get people - to
14 transition people to GPs in the community can't get done
15 because the urgent work is being dealt with, et cetera.
16 So, it's very much - we call it firefighting, it's just
17 dealing with emergencies.

18
19 Q. You've also talked, and you mentioned earlier, about
20 "the missing middle", and I think what you mean by that is
21 to refer to patients who have moderate or severe illnesses
22 whose needs are not urgent in that sense?

23 A. Urgent, yes, correct, and whose risks are not, you
24 know, high.

25
26 Q. I think you have prepared an interesting infographic
27 that illustrates what you want to say about that.

28 A. Yes.

29
30 Q. I'm going to ask for that to be shown, please.

31 A. Look, this was just a bit of indulgence on my part
32 trying to put together the data. You'll find in the
33 submission the data is presented in a narrative form and I
34 found it hard to follow at times myself, so I put this up
35 to try and make it a little clearer; you'll tell me whether
36 I met that objective.

37
38 But really the story that's told here is the story of
39 how - you know, we see a very varied group of patients in
40 the emergency situation, but as we move from there into the
41 community many of those other diagnoses disappear.

42
43 You'll see that, say within the crisis team - and I'll
44 just point you to the red zone which is patients with
45 schizophrenia - I'm not trying to pick on people with
46 schizophrenia - I'm simply trying to make the point that
47 within the emergency space in the CAT Team for example,

1 they comprise just over a third of our clients. By the
2 time you get into the community/adult area, they're
3 comprising about three-quarters of the clients we treat,
4 and that's not because they represent three-quarters of
5 patients in the community with mental health problems, it's
6 because that's what the system ends up focusing on as
7 people move through these different filters.

8
9 So when we talk about the missing middle, I find that
10 a sort of interesting concept because I don't think they're
11 missing; I think we're seeing them, it's just that we're
12 seeing them during emergencies and then we pass them on to
13 the primary sector.

14
15 So, there's really significant opportunities here for
16 us to be involved in the care of people with a whole
17 variety of needs if in fact that's what they wanted, but
18 don't do so because - partly because we're not resourced
19 and partly because the model is designed not necessarily to
20 cater for the needs of clients with those problems.

21
22 Q. In terms of being able to capitalise on those
23 opportunities, you would say there is an issue of capacity
24 but also system design?

25 A. Correct.

26
27 Q. Can I ask you about PARCs and what specific needs
28 they --

29 A. Sorry, before you do that. And at some point I hope
30 we'll be able to talk about this: that assessment really
31 comes, I think, from our experience in the child and youth
32 space, where we tried something a bit different and I think
33 have slightly different experiences. We can come to that.

34
35 Q. Why don't I ask you about that now.

36 A. Within the child and youth space we've had the
37 opportunity to be involved in the Headspace initiative and
38 the national initiative, and we are the lead agency for a
39 Headspace Primary Centre, and we're also the lead agency
40 for a Regional Youth Early Psychosis Program, and the
41 consequence is that we've been able to integrate within a
42 single framework - a Headspace Primary, Youth Early
43 Psychosis Program, and a state funded Child and Youth
44 Mental Health Service.

45
46 And so, the experience there is that, in having
47 different platforms with different designs, we've been able

1 to engage a much broader range of patients. We receive
2 around 3,500 referrals a year through the Headspace Primary
3 Centre, around 700 referrals a year through the youth early
4 psychosis program, about 1,100 referrals through the Child
5 and Youth Mental Health Program.

6
7 We are able, I think, to create a system of care where
8 entry, access for a young person, should be fairly easy,
9 because they literally can walk through the door and make
10 an appointment to see somebody, albeit at one - you know,
11 at five centres that are scattered through a very large
12 region, but it is literally that easy if that's what you
13 choose to do. Whereas that is not how the public mental
14 health sector works.

15
16 Q. What benefits do you say that having this integrated
17 into your system confers in terms of moving people through
18 this system when their needs change?

19 A. Well, I mean, I think it has benefits both in terms of
20 how the service system operates - it has benefits both in
21 terms of patient care, but it also has benefits in terms of
22 system reform as well.

23
24 With respect to patient flow, a person can walk into a
25 Headspace Centre at Elsternwick, present with a mild to
26 moderate illness, get treatment there. Alternatively, they
27 may in fact have a serious and complex presentation and the
28 clinicians there should be able to make a warm referral to
29 the Child and Youth Mental Health Program and appointments
30 should be able to be arranged in a very short period of
31 time. You know, you're not having to re-litigate things
32 all the time, it does work as a reasonably unified program.

33
34 I think what was also very interesting for us was, as
35 a state funded mental health service, was the opportunity
36 to really look into a different way of thinking about
37 mental health service delivery. So, Headspace, I think -
38 and I want to mention this really because I think it gives
39 us some clues as to how we might want to move forward with
40 respect to Victoria's mental health system.

41
42 Headspace paid a lot of attention to the look, the
43 feel, the branding of the organisation; it was very
44 interested in ensuring that it created a respectful space
45 that was welcoming, a product that was desirable.

46
47 Now, when I first was exposed to this I really thought

1 it was nonsense and it just didn't fit in with the way I
2 saw the world, but the impact I feel has been completely
3 different to the impact that one used to have - this was in
4 the mid-2000s coming into one of our community clinics
5 which had a big sign at the front saying, you know, "Alfred
6 Psychiatric Service", and it wasn't quite as welcoming in
7 appearance and we certainly didn't spend a lot of money on
8 the appearance of the environment; in fact it was pretty
9 dowdy, to be quite frank.

10
11 And so, the contrast then is a difference between
12 respect and dignity and, you know, the soft bigotry of low
13 expectations: not just saying, you know, you just put up
14 with what you get. And that was just the start.

15
16 Then there was the client engagement, the youth
17 advisory committees, the peer workers, and all of that just
18 I think helped to drive a very different culture and really
19 opened up the door to ideas like co-design and
20 co-production which again, ten years ago, eight years ago,
21 I wouldn't have understood at all.

22
23 So, being able to be involved in that process I think
24 really had a big impact on the way that we thought about
25 the service system more broadly within our program.

26
27 Q. Can I just take you back to something you said before.
28 You referred to the engagement with the Headspace Centre
29 facilitating a warm referral: what do you mean by a warm
30 referral?

31 A. The difference between a warm and a cold referral is
32 that, with a warm referral you'll take the initiative to
33 actually call the service that you're recommending the
34 patient to go to, and so, you call, you hand over the
35 information, you might make a decision at that point about
36 whether in fact the referral's to be accepted. So, rather
37 than getting the patient to ring up cold and basically
38 restate what's going on and re-litigate whether in fact
39 they're eligible for a service or not, that work is done in
40 the background and at the end of it the client has a
41 service option.

42
43 You know, they don't end up being told by two services
44 that seem to be your only options, that you're not eligible
45 for either one, meaning that you end up with nothing, so
46 that's the idea.

1 Q. And is it connection between parts of the system via
2 personal relationships that makes that warm referral
3 possible?

4 A. Look, those personal relationships are absolutely - I
5 was going to say indispensable - they're really important,
6 they make a big difference to the degree to which these
7 processes are undertaken or are experienced without too
8 many barriers, yeah.

9

10 Q. Can I ask you about PARCs and what they're intended to
11 achieve and whether you think they are achieving their
12 intended goal on the basis of your experience.

13 A. Look, I think that that's a difficult question to
14 answer because I'm not clear in my mind at times what their
15 intended goal actually is.

16

17 So, I know that they're intended to provide an
18 option - and so, when I say this I don't mean to say that
19 we're running a part of our clinical program that we don't
20 know what to do with. I just think that, when the PARCs
21 were introduced, not just in Victoria but in other parts of
22 the country, it was hoped that they would help reduce
23 demand significantly on acute beds, and I think that the
24 impact they've had on acute demand has not been as great as
25 was anticipated initially.

26

27 In fact, just in the past year the department has
28 provided additional funding in order to increase the
29 clinical input into that program in the hope that it will
30 in fact - in order to see whether or not it will have this
31 impact.

32

33 I have to say, you know, one of the points that I've
34 tried to make in my submission is that we do need to - as a
35 system we do need to be prepared to try things out and see
36 how they work and learn from those experiences and improve
37 upon them, so I don't say any of that as a form of
38 criticism. The PARCs were an interesting idea, are an
39 interesting idea; they provide genuine alternatives for
40 some clients.

41

42 We've had clients who have told us very clearly that
43 they would contemplate an admission to a PARC when they
44 would never contemplate an admission to an acute
45 psychiatric inpatient unit, so we know that it fulfills a
46 need. My question is about whether or not we can say with
47 any confidence that ten beds in the system will release X

1 beds in the other system; I don't know that we're in a
2 position to make those comments with a great deal of
3 confidence.

4
5 Q. There hasn't been enough time to tell; is that right?

6 A. There's been a lot of time. You see, I think the gaps
7 between some components of the system are so large that you
8 can put something in to fill those gaps and in fact you'll
9 only be dealing with a part of the demand and a part of the
10 need, and so, the fact that PARCs have not necessarily had
11 a massive impact on demand for acute psychiatric inpatient
12 beds does not mean they are not required. These are two
13 different questions.

14
15 Q. Yes.

16 A. And so, I think the PARCs serve a really useful
17 purpose for patients whose needs can be managed within that
18 kind of open recovery-oriented environment, where in fact
19 risk to self and others is not the major priority.

20
21 You know, acute inpatient beds have been very much
22 designed currently - at least I speak certainly for the
23 units that I've worked in - have been designed with risk to
24 self and others as the primary consideration. And so, both
25 the physical design and the models of care are orientated
26 towards those particular needs, and that can be experienced
27 by many people, as it is by many clinicians, as at times
28 overly coercive and restrictive. And so, the PARCs offer a
29 massive alternative which is very valuable, but it doesn't
30 necessarily then have the impact on the acute system that I
31 think it was once hoped it would.

32
33 Q. Yes. Can I turn now to ask you about crisis
34 assessment teams. You've said that they were and are a
35 very important feature of community-based mental health
36 services.

37 A. Yes, they are for us, yep.

38
39 Q. You've spoken about the barriers that can limit the
40 effectiveness of the CATs. What are they?

41 A. Look, I think, to the extent that the CATs act in
42 order to provide a short period of intensive care as an
43 alternative to hospitalisation, I think that there are
44 features built into the model which do create some
45 limitations. So, I think this is just something we've been
46 thinking about, you know, how do we improve this.

1 CATs rely upon rosters. Staff are rostered mornings
2 and evenings, and so, clients will often see different
3 people in the course of an episode of care and that's not
4 necessarily conducive to the best possible outcomes, but
5 it's a compromise you make in order to make sure that
6 you've got people who are available to you from 7 o'clock
7 in the morning until 10 o'clock at night.

8
9 So that, I think, is a bit of a barrier insofar as
10 continuity and satisfaction and the sense that you're
11 engaging is concerned. I think many of our clients still
12 experience, and tell us, you know, by way of feedback, that
13 they value that opportunity to be cared for in their own
14 homes in an intensive way, they value that quite a great
15 deal.

16
17 Q. You've also mentioned the importance of the Hope
18 Program which commenced at The Alfred in 2017; is that
19 right?

20 A. Yes.

21
22 Q. You received funding to implement that?

23 A. Yep.

24
25 Q. Is that program being trialed or is it permanent?

26 A. I think it's - to be honest with you, I can't quite
27 recall, but I do think it has time-limited funding but,
28 given that it was extended this financial year, I would say
29 that the department's pleased with the results that it's
30 getting so I would anticipate that it will continue but I
31 can't know that for certain. It's being evaluated at the
32 moment by a consulting group and I can't quite recall the
33 details.

34
35 Q. I see. And, because it's currently being evaluated,
36 are you in a position to say whether you think that program
37 is going to make a real difference to patients who present
38 to it, or are you reserving your judgment?

39 A. So, I think I can say with some confidence that the
40 people who have used the service that we've provided, and
41 who have in turn then provided feedback to us, have been
42 very satisfied with the service.

43
44 I like the idea of it. So, for us, the Hope Team was
45 an opportunity to do something a bit different. We were
46 drawn to it because it provided an opportunity for
47 intensive care, brief intensive care following a suicide

1 attempt and/or suicidal ideation and a presentation to the
2 emergency department. And we knew from the literature and
3 from our own experience that, when the majority of those
4 clients were sent home for follow-up by their GP, that the
5 follow-up they received was inadequate; that's a fairly
6 well understood reality.

7
8 And so, this was an opportunity to provide intensive
9 follow-up for a 12-week period for people who are assessed
10 at the point of discharged from the ED as being of moderate
11 to low risk.

12
13 And so, it's important to make this point, I think,
14 that moderate to low risk does not mean moderate to low
15 need, they're two different concepts. And so, we knew that
16 many of the patients who were being discharged to their GP
17 with moderate to low risk in fact had high needs, and so,
18 the Hope Program offered an opportunity to meet that need.

19
20 What was interesting about the model at The Alfred and
21 in different parts of the state, it can involve a
22 combination of clinical and support workers. This is
23 something I think that we often find, is that suicide is
24 often an outcome of multiple factors and multiple forces,
25 not just clinical factors, but also non-clinical factors:
26 relationship breakdown, drug and alcohol abuse and
27 dependence, job loss, you know, grief and bereavement and
28 so many different things. And so, having this capacity to
29 provide a combination of both a clinical response and a
30 non-clinical response has been really effective.

31
32 In this particular team, I would say that perhaps the
33 only limitation is that the volume, the numbers of patients
34 we've been able to manage has been, you know, it's
35 relatively low when you look at the population as a whole,
36 but we do undertake patient reported outcome measures and
37 so we know, because we collect the data fairly
38 consistently, that the level of satisfaction with that
39 particular service is extremely high compared to some of
40 our others.

41
42 Q. Thank you. We've asked you what you think are the
43 most critical unmet needs in the system and you have said
44 there are not enough inpatient beds. Can you elaborate on
45 that?

46 A. Look, this is a very contested issue and, you know, I
47 can't get away from the fact that I'm a clinician and I

1 manage a clinical service, and so, my perspective is biased
2 in that regard.

3
4 But I see a lot of people coming in through the front
5 door who need acute inpatient beds and we just don't have
6 enough for them. And I'm also very persuaded by the data -
7 you know, there have been various data analyses. You know,
8 Victoria doesn't provide as many acute beds per 100,000
9 population as New South Wales, as the country as a whole,
10 anywhere near the OECD average --

11
12 Q. While you're there can I get you to say a little bit
13 more about that. How do the rates in Victoria compare, for
14 example, to New South Wales?

15 A. Look, I'm pretty sure, if I remember correctly, the
16 figures are something like 19 - I think it's 19 per 100,000
17 versus 22 per 100,000, 23 per 100,000. I'd have to refer
18 to some documents, I don't have that data off the top of my
19 head.

20
21 We do badly both in terms of acute beds and non-acute
22 beds as well; your sort of secure extended care or your
23 extended care type beds. We're doing quite well with
24 respect to subacute beds, like your PARCs and so on, but my
25 understanding is that both your acute and your non-acute,
26 Victoria lags behind.

27
28 So, I think under those circumstances - you know,
29 taking that evidence and combining it with what we see on a
30 day-to-day basis, you can't help but think there has to be
31 a problem here.

32
33 That's not to dismiss, though, the importance of
34 managing the social determinants of health and ensuring
35 that you've got robust, sophisticated community mental
36 health services that have a capacity to deal with a range
37 of needs, and I think we still don't quite understand -
38 sorry, my apologies.

39
40 Q. That is your phone this time.

41 A. I've just turned it off, thank you. Apologies.

42
43 We need to bear in mind that there's lots of evidence
44 that sophisticated services at that level can help prevent
45 admissions. I think, though, the problem is that we just
46 don't quite know how many and, you know, it's hard to
47 quantify one and the other but nevertheless the lack of

1 options and opportunities in that space does stand out as a
2 bit of an issue.

3
4 Q. Yes. Is there a temptation from a systems perspective
5 when considering how to resource it, to adopt an either/or
6 mentality; to say, you either need to invest in
7 community-based services or inpatient beds?

8 A. Look, there are problems occurring at a number of
9 levels, or that have been occurring at a number of levels.
10 So, at a programmatic level, we are required operationally
11 to deal with the urgent and high risk problems that present
12 to us on a day-to-day basis, and so, we have to have our
13 emergency and acute services able to respond to that.

14
15 When it then comes to the community, we stray into
16 this space that sits between the Commonwealth and the
17 state, and this is a problem. Within this area there are
18 problems because, if there's one barrier to the effective
19 functioning I think of a public mental health system, it is
20 the state/Commonwealth divide and it is the fact that these
21 services are resourced in different ways - and not just
22 resourced in different ways but governed in different ways,
23 and the governance of Commonwealth funded services is quite
24 complex. You know, we have a central office in Canberra,
25 we have local primary health care networks, and then often
26 we have services that are allocated to non-government
27 organisations. So, you know, there's many different
28 players there.

29
30 And getting that to connect with what we're doing in
31 the clinical system can be quite tricky and I don't know
32 that we've got those levers right, I don't know that we've
33 got those systems operating as well as they could be
34 operating, which is partly why I am so drawn towards the
35 Headspace model because we've had the opportunity to be
36 operating in both the primary and in the clinical
37 specialist space and for me it's just worked a lot better
38 for us and for our clients.

39
40 Q. Is what draws you to that, particularly the
41 integration between primary and secondary?

42 A. What draws me towards it?

43
44 Q. Yes.

45 A. What draws me towards it is the experience of being
46 able to serve larger numbers of patients, being able to get
47 a much better sense of what the community demand looks

1 like, because you're not creating barriers between one
2 level of complexity and the other, and what draws me
3 towards it is an ability to provide a much more nuanced and
4 therefore much more stepped system of care for patients
5 according to the complexity of their issues and their
6 needs.

7
8 Within our current system, if you get to a particular
9 point, there's a sense, well, this could be managed in the
10 primary health sector, but of course there's nobody in the
11 primary health sector, there's no arbiter of standards in
12 the primary health sector that says, yeah, we can take that
13 on. And so, you're always guessing.

14
15 There's one public mental health sector in every
16 catchment: there's hundreds of GPs and psychologists and,
17 you know, mental health counsellors and so on and so forth,
18 so how do you knit all that together? It's quite
19 difficult.

20
21 Q. I want to ask you now about the funding gap. Do you
22 say there's a meaningful gap between the funding provided
23 and the costs incurred in running an area mental health
24 service?

25 A. Yes, and of course, you're asking me a question that
26 the answer to which is changing because funding is changing
27 and has done over the past two or three years now.

28
29 As of the 2019/2020 budget I would say that it
30 appears - and I hesitate to say this because it's a change
31 from over 20 years of experience - it appears that our
32 inpatient services may be breaking even in terms of costing
33 about, you know, as much as we're spending on them - sorry,
34 costing as much as we're receiving for them once you take
35 corporate costs into account.

36
37 Where we continue to sort of lag behind, where there
38 is a mismatch, is in our consultation liaison and emergency
39 services, like, there's a big gap now. Bearing in mind
40 that I think one of the consequences of a public mental
41 health system that has struggled with acute demand has been
42 that a lot of this work now - you know, a lot of the growth
43 in demand is being managed by our emergency services, our
44 consultation liaison services, and so our organisation has
45 responded by resourcing these services differently, and so,
46 at the moment the gap between revenue and expenditure is,
47 you know, of a factor of several million dollars.

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Q. Yes.

A. And I would say that the revenue probably accounts for about half of what we spend in those areas.

The other area where I think we see a bit of a gap is in aged mental health as well, and that would probably be the sort of - oh, and a slight gap in child and youth, but that's a relatively small one.

Q. So, you spoke about breaking even under the current budget for 2020?

A. Yes.

Q. So over the last five years if you can say?

A. No, that hasn't been the case.

Q. What's been the level of the funding shortfall?

A. With bed-based services - again, these are difficult questions to answer because we're talking about - you know, we're talking about current service provision, we're not talking about ideal.

Q. Of course.

A. And I think there could be an argument, for example if we're talking about our service, that we could use some additional allied health service staff. We've had constraints, not just budgetary constraints, we've also had space constraints, we actually have had no space to have additional staff because our facility was so crowded, it is so crowded and so small and so on.

I think it would be reasonable to say that there are those problems that exist. But given our current spending we are definitely breaking even at the moment. Over the past five to 15 years that has not been the case. The shortfall has been something in the order of 10-20 per cent and, you know, there was always a sense that we had to cross-subsidise the inpatient services from community dollars essentially.

Q. I was just about to ask you that. So, in that context, what has been cross-subsidised by what?

A. Again, difficult questions to answer. When revenue comes in for a program, there is a budgetary process that starts of with a top-down budget, where our corporate costs are taken out and a certain amount of money is made

1 available to build the service up from the bottom, and then
2 you see where the gap is and then you negotiate the gap.

3
4 So, within our service the corporate costs have been
5 quite reasonable, certainly when compared with industry
6 benchmarks I suppose. But what we found is that our
7 organisation has - you know, we've built the budget from
8 the bottom up and our organisation has taken the initiative
9 to fund additional services that the organisation as a
10 whole has deemed important to it.

11
12 So, Alfred Health has invested quite heavily in its
13 emergency mental health arm, the specialist team that sits
14 within the emergency department, and it's invested quite
15 heavily in the consultation liaison service for a whole
16 host of reasons.

17
18 Of the 80,000 people who were admitted to the Alfred
19 over the last financial year, about 10 per cent would have
20 a mental health diagnosis that was listed on their
21 discharge summaries; that doesn't necessarily reflect who
22 was suffering from a mental illness but simply where it's
23 been noted. We would see about a quarter of those people
24 through the CL service, so there is a need and there are
25 demands there that drive the organisation to make these
26 choices.

27
28 Q. Yes, indeed. We've asked you the question whether in
29 your experience clinical mental health services are
30 crisis-driven, and you've said in your statement that
31 that's undoubtedly the case. To summarise, what in your
32 view are the hallmarks of the crisis-driven services?

33 A. I suppose the key hallmark is an attitude that says,
34 if you no longer have an urgent need and you are no longer
35 presenting with a high risk of harm to self or others, and
36 you are not likely to be at high risk of experiencing a
37 relapse of illness that will put you in that position
38 again, that we'll seek to transfer your care into the
39 primary sector. And that doesn't necessarily reflect the
40 complexity of the case, of the client's needs, the family's
41 needs.

42
43 For example, I meet with families and carers in our
44 region from time to time, and I was told a story of a young
45 man with a severe mental illness that was stable for all
46 intents and purposes, insofar as he had not had a hospital
47 admission in about two years, but was essentially spending

1 most of his time in his room, isolated from the community,
2 and from time to time he would go out and use drugs and
3 have a period where he would be missing for about three or
4 four days and then return home and then spend the rest of
5 the fortnight in his room doing very little.

6
7 And his mum was telling me, you know, "What am I
8 supposed to do here?" It was a very - you know, these are
9 absolutely reasonable questions: you know, where does
10 somebody like that fit in the system?

11
12 Now, I can give you a sort of an operational answer,
13 but it's not one that necessarily touches upon the burden
14 that that family is experiencing and the need that that
15 person has. There's all sorts of complexities: how
16 motivated is that person? Does he want us to be involved?
17 Does he have a right to tell us not to be involved? All of
18 that is in the background there because, you know, need is
19 not the only driver in this system. Human rights are also
20 a driver and personal choice and autonomy. But, you know,
21 where does somebody like that get care in the system?

22
23 And our system does not focus necessarily - sorry:
24 clinical services do not focus necessarily on that kind of
25 a problem and there's an argument about, therefore, if not
26 the clinical sector, who and how effectively and how well
27 is that undertaken and how successfully can that be
28 undertaken?

29
30 Q. So, are you suggesting that, if the system is
31 crisis-driven, it doesn't really have time to ask itself
32 how might it respond to someone in that sort of a
33 situation?

34 A. I think one of the great things about this Royal
35 Commission has been that it has generated lots of
36 conversations about, you know, what should we be doing
37 differently and how should we be doing it. The clinical
38 system is not the only player in this space, and that's why
39 a Royal Commission I think is so important, because we all
40 need to understand how all of the different components of
41 the system can operate collectively in order to make that
42 person's - you know, the mum I was talking to, to make her
43 life better and to improve the lot of the son who she was
44 looking after.

45
46 Q. You've made some observations about workforce and the
47 difficulties finding a suitable workforce with the right

1 competencies. What do you want to say about that?

2 A. I guess again, because our system - because we're
3 asking ourselves these questions: you know, what does
4 "good" look like? How do we know that we are providing a
5 system that is fit for purpose, that is fit to meet the
6 needs of the people that we're looking after? I think one
7 of the conclusions that we come to is, of course, we need
8 to be delivering evidence-based interventions and so what
9 do they look like? And when you start to tease them out
10 and you start to try and work out, okay, who has been
11 trained to deliver these evidence-based interventions, the
12 answers are not always clear.

13
14 So, if we're talking about, for example, cognitive
15 remediation therapy or cognitive behavioural therapy, or if
16 we're talking about family-based treatment for eating
17 disorders for example, who's been trained to do this and
18 where does that training occur?

19
20 So, the training is not occurring, as far as I can
21 tell, in the universities, you know, in large enough - at a
22 large enough scale for us to be able to confidently say the
23 graduates will present with these competencies and these
24 skills. So, it then falls upon the system, such as it is,
25 to provide that training and I don't know that we have a
26 consistent approach to this particular task.

27
28 Q. Can I also ask you about the role that falling
29 investment infrastructure has played in getting the system
30 to where it is now?

31 A. Well, we had the opportunity to spend some time
32 reflecting over the last two or three years for a whole
33 host of reasons, and one of the conclusions we came to very
34 early on was that we were providing an inpatient unit, for
35 example, that we thought was from a physical design
36 perspective, you know, not fit for the purposes that we
37 wanted it to be used for, for example.

38
39 Since that time we've been fortunate in getting some
40 substantial funding for renovations, and we've been able to
41 lift the appearance, but I would argue that we need to be
42 putting in more effort. You know, I say this with some
43 hesitation because I know that there are new inpatient
44 units that have been built over the last decade that
45 clearly are much more appropriate for the purpose for which
46 they're being built.

1 But I think we need to be thinking much more carefully
2 about how we design our physical spaces for inpatient care,
3 for subacute care, for community care. Because not only do
4 we want - somebody else has said this: that you can set up
5 services, and you can set up health care systems in
6 order to avoid harm, or you can set them up in order to
7 promote health, and sometimes promoting health actually is
8 the thing that works the best for minimising harm, and I
9 don't know that we've had that ethic sort of firmly
10 embedded in the way that we've thought about the design of
11 infrastructure and the maintenance of infrastructure.
12

13 And so, when you walk into a ward where water is
14 leaking through the roof, where you're sharing a bedroom
15 with a second person who makes you feel scared, where
16 you're having to endure having somebody stand over you in
17 the middle of the night, these are not - this is not good,
18 this is not a place where you would think that healing
19 takes place, where recovery takes place. And we see this
20 as clinicians and we despair about this stuff.
21

22 I can tell you that the clinicians who are working at
23 the coalface work really hard to manage these realities.
24 It could be so much easier if we just got it right the
25 first time, you know, and if we were able to improve and
26 respond to problems much more quickly than is currently the
27 case.
28

29 I think one of the weaknesses of our system is that we
30 set up an architecture - and I mean a system architecture,
31 but you can also argue a physical architecture - and we
32 don't seem to have then the capacity to respond quickly to
33 the lessons we learn in order to continue to improve the
34 care that we're providing. We sit there and we wait and we
35 just hope for something - somebody else will make this
36 decision. This cannot be the way for the future, we need
37 to be able to respond in a much more agile and nimble way.
38

39 Q. Yes. You've written a piece that we're most
40 interested in which includes this statement:
41

42 "Strictly speaking, the mental health
43 system isn't broken, it was just built this
44 way and is producing the results it was
45 designed for."
46

47 Can you say a little bit about that?

1 A. It's unfortunate that you showed that video before we
2 started which made the opposite sort of claim.

3
4 The point I was trying to make there was that, to
5 describe the system as broken is to suggest that it was
6 once fixed, and it also implies to me this notion that
7 something has happened, something out there has happened
8 that has blown it off course. I think we all need to take
9 responsibility for it, and I mean "we" in the very broadest
10 sense possible.

11
12 The system is doing exactly what it was designed to
13 do, it's doing exactly what it was resourced to do, it's
14 doing exactly what it was given permission to do. Every
15 single time a decision was made to take funding out without
16 thinking about or indeed monitoring the impact on patients
17 and families, every time the new element was introduced
18 into the state/Commonwealth split with no consideration
19 about how it would actually link in, this is what we've
20 got. What we have is the result of all these small
21 decisions that we've made along the way at a policy level,
22 at a funding level, at an operational level, at a clinical
23 level; we've all had a part to play in this.

24
25 Again, it's why I think the Royal Commission is a
26 really important exercise because I think it's a way that
27 we all sit down together and we all think, you know, where
28 are we and do we really want to be here and how do we make
29 this better than it's been before, because it's so uncommon
30 to have all these elements in the room and, you know,
31 conversing with one another and actually trying to work
32 through things collectively.

33
34 Q. I've just got a couple more questions for you because
35 we are running short of time. We could ask you many, many
36 more questions. One is about data, and you've said this
37 that you:

38
39 "... believe that the DHHS must provide
40 epidemiological surveillance of psychiatric
41 morbidity in the community, including
42 suicide, and better reporting on service
43 performance with a particular emphasis on
44 the development of metrics for community
45 practices in all aged groups."

46
47 Why do you put it that way in relation to surveillance

1 data?

2 A. Well, look, because I still have a view that the
3 clinical service - I still have a view that there needs to
4 be a public health approach to the problems of mental
5 illness and, you know, mental disorders, mental health
6 problems, et cetera.

7
8 I was always very drawn to the notion of catchments
9 because I thought that they would actually provide us with
10 an opportunity to provide some of that population-based
11 activities, or that population-based planning for mental
12 health problems in our community. And I have to say I
13 would include addiction within that; I think it's really
14 important for us not to - one of the things that we try to
15 do in our submission for Alfred Health is really to make
16 that claim, that you really need to look at these two areas
17 together.

18
19 I think I mentioned at some point somewhere that, you
20 know, at The Alfred we were looking to reposition our
21 program and introduce addiction services into our program.
22 I spoke to an addiction physician up in New South Wales and
23 he said to me, "No, I don't think it's going to work very
24 well", and I said, "Why not?" He said, "There's a big
25 cultural difference between addiction services and mental
26 health services." He said to me, "As far as I can tell,
27 addiction services, we're far more public health-orientated
28 than mental health services are. As far as I can tell,
29 mental health services, you've just got a few beds, you
30 look after them and that's all you're really concerned
31 about. You don't really think about the needs of the
32 population with respect to mental health."

33
34 And, I think he was right, and I think that we need to
35 be able to have the tools to be agents of change with
36 respect to responses to the mental health needs of our
37 communities. If we are to meaningfully have catchment area
38 responsibilities, we need to be able to have the
39 information in order to respond to what's going on out
40 there in the community, as well as a whole bunch of other
41 sort of elements and resources.

42
43 The department, of course, has a capacity, I believe -
44 I'd like to think anyway - that either the Commonwealth or
45 the state departments have a capacity to collaborate in
46 order to produce some of the surveillance data in order to
47 help drive some of these responses locally, and I think

1 it's a really missed opportunity.

2

3 I don't know for example, within the inner south-east
4 of Melbourne if there's a spike in suicides. I just don't
5 get that information. Unless those suicides involve
6 patients that are registered at The Alfred, I wouldn't know
7 about it. Now, I would have thought that as a public
8 mental health sector that it would be a useful thing to
9 know about and a useful thing to collaborate with other
10 agencies and other thought leaders within the area in
11 order to find a solution if that was in fact a problem.
12 That's really what I'm getting at: are we just a clinical
13 service or are we going to be something more than that?

14

15 Q. We've asked you, how do you think this Royal
16 Commission can make more than incremental change and the
17 first thing you said was that:

18

19 "Victoria should set an ambitious target of
20 ensuring that its coverage of the
21 population increases from 1 per cent to
22 3 per cent."

23

24 A. Yes. I mean, I think that's just a simple way, I
25 think, of creating a bit of an uplift. So, we engaged in
26 thinking about this possibility at The Alfred, and it just
27 opens up the door in terms of a different way of thinking
28 about the kind of service that you are delivering, about
29 the priorities that you will set for yourself, about the
30 models of care that you provide.

31

32 Because when you move from 1 to 3 per cent you're
33 seeing people with a whole bunch of different kinds of
34 problems, and you might be providing more continuing care
35 for people whose needs are less than urgent and less than
36 sort of high risk to self and others, and you start to open
37 up the possibility to models of care that involve therapy
38 and that involve interventions that make a difference to
39 people's functioning and their relationships and so on.
40 So, I think that's just a really interesting way to perhaps
41 lift the bar.

42

43 Q. Unfortunately, we are getting short of time.

44 A. That's all right.

45

46 MS NICHOLS: Chair, do the Commissioners have any
47 questions?

1
2 CHAIR: Q. Yes, I do, I have a number. The first one:
3 I'm pleased that you dealt with the fact that your title
4 actually is as Program Director of Alfred Mental and
5 Addiction Health.

6 A. Yes.

7
8 Q. And that emphasis on addictions. I was noting in the
9 data you provided, I think you said that patients in whom
10 substance abuse disorders represent a primary or secondary
11 diagnosis occupy at least 47 per cent of bed days on an
12 inpatient unit. And you gave some data also about the
13 number of people with a similar condition who are involved
14 with your CAT Team response.

15 A. Yes.

16
17 Q. What's the implication of that, because it seems very
18 much like your argument that you've just put, you can't
19 really separate the mental health and addiction issues.

20 A. So, in the primary space I think these are different -
21 one could make an argument for there being different needs.
22 The problem that we're dealing with in the clinical
23 services is that we get patients with undifferentiated
24 problems. You know, by virtue of the fact that they are
25 complex, they will have lots of things going on in their
26 lives.

27
28 It's about as sensible at a tertiary hospital level to
29 separate addiction from mental health as it would be to
30 separate housing from mental health. I mean, you know, how
31 could you possibly function that way and how could a
32 patient properly get any benefit from being told you've got
33 to go over here for this problem and over there for that
34 problem?

35
36 So I think we need to be a bit more generalist in our
37 approach. We need to be able to say, listen, you come to
38 the one place, we'll organise the services around you, and
39 when you look at the data you'll understand why for us it
40 was such an imperative to start thinking this way, even
41 though we don't have any dedicated funding for it, but we
42 sort of make budgetary decisions in order to deal with the
43 demand that we're seeing on a day-to-day basis.

44
45 The implications are that we have a lot of work to do
46 with respect to our models of care. Whilst we aspire to
47 being a mental and addiction health service, I think we

1 have a lot of work to do to ensure that the people that
2 come to us with severe mental illnesses and serious
3 substance use disorders are getting as much evidence-based
4 attention for the one as they do for the other. Of course,
5 we've got a particular challenge because so many of the
6 treatments for substance use disorders rely upon people who
7 are motivated and engaged, and so, we have a unique
8 challenge in trying to help people who may not necessarily
9 be motivated to deal with their substance use disorder, but
10 I think it's a challenge that, as a system, we need to be
11 prepared to take up and we will learn as we go along about
12 the best way to do it.

13
14 Q. One other issue, and then I know Professor Fels wants
15 to ask a question. I think you also highlighted in your
16 submission about that tension where people who present to
17 an ED department do not meet the criteria for an urgent
18 response, and I think it's said therefore a referral is
19 made.

20
21 We've heard many times from particularly consumers and
22 family members about their distress attending to an ED
23 where they feel they're in need of urgent care and
24 attention. Having that explained to them, that they don't
25 meet the criteria, who does that explaining and how is that
26 done, and how confident are we that they actually do get a
27 referral on to other alternate forms of support?

28 A. Well, the people who do the explaining are the
29 clinicians, and these are difficult conversations to have
30 at the best of times. I think we like to think that people
31 are being offered with a pathway forward irrespective of
32 how they present.

33
34 But, of course, you know, the reality is that
35 inevitably you've been sitting on the problem for a period
36 of time, it's been a massive effort to get - to seeking
37 help in the first place, the last thing you want to be told
38 is, now, why don't you take a ticket basically and go off
39 and start again, and so, this is inevitably going to be
40 enormously frustrating, disappointing and devastating I
41 think for some people as well.

42
43 You asked the question about, how do we know that
44 people are following up with what's being recommended --

45
46 Q. Or being actually recommended a pathway forward.

47 A. Yeah, yeah. So, we know from a lot of the work that's

1 been done on people who present to EDs following suicide
2 attempts that in fact a lot of the advice is not followed
3 up, and people become - you know, for whatever reason: they
4 either feel better and therefore the problem's not as
5 urgent as it used to be and therefore the motivation to do
6 something about it has diminished, or they've been
7 demoralised by the experience and have just given up.

8
9 There's been a really interesting experience I think
10 that we've had through our Hope Team. So, the Hope Team
11 provides care for 12 weeks, it's pretty strict about that
12 because we want to make sure that everybody gets a go, sort
13 of thing. Part of the job of the Hope Team is to connect
14 people, is to do that warm referral. So, people come
15 along, they've had a suicide attempt, they may be
16 presenting because of suicidal ideation or following a
17 suicide attempt, the Hope Team picks them up and for the
18 next 12 weeks somebody's following them through, regular
19 phone contact, visits at home, et cetera.

20
21 Part of their job is to connect them to community
22 supports: psychologists, psychiatrists, GPs, but make sure
23 they've had that first appointment, they've gone back
24 again, that the needs that are still present are being met
25 appropriately from a clinical perspective.

26
27 It takes around six weeks for most patients to make
28 that first contact with support, so one can only imagine
29 what happens in the alternative circumstance which is of no
30 support and where we're not actually monitoring the
31 outcome.

32
33 I can only assume that, for many people, that is a
34 task that is not undertaken, you know, to the conclusion
35 that we assume is going to be the case at the point where
36 they leave the emergency department.

37
38 Q. Thank you. The last point from me was in relation to,
39 you talk about how along the continuum the pressure on
40 balancing demand considerations relative to the state of an
41 individual's capacity, and health and wellbeing, and talked
42 about the fact that sometimes there is a tension and people
43 might be discharged before you might clinically think it's
44 the preferred outcome for them.

45
46 What implication does that have for re-admission
47 rates?

1 A. Well, look, it's a question that's very difficult to
2 answer, and I'll tell you why. Our length of stay has
3 dropped from around the high teens to the mid-teens. I
4 think it was around 18 days, it's sitting at 14 or 15 days
5 in the past two or three years. That's our average, not
6 our trend. There is a difference, but it doesn't matter.
7 And our re-admission rate has sat around 11-12 per cent the
8 whole time, so it's had no impact.

9
10 I think I'm fairly confident in saying that the
11 research would indicate that there are many, many factors
12 that impact on re-admission rate, so we would not
13 necessarily expect a linear association between one and the
14 other.

15
16 We do actually have - you know, I think it's really
17 important for people who are listening to this to
18 understand that when we discharge somebody a little
19 earlier, we're not abandoning them, there are community
20 services.

21
22 There is an argument that is quite legitimate as to
23 whether or not those services are equally useful, and
24 certainly I think from a clinician's perspective part of
25 the reason why we keep people in hospital is because they
26 have access to a multidisciplinary team that can provide
27 lots of inputs in a relatively short period of time, and
28 knows multidisciplinary inputs may not be as available in
29 the community, so this is one of the gaps in the system, is
30 really recreating a multidisciplinary team that can provide
31 intensive input at that post-discharge phase or during that
32 post-discharge phase.

33
34 Because I think, if we had something like that and we
35 could potentially - we're exploring actively ways of
36 accessing that now that our caseloads are coming down, but
37 if we had access to that more reliably, then we could
38 perhaps provide an alternative to hospitalisation that
39 would provide something that was roughly equivalent in
40 terms of the inputs.

41
42 And so, I think there are ways of managing this quite
43 effectively, but we need to try out a few different things.
44 I don't think that the one immediately leads to higher
45 re-admission rates automatically.

46
47 CHAIR: Thank you. Professor Fels.

1
2 COMMISSIONER FELS: Q. Thank you for your excellent
3 witness statement and evidence. I just wanted,
4 notwithstanding the time, if you could give us a short
5 minute or so on what you said about the power situation and
6 what you're getting at in terms of its implications for
7 practice.

8 A. The new power reference?

9
10 Q. Yeah.

11 A. Okay, so I'm not an expert in this area, this is not
12 my idea, I was simply drawing attention to, I think, an
13 interesting construct.

14
15 I think mental health services, like the rest of
16 health, has been challenged by the notion that it's
17 important for us to bring consumers and families into the
18 leadership mix, and consumers and carers, families, need to
19 be more present within the leadership of clinical services
20 but also more engaged with and involved in the design, and
21 possibly in the production, the delivery of services as
22 well.

23
24 I think from a clinical perspective, clinical services
25 are highly technical organisations that are very
26 hierarchical. We've had a lot of difficulty trying to
27 understand how do we make this work? There are a number of
28 models, I suppose, that have tried to, I think, to address
29 these challenges of increasing participation right across
30 society. So, health care is not the only sector that is
31 grappling with these issues, I think.

32
33 So, new power was an interesting concept because it
34 seemed to describe very accurately situations that I found
35 very familiar. You know, the description of old power,
36 which is in my statement, is of, you know, a form of power
37 that derives from hierarchical organisations, that are very
38 authoritative, where power is like a currency that is given
39 out and that is held by the sort of, I suppose, the
40 technical experts in this particular situation.

41
42 Whereas new power, the kind of power that we see sort
43 of very much on display in social movements and which are
44 becoming much more frequent and much more visible nowadays
45 is more like a currency, it goes from the ground up, it is
46 much more widely dispersed and so on and so forth. I mean,
47 I put the definitions sort of in my statement.

1
2 I think what's interesting about that really is a
3 recognition that health services represent old power, and I
4 think mental health services are particularly challenged by
5 this; because, not only do we come from a clinical
6 framework that is hierarchical - and I think, you know, I
7 have to say, hierarchies have their uses and I'm happy to
8 expand on that further - but I think we have a statutory
9 hierarchy as well.

10
11 So, we have a clinical hierarchy, we have a statutory
12 hierarchy that is as a result of the Mental Health Act, and
13 then we have paradoxically, compared to the other parts of
14 the health system, quite a number of the patients who we
15 treat - certainly in the hospital setting - a third to a
16 half - don't actually want the service we're providing.
17 This is very different to the rest of the sector, where in
18 fact managing demand is part of the challenge. For us it's
19 actually trying to drive the demand at certain points.

20
21 And so, I think it's really interesting then to sort
22 of take that perspective and say, okay, so how do we open
23 ourselves up to a more bottom-up approach and it does
24 involve letting go of some of the privileges and some of
25 the control that sits with old power, but it also involves
26 risks as well. I think I would hesitate to say this is an
27 either/or situation.

28
29 I've worked in circumstances where the hierarchies
30 were replaced by very flat structures and I've seen the
31 problems arise when people fail to take responsibility, and
32 when people fail to provide oversight and supervision. I
33 think clinical services and their hierarchies can be very,
34 very powerfully useful.

35
36 Where they are not particularly effective is in
37 managing change, in coping with shifts in what is required
38 by communities, and I think trying to find some way of
39 combining the rigor of the clinical hierarchical system and
40 the creativity of a new power approach, of an approach that
41 actually increases participation, I think that is where the
42 goal is, somewhere in that space

43
44 COMMISSIONER FELS: Thank you.

45
46 COMMISSIONER COCKRAM: Q. Associate Professor Stafrace,
47 you mentioned in your evidence about the complexity of the

1 number of service providers and Commonwealth/state funding
2 systems in the community space, if I can describe it that
3 way.
4

5 In your opinion, what do you see as the opportunities
6 for leadership and, I guess, maybe hierarchy governance in
7 the adult hub model that you've proposed?

8 A. I'm not sure I understand that question fully.
9

10 Q. Okay, I'll go again if I need to.

11 A. Yeah, see if you can.
12

13 Q. In your statement you describe one of the things that
14 you would be interested in the Commission pursuing is adult
15 hub community spaces.

16 A. Yes, built on the foundations of existing services but
17 expanded, yes, absolutely.
18

19 Q. So, how do you see, in the complex world you've
20 described, leadership, governance and those aspects being
21 brought to bear?

22 A. Yeah, very good question, very good question. I don't
23 have the answers and I think that's part of the challenge,
24 is that, to be open to the fact that in fact the answers
25 are to be explored and to be tested out.
26

27 I think that - so what I was trying to talk about
28 there was, and what we're trying to build at The Alfred is
29 really putting together a community mental health service
30 that has co-located addiction, a physical health capacity,
31 and psycho-social services, and it's difficult, it's
32 complicated, and part of the difficulty is setting
33 expectations that you can't meet and failing to deliver on
34 what people need but I think it's worth sort of pursuing.
35

36 But the way in which these hubs could really work well
37 I think is if in fact they involve a co-location of
38 services. So, not only would you have then a service
39 designed that would engage consumers and carers within the
40 leadership and within the co-design, but you would have
41 people with different - organisations with slightly
42 different perspectives that would share space.
43

44 You know, like one approach to this would be something
45 like a Headspace model, but you know, on steroids, it would
46 be quite different. I mean, Headspace at the end of the
47 day is a small primary care centre, mental health centre

1 that has limitations in terms of the resources that are
2 brought to bear.

3
4 But there is an opportunity I think, for example to
5 collocate, say, community health and community mental
6 health and potentially an employment provider and include
7 addiction services and primary care within that space, and
8 to actually run specific programs together.

9
10 And so, how that governance would work: there are a
11 number of approaches to that. It could be some kind of
12 advisory body, it could be a joint sort of management
13 structure, it could be a consortium, but I think one would
14 have to sort of think through the implications of all of
15 those options carefully.

16
17 COMMISSIONER COCKRAM: Thank you.

18
19 MS NICHOLS: May Associate Professor Stafrace be excused,
20 please.

21
22 CHAIR: Yes, thank you.

23
24 <THE WITNESS WITHDREW

25
26 MS NICHOLS: The next witness is Associate Professor Vine.
27 Chair, do you wish to continue with the evidence or to have
28 a short break?

29
30 CHAIR: I think we'll have a short break.

31
32 **SHORT ADJOURNMENT**

33
34 MS BATTEN: Commissioners, the next witness is Dr Ruth
35 Vine. I call Dr Vine.

36
37 <RUTH GERALDINE VINE, sworn and examined: [11.58am]

38
39 MS BATTEN: Q. Dr Vine, have you, with the assistance of
40 lawyers, prepared a statement for this Royal Commission?

41 A. I have.

42
43 Q. I tender that statement. [WIT.0002.0002.0001]

44 Dr Vine, would you please briefly outline your relevant
45 background and experience?

46 A. Certainly. I'm a consultant psychiatrist by training.
47 My career has spanned, I guess, three major areas: I was a

1 consultant psychiatrist in forensic psychiatry for about a
2 decade. I worked with the Department of Human Services,
3 then the Department of Health, then the Department of
4 Health and Human Services for about 13 years in roles as
5 the Deputy Chief Psychiatrist, Director of Mental Health
6 and Chief Psychiatrist. And most recently I've been the
7 Executive Director of NorthWestern Mental Health which is a
8 large mental health program auspiced by Melbourne Health.

9
10 Q. In summary, is it fair to say that you've been
11 involved in clinical, bureaucratic and administrative
12 aspects of the mental health system?

13 A. Yes.

14
15 Q. In your statement you've stated that in your role as
16 Executive Director of NorthWestern, you attended Melbourne
17 Health's board meetings which increased the visibility of
18 NorthWestern to the board. Can you explain what you meant
19 by that, please?

20 A. Yes. NorthWestern Mental Health is different from
21 many other mental health services by reason of its size and
22 geographic coverage. It covers a large chunk of north and
23 western Metropolitan Melbourne.

24
25 That means that it's also a significant part of
26 Melbourne Health's funding and clinical responsibilities
27 and I think, by being on the board, that the size of the
28 program and the importance of the recognition of the
29 program was enhanced.

30
31 I think also by and large health services in Victoria
32 are hospital-focused and mental health is very much a
33 mixture of both bed-based and community-based services, so
34 I think again by having my presence on the board and
35 hopefully my contribution to board discussions, that
36 significance of the community aspect of management, the
37 significance of the risk that is managed by mental health
38 programs including risks of access, risks of critical
39 incidents and outcomes such as of course tragically
40 suicide, and some of the pressures that the system were
41 under were more front of mind for the board than they might
42 otherwise have been.

43
44 Q. Thank you. I would like to ask you some questions
45 about NorthWestern, and I understand that you've prepared
46 some slides to help you illustrate NorthWestern. So, may
47 we have the first slide, please, which is "NWMH at a

1 glance". [WIT.0002.0002.1000] There are a number of
2 slides, but starting with this one, can you please explain
3 what NorthWestern is and the services that it provides.
4 A. As the Commission would be aware, Victoria has an age
5 based/area based mental health system. NorthWestern Mental
6 Health grew out of a previous phase of Victoria's
7 development when there were health networks and it actually
8 includes four adult mental health services, as well as a
9 very large youth mental health service run through Orygen
10 and a large aged mental health service. That means that we
11 have a very large population base, one that is also rapidly
12 growing, we cover a number of growth corridors. It says
13 there 1.3 million - and counting, I sort of lose track of
14 whether it's 1.3, 1.4, 1.5, because it really does grow so
15 fast.

16
17 It's a big program, it has a budget that, as you've
18 seen there, of \$210 million. It's probably a bit more
19 this year. It has many staff members, where probably about
20 85 per cent of the funding that goes to the operational
21 part of the service goes to pay for staff, and it's
22 multi-site and across some very complex communities. So,
23 many, many different languages are spoken across our
24 different areas, and perhaps because of those growth
25 corridors we do have areas of considerable socio-economic
26 disadvantage and areas with comorbidities with substance
27 use or with homelessness are very high. We cover the
28 central business district so homelessness is a big issue
29 there, as are new populations of, for instance,
30 international students.

31
32 But NorthWestern Mental Health also has a very strong
33 research focus, we have several research centres and cover
34 research across from the neurobiological aspect right
35 through to psycho-social and multidisciplinary as well.

36
37 Q. We have two slides that help illustrate the catchment
38 areas. The first one is "NorthWestern's catchment areas
39 and sites." [WIT.0002.0002.1001]

40 A. Yes.

41
42 Q. So, just speaking to this, can you explain the area
43 that you cover and then the next slide deals with the
44 population growth which we'll come to when you raise
45 population growth.

46 A. Alright. Look, I almost can make no apology for the
47 complexity of NorthWestern Mental Health, our coverage is

1 historical.

2

3 You can see from that slide that we cover the northern
4 area, the northwest, midwest. Southwest, we don't actually
5 provide the adult services for but we do provide the aged
6 and the youth services for. And northern, we do provide
7 the aged services for but we don't provide the youth
8 services which are provided by the Austin. So, that just
9 demonstrates some of the complexity.

10

11 You can see from that, the little dots are where the
12 actual buildings and health services are, and of course, as
13 the population expands and rolls out across the western
14 plains and the northern plains, the accessibility of the
15 actual buildings becomes more and more challenging, as does
16 our ability to provide outreach, because the geographic
17 distances become greater.

18

19 Q. Can we go, please, to the next slide that is titled,
20 "NorthWestern has four of the largest and fastest growth
21 corridors in Metropolitan Melbourne." [WIT.0002.0002.1002]

22

23 You mentioned growth corridors before, but can you
24 elaborate on the growth that's been experienced in the
25 NorthWestern region?

26 A. Yes, I think people are aware that Melbourne's
27 population is growing rapidly and there are particular
28 corridors of growth, one of those is down the South East.

29

30 But NorthWestern has got, if you like, more than its
31 share, because the growth out towards Melton and Rockbank
32 is, I think, up there at number one or two, as is the
33 growth out through the northern corridor which is the South
34 Morang/Whittlesea corridor, and then North West is the
35 Craigieburn and Hume corridor.

36

37 On top of that, the development in the Inner West,
38 particularly of apartment buildings and student housing, is
39 also greater, and of course the homelessness population has
40 increased as well, so it's sort of every area of
41 NorthWestern is experiencing considerable growth.

42

43 Q. The final slide at this point is, "An overview of
44 NorthWestern's service model". [WIT.0002.0002.1003] can you
45 firstly explain over what time period do these figures
46 relate to?

47 A. Yes, this is over a 12-month period. I actually can't

1 recall if it was a financial year or a calendar year, but
2 it was a 12-month period. Effectively what it shows is
3 that, we have a centralised triage; that triage probably
4 has about 50,000 - or over 50,000 calls per annum. The
5 triage, of course, doesn't direct everyone to the emergency
6 department, this is a sort of a model.

7
8 But we cover three emergency departments: the
9 emergency department at the Sunshine Hospital, at the Royal
10 Melbourne and at the Northern Hospital at Epping. The
11 numbers, that's the numbers of occasions of service, it's
12 probably - that is greater than the numbers of actual
13 presentations that we see, which is closer to 5,000. But
14 again, each of those emergency departments has been
15 experiencing considerable growth year-on-year in the
16 numbers of people presenting.

17
18 Overall, NorthWestern Mental Health then provides
19 services in a given year to about just under 24,000 people.
20 The occasions of service is the actual contact, so the
21 department records both the number of contacts and the
22 duration of contacts, contacts hours, and that's what that
23 refers to. You can see that there's considerable turnover
24 by the number of new registrations in a given year.

25
26 We provide across our about 200 acute beds, about
27 5,000 acute admissions, and in the community just under
28 half a million occasions of service. The specialist
29 inpatients there are our eating disorder and
30 neuropsychiatry admissions, and the subacute and
31 residential refer to the secure extended care and the
32 community care units admissions.

33
34 Q. Just to clarify, does NorthWestern record the number
35 of people who contact triage but who are not provided with
36 service?

37 A. Yes, we do, and so - I can't give you an exact number
38 of the total incoming and outgoing calls, but it is
39 considerable. The screening events is when we just look at
40 the screening register on the client management interface,
41 the database, as opposed to actually enter someone as a
42 case managed client.

43
44 Q. We can take those slides down for the moment, please.
45 I'd like to ask you questions about funding, Dr Vine. Can
46 you tell us briefly how NorthWestern is funded?

47 A. It's a bit hard to be brief on this, but I'll do my

1 best.

2

3 Q. Sure.

4 A. Mental health is largely input or block funded and
5 what I mean by that is that, there is a notional bed day
6 rate and you are funded for 100 per cent occupancy of those
7 beds and there's a notional effective full-time rate which
8 is to do with staffing. In reality, of course, that just
9 becomes a bucket of money.

10

11 And so, the money comes in based on those sort of
12 historical levels, but the Department of Health and Human
13 Services indexes funding annually, so the index rate is
14 usually about 1.5 per cent. People would be aware, I
15 guess, that the actual Consumer Price Index or cost of a
16 service goes up by much more than that, usually closer to
17 3 per cent and sometimes more than that if there's been
18 industrial agreements.

19

20 So, the funding is notionally allocated to particular
21 parts of the service. It's provided up-front, so it's not
22 an activity-based funding which is a significant proportion
23 of the acute health budget, it depends on activity as
24 opposed to just input. And then, when that money comes in,
25 we build up our budget and the budget is built up based on
26 the sort of corporate costs that are required, and of
27 course NorthWestern Mental Health pays corporate costs to
28 Melbourne Health for its services there, but also to
29 Northern Health and Western Health for the services we
30 obtain from them.

31

32 Savings are built in because you have to if you're
33 cost rises greater than your funding rises. You build in
34 savings or find other ways to reduce spending, and then the
35 money's allocated out as a forward year to meet the budget
36 required.

37

38 Q. I have a couple of questions arising from that.
39 You've referred to the fact that the block funding is
40 historically based. Can you just elaborate on that?

41 A. Yes, and again, bear with me. When the area-based
42 mental health services were first established, which is
43 sort of back in the 1990s, there was a thing called the
44 resource allocation formula. Basically, that took into
45 account the numbers of beds and the population size and
46 built into it some, I think a slight increase in funding
47 for rural regions, a slight increase in funding for places

1 that had large ethnic communities, but effectively
2 allocated it out to the areas.

3
4 The trouble of course is that that resource allocation
5 formula has largely not been revisited, so effectively what
6 that means is that services whose population has grown more
7 than others have effectively got less money per capita than
8 those services where the population growth has been less or
9 where population's even diminished.

10
11 The historical basis, every year it goes up a bit
12 according to that indexation and CPI, but there hasn't been
13 a recalibration to say, oh, NorthWestern Mental Health,
14 your population's risen by 50 per cent compared with, let's
15 say The Alfred's that hasn't risen by 50 per cent, to
16 recalibrate that funding.

17
18 Q. You referred to the need to make savings. How has
19 NorthWestern been making savings?

20 A. In a service where 85 per cent of the funding goes on
21 salaries and wages, it becomes immediately apparent that it
22 is hard to make savings without reducing staffing or
23 changing the staffing model.

24
25 Certainly over the years I think many services have
26 tended to, for instance, reduce the roster availability of
27 their out-of-hours service; that's a way of saving money or
28 change the staffing profile.

29
30 There are low hanging fruit, like trying to make
31 savings through reduction of fleet cars or not investing in
32 the same level of infrastructure amenity and things like
33 that, but often the only way to make savings is actually by
34 not spending the growth money. So, when a new service is
35 funded, by delaying the onset of that new service in
36 order to get some of the money at the beginning to offset
37 the savings required, there are various means, but it's by
38 changing service, reducing service or failing to invest in
39 new services that predominantly you get savings.

40
41 Q. You've also referred to the fact that the
42 under-funding of inpatient units is cross-subsidised by
43 community teams. Can you explain how that happens?

44 A. Indeed. I think the bed day rate in the current
45 policy and funding guidelines is in the region of \$850 per
46 bed day. The actual cost of an inpatient unit is not quite
47 twice that but perhaps nearly twice that.

1
2 And the cost, unfortunately, in inpatient units is
3 fixed because there are fixed rosters that are agreed on
4 industrially. There is a requirement for a certain amount
5 of medical coverage and to have on-call and weekend
6 coverage, so the costs of an inpatient unit are relatively
7 fixed and do not bear very much resemblance to the funding.
8

9 I noticed that Dr Stafrace said that his was balanced.
10 I actually can't comprehend how that can be. It may have
11 to do with the Alfred having a large number of beds and
12 having some beds funded at a higher rate, I don't know, but
13 certainly from our perspective over many years we've just -
14 we just know that the inpatient unit costs are greater than
15 the funding and we cross-subsidise accordingly.
16

17 Q. What is the impact of this insufficient funding on the
18 amount and quality of NorthWestern's services?

19 A. Clearly we do our best to deliver a safe and
20 clinically appropriate service.
21

22 So, in an inpatient unit the impact I think is that we
23 don't have the sort of experienced level of staff or
24 perhaps the amount of medical coverage that we might
25 desire.
26

27 Certainly, we don't invest, we don't have funds to
28 invest in improving the amenity at the pace we would like,
29 and I totally agree with what Dr Stafrace said about the
30 amenity in inpatient units, but also it just means that we
31 find savings in the community because that is less fixed,
32 if you like, by reducing roster availability, by again
33 reducing the level of medical input.
34

35 What it means, I think, is that we reach as many
36 people as we can, but the quantum of care that we provide
37 and the sophistication of that care is reduced by just
38 needing to contain the cost of it.
39

40 Q. I'll return to some of those issues in a moment. I
41 wanted to ask you some questions about key performance
42 indicators. You've stated that:
43

44 "The key performance indicators are largely
45 focused on processes with some KPIs easier
46 to meet than others depending on the
47 clinical capacity of a particular health

1 service."

2

3 Can you just explain what you mean by that?

4 A. Certainly. So, KPIs, key performance indicators, some
5 of them are set at a national level, so they're part of the
6 national agreements; that is things like whether a person
7 who requires an admission has had a contact with a service
8 seven days beforehand and seven days after discharge.

9

10 That's relatively easy to meet; a contact can mean
11 almost anything, it doesn't say that the contact was
12 necessarily intensive or therapeutic or of benefit, it just
13 says there was a contact.

14

15 Compared with that, the National Emergency Access
16 Targets, which is set at a 4-hour KPI, that 80 per cent of
17 people who present to an emergency department should, in
18 effect, have their decisions determined and the issues
19 underway within four hours. For a service where the
20 numbers coming are very large, as I've outlined previously,
21 and the bed capacity is very tight, it's well nigh
22 impossible for us to meet that KPI.

23

24 I think at last count I think for a mental health
25 patient who required an admission to a bed, our 4-hour meet
26 was under 20 per cent, so you can see that's quite a gap
27 between 20 and 80 per cent, and that's because it takes a
28 long time both to adequately assess a person who's
29 presenting with a complex mental illness, but also to
30 obtain necessary collateral history and to find, not just a
31 bed, but the appropriate bed, and that can take many more
32 hours than four hours.

33

34 Q. In your view, are the KPIs appropriate measures for
35 mental health presentations?

36 A. I think there's been a lot of work over many years
37 trying to find the right KPIs that are measurable,
38 accurate, comparable, and what we've got is sort of what
39 people have come up with that at least provides some
40 window.

41

42 I think we're still trying to get a better handle on -
43 Simon mentioned patient-reported outcome measures, so that
44 some of the actual measures from individuals and their
45 families about our performance, I think we're still trying
46 to find the right ways of measuring that.

47

1 I think we do need more work on measures that give
2 both a qualitative as well as a quantitative window on
3 services, so more work to be done I think.

4
5 Q. I'd like you to ask you now some questions about
6 demand for services which you've touched on a little bit
7 already but just to explore in more detail. You've stated:

8
9 "Over the past decade the population has
10 increased substantially such that on a per
11 capita basis our funding, bed stock and
12 equivalent full-time positions have
13 declined."

14
15 Could you take them one at a time and first explain
16 how your funding has declined?

17 A. So, in absolute terms our funding has increased; it
18 increases year-on-year. But if the costs have increased at
19 a greater rate than the funding, then in terms of what you
20 can actually buy with that funding, that is less.

21
22 And so, if you were to look at - and this is what
23 comes out in the Australian Institute of Health and Welfare
24 Mental Health Report, the per capita funding for Victoria
25 is lower than the national average, and for NorthWestern
26 Mental Health, because of our population growth, it's lower
27 than the Victorian average, and so that's what I mean by
28 that.

29
30 The beds, is it?

31
32 Q. Yes, the next one is the beds, the bed stock.

33 A. Yes, so as Dr Stafrace mentioned, Victoria has fewer
34 beds than the national average. I actually think The
35 Alfred is pretty close to the national average or not so
36 far away. But across NorthWestern Mental Health - this is
37 talking now about acute beds - varies from a little over
38 11, which is compared with the 19 which is the sort of
39 average per 100,000, to maybe, I think our best off area is
40 Northern which is about 20 per 100,000.

41
42 So, again, as the population increases, the bed
43 capacity has been largely static. So, in the last - most
44 of our inpatient units were opened in the 1990s, that's
45 when the big shift from the stand-alone services to the
46 area-based services happened, and since the 1990s we've had
47 additional capacity at Northern Hospital at Epping, and

1 marginally at both Royal Melbourne and Sunshine Hospitals,
2 but marginally.

3
4 So pretty much you'd have to say that the capacity has
5 remained static while the population has exploded. So,
6 beds per capita has gone down. And so, there was funding
7 and beds, and EFT was the other one, I think?

8
9 Q. Just before you go to EFT. In simple terms does that
10 mean the basic bed numbers hasn't really changed, there's
11 just been marginal change since the 1990s?

12 A. Yes, so an example there is that the Sunshine unit
13 opened in I think the mid to late 1990s with 25 beds, it
14 now has 29 beds, but in that time the population it's
15 expected to cover has grown. So, the only way you cope
16 with that, you do two things: you increase the throughput,
17 that is, the length of stay goes down, so our length of
18 stay is now ten days or less on average, which again is
19 different from the Alfred's, and you maintain a higher
20 occupancy.

21
22 So, there is a generally accepted view that, to
23 maximise the efficient use of beds you need an occupancy of
24 90 or 85 per cent. If you run an occupancy close to
25 100 per cent, you can see that, for someone to get in,
26 someone has to move out and moving out takes time and
27 planning, and we've already talked this morning about some
28 of the less than desirable discharge practices, and
29 certainly some - we absolutely do our best and our social
30 workers work like fury to get the best results, but there
31 is no doubt that we are sometimes forced into discharging
32 into unstable accommodation or even homelessness, which is
33 a terrible tragedy to the person involved, their family and
34 very hard for clinicians. So, that's the only way you can
35 make that static bed number cope with an increasing
36 population and presentation demand.

37
38 I think that that demand has been exacerbated, perhaps
39 more so in some of our areas than others, by a shifting
40 substance use pattern particularly with increased use of
41 methamphetamines which makes for a much more acute and, if
42 you like, dangerous presentation, so that then into that
43 hothouse of people that are being moved through too fast,
44 with too many new or unknown patients comes the added risk
45 of occupational violence and indeed inter-patient or
46 inter-consumer violence which is very difficult.

1 Q. I think you've covered the issue of the equivalent
2 full-time positions declining. Can I ask you about
3 criteria to access services. How sick do you need to be or
4 how are you going to get in?

5
6 A. Yes. Well, firstly, you need to be very unwell, and I
7 do just want to emphasise something that Dr Stafrace
8 mentioned, that one of the complicating natures of serious
9 mental illnesses such as schizophrenia or bipolar effective
10 disorder or schizoaffective disorder, is that for many
11 people the more unwell they become the less they wish to
12 engage in a service, which means that people often present
13 late and they often present through police or ambulance,
14 and that adds, if you like, to how unwell people are when
15 they access service.

16
17 Partly that is driven just by the nature of the
18 illness and people delaying their own presentation, but
19 also just that pressure for throughput means that I think,
20 in my time as a psychiatrist, people get admitted more
21 unwell than they used to and they get discharged more
22 unwell than they used to.

23
24 I guess our numbers are not very dissimilar from the
25 Alfred, in that, inpatient presentations are particularly
26 people presenting in severe crisis, but largely with people
27 with psychotic illnesses or with comorbid substance use or
28 very, very severe effective, that is, depression or
29 elevated mood sort of presentations.

30
31 And the same in the community: again, the large number
32 of our caseload would be people with those severe psychotic
33 illnesses that may well have a course where there's
34 relapses and where the episodic, the pressure for episodic
35 care is not well aligned with the actual needs of the
36 presentation and the degree of just how unwell people are
37 to get into the system.

38
39 Q. You've also referred to the fact that:

40
41 "The greater the demand for services, the
42 higher you have to raise the threshold for
43 acceptance to our services and this
44 threshold's much higher than [you] would
45 currently like."

46
47 You've referred to the fact that:

1
2 "This is because the amount of services
3 that you can provide is capped by the
4 funding available, creating a form of
5 rationed service."
6

7 Can you clarify for us who do you see and who is it
8 that you should be seeing?

9 A. Yes, I think you outlined this a bit with your video
10 at the beginning, that the state system is funded to see
11 those with the most severe illness, that's its stated
12 policy aim, is that, people who cannot or are unable to
13 access care in other parts, so we are set up to see people
14 with the most serious illnesses and who are most unwell.
15

16 We also do see people with a whole range of illnesses
17 who might present either through our triage system or
18 through our emergency departments, and we would like, I
19 think, to be able to see people with more moderate
20 presentations and also I think the other thing that the
21 state should be seeing is people who present with more
22 complex presentations: so, for instance, a combination of
23 substance use and mental illness or a combination of
24 intellectual disability and mental illness, and quite often
25 those people, I think, we struggle to provide the sort of
26 joined up multidisciplinary service, but we probably do it
27 better than other people but we should be doing it a lot
28 more.
29

30 I think it is absolutely appropriate that people with
31 mild to moderate illnesses mainly receive their services in
32 the primary care sector. At times they will also of course
33 come to an emergency department but probably only need
34 relatively brief service.
35

36 I think it's been talked about, that the state funds
37 the sort of most severe, and the Commonwealth through
38 Medicare and some other initiatives, supported private
39 psychologists and psychiatrists funds sort of mild to
40 moderate, and both the state and the Commonwealth have
41 tried to find ways to fund some of the presentations in
42 between; the Commonwealth through things like the Mental
43 Health Nurse Incentive Program, or Partners in Recovery,
44 the Headspace sphere which Simon mentioned.
45

46 The state has also tried to do that through increasing
47 funding to things like primary mental health teams or to

1 improve the response to people with more complex needs
2 through specialised services, but there are people who
3 would present or who would like to present to the state
4 funded mental health service who we just don't have
5 capacity to see.

6

7 Q. And so, where do you send those people?

8 A. We try and make referrals to other practitioners, so
9 to general practice or to private psychiatrists or private
10 psychologists. We would try and provide people with
11 appropriate information, but I think, this has been talked
12 about earlier, that whether those referrals are actually
13 followed up and whether they are successfully followed up,
14 we don't know a lot of the time.

15

16 Q. So you don't have any visibility about whether those
17 people received the treatment that they need?

18 A. We don't have that visibility. Of course, if they
19 come back to us, then we would receive - we'd get their
20 feedback as to whether it worked or it didn't work and
21 whether they re-presented, but otherwise, no.

22

23 Q. You've referred to a number of barriers for receiving
24 appropriate treatment. Are there any others that you want
25 to raise?

26 A. I think that the separation between the Commonwealth
27 and state funding is a real issue and the different models
28 of funding, the different market pressures, if you like,
29 are very important.

30

31 The state can geographically fund, but the
32 Commonwealth is largely a market-based fee for service
33 system which means practitioners go where they want to go,
34 and so, the outer - again, our outer metropolitan services
35 are very under-served by private practitioners and other
36 practitioners, so that's a barrier to access.

37

38 I think that the separation of drug and alcohol
39 services and mental health services, while it may have had
40 some benefits for people at the severe end, people
41 particularly with comorbid mental illness and substance
42 use, that separation again provides a barrier to access.

43

44 There's been a lot of work through the government of a
45 so-called no wrong door policy, but to actually implement a
46 no wrong door policy means you need the appropriate
47 staffing and skill mix, and we haven't developed that, so I

1 think that's a barrier to efficient access.

2

3 I think the other very important - Victoria's
4 witnessed as we've read in the papers in recent days, an
5 enormous growth in the prison population. There tends to
6 be an increased rate of mental illness in prisoners and
7 there is a real barrier to access for appropriate,
8 particularly compulsory care, for prisoners with severe
9 mental illness who need that level of care. That's very
10 poor.

11

12 Q. You've said in your statement:

13

14 "Until the deficit in inpatient capacity is
15 addressed, the needs of the community will
16 be hard to fix."

17

18 Can you just explain to the Commission why you hold
19 that view?

20 A. As I've said, as the inpatient capacity has been
21 reduced, the level of acuity and at times the need for
22 people to be treated as compulsory patients under the
23 Mental Health Act has increased.

24

25 I think the level at which people currently enter
26 inpatient care, they are unable to be managed safely in the
27 community at that level of acuity, they need an inpatient
28 bed. So, until you could reduce the level of acuity that
29 inpatient beds are managing, I just think that the level of
30 acuity in the community won't be able to be managed. It's
31 not safe and it's almost, I think, beyond the skill set of
32 the - just in my view, just putting more resources into the
33 community will not enable the system to function. And it
34 is a system, it's an interdependent system, both need to be
35 invested in, but the bed systems at the moment are not
36 being functional because there's just not enough of them.

37

38 So, for people to wait for hours in an emergency
39 department to access the appropriate bed, that doesn't help
40 anybody. To give a very difficult example, I met with some
41 parents not so long ago, they were very distressed because
42 their daughter had been moved between three different
43 inpatient facilities in the space of a week. Those
44 movements had been made necessary in order to free up a bed
45 to create a space for someone who had a more urgent need in
46 an emergency department, but that would have delayed that
47 person's recovery, and certainly negatively impacted that

1 person's experience of the system considerably.

2
3 So it's just, without more inpatient capacity, I don't
4 think we will get beyond our current dysfunctional state.

5
6 Q. You've referred to the fact of having an area-based
7 mental health service is appropriate for people who need
8 the protection of the Mental Health Act. Can you clarify
9 who you think an area-based mental health service should be
10 responsible for?

11 A. Yeah, so the rationale I think behind having an
12 area-based system, which means of course that where you
13 live geographically determines where you are going to
14 receive a service - there's a planning rationale - but as I
15 mentioned earlier, a significant proportion of people with
16 severe mental illness perceive their problems as being
17 external to them. So, they don't perceive that their
18 experiences, their emotions, their thoughts, are part of an
19 illness; they perceive it as having an external cause, if
20 you like.

21
22 Those people will not engage voluntarily in treatment,
23 and so, having an area-based responsibility makes it very
24 clear that it is the service system's responsibility to
25 promote continuity of care and to ensure that person has
26 access to care.

27
28 I think there is less rationale, if you like, for
29 people who seek to access care, and maybe you could argue
30 that that net doesn't need to have an area of
31 responsibility. The trouble is of course that, to try and
32 promote a degree of equity of amenity and equity of access,
33 that's helped by having an area of responsibility.
34 Otherwise, we might all go to the Alfred and then the poor
35 person who needs to go to the Alfred will find there's no
36 room at the inn.

37
38 So, it's trying to match health planning with
39 particular health needs of a particularly vulnerable,
40 disadvantaged and indeed discriminated against population
41 of people with very serious mental illness.

42
43 Q. Can I ask you now some questions about the mental
44 health system more broadly. In your experience how does
45 the system we have now compare to what was envisaged in the
46 1990s, and in particular what has been lost?

47 A. Yes, so people might be aware that Victoria - back in

1 the 1990s there was a Commonwealth and national policy of
2 moving away from structured stand-alone institutions to
3 more integrated mainstream mental health services, and
4 Victoria embraced that policy and in Victoria we'd closed
5 all of our stand-alone services other than the forensic
6 service by the mid-to-late 1990s.

7
8 In so doing, Victoria developed a range of policy
9 documents that have been referred to called the Frameworks
10 Documents. They envisaged that the components of care and
11 the sort of functional streams of care that would be
12 provided - I'm not saying they were perfect and nor that
13 they were complete - but at the time they envisaged that
14 there would be a capacity for urgent, home-based outreach
15 24-hours a day, seven days a week, and also longer term
16 outreach, assertive care, assertive engagement, again seven
17 days a week, as well as a clinic-based or continuous care,
18 and there'd also be that available for younger people and
19 adults and older people.

20
21 Over time there have been additions and improvements
22 made to that. So, through for instance additional services
23 like mother and baby services or perinatal services or
24 additional eating disorder services or services for
25 personality disorders.

26
27 So, there have been improvements, but over time, that
28 funding constraint against the population growth which I've
29 mentioned just meant that each of those components got a
30 bit squeezed, so there is now probably not a 24-hour a day,
31 seven day a week emergency short-term treatment available;
32 people need to come into the emergency department; or the
33 capacity to provide that assertive outreach is often more
34 about medication supervision than around active
35 rehabilitation and treatment.

36
37 So we've sort of moved in some places to, we're still
38 providing treatment, but the treatment spectrum is more
39 narrow, perhaps more biologically focused than
40 psychologically and socially focused in parts. And for
41 some of our staff, I think we do much more around
42 monitoring and assessment, risk assessment particularly,
43 than we do necessarily around therapeutic engagement and
44 provision of therapies that might increase that person's
45 coping strategies or increase that person's resilience.

46
47 Q. Are you able to comment on what that means in terms of

1 therapeutic outcomes for the person?
2 A. Well, firstly, one thing I'd say is that the premature
3 mortality of people living with severe mental illness,
4 while the rest of the population has got fantastic - we've
5 got much, much better, for people with mental illness it
6 has not and some would even say that it's got worse.

7
8 So that, in terms of physical health and physical, the
9 sort of implications of - this is to do with things like
10 lifestyle and social engagement, that has not improved for
11 our patients. For some of our patients - you know, I do
12 want to clarify we're not talking about everybody here.

13
14 I think also, the other thing that patients and their
15 families describe is, despite desiring to do the opposite,
16 they describe less continuity of care, they see different
17 clinicians more often. They describe greater turnover and
18 churn of the people that they see, and I think that brings
19 a more negative outcome because people feel like they have
20 to tell their stories to different people, and much of the
21 therapeutic engagement is at the core of good psychiatric
22 practice, that's what's important; and, if you tend to see
23 a younger workforce that has greater throughput, I think
24 you get less benefit from that.

25
26 I mean, there are many other social factors that have
27 also influenced outcomes, including of course problems with
28 housing and homelessness and problems with substance use,
29 and indeed increased contact with the criminal justice
30 system. All of those I think contribute to negative
31 outcomes that are not just about the mental health system,
32 but regrettably folk with serious mental illness are more
33 likely to be among people who are homeless or people who
34 are incarcerated or people who are using illicit
35 substances.

36
37 Q. I'd like to ask you more questions about how the
38 system has got to where it is now. I'm going to pull up
39 another slide that you've prepared. This slide is, "The
40 state and Commonwealth mental health plans 1992 to 2017."

41
42 There are two slides, so this first one is the mental
43 health plans which outlines the number of plans
44 [WIT.0002.0002.1004] And then this is also depicted in a
45 graph format. We might go to the next slide with the same
46 title. [WIT.0002.0002.1005]

47 A. Yes. The beauties of a Gantt chart.

1
2 Q. Can you explain the Gantt chart to us, and in
3 particular you made the comment in your statement that you
4 feel that:

5
6 "We are in a constant state of consultation
7 and distraction."
8

9 A. Yes. You can see from that, that at both a state and
10 a Commonwealth level we are great at plans. The
11 Commonwealth level - or this is the Australian Health
12 Minister's Advisory Council, AHMAC, have continued to have
13 a national mental health policy and that national mental
14 health policy has been underpinned by a succession of
15 national mental health plans.
16

17 It is my perception that, while the first and second
18 plans were reasonably structured and I think reasonably
19 implemented, as we've gone through to the third, fourth and
20 fifth, the plans have sort of broadened in their approach
21 but lessened in their impact. Some of that's probably
22 because they haven't had funding tied to the plans, whereas
23 the first plan and to a lesser extent the second plan had
24 significant funding attached.
25

26 But also at a state level, the long line there is the
27 Victorian framework which is, I guess, not strictly
28 speaking a plan as such, but we still have an area-based,
29 age-based system which was put in place through the
30 framework, so it's still in play. But on top of that we've
31 had a succession of state planning documents that often are
32 linked to a change of government. Perhaps the most obvious
33 example of that was in 2008/09, because Mental Health
34 Matters came out as lasting - I think it had a 10-year
35 framework - the government changed shortly after that and
36 there was then Victoria's - which I might not have even
37 squeezed onto that - Victoria's priorities for mental
38 health reform, 2013-15, and then the government changed
39 again and then we got the ten-year mental health plan which
40 went from 2014 to 2024/25.
41

42 The difficulty I think is that, each time one of those
43 processes happens, perhaps quite appropriately, there's a
44 round of consultations and focus groups, and lots of
45 effort, and we get a beautiful document, but if the
46 beautiful document contains promises or assurances over
47 many, many areas, it's very hard to keep a steady course of

1 improvement.

2

3 So, my own view on this, which is why the Gantt chart
4 came about, is that, we've been distracted by plans rather
5 than by implementation and performance and improved
6 outcomes. I think - maybe I'm being too sort of
7 Pollyanna-ish here or hoping for a nirvana that doesn't
8 exist - for state and Commonwealth to actually reach some
9 agreement about what they are or are not going to do, and
10 then work together to do it would, in my way of thinking,
11 make for improvements that that succession of plans has not
12 necessarily delivered.

13

14 Q. You've referred in your statement to bipartisan
15 support; do you mean both at a state level and in between
16 the state and Commonwealth governments in terms of going
17 forward for mental health?

18 A. I do. Again, when the National Mental Health Policy
19 was created back in about 1992, that was a policy agreed at
20 both a state and Commonwealth level, but also back at that
21 time there was bipartisan agreement about the general
22 policy, and that general policy was around working towards
23 mainstreamed and away from those stand-alone services.

24

25 To me, mental health - I think others have said that
26 mental health or mental illness should be above politics.
27 We've heard quite a lot, I think, about a lack of
28 infrastructure planning and the VAGO report released
29 in March this year was very critical about that planning.
30 That planning can't happen in a single government cycle.
31 Planning and its implementation takes many more years than
32 a single cycle. So, to have some bipartisan agreement at
33 state and Commonwealth and between the major parties seems
34 to me an imperative if we're going to move forward.

35

36 One of perhaps the most difficult moments for me
37 recently was when we didn't get extra funding for beds at
38 Sunshine. We'd put in about four business cases in
39 successive years and you sort of think, wow, when is that
40 going to be mutually bipartisanly agreed upon to create
41 that sort of service?

42

43 Q. A separate issue you've raised is the loss of respect
44 or regard for the expert in public clinical services. Can
45 you explain what you mean by that?

46 A. Yes. Look, I think firstly, working in public
47 psychiatry does bring its particular challenges, because a

1 proportion of those who we provide treatment and care to
2 don't want us to, so we provide treatment and care to
3 people who are compulsory patients, so I think that leads
4 to a degree of difficulty.

5
6 I absolutely firmly believe in having peer engagement
7 and having the input of consumers, patients, carers and
8 family - very, very important. But I think, in mental
9 health or psychiatry compared with other health
10 specialities, there is a greater propensity to criticise
11 the clinical expert.

12
13 Maybe I'm oversensitive on this, but I think rather
14 than paying attention to the sort of evidence base that
15 exists around psychiatric treatments for illnesses, I do
16 think by and large there's a greater criticism of
17 professionals working in particularly public psychiatry - I
18 don't think the same is said of private psychiatrists to
19 the same degree - but I think we have lost some of that
20 respect or value of the expert.

21
22 Q. On Friday Professor McGorry said that the old model
23 was that the person in charge of a mental health
24 organisation also had content expertise and that's
25 gradually been separated out so that the person in charge
26 of the budget wasn't necessarily the person with the
27 content expertise.

28
29 Do you have a view on whether the person responsible
30 for a mental health services budget should have content
31 expertise?

32 A. Well, I'm a little bit biased here because I'm a
33 psychiatrist and I've also been the Executive Director, so
34 you could say had ultimate responsibility for the budget,
35 so I think it's useful to have both. Having said that, you
36 certainly need great accountants and great finance managers
37 to help you understand that budget.

38
39 I'm not sure that I agree with Professor McGorry
40 there. I think many of the area managers who are really
41 the directors of operations, if you like, of area mental
42 health services do have a clinical background and many of
43 them have risen up through being a case manager or clinical
44 manager to a director of services.

45
46 I think it would be - I would agree with Professor
47 McGorry that, to completely separate operational management

1 from clinical realities would not be in anyone's best
2 interests. I personally quite like the partnership model,
3 where the clinical expert is hand-in-hand with the
4 operational manager and they both understand the business.

5
6 Q. You raised the issue of your business case for
7 Sunshine and not getting the funding. Can you tell the
8 Commission in your experience what are the challenges for
9 making a successful business case to government for reform
10 of mental health?

11 A. Yes. Firstly, I do think it's a challenge, and just
12 briefly to touch on the poor old business case for the
13 Sunshine beds: at one level you'd think that just the
14 population data would argue that you need more capacity.

15
16 The difficulty I think we have in this area is, the
17 people who don't receive a service who need a service often
18 are not the most vocal, so we don't necessarily have that
19 sort of community argument. And, while the adverse
20 outcomes, like the tragedy of suicide: suicide is a
21 multi-factorial and overall has a low base rate, so we
22 don't collect well what our unmet need is. We measure who
23 comes, we measure some of our throughput, but the unmet
24 demand is a bit sort of invisible. And so, making a cogent
25 business case that demonstrates not only that there is an
26 unmet demand, but that, if you provide it, if you met that
27 demand - met that need rather, that you'd improve outcomes,
28 it's just hard to make that argument, but I think that's
29 the argument that needs to be.

30
31 Again, if we were to look at the costs, I think the
32 Productivity Commission is doing this work now, looking at
33 the costs to employment and housing and family disruption
34 and poor early child development and rates of incarceration
35 and all of the other social outcomes to not providing good
36 mental health services; you know, I think that argument is
37 gradually being put together.

38
39 But it has been a difficult argument to make for
40 reform because I think perhaps from the point of view of
41 government funders it feels like this is an endless sponge
42 that will just absorb and will never stop saying,
43 "Next year I want more." But I think if we did reach an
44 agreement on what is a reasonable level of coverage, as
45 Dr Stafrace said, sort of 3 per cent; if we were to truly
46 say, if we did that, what would the outcomes be? I think
47 we'd find considerable attractive outcomes in a whole range

1 of social - social inclusion sort of outcomes.

2

3 Q. You've referred in your statement to there being some
4 compelling and costly areas to be considered in making that
5 business case, and areas that are not necessarily mental
6 health-specific; for example, homelessness, prison
7 population, community safety. Can you clarify why you say
8 these areas need to be part of the broader social policy?

9 A. Well, firstly, I guess they are very important areas.
10 They're not health areas as such, so again, it's been a
11 difficulty I think with some of the national mental health
12 plans; the national mental health plans are the Health
13 Minister's plan, but really, you need also need to consider
14 some of the impacts on other government portfolios, and
15 you've outlined a number of those.

16

17 So I think that's why recognition of the - mental
18 illness is a bit different from physical illness in its
19 impact on other, and that is, its impact on other members
20 of the family, its impact on other aspects of our community
21 and other aspects of government endeavour across the
22 whole - particularly the human services portfolios, but
23 really across a whole range of portfolios.

24

25 Q. You've stated:

26

27 "I think it is time to be brave again about
28 the effectiveness of treatment and the
29 importance of incremental but steady
30 investment to pre-empt outright scandal."

31

32 A. Yes, I have.

33

34 Q. Can you please explain what you mean by that?

35 A. Well, it's linked a little bit to some of my earlier
36 comments about valuing the view of experts. One of the
37 things about psychiatry is, I don't think we've had the
38 game changers that have occurred in other areas of health,
39 such as perhaps some of the cancer treatments and some of
40 the improvements in things like stroke or cardiovascular
41 disease, but we have made improvements, and I think we need
42 to be absolutely up-front and out there to say, there are
43 effective treatments for severe mental illness, there are
44 effective treatments for things like borderline personality
45 disorder which has often been thought of as too hard.

46

47 We as a profession I think need to be much stronger in

1 having more consistency and clarity across the whole range
2 of services, but to say that it is worthwhile investing
3 because you do get good outcomes because treatment is
4 worthwhile. Regrettably sometimes that treatment has to be
5 compulsory under mental health legislation and with rights
6 and protections built in around that.

7
8 I just feel that sometimes we're backward in coming
9 forward about the benefits of treatment for psychiatric
10 illness and how good it can be, if it's done well.

11
12 Q. I have two final questions, Dr Vine. When we asked
13 you the questions about challenges to successful reform you
14 referred to activity-based funding in your statement, and
15 also seemed to suggest that there's yet to be an agreement
16 on an appropriate activity-based funding model. Is that
17 right, and can you explain the difficulties in trying to
18 get an agreement?

19 A. Yes, I can. As I mentioned earlier, particularly in
20 Victoria but other parts of the country as well, there's
21 been an activity-based funding that is some proportion of
22 funding that is linked to what you do and how much you do
23 in acute health for some time.

24
25 In Victoria this has sort of been - oh, not in
26 Victoria. In mental health, finding the appropriate
27 formula for that has been a bit of a Holy Grail. People
28 started trying to work out an appropriate coding and
29 formula for that a couple of decades ago now, and around
30 the world different models are in place, but they're all
31 still a bit flawed.

32
33 The problem is that, whereas in other parts of health,
34 diagnosis is much more closely aligned to the cost, if you
35 like, of providing the care, in mental health diagnosis
36 alone doesn't really discriminate. What does discriminate
37 is much more social factors, such as homelessness or legal
38 status, you know, whether a person - it costs more to
39 provide treatment to someone under the Act because there's
40 a whole heap of other tasks that have to be provided to
41 someone who's being treating under the Mental Health Act -
42 so finding the right formula for that and then implementing
43 it has been an ongoing program.

44
45 The Independent Hospital Pricing Authority, IHPA, has
46 been working on a mental health cost classification now for
47 some years and is getting closer, and does combine a mix of

1 diagnosis, a score on a thing called the Health of the
2 National Outcome Scale, HONOS, which is a sort of
3 behavioural tool, as well as some of the other social and
4 legal parameters that I just mentioned. So, I think it's
5 coming closer.

6
7 The reason I think it's so important, is that, at the
8 moment for a mental health service to get better outcomes,
9 they don't actually receive any reward or any particular
10 recognition. It would be helpful, I think, for government
11 to think, if I spend this much I will get a different or a
12 better quality service that will have a different or a
13 better outcome, and that's very hard to define at the
14 moment, but I'm optimistic.

15
16 Q. Finally, are there any other matters that you want to
17 raise in terms of lasting improvement to the mental health
18 system that you haven't covered already?

19 A. Well, I think that stigma and discrimination has been
20 a focus for this Commission already and I do think that the
21 amenity in which people receive care absolutely needs
22 urgent attention. Simon mentioned this as well, that it's
23 a very different experience coming to a bright, warm, safe,
24 welcoming environment than it is to coming to a place
25 that's poorly looked after, poorly maintained, and so, our
26 ability to invest in infrastructure - and I don't just mean
27 now new buildings or more buildings - but just to invest in
28 improvement and amenity has been also very constrained in
29 recent years and I think that impacts enormously on the
30 feeling a person has when they come to the service, but
31 also the morale and wellbeing of staff.

32
33 The mental health workforce is probably the most
34 critical element in whether you have a good or a bad
35 service and a good or a bad service experience, so you
36 really want to attract the best, the brightest, the most
37 committed, the most engaged, and I think that that's
38 another area: so, workforce and infrastructure would be two
39 other areas that I'd like to highlight.

40
41 MS BATTEN: Thank you, Dr Vine. Chair, do you have any
42 questions for Dr Vine?

43
44 CHAIR: Q. I just have two brief ones. The first one,
45 Dr Vine, thank you very much for your comprehensive
46 overview: I was interested in some of the points you were
47 making when you were talking about the bed capacity, but I

1 did notice in your description of NorthWestern you
2 introduced something I hadn't heard about before which was
3 that you said some of the accommodation was rented from
4 private hospitals, can you explain what that was?

5 A. Yes, and the terminology's not quite right. In the
6 context of no bed capacity, the State Government provided
7 funding for us to effectively buy six beds in the private
8 sector: so some in Melbourne Clinic, North Park and Wyndham
9 Clinic. They've done that previously, at times of very
10 constrained capacity.

11
12 It's useful, but of course the type of patient that
13 can be admitted to a private facility, firstly, can't be
14 anyone under the Act and, secondly, it has to be someone
15 who you can reasonably rely on will remain and be able to
16 provide treatment in the private sector, so it's a very
17 small little top up of beds.

18
19 Q. Thank you. The other thing that you did talk about
20 when you focussed on reform that I thought would be
21 worthwhile just making sure we're clear about your intent
22 around this, is you did say about the business cases and
23 the approaches that we need to make to the sort of reform
24 you think's required. You said it should be incremental
25 but steady. Why do you give the emphasis on incremental?

26 A. Well, I think it comes back a bit to my comment about,
27 it can't happen in a single electoral cycle.

28
29 If my business case for Sunshine had got through, it
30 would still be five years before those beds came online.
31 So, if we are going to build on the system, we sort of
32 know, you can't suddenly build hundreds of beds, it has to
33 be done in a steady and incremental way that says, here's
34 where the area is greatest, but in 10 or 20 years the
35 population of this area will have doubled so we're going to
36 plan ahead and maybe even think about purchasing the land
37 or, you know, the planning monies that go into that.

38
39 I do think that, despite considerable effort, to have
40 that sort of incremental but longer-term steady investment
41 of both capital and workforce just hasn't been made.
42 Again, we can't - Werribee built some beds recently and it
43 took them, I think, nearly two years to find the staff for
44 those beds. So, the staffing, getting additional
45 workforce, has to be done in line with that planning and
46 both of those are very long-term investments.

1 CHAIR: I don't have any more questions, thank you.

2

3 COMMISSIONER McSHERRY: Q. Dr Vine, I think you've set
4 out very clearly how some people want access to the mental
5 health system, can't get it, some people are in the system
6 but don't want to engage. I'm just wondering in your
7 opinion what might help perhaps to lessen compulsory
8 treatment under the Mental Health Act?

9 A. Firstly, as I mentioned, I think often, partly because
10 of the constraints of the system, we are seeing people
11 late, and also, when a person is under a compulsory phase
12 of treatment, because we don't have capacity for really
13 strong engagement and assertive treatment, when that person
14 stops the compulsory treatment they stop treatment and then
15 they will come back again late. And indeed, it has to be
16 said that, for illnesses like schizophrenia, if you have
17 recurrent relapses your overall prognosis overall gets
18 worse. You know, with each relapse there is a loss of
19 functional ability and the recovery may not be as complete.

20

21 I think that, if there were greater capacity for more
22 assertive treatment, be that clinic based or outreach, and
23 if there were greater capacity to particularly have
24 long-term engagement with a smaller number of clinicians -
25 again, people are more likely to turn up for appointments
26 and engage and accept treatment and want to explore
27 treatment if they have a good relationship with the person
28 who is providing that treatment.

29

30 So I think continuity of care and greater flexibility
31 and - well, greater levels of expertise. Again, you're
32 less likely to have compulsory care if you are not just
33 providing medication but you are also providing other
34 psychotherapeutic inputs, some family-based treatment.

35

36 I think it's a multidisciplinary issue, but there will
37 always need to be compulsory care. Schizophrenia and other
38 illnesses by their nature, their prevalence hasn't changed,
39 their presentation hasn't changed greatly over the
40 centuries, we will always need that, but I think we could
41 lessen it if we had greater capacity for more intensive and
42 multi-faceted treatment

43

44 COMMISSIONER FELS: Q. Thank you for your excellent
45 witness statement and evidence. You've ranged far and wide
46 but could we just hear from you a touch more on yet another
47 topic of workforce, challenges, development needs,

1 et cetera.

2 A. Yes, and I mentioned earlier perhaps a concern about a
3 loss of value of the expert, and I do think that one of the
4 challenges for public mental health at the moment is that
5 the workforce don't necessarily feel as valued or protected
6 as they should be.

7

8 I think a startling example of that was when the law
9 changed to protect emergency workers from occupational
10 violence but didn't include people who work on inpatient
11 units who are daily exposed to verbal and physical abuse.
12 I mean, that seemed to me mind-boggling that that would not
13 have been included.

14

15 I think, to attract a workforce, the workforce needs
16 to be assured that: the work can be rewarding, that it will
17 be safe, that if it's not safe they'll be protected and
18 responded to, and that they will be appropriately
19 remunerated.

20

21 I think that one of the pluses of public mental health
22 is that we work in teams, multidisciplinary teams, so it's
23 a less hierarchical health workforce than in other parts of
24 health perhaps, so that's a plus, and I think it's
25 important to build on that.

26

27 I think there have been some gains in the sort of
28 training we provide to people across medical and nursing
29 and allied health, but I don't think they're very - they're
30 not universal across the state. I think there does need to
31 be a greater attention to the sort of training requirement
32 but also the sort of ongoing supports and supervision.

33

34 I think that there are, probably from my way of
35 thinking, too many constraints in some of the psychiatry
36 trainee rotations. The colleges impose pretty strict
37 guidelines that are sometimes hard for us to comply with.

38

39 Regrettably, I think public mental health has had to
40 rely a lot on international graduates, be they nursing or
41 medical. We get some terrific people, please don't think
42 we don't, but nonetheless there are different imperatives
43 if a person is working in psychiatry because they can
44 rather than because they want to, and I do think that's
45 been an issue for us around workforce.

46

47 So, levels of training, the skills expected of a

1 person, but particularly the environment within which
2 people work and their sense of reward, and I don't just
3 mean monetary reward, I mean therapeutic reward and
4 engagement I think all need attention.

5
6 The Mental Health Act is a beautiful thing, but it
7 does have very high administrative burdens, and I'm not
8 sure that that is well recognised in some of the timeframes
9 and time availabilities and therefore the workforce levels,
10 particularly medical, in some of our inpatient and
11 community services.

12
13 MS BATTEN: Thank you, no further questions?

14
15 CHAIR: No, thank you.

16
17 MS BATTEN: May Dr Vine please be excused?

18
19 **<THE WITNESS WITHDREW**

20
21 MS BATTEN: Chair, is now a convenient time to adjourn for
22 lunch?

23
24 CHAIR: Yes, it is.

25
26 **LUNCHEON ADJOURNMENT**

27
28 **UPON RESUMING AFTER LUNCH:**

29
30 MS BATTEN: Chair, the next witness is Ms Erica Williams.
31 I call Ms Williams.

32
33 **<ERICA WILLIAMS, affirmed and examined: [2.03pm]**

34
35 MS BATTEN: Q. Erica, with the help of lawyers, have you
36 prepared a witness statement for the Commission?

37 A. Yes.

38
39 Q. I tender that statement. [WIT.0001.0017.0001] Erica,
40 you moved out of home when you were 15 in difficult
41 circumstances?

42 A. Yep.

43
44 Q. And you move to Mildura and did Year 12 in Mildura?

45 A. M'hmm.

46
47 Q. Then you got into university?

1 A. Yep.

2

3 Q. About five years ago you were 17 and that's when you
4 started your first year of university?

5 A. Yep.

6

7 Q. Can you please start from that point, your first year
8 of Uni, and tell the Commission about your experience with
9 the mental health system?

10 A. For brief context: as you said, I have a complex
11 trauma background which I think informs my experience with
12 the whole system. But basically five years ago I was 17 in
13 my first year of Uni and I started to experience kind of
14 like anxiety and depression symptoms that I didn't really
15 know what to do with. So, yeah, I would get really
16 anxious, my mood was quite low.

17

18 I also engaged in a lot of reckless behaviour during
19 this period of time, so I was self-injuring. I think I ran
20 in front of some traffic a couple of times, and we didn't
21 really know what to do with the symptoms that I was having.
22 So, I think during my first year of university I sought out
23 kind of health care from a number of different general
24 practitioners and I think during this period I was
25 diagnosed with depression and anxiety, but I wasn't
26 medicated for any of my symptoms during this period.

27

28 I think during this time, my partner Brendan and I
29 kind of knew that there was more than depression and
30 anxiety going on but we felt the health care system was
31 really kind of hesitant in making any other kind of
32 diagnoses.

33

34 So, fast-forward a little bit of time. In my
35 second year of Uni we kind of got some money together to
36 see a psychiatrist privately. We at that point didn't have
37 any access to public psychiatry apart from through
38 Headspace, and I felt that Headspace wasn't able to help me
39 with any of my kind of bigger symptoms aside from my
40 depression and my anxiety. So, I only went to Headspace
41 twice, I think, and then, yeah, we saw a psychiatrist in
42 the private system.

43

44 I think it was kind of difficult for the psychiatrist
45 to diagnose me with anything because we were only able to
46 see him once, but he diagnosed me with bipolar disorder and
47 I was put on medication for bipolar disorder, which I'm now

1 not now diagnosed with but that remained my primary
2 diagnosis for about two years I think.

3
4 After that point, we were kind of - actually, we
5 didn't really know what to do with the mental health care
6 system for a little period of time. My symptoms kind of
7 got worse and worse and my relationship with Brendan was
8 very tumultuous and I was increasingly suicidal,
9 increasingly self-injuring.

10
11 We moved a couple of times, I think, and I didn't have
12 really any contact with the mental health care system after
13 I was diagnosed with bipolar until things kind of hit a
14 head at - in my fourth year of Uni, so that was at the end
15 of 2017, but before that I had kind of been failing
16 subjects at Uni, everything was getting worse. But because
17 I didn't have a long-standing relationship with a GP in the
18 city I wasn't able to get any documentation for why I was
19 getting worse.

20
21 I think it's important to know that, like, with my
22 diagnosis which I now know is borderline personality
23 disorder, I can present very well and be very unwell at the
24 same time. So, I think it was very difficult for GPs to
25 understand that, if I was presenting as a suicidal patient,
26 I would also present kind of well dressed and appearing to
27 be very well within myself, and so, I think it was
28 difficult for GPs to take what I was saying seriously.

29
30 So, at the end of 2017, I was very unwell, I don't
31 think I was leaving the house very often. Yeah, I found it
32 very hard to get outside. My symptoms have disassociation,
33 so I lose track of time. So, I can be kind of walking
34 somewhere and then there will be just a gap in my kind of
35 temporal awareness, and then I kind of come to and I'll be
36 somewhere and I don't know how I've got to that place.

37
38 The disassociation also means that I can kind of
39 injure myself without realising that I've done a lot of
40 damage to my body, and so, that was happening quite
41 regularly at the end of 2017 and I was also quite suicidal
42 as well.

43
44 So eventually I self-referred to Orygen Youth Health.
45 I found the service on the internet, I wasn't referred to
46 them by a doctor or anything, I just kind of found the
47 service out of the blue, which we were very thankful for,

1 we were very lucky that we found the service and they kind
2 of took me in. After that I was diagnosed formally with
3 BPD as well as major depressive disorder and anxiety.

4
5 I started some medication to combat the depressive
6 symptoms of BPD but, as far as I understand it, BPD isn't
7 an illness that can be completely combatted with
8 medication, it involves intensive psychotherapy as well
9 which Orygen offered through the form of CAT, which is a
10 form of therapy that seems in the literature to be very
11 effective for borderline personality disorder, but
12 basically it understands BPD as a relational illness which
13 means that it can come about in relationships that we have
14 with other people. It can also emerge in relationships
15 that we have with our services.

16
17 So our services, we're more aware of the fact that
18 with borderline personality disorder, the illness itself
19 can emerge in how we relate to our services. I think
20 Orygen did that for me, so they were really great in early
21 2017. And I was seeing a therapist weekly, I think, and I
22 also had a few brief admissions to Orygen's inpatient
23 facility for suicidality and self-injury, and these
24 admissions to Orygen's inpatient facility have always been
25 quite helpful. I found them to be really supportive,
26 except for the fact that they're also part of NorthWestern
27 Health. So, yeah, as Doctor - what was her name?

28
29 Q. Dr Vine.

30 A. Dr Vine was saying earlier, yeah, NorthWestern Mental
31 Health still has really limited beds, and so Orygen was
32 limited within that system. So, my discharges were
33 sometimes a little bit too early, but ultimately I found
34 that I was getting better in 2017.

35
36 But then I ended up developing anorexia as well, so I
37 had an admission for my anorexia in 2017 that wasn't
38 through Orygen because there weren't beds available at
39 Orygen, but Orygen also don't have eating disorder-specific
40 treatment.

41
42 Q. So, where was that admittance? Don't name the
43 hospital, but that was a hospital other than Orygen?

44 A. Yeah, that was at a separate hospital other than
45 Orygen.

46
47 Q. Can you tell the Commissioners about that inpatient

1 admission?

2 A. Yeah, so that eating disorder-related admission: I was
3 first admitted to another hospital other than Orygen. And
4 then, it was interesting what Dr Vine was saying earlier
5 about the public system being able to buy beds from the
6 private system. I was one of those patients.

7

8 So I was transferred from the public hospital to a
9 private hospital with the, kind of - we were informed that
10 my eating disorder would be treated by the private hospital
11 that I was transferred to, and so, that's what everybody
12 was kind of hoping for and by that point I was quite
13 underweight and quite unwell, like, with the anorexia. And
14 so we ended up being transferred to the private hospital.
15 But often the private facilities have different wards
16 within them, and so I was transferred to a general ward and
17 a general bed, and the public system hadn't paid for an
18 eating disorder bed, so I ended up being in the general
19 hospital and then physically deteriorating for, I don't
20 know how long it was, maybe a week or two weeks whilst we
21 kind of were tussling with the private/public system and
22 whether or not I would be able to have an eating disorder
23 bed.

24

25 It's funny because the ward for the eating disorder
26 treatment is just upstairs. I was below just downstairs
27 kind of waiting to get the go-ahead so that I could get
28 treatment just upstairs.

29

30 Q. Were you on a general ward at that point?

31 A. I was on a general ward at that point, yeah.

32

33 Q. Was there treatment for your eating disorder at that
34 point?

35 A. No, I never received any treatment for my anorexia.
36 So, I didn't end up getting a transfer upstairs to the
37 eating disorder ward and I physically got worse and worse
38 and worse until the private hospital was afraid that I was
39 physically deteriorating too much for them to be liable to
40 care for me.

41

42 So, I was transferred, without any warning, I was put
43 in an ambulance. I got told that I was going to be
44 transferred to a different hospital from the private
45 hospital. And then, I think 20 minutes later I was in an
46 ambulance with all my belongings - I had a lot of personal
47 belongings because I'd been in hospital for a while at that

1 point - and I was transferred with all my stuff, in my
2 pyjamas, to an emergency department straight from the
3 private hospital. Yeah, none of my family were contacted.
4

5 Q. How were you transferred there?

6 A. By an ambulance. From that point everyone was really
7 concerned about whether or not I was medically stable. So,
8 I stayed in the emergency department for about 14 hours,
9 and because everything had happened so rapidly, and there
10 was so little communication between each different hospital
11 that I'd been in about the complexity of my case, because I
12 have multiple diagnoses, people were kind of uncertain
13 about which one they were treating when I arrived at a
14 hospital. But, yeah, there was no - my family didn't know
15 what was going on. I had all my belongings and, yeah, I
16 was in the ED.
17

18 Q. You said you were in the ED for about 14 hours.

19 A. Yep.
20

21 Q. Sorry, we just need to slow down a little bit. You
22 were in the ED for about 14 hours, and then what happened
23 after you were in ED?

24 A. After that I was transferred to Orygen inpatient unit,
25 and from there, I think just with the help of the team at
26 Orygen, even though they don't have any facilities to treat
27 anorexia, my treating team was just amazingly -
28 astoundingly supportive of my recovery, and I think they
29 just really pushed for me to get physically well while I
30 was at Orygen's inpatient unit, and so I eventually
31 recovered from the anorexia while I was with Orygen, even
32 though Orygen don't have the formal facilities to treat
33 anorexia in the first place.
34

35 Yeah, and after that I had a period of kind of
36 wellness, I think, for about six or seven months after my
37 discharge the last time with my eating disorder, and
38 throughout this whole period I've always had contact with
39 Orygen, so I was never fully discharged from their service,
40 even though I wasn't - they kind of adapt care so that if
41 you're in a really intense period of time you'll have
42 multiple points of contact and, I don't know, if you're
43 having a more calm period of time the points of contact
44 move away. But there was always the knowledge that, if
45 things got worse, we would be able to contact them and
46 they'd pick up that level of care again.
47

1 Q. You said you were re-admitted to Orygen in late 2018?

2 A. That's correct.

3

4 Q. Can you tell the Commissioners about that admission?

5 A. I was readmitted to Orygen late 2018 and my mental
6 health was the worst that it's ever been at that point.
7 Sometimes it's hard for people with mental illness to know
8 what causes a relapse, I'm not sure what causes relapse, it
9 just kind of happens sometimes, but I think things were
10 really bad at that point and I was put on a compulsory
11 treatment order. So, there's different levels, everybody
12 probably already knows, of treatment orders. So, it began
13 as a temporary treatment order which is, I think, only 24,
14 48 hours. And then, after that, it was decided that I was
15 too unwell and too unsafe to stay in the hospital as a
16 voluntary patient.

17

18 I think it's also worth noting that, as Dr Vine was
19 saying earlier, compulsory treatment or treatment orders,
20 sometimes they're used - even if I felt like I could be a
21 voluntary patient in a hospital, sometimes my psychiatrist
22 would put me on a treatment order so that I would be able
23 to stay so that we could avoid premature discharge. But at
24 that point I was on a compulsory treatment order which,
25 it's a long period of time, I don't know how long it is,
26 but it's a long period of time, and that was with Orygen so
27 they had decided that I needed to be involuntary at that
28 point because I wasn't safe.

29

30 Q. You said you were very unwell at that point. Did you
31 try to leave Orygen?

32 A. Yeah. I absconded from Orygen four times. I think
33 that's a serious, like, infrastructure issue. I was able
34 to climb over the fence on four different occasions, and I
35 was brought back by police and physically detained with
36 handcuffs each time, and with each time I was leaving with
37 the intent to commit suicide, so it was very lucky that
38 emergency services were kind of made aware of my situation
39 as it was happening.

40

41 I have heard of other absconsions where the hospital
42 hasn't informed emergency services straight away, which
43 obviously puts the person in immense danger of committing
44 harm to themselves or to other people. But, yeah, I
45 absconded four times.

46

47 And, after this, it was decided that I would have ECT.

1 So, ECT, electric convulsive therapy. Basically, you're
2 put in a brief induced seizure, but you're not conscious
3 for any of it, it's not scary, everyone thinks it's so
4 scary, it's not particularly frightening. But because I
5 have a trauma history I found it really difficult to
6 tolerate ECT.

7
8 I think that's another point; the system probably
9 needs to be very aware that trauma really impacts how a
10 person can tolerate certain methods of treatment, even
11 being in a hospital can kind of trigger a person's trauma.
12 And so, yeah, I had the ECT but I was only able to have
13 about six sessions just because of how my body was
14 tolerating the procedure, just in relation to my trauma.

15
16 Q. Then you were eventually discharged home after this
17 admission?

18 A. Yep.

19
20 Q. How did you go at home?

21 A. Yeah, so I was discharged home. It had been a long
22 admission and at that point we were kind of - everyone was
23 so uncertain about what to do with the case because there
24 was a lot of different things going on: there was kind of
25 issues with eating and the BPD, major depression and my
26 trauma history, so we tried a lot of things.

27
28 Eventually I was discharged home, but we weren't
29 ready - nobody was ready for that to happen, and I think
30 that the hospital, or Orygen as a service kind of
31 acknowledged that, but there was a real lack of middle
32 ground being intensive hospital and being at home, and we
33 just kind of had to test the waters and see if things would
34 get better, and they didn't.

35
36 I had my partner with me most of the time. If he
37 wasn't there, my friends would be with me. Basically, I
38 was on 24-hour watch while at home. So, my community was
39 asked to play the role of a hospital for about two or three
40 weeks, I think, and things weren't getting better. I
41 wasn't safe and it was just like an enormous strain on
42 everybody around me too, because nobody kind of has - not
43 everybody is a mental health nurse, we don't all know what
44 to do in these situations, and a lot of the time that's
45 what they're being asked to do when we discharge patients
46 from a kind of really high intensity inpatient service to a
47 home environment.

1
2 And so, eventually I did end up back in hospital. And
3 this time I think on my second - so this happened twice, I
4 was re-admitted and then admitted to Orygen twice, but on
5 my second re-admission I wasn't admitted to Orygen straight
6 away because there weren't any beds.

7
8 So, I was admitted to a different public hospital and
9 in this hospital I was admitted to the High Dependency
10 Unit. So in public mental health hospitals there's
11 different kind of areas, inpatient areas. The High
12 Dependency Unit, there's no - in the particular hospital
13 that I was in I found the experience to be very traumatic
14 and I think it's also maybe quite an invisible part of the
15 hospital. Because most people in the High Dependency Unit
16 are very vulnerable to begin with, and so, it's very
17 difficult to have your voice heard in a way that isn't, I
18 don't know, it's often understood that you're looking for
19 attention or being sensitive about the things that go on in
20 these units, and so, your voice is kind of overlooked a
21 little bit.

22
23 Q. Erica, if you can, can you tell the Commissioners
24 about why you found the experience in the High Dependency
25 Unit traumatic?

26 A. Yeah, so when I first got there - I have never been a
27 risk to other people and never been kind of violent or
28 never resisted being admitted to hospital, but when I came
29 to the High Dependency Unit my partner was with me and
30 there was, like, six or seven guards and they all wear
31 black, kind of like the guys downstairs except a bit more
32 scary, and they kind of herded me in, and I was with my
33 partner at the time, and I was kind of herded in to these
34 doors, and I looked around and he was gone and I didn't
35 know where he'd gone because he'd been herded the other
36 way.

37
38 And then I was just told to sit in the main sitting
39 area of the High Dependency Unit. I was one of two women
40 on the unit and the rest of the patients were men. With my
41 trauma history, which the hospital knew about, I already
42 found that quite frightening, but there aren't any locks on
43 the bathroom in this unit that I was in either, which I
44 understand because it's a safety issue. But with a ratio
45 of 1:1 nurse to patient, I found it quite surprising that
46 no nurse would make sure that male patients wouldn't come
47 into the bathroom when you're using the bathroom, and that

1 happened to me a couple of times.

2
3 I also had my period whilst I was in the unit and I
4 wasn't allowed to have more than one menstrual product on
5 my person at a time, even though I had - you know, I had
6 expressed I'm not going to eat anything or I'm not gonna -
7 yeah. And so, I had to go and ask my contact nurse, who
8 was male, every time I wanted to use menstrual products,
9 and then I wasn't safe, I didn't feel safe to go into the
10 bathroom to use them because I was afraid that the male
11 patients were going to come inside.

12
13 At this same hospital I was very, very anxious, and
14 so, I recall asking one of the staff for her PRN, which at
15 that time I had been using the same PRN medications for
16 quite a long time because I had been in hospital for such a
17 long period on and off, so it wasn't surprising that I was
18 using these medications.

19
20 But the nurse, I remember being very belittling. She
21 took me to a room, a private room where I couldn't see
22 anybody else, and talked to me for, like, 25 minutes about
23 why on earth I would need my PRN. So, PRN medication is,
24 like, whenever you need medication if you're feeling really
25 anxious or something. She was just asking me why on earth
26 I'd be needing this medication, and if I'd tried anything
27 else, all of these things at the same hospital.

28
29 And this all occurred kind of in a high dependency
30 setting which means it's really difficult to have visitors.
31 If you want to have visitors, you've got to have them in a
32 kind of little box room. It's really difficult to have
33 outside contact with anybody.

34
35 I wasn't allowed to have my mobile phone, but I also
36 wasn't allowed to use the nursing phone very often. I
37 think that's illegal. I think you're supposed to have,
38 kind of, outside contact in some form at every point, even
39 if you're not a voluntary patient. So, I found the whole
40 experience to be quite traumatic.

41
42 And, after that, I think it's important to note as
43 well that with mental health care, I don't know if when you
44 break your arm if you present to the emergency department
45 and somebody is rude to you, but they still fix your arm,
46 you probably still have a better arm. But if you have a
47 mental illness and somebody isn't kind to you or you aren't

1 regarded with empathy, your illness gets worse, so the way
2 people treat you can directly impact the course of illness.

3
4 I think that's what happened when I was admitted to
5 the High Dependency Unit. After I was transferred from
6 this High Dependency Unit back to Orygen, I felt things
7 were worse than what they had been before I got there.
8 Because I stayed in Orygen at this point I think for
9 another few weeks or something, and then yeah, I was
10 eventually discharged back into the community.

11
12 Again, that was a really difficult time because, once
13 you've been in hospital for so long, you kind of forget
14 like when to take a shower or when to eat food or how to
15 have a job or how to interact with other human beings, and
16 I think there's a real lack of kind of occupational
17 therapy, I guess, middle ground services for people who
18 have been in hospital for a long time, or even for people
19 who have experienced really intense periods of illness.

20
21 And, yeah, we just had really little contact with
22 Centrelink services and services regarding employment. And
23 that's not because - I've been exceptionally lucky in that
24 I've had a service at Orygen who has probably saved my life
25 multiple times, but I think they just don't have the
26 resources to provide some of this middle ground for people
27 who are severely unwell.

28
29 Q. Thank you, Erica. Along the way you've identified
30 different areas where there is room for reform. Were there
31 any other matters that you wanted to touch on that you
32 think are in dire need of reform?

33 A. I think, coming from my perspective as somebody with a
34 diagnosis of borderline personality disorder, I think that
35 the way the system understands this illness probably needs
36 a lot of reform. I think it's often regarded as something
37 that's frightening or something that people don't want to
38 diagnose and treat, and I think the treatment of the
39 illness is often shrouded in stigma rather than actual
40 treatment.

41
42 As Dr Vine said earlier, there's a lot of literature
43 around how BPD is actually a very treatable illness, it's
44 not untreatable. It's not non-understandable, it's very
45 understandable and it's very treatable.

46
47 There's a lot of research that we have around how we

1 can treat this illness and I think Orygen's model of care
2 and CAT therapy is a good example of how BPD can be treated
3 successfully to a point of, I don't know, middle ground
4 recovery.

5
6 But I think that in emergency services and in a lot of
7 kind of general practise medicine as well, BPD is still -
8 it's scary and we don't know what to do with it and there's
9 not a standardised cause of action for treating somebody in
10 BPD crisis like there is for treating somebody with a
11 broken leg, people just don't know what to do. I think
12 maybe there needs to be a lot more understanding about how
13 to treat the illness, and also a lot more empathy and
14 kindness towards it, rather than so much rejection and
15 fear.

16
17 MS BATTEN: Thank you, Chair. Are there any questions from
18 the Commissioners for Erica?

19
20 CHAIR: Professor McSherry.

21
22 COMMISSIONER McSHERRY: Q. Erica, thanks very much for
23 telling us your story. Just one question: when you were in
24 the High Dependency Unit did you ever meet an advocate, a
25 human rights advocate or a peer worker who could help
26 support you?

27 A. No. No, in other units definitely, but in this
28 particular High Dependency Unit, yeah, we were never
29 offered, even if there would be legal counsel, let alone
30 legal counsel ever occurring at all. We didn't know, yeah.

31
32 COMMISSIONER McSHERRY: Thank you very much.

33
34 CHAIR: Q. Thank you, Erica. Just one thing from me: I
35 noticed in your witness statement you say that Orygen had
36 been your primary source of support since late 2017 and you
37 had your GP, psychologist, psychiatrist and case manager
38 all in one place.

39 A. M'hmm.

40
41 Q. You also then went on to explain how they helped and
42 persisted - you said, persisted with you even when things
43 were very severe. And so, I guess it's helpful for us to
44 have that understanding, what was it about their
45 persistence that you found so important to you?

46 A. I think having a service that keeps faith in you even
47 when you're very unwell was very, very important. And also

1 knowing that there was a whole team of people around me
2 that all spoke to each other and had a decent understanding
3 of my illness, I think that's a big one. And also, just
4 had a decent understanding of my case and my individual
5 history.

6
7 So, my treatment with Orygen was always really,
8 really, individual and I think that the CAT therapy model
9 allows for that to happen. I think the point of it is that
10 it's individual. And then that kind of knowledge that you
11 come to understand through CAT, everybody in the team
12 understands that, not just your psychologist, everybody: so
13 the doctors, all of the doctors, even the GPs, dieticians,
14 group workers, everybody has the same kind of baseline
15 understanding of what this illness is through the CAT model
16 and how it can interact. And then, with everyone's
17 persistence I think that that just - I don't know, having a
18 team that has faith in you, I guess, is really important,
19 and a team that treats you as a person is really valuable.

20
21 Q. Thank you. One other thing you talked about was what
22 happened when you were discharged from hospital and your
23 partner and friends provided the support role. Can I just
24 confirm, did you have any follow-up from the hospital at
25 that time and were they given any guidance on how to care
26 for you?

27 A. Um, we had a little bit of guidance. So, I was
28 discharged from Orygen. So, Orygen always had contact with
29 us, especially in my second admission, because I think as a
30 service they really learn and they don't keep making the
31 same mistakes that they made before with you again.

32
33 So they learnt about how I wasn't in contact with my
34 family and they brought my family in for me when I couldn't
35 do that myself. But I think, again, as a service they can
36 only do so much. And so, even with all the information
37 about my illness that my family had, and kind of all of the
38 support that we had - which we did have, we had over the
39 phone support, it's just the day-to-day stuff is really
40 hard. Like, having to be with somebody when they're having
41 a shower and having to be with somebody to make sure that
42 they don't not eat for 48 hours by accident. It's just an
43 intense role and I think it's really hard for services to
44 kind of fill that place. So, yeah, we did have follow-up
45 support, I just don't know whether it - Orygen had this
46 systemic, kind of, means to make it enough.

1 CHAIR: Thank you. Thank you very much for sharing that
2 with us.
3
4 MS BATTEN: Thank you, may Erica please be excused.
5
6 CHAIR: Yes, thank you.
7
8 <THE WITNESS WITHDREW
9
10 MS NICHOLS: Commissioners, the next witness is Dr Neil
11 Coventry, I call him now to give evidence.
12
13 <NEIL DOUGLAS COVENTRY, affirmed and examined: [2.32pm]
14
15 MS NICHOLS: Q. Dr Coventry, have you prepared a
16 statement, with the assistance of the VGSO, which is in
17 response to a request by the Royal Commission that you do
18 so?
19 A. Yes, I have.
20
21 Q. I tender the statement. [WIT.0003.0004.0001]
22 Dr Coventry, are you Victoria's Chief Psychiatrist
23 appointed under the Mental Health Act?
24 A. Yes, I am.
25
26 Q. Noting that your role is defined under the Act and
27 described in some detail in your statement, in summary do
28 you have a strategic system-wide role with responsibilities
29 for clinical leadership, quality assurance and improvement
30 in the delivery of mental health services?
31 A. Yes, I do.
32
33 Q. Do you have a particular role in promoting the human
34 rights of people receiving mental health services?
35 A. Yes, I do.
36
37 Q. Commissioners, I note that at a later phase in the
38 Commission's work we may ask some further matters of
39 Dr Coventry, but we're concentrating particularly on access
40 issues today.
41
42 Dr Coventry, it's not your role, is it, particularly
43 to investigate and resolve individual complaints?
44 A. No, I don't. Under the new Mental Health Act - well,
45 it's not new, but 2014, complaints management changed. So,
46 it was quite appropriately thought that that should be
47 managed independently, so there was a Mental Health

1 Complaints Commissioner appointed which has the authority,
2 the statutory authority, to investigate complaints. Hence
3 I was able to actually take much more a strategic
4 leadership role.

5
6 Q. In relation to your strategic leadership role, can we
7 just get an understanding about how it is you engage with
8 mental health services in your day-to-day work, and
9 starting particularly with the management of mental health
10 services across the state.

11 A. Yes, it's a good question. It's really a variety of
12 ways that I engage with mental health services, really it's
13 my core business.

14
15 So I have a statutory role which is defined. So, my
16 statutory role is around monitoring the provision of
17 electroconvulsive therapy, ECT, as we heard from the
18 previous witness. I also have a role in monitoring and the
19 reporting of restrictive practices, so these are things
20 under the Mental Health Act such as seclusion and
21 restraint.

22
23 I also have a role of monitoring deaths, so these are
24 called reportable deaths to me as Chief Psychiatrist for
25 any consumer in inpatient or community care or people who
26 have left community care within three months of their
27 death.

28
29 But, much broader than that, I have really a daily
30 role of engagement with services. So, services might
31 contact me because of my leadership role when they're
32 struggling with an issue. I also have the authority under
33 the Act to do various types of investigations such as
34 audits, clinical reviews or formal investigations, always
35 with a safety and quality framework to look at the
36 learnings that can come from that.

37
38 I'm also available with my colleagues, particularly
39 the Chief Mental Health Nurse, to go out to visit services
40 on a needs basis when there's been a particular issue that
41 we have concerns - or a service might actually invite us to
42 come and assist them with management.

43
44 Usually when I'm involved after doing a formal
45 investigation, I will partner with the service for a
46 considerable period of time to help them implement the
47 changes that I've directed them to do and to undertake the

1 change management process.

2

3 Q. So, is it fair to say that you've got a pretty good
4 working knowledge of Victoria's mental health services?

5 A. Yes, I think I do.

6

7 Q. Does your office gain input from consumers and carers?

8 A. Yes, we do, and I've been fortunate I think in my long
9 career over 40 years to see the involvement of consumers
10 and carers which has been, I'd have to say, the single most
11 important driver of improving safety and quality. We have
12 to do this in partnership.

13

14 So hence, in my own office to try and model hopefully
15 good practice, I have a number of positions for people with
16 lived experience, both consumers and carers, at every one
17 of my clinical meetings, my statutory meetings that I have
18 and sub-committees and investigations, developing Chief
19 Psychiatrist guidelines or frameworks; we do this with
20 input and collaboration and partnership with consumers and
21 carers.

22

23 We also link in through the consumers and carers in my
24 team with the peak bodies such as VMIAC and Tandem and many
25 others as well, so I think it's really vital to have that
26 input to really shape and develop and improve our services,
27 particularly from a safety and quality lens because these
28 are the people who have the most vested interest in getting
29 the best outcomes.

30

31 Q. Do you also engage with the Department of Health and
32 Human Services?

33 A. Yes. Well, my office sits within the Mental Health
34 branch, so there's another team that's involved with
35 engagement with lived experience and, as I said before, we
36 also engage with the peak bodies as well and we have them
37 represented on all of my advisory committees so that I'm
38 always having that lens.

39

40 We aspire to co-production, co-design. We haven't
41 probably got all those principles lined up but we certainly
42 try and utilise those principles. And the practice, wisdom
43 and advice has been immeasurable really with that process.

44

45 Q. I was asking you actually about your engagement with
46 the Department of Health and Human Services, do you have a
47 supporting line into the department as well?

1 A. Yes, I do, so I sit within Health and Human Services
2 and I also engage with a number of other parts of Health
3 and Human Services that are outside the mental health
4 branch such as Safer Care Victoria, Child Protection,
5 Disability, et cetera, so all the key other stakeholders
6 that need to be joined up.

7
8 Part of my role, I sometimes think I'm sort of the
9 glue as Chief Psychiatrist to get the right people around
10 the table to develop the right wrap-around service.

11
12 Q. We've asked you a number of questions about the mental
13 health system. Can I just start with some definitions so
14 we can be clear about what we're talking about?

15 A. Yes.

16
17 Q. You've said in your statement that:

18
19 "The specialist mental health system
20 includes both clinical and non-clinical
21 services."

22
23 What do you mean when you say "specialist" in this
24 context?

25 A. Yes, good question. So, we've heard from the other
26 witnesses. The specialist mental health service is the
27 area-based designate - what are called designated mental
28 health services under the Mental Health Act which, probably
29 the simplest way to understand that is, under the Mental
30 Health Act, they have the capacity to provide care and
31 treatment for people in a voluntary or in an involuntary
32 capacity.

33
34 So these are what we call the specialist mental health
35 services. We've heard that they see somewhere between
36 1 per cent to 1.5 per cent of people with mental illness.

37
38 The non-clinical - and these are not great terms, I
39 must say - so that's the clinical services which are linked
40 in with health services or they're situated in the
41 community. The non-clinical services are what we call the
42 mental health community support services, MHCSSs. The
43 reason they're called non-clinical is they're focused on
44 psycho-social rehabilitation, they're non-government
45 agencies. They have in-reach from mental health clinicians
46 and can provide a number of services, including supported
47 residential accommodation. So, that's the non-clinical

1 mental health part of the service system.

2

3 Q. Do the non-clinical services engage clinicians to work
4 in --

5 A. Yes, they do and need to when they take consumers with
6 significant mental health complexity. I also have
7 jurisdiction and oversight of those services when they have
8 mental health patients/consumers as part of their clients.

9

10 Q. And both clinical and non-clinical aspects of the
11 system have peer work?

12 A. Yes, this is a really interesting and innovative
13 approach. We now have quite a number, I'm not sure how
14 many totally in Victoria, but it's quite a considerable
15 number and growing. To add value to our existing clinical
16 workforce, with people with lived experience previously
17 these people have been employed as consultant positions.
18 Now we have them as peer workers working alongside the
19 clinical service with a different sort of role and
20 function.

21

22 The feedback from consumers of carers is invaluable,
23 that they are able to relate and get support that really
24 can't be provided from people who don't have that lived
25 experience, so I think it's a great asset to our workforce.

26

27 Q. I asked you about the difference between acute and
28 subacute in the context of those definitions.

29 A. When we talk about acute, or when I'm talking about
30 acute, I'm meaning the acute inpatient beds that we have
31 that are in health services. So, that's about, something
32 like half or a bit over half of our bed stock.

33

34 The subacute are the step-down or the step-up
35 services - and the Commissioners have heard about some of
36 those - so these are things like PARCs which are prevention
37 and recovery, residential services for time-limited period.
38 We have community care units, we also have - we love
39 acronyms, SECUs, which stands for secure and extended care
40 units which can take consumers for a longer period of time.

41

42 We also have PAPUs, again a lovely acronym, in
43 emergency departments which are psychiatric assessment and
44 planning units, again short stay units. So we have a
45 number of subacute plus our acute services.

46

47 We also have our acute forensic hospital, which is

1 Thomas Embling Hospital.

2

3 Q. Thank you. Can I ask you a question about catchments?

4 A. Yes.

5

6 Q. You make a point in your statement that:

7

8 "Catchments are a system design and funding
9 issue over which you don't have
10 jurisdiction under your statutory
11 functions."

12

13 But you do say that you often play an informal role
14 negotiating outcomes when services are unable to reach
15 agreement about where a particular consumer is to be
16 treated.

17

18 What kinds of difficulties do you see consumers facing
19 when they get themselves into that situation where they are
20 falling in between one catchment and another?

21 A. Look, it's very challenging and I'm thinking
22 particularly, this was challenging during the terrible
23 bushfires, where our catchment areas didn't make sometimes
24 a lot of sense for where people were actually living - or
25 where people's houses had been destroyed.

26

27 So really the goal is, well, we have catchment areas
28 to try and be sensible and have some degree of flexibility.
29 As we've heard from previous speakers it's important that
30 our consumers and their families don't fall between the
31 gaps and it's very clear with the catchments that there is
32 a designated service provider.

33

34 However where I find the challenge is when we're
35 dealing with people who unfortunately suffer unstable
36 accommodation or are incredibly itinerant, so they don't
37 have a stable address that links them with a catchment.
38 Then you try and be sensible about where their networks may
39 be.

40

41 We also have situations where there are practical
42 reasons where the local service or the inpatient service
43 may be further away than another catchment area's service
44 so you try - or I try to negotiate what would be in the
45 best interests of the consumer and their family and what's
46 really going to be the most sensible way to proceed that
47 has the best sort of outcome, particularly long-term.

1
2 So I always encourage within the catchment area
3 boundaries that we work with in come degree of flexibility,
4 and at the end of the day I also have the authority of the
5 Chief Psychiatrist to direct a service. I don't use that
6 authority very frequently and find a sort of roundtable
7 discussion that looks at the sensible issues and the
8 patient's request and family's request and the
9 practicalities can in most cases resolve that dilemma.

10
11 Q. Can I ask you a further clarification question.
12 You've described community-based mental health services in
13 your statement in these terms. You say:

14
15 "They're provided in clinics and as
16 outreach services to people's homes or
17 other locations in the community. Services
18 include crisis assessment, case management
19 and individual family and group therapy."

20
21 Would you agree that that's a description really of
22 the function in the system as it's intended to operate more
23 than a comment on whether or not it's being effectively
24 implemented?

25 A. Yes, good question. I do believe that's how it should
26 be operated and was intended to.

27
28 We've heard from other speakers this morning that
29 there's been some slippage really due to demand.
30 Previously we had discrete teams who might be providing
31 these functions. We still have that in some services but
32 other services have gone to a more integrated model which
33 means a more sort of generic approach rather than having
34 these discrete teams so that people might be doing various
35 tasks.

36
37 For instance, the staff designated to be working in
38 the CAT Team may also be managing intake and triage. I
39 think that's diluted some of the capacity to offer the
40 variety of interventions that we should be offering.

41
42 Because we need to remember, for our consumers and
43 carers, generally they're going to require multimodal
44 interventions, which just means that they need a lot of
45 different types of intervention, there's not one single way
46 of helping people, it's usually got to be multiple
47 different types of intervention.

1
2 Q. You used the words both "integrated" and "diluted"
3 when you were answering my question.
4 A. Yes.
5
6 Q. Is it correct that really what you were saying was,
7 the functions have been diluted because staff are trying to
8 fulfil more than one role at one time?
9 A. Yes, I think that's certainly the case, and as an
10 example we see that, I think, particularly with after hours
11 triage which is done by staff who are also covering the
12 emergency departments and dealing with those sort of
13 crises, so it's very difficult for them to balance the
14 priorities of a telephone triage role with providing
15 support to the emergency department, and I think we've also
16 diluted our capacity to provide the sort of safe outreach
17 service that we used to provide.
18
19 Q. I'll ask you more about triage shortly, but can I just
20 get you to explain what you mean by the capacity to provide
21 the safe outreach service?
22 A. I think, if you don't have a team with a low
23 caseload - I think we've gone to a situation where we have
24 generic teams with what we call generic case managers, and
25 I think that's created some difficulty to provide a number
26 of the subspecialty areas such as the mobile outreach
27 support in a safe way. It really needs a team that has, as
28 we heard this morning, low numbers of consumers that they
29 are involved with so that they have that capacity to be
30 available to do that sort of outreach.
31
32 And we know that, for some of our consumers and
33 carers, having an office-based approach is never really
34 going to cut it for them.
35
36 Q. Can I get you to explain what you mean by generic
37 teams, and firstly, can you contextualise it? What level
38 of service are you discussing in this context?
39 A. Well, I'm talking about community, so these are the
40 mental health specialist teams that are in the community.
41 And when I say "generic", what I'm meaning really is, we
42 aspire to multidisciplinary team work and that's what we
43 should be doing.
44
45 What's happened is, positions have been recruited as
46 generic positions so they haven't been discipline-specific.
47 It's quite complex but it's also due to some industrial

1 issues as well, but I think we would find in most services
2 in the community that we have lost some of our expertise
3 having clinical psychologists as members of the team.
4

5 I think that's a particular concern that I have as
6 Chief Psychiatrist where we really need multidisciplinary
7 input from clinicians who are well trained in a lot of
8 different disciplines: nursing, social work, occupational
9 therapy, speech and language therapy, clinical psychology,
10 neuropsychology, et cetera, et cetera. We have lost that
11 capacity I think with employing what we call generic
12 clinicians, which doesn't acknowledge that every discipline
13 has a specialty background that they can offer for our
14 consumers.
15

16 Q. Is that something that you see right across the state
17 in relation to community-based mental health clinical
18 services?

19 A. To an extent, yes, I think it's pretty much the case
20 in many adult services. I don't think it's the case in
21 Child and Youth Services and Aged Mental Health Services,
22 they still aspire to having multidisciplinary teams and
23 have the variety of disciplines.
24

25 But in adult services, for the complicated reasons I
26 was mentioning, I think we've moved much more to a generic
27 model that doesn't have the variety of the
28 multidisciplinary input.
29

30 Q. Can I ask you a question about community support
31 services. You have discussed in your statement the
32 provision of continuity of support for clients of programs
33 that are transitioning to the NDIS where the program is no
34 longer funded. What kind of gaps have you observed occur
35 for consumers whose service is no longer funded under the
36 NDIS?

37 A. Yes, this is an absolute headache for my office and
38 for myself really.
39

40 So, the NDIS scheme - again, I can only really speak
41 from the perspective of people who are falling between the
42 gaps, and I'm sure for the majority of consumers this has
43 been of great benefit.
44

45 Where I think we struggle with mental health consumers
46 is the definitions that NDIS use. So, they use terms like
47 "permanent and enduring psycho-social disability", which

1 isn't really well defined.

2

3 This is particularly a problem, I think, when we're
4 talking about young people to be able to present their
5 situation where it may not be permanent. One hopes that it
6 wouldn't be and we keep a recovery focus.

7

8 It's very difficult when we talk about a person
9 needing episodes of higher needs and higher level of care.
10 So, I don't think the NDIS system has really been able to
11 grapple appropriately with mental health disability and
12 what that actually means. It does mean unfortunately some
13 of our consumers fall between the gaps and one of my roles
14 is, again, to get the players around the table to try and
15 look at where we need to get the right funding.

16

17 It also appears, again from where I sit, that the NDIS
18 process isn't a timely process, it can take quite a long
19 period of time before you can actually get the package
20 that's required and I think the expertise of the NDIS
21 coordinators can be lacking in understanding the
22 complexities of the mental health system and the specific
23 needs.

24

25 In answer to your other question about MHCSSs, as this
26 was being rolled out in Victoria, it meant that it was a
27 different funding model, so there was loss of staff from
28 the MHCSS sector because they needed to have the funding
29 package to know they could actually employ the staff.

30

31 There probably have been some people, certainly some
32 mental health patients, who despite the best intentions
33 were meant to have their packages of support rolled over
34 but it hasn't in practice turned out that way. So, I think
35 we still have a way to go with NDIS system, particularly
36 with respect to our mental health consumers.

37

38 Q. Can I just get some clarification about that. So,
39 does the gap arise where a consumer has been a client, if
40 you like, of a service which is no longer being funded
41 because of the change in the funding structure, but the
42 consumer has not yet or will not at all get a package under
43 the NDIS?

44 A. Look, it's quite complex. People who were previously
45 on packages were meant to roll over. NDIS involves the
46 consumer being active in determining what their wishes are.
47 Some of our mental health consumers struggle with that and

1 probably do need people to advocate for them, they don't
2 have the capacity.

3
4 I think sometimes there has been an absence of
5 appropriate providers to do this. Probably the most
6 extreme example that I see is when, for various reasons,
7 people have ended up in inpatient settings which often
8 aren't really the most appropriate setting, and their issue
9 is having a package that can provide some more stable
10 accommodation.

11
12 These people can stay, as we're hearing already about
13 the man with the acute inpatient units, I've certainly
14 worked with situations where people have stayed many,
15 many months in an acute inpatient setting, while I've tried
16 to work with services and NDIS and other support services
17 to get them an appropriate package that can actually assist
18 them to move into the community which is where they really
19 should be.

20
21 So, it's certainly not a timely response and, as I was
22 saying earlier, I think there are problems with the
23 definition and also problems with the need to reassess. In
24 one case I was talking about where the person had been in
25 an inpatient unit for many months, there was a wealth of
26 assessments that had been provided by the staff and
27 inpatient unit, so there was actually no need for NDIS to
28 go through another cycle of getting more assessments. It
29 was sometimes just the language that needed to be put in a
30 different phraseology, I suppose. But, from the consumer's
31 point of view, it's a very, very untimely sort of process.

32
33 Q. Thank you. We've asked you about the design
34 principles intended to be embodied in the mental health
35 system, and you've set out in your statement the principles
36 which are of course recorded in the Mental Health Act.

37
38 You've said in answer to our question about whether or
39 not the system embodies those principles and the extent to
40 which it does that:

41
42 "On the one hand the principles are
43 becoming embedded in the philosophy of
44 treatment."

45
46 And you've given some examples about how that works,
47 and on the other you say:

1
2 "In practice, however, these principles may
3 be compromised due to resourcing and demand
4 pressures."

5
6 So my question is, when you say "may be compromised",
7 are you in fact saying that there are aspects of the
8 Victorian mental health system that do not in fact reflect
9 the 12 principles embodied in the Act?

10 A. I would hope that every service does aspire to that.
11 I guess what I was meaning there, in terms of the
12 practice - maybe if I give some examples about this.
13

14 So, one of the significant additions of the Mental
15 Health Act in 2014 was the capacity for consumers to make
16 advanced statements and to have nominated persons that
17 could assist when they weren't able to make the decisions
18 themselves. The take-up hasn't been great for those and I
19 think that's probably due to a number of things: one would
20 be, our consumers don't necessarily know that they have
21 that right and treating services with this short length of
22 stay aren't actively encouraging people to do this. So,
23 when we've done audits the take-up has been fairly limited.
24

25 I think we also are concerned that people should be
26 told what their rights are when they come into a service.
27 Sometimes this is done in a very robust manner and it's
28 done in a repeated way with different ways of talking to
29 the person and their family.
30

31 At other times it's done at the acute entry to the
32 service and it's giving people a document to read, and we
33 don't have enough of our documents translated into all the
34 different languages, and we also have people who aren't
35 literate, so we need to have different ways of
36 communicating that.
37

38 I firmly believe that you don't do it at one single
39 entry point when people are the most unwell when they come
40 into a unit, this needs to be revisited, so it shouldn't
41 ever be a sort of tick the box approach that we've given
42 someone a document to read. So, that concerns me. As I
43 say, the practice is variable, there are many examples of
44 services who do that very robustly and really spend a lot
45 of time to do that and involve their consumer and carer
46 consultants who are members of their service, but I also
47 hear other stories that are very worrying that the person

1 was only exposed to that on their first point of entry and
2 it wasn't revisited and there was no discussion.

3
4 Q. Can I perhaps take you to the examples that you
5 mention in your statement about the way in which the
6 principles set out in the Act are not being reflected in
7 the system.

8
9 One of the things you say is that:

10
11 "Resourcing and demand pressures mean that
12 the focus has to be on the most acute and
13 severely ill consumers."

14
15 Which means that consumers are receiving less
16 treatment and they're receiving it later in an episode of
17 illness and, as a result, severity of symptoms increases.
18 That's a general trend that you've talked about in your
19 evidence.

20 A. Yes.

21
22 Q. In what ways does that not reflect the principles
23 embodied in the Mental Health Act?

24 A. Well, look, certainly our principle is to have
25 voluntary treatment and decision-making, voluntary
26 decision-making wherever possible, so it's not too
27 difficult to hypothesise, if we're not seeing people early
28 in their stage of their illness early in their episode,
29 we're running the risk of people getting more and more
30 unwell and probably, because of their illness, having less
31 capacity to be making informed decisions about the sort of
32 treatment that they would want, so that's really very
33 concerning.

34
35 It's also very concerning that, as we've heard from
36 other speakers and it's certainly fitting in with my
37 evidence, length of stay is falling dramatically, and
38 that's not a good thing, it's really to do with demand.

39
40 So we would have gone from a situation maybe a decade
41 ago where our length of stay was roughly around 15 days, to
42 something now of the order of about 9.7 days, which means
43 the time that someone's actually in an inpatient acute unit
44 to get those sort of interventions has really diminished
45 dramatically, which is primarily due to the pressure as
46 we've been hearing about the demand at the front-end to
47 move people through before perhaps they're really ready to

1 be able to be discharged.

2

3 Q. You also mentioned that the transition to supported
4 decision-making has been:

5

6 "... slower to occur than desirable."

7

8 Can you say briefly what supported decision-making is?

9 A. Yes, this is really a change from what used to be
10 called substitute decision-making where someone would be
11 making the decisions for the patient, on behalf of the
12 patient, to basically supporting the patient - the
13 consumers - I slip into "patient" because we use the Mental
14 Health Act terminology which has "patient", so I apologise,
15 it's very confusing.

16

17 The idea is really that consumers wherever possible
18 should be able to make decisions themselves. They may lack
19 capacity in some areas, but capacity isn't a universal
20 thing, so that we need to consider, for instance, like
21 electroconvulsive therapy, we've really changed our
22 approach and my office has provided some documentation for
23 consumers and for our clinicians working with consumers to
24 assist them in knowing that people can actually have a
25 capacity to be making a choice, and that might not always
26 be the choice that the treating team thinks is in the
27 person's best interest but allowing the consumer to
28 actually do this.

29

30 I think we need to become more sophisticated at
31 understanding that sense of capacity, and also when we are
32 comfortable to allow people to make decisions themselves
33 that might involve some degree of risk. We have services
34 that are incredibly risk-averse and we need to allow people
35 to have some degree of autonomy when it's appropriate, I
36 think, to be able to be taking a level of risk and making
37 their own decisions.

38

39 Q. I'll take you up on that point. You said in your
40 statement that the principle of being able to make
41 decisions with a degree of risk is of course required to be
42 observed by the Act.

43

44 A. Yes.

45

46 Q. And that the implementation of it is less than
47 desirable. What causes a risk averse culture in your
experience?

1 A. There's probably a number of features with this. I
2 think sometimes our whole health service is very risk
3 averse, and when something happens or goes wrong, it may be
4 a particular cause, it may be multiple causes, but
5 clinicians are very concerned that they're going to be
6 blamed for this, so this can then lead to a sense of taking
7 over from someone's autonomy. You know, right from even
8 should someone be in hospital under an involuntary
9 treatment order.

10
11 We do have a system in Victoria that uses the Mental
12 Health Tribunal, that is our separate independent body that
13 decides whether someone does need to be having involuntary
14 treatment. So, the person might be on an in-treatment
15 order but the tribunal has the authority to actually take
16 them off if they don't think it meets their need.

17
18 So, how I would like to see this in the future, is
19 that, particularly our consumers who have a number of
20 episodes where they require a higher level of care, at a
21 time when they're well can be presenting what we call an
22 advanced statement where they're able to say what would be
23 the sort of care they'd like to receive when they're
24 unwell.

25
26 Now, it's not black and white and we have some people
27 who are very grateful that other people are able to make
28 the decision for them when they're unwell, but that would
29 be good to know that as an advanced statement. So that,
30 while advance statements don't necessarily have the legal
31 authority that perhaps they should do, services need to
32 give note, that's very clear under the Mental Health Act,
33 to give note to someone's particular wishes.

34
35 So, my goal and idea would be a much more partnership
36 collaborative way of doing this, even for patients who are
37 under involuntary treatment orders which, as I said
38 earlier, doesn't mean that they lack capacity to make any
39 decisions about anything in the various domains of their
40 life.

41
42 Q. Can I ask you about the extent to which meaningful
43 carer involvement is occurring. You've said in your
44 statement that it's not always occurring.

45 A. Yes.

46
47 Q. In your assessment, how far short are we from the

1 extent to which carer involvement should occur under the
2 Act?

3 A. I think we are falling short in adult psychiatry,
4 adult mental health. Clearly in child and youth, that's a
5 key part of the treatment, and I think in aged mental
6 health as well.

7
8 This should be a key part of adult mental health
9 services. We should always be considering a consumer in
10 the context of the people around them: whether it's family,
11 social network, whatever that might be.

12
13 It's also imperative, I think, to be getting what we
14 call collateral information so that we get information from
15 multiple sources that will help us understand the
16 significance of what might be happening.

17
18 Having said that, we also have to respect
19 confidentiality too and an individual may decide that they
20 don't want their carer or family involved in their
21 treatment. I've certainly been involved in some cases
22 where we've actually not thought that was perhaps in the
23 best interests of the person and may not be safe when they
24 need to be cared for by their carers, but we also have to
25 respect at the end of the day a person's autonomy and, in
26 some cases, that's very appropriate.

27
28 Having said that, I think when we get people coming in
29 at the first point of entry through emergency to acute
30 inpatient unit for adult consumers, with a very tight
31 length of stay, it seems to me that there's not always
32 sufficient time to be taking that sort of care and
33 diligence to be involving the consumer's family and making
34 sure that we've even got that accurate information. I do
35 get worried that we don't even necessarily sometimes record
36 that appropriately.

37
38 Q. Are the demand pressures making it more difficult to
39 involve carers to the extent as is expected under the Act?

40 A. Look, I think it's partly that. I don't think it's
41 totally that. I think we have moved to a culture that's
42 much more crisis-driven.

43
44 We did invest a lot well over a decade ago in what we
45 called family-sensitive practice and we did a lot of
46 training in both inpatients and in the community. I think
47 we've lost some of that expertise and that culture, so I

1 think it's - while it's partly driven by the demand
2 pressures and time, I think it's also a practice issue as
3 well that we need to invigorate.
4

5 Q. You said in your statement that:
6

7 "The separation of treatment systems such
8 as alcohol and other drugs system is a
9 barrier to people having their medical and
10 other health needs responded to and that at
11 times this separation can result in
12 consumers being lost between two systems."
13

14 Can you say what you mean there by two systems and why
15 they're separated?

16 A. Yes, I can. I've been around for long enough that I
17 trained when alcohol and drugs was actually part of mental
18 health, it was an integrated system.
19

20 We've got different models really. So, we have one
21 that's in mental health, bio-psychosocial or a medical
22 model and we have more a psychosocial model with alcohol
23 and other drugs services.
24

25 So what I think this has done in practice, which is
26 very concerning given the high degree of what we call
27 comorbidity, which means mental health patients who have
28 other conditions like a substance use condition. So, I
29 think we've deskilled our mental health clinicians to be
30 able to appropriately assess and have expertise in the
31 different forms of treatments for drug and alcohol services
32 conditions.
33

34 I think we've also deskilled the AoD, alcohol and
35 other drugs sector to have sufficient expertise with people
36 with significant and serious mental illness who present.
37 So, the dilemmas I think are - there can be multiple
38 entrance points and, as we've heard from other speakers,
39 it's often very challenging for people with these sort of
40 problems to engage in a service, so when they do engage
41 that's when you need to provide the wrap-around service
42 regardless of which point of entry.
43

44 So I think we've actually got the separation and when
45 some consumers are being referred to an alcohol and other
46 drugs treatment service, we're not doing - what did Ruth
47 Vine call this - or Simon Stafrace, the sort of warm

1 referral? I think you need to actually walk with the
2 person to assist and they're still your responsibility
3 until you've been able to have them engage with a service.
4 Instead what I think we do is we give them a referral and
5 expect that they will use that and often they don't.

6
7 So, I think that idea of actually cross-referral and
8 engagement is our responsibility, not the responsibility of
9 the consumer and we --

10
11 Q. And to what extent are the demand pressures on the
12 system allowing those warm referrals to occur in your
13 observation?

14 A. I think that's right and I think it's particularly
15 with the rapid throughput and discharge, that it can be a
16 sense of just, let's link in with the support services by
17 giving someone the information and hoping that they will
18 engage, rather than taking the time to actually assist in
19 that engagement process which I think is our responsibility
20 to do.

21
22 Q. We've asked you to think about how the system now
23 compares to what we had in the 1990s, and you've said that
24 whilst community-based treatment is always to be preferred,
25 at times hospital admissions will be necessary.
26 Acknowledging that, you've said that:

27
28 "Where that occurs, treatment should be in
29 high quality environments with a safe and
30 therapeutic approach."

31
32 A. Yes.

33
34 Q. You've gone on to say that:

35
36 "Infrastructure investment is not aligned
37 with the needs of the community."

38
39 In what ways do you see that?

40 A. Well, again, the Commissioners have heard frequently I
41 think over the last few days, the concern that in the 90s
42 when we went into the cycle of mainstreaming, I think the
43 aspiration was very worthy and to try and bolster community
44 services because the previous era of the institutions was
45 focused very much on the stand-alone institutions rather
46 than community care.
47

1 But in the process we lost the inpatient beds that
2 were already existing in health services. So, we had two
3 separate systems of the gazetted institutions, but we also
4 had psychiatric inpatient and outpatient services in all of
5 our leading hospitals. They got eroded as we had this
6 amalgamation, so what's happened is we have an insufficient
7 bed base so that - I really struggle with this, because we
8 really should expect the same standard of health care
9 whatever your health problem is. We shouldn't accept that
10 mental health is a second cousin to general health.

11
12 However, we know that we don't have sufficient beds,
13 we're hearing about the 4-hour, 8-hour and 24-hour delays
14 in emergency departments, primarily driven by mental health
15 patients and consumers who can't get access to inpatient
16 care.

17
18 So, that's what I was meaning in terms of the
19 infrastructure, that to actually drive change in community
20 services and models of care, we need to have the foundation
21 of a back-up of sufficient acute and subacute inpatient
22 beds when necessary. The bulk of service provision still
23 needs to be in the community, but we need to make sure we
24 have that appropriate mix, I think, of services.

25
26 Q. Can I ask you about the occupancy rates you mention in
27 your statement. You've said:

28
29 "Since 2007/2008 the state-wide average
30 occupancy rate for acute inpatient beds is
31 92 per cent and 94 per cent for
32 metropolitan services."

33
34 Can you explain why it is that an occupancy rate at
35 that level is problematic?

36 A. Yes, and look, that's an average.

37
38 Q. Yes, sure?

39 A. We would also have services that are running at
40 100 per cent or actually over 100 per cent, which sounds
41 really strange to understand due to the sort of bed
42 pressures.

43
44 So, ideally what we need to have, I think, is an
45 occupancy around about 80-85 per cent. If we have that
46 occupancy, it means you have the flexibility to look at the
47 mix of people who are coming into your unit to make sure

1 that's done safely. You can provide a timely response when
2 a bed is required rather than, as you were hearing this
3 morning, you have to discharge someone and then admit
4 somebody else back into that bed pretty quickly. So, we
5 need to be doing that at the time when we need to do that
6 with the consumer rather than, they have to wait until we
7 can actually discharge someone.

8
9 So, having occupancy rates in the 90s or even higher
10 takes away that flexibility. It also means that - I
11 struggle with our issue of sexual safety in inpatient units
12 and having areas that are designated safe areas for
13 predominantly vulnerable females, and hearing that at times
14 that capacity goes because of the pressure on beds and
15 males will be admitted to that area, which is totally
16 against the whole philosophy and approach.

17
18 So, I think that level of occupancy then drives
19 particular models of care and less than safe practices
20 really, and so, this has sort of crept up over a decade.

21
22 If we went back to that sort of approach, I think we
23 would have more capacity during the length that someone is
24 staying in the unit, we'd have better discharge planning,
25 we could manage a more timely response when someone is
26 needing to come in. So, I think universally, everyone
27 would agree, that over 90 per cent capacity occupancy rate
28 really limits the flexibility to do that in a safe way.

29
30 Q. What models of care does high occupancy rates drive?

31 A. One of the particular concerns I think with the high
32 occupancy is the need to be discharging people far too
33 early in the course of their treatment, in a way that we
34 would never do in general health.

35
36 We heard from the previous witness about the burden
37 that sometimes we create on carers and family. In no way
38 would we do this for instance in a coronary care unit and
39 expect the family to have that expertise to be coronary
40 care nurses and look after someone because we needed the
41 bed for the next patient who's had a heart attack coming
42 in.

43
44 What this means in practice is that we don't have
45 periods of trialling for getting close to discharge, we
46 don't have the capacity to allow our consumers to have
47 trial leave necessarily with their family to see how

1 they'll cope in the community. We're often discharging
2 people, unfortunately, at various hours of the day and the
3 night when there will be less in the way of any support
4 services immediately in that vulnerable period of time.
5 So, I think that drives the sort of throughput that's to
6 create the bed access and puts incredible pressure on the
7 community services to be managing people who are high at
8 risk.

9
10 And we do have evidence of this: again, we heard this
11 morning about ways we look at severity of conditions. We
12 use many tools, but one of the tools is called HONOS, the
13 Health of a Nation Outcome Study. We've certainly got
14 trend data that shows that the people who are coming into
15 our units are scoring higher, in other words their illness
16 is more severe. There's sometimes unfortunately not the
17 significant drop in change in the HONOS scores at the time
18 that they're discharged, and we're seeing the HONOS scores
19 of the patients, the consumers who are in the community, at
20 a much higher level than they need to be.

21
22 So, our community services are dealing with more
23 severely unwell people, inpatient units are taking in
24 people who are more severely unwell, and they're
25 discharging them before there's been the significant change
26 in their level of severity, so that's very concerning.

27
28 Q. You've said that the resources of community-based
29 services do not allow them to provide:

30
31 "evidence-based psychological interventions
32 which assist with longer-term recovery."
33

34 A. Yes, I am concerned about this. Again, I think the
35 variation is across the age range. I think child and youth
36 services still are able to do this to some extent and aged
37 mental health services.

38
39 But we need to recognise that there should be
40 continuity of care. Although we talk about mental illness
41 having these episodes, often people need different levels
42 of care depending on what stage they are in their illness.

43
44 What's happened, I think, is that we have a community
45 model of care that's much more focused, like our inpatient
46 model of care, on crisis intervention, and probably much
47 more focused on single modality of treatments, so we're not

1 offering the family treatments that we used to offer.
2 We're not offering the psychological treatments that have a
3 strong evidence base.
4

5 There's a wealth of different approaches for what I
6 call "psychological, cognitive behavioural treatments",
7 inverted commas, we talk about psychotherapies, but it's
8 really quite a broad school to talk about all the different
9 evidence-based, particularly cognitive behavioural
10 therapies, for specific conditions that require trained
11 staff but also the capacity to be able to deliver this,
12 they're often not short-term treatments either. So, I
13 think we've deskilled what should be being provided in our
14 community mental health services because it's much more on
15 this risk/crisis model of care.
16

17 We also don't have the variety of the disciplines to
18 actually deliver that, so I think in terms of workforce
19 development, that's got to be a key aspect, that we train
20 and supervise our staff to make sure that they are capable
21 and have the competencies to deliver this sort of
22 treatment.
23

24 Q. Having had an overview of the system for quite a
25 number of years and having worked in the mental health
26 system for many years, what's the level of your concern
27 about the unavailability of inpatient beds and the pressure
28 that places on the rest of the system?

29 A. Look, that's probably the one thing - well, many
30 things keep me awake at night, but that's probably one of
31 the most concerning. And really, it's around, I suppose,
32 the stigma and the dilemma that we - collectively we, I
33 say - have accepted this situation in a way that would
34 never be acceptable in any other parts of health.
35

36 I firmly believe that, as I've been in mental health
37 for over 40 years now, that we should be providing the same
38 standard of health care in mental health as we would expect
39 in physical health.
40

41 Can I just add with that point, because I don't think
42 it's been touched upon today as yet: one of the areas that
43 again causes me enormous concern is the interplay between
44 poor physical health outcomes and mental health. We've got
45 a lot of evidence now, a lot of longitudinal data that
46 shows our mental health patients are dying, if they're men,
47 up to 15 years earlier than their counterparts. If it's

1 female, up to 10 years.

2

3 Dare I say, the double jeopardy, if you're Aboriginal
4 or Torres Strait Islander person with a mental illness,
5 it's a double-whammy really. So, these are terrible
6 outcomes and we need to, again, get much better integration
7 between our mental health services and our physical health.

8

9 Because, when we look at the causes of this decrease
10 in life expectancy it's not, as we might think, that it's
11 due to our mental health patients committing suicide, it's
12 actually from the same illnesses that we all suffer from
13 which are treatable. So we have patients who are dying of
14 cancers because they're diagnosed late and would have been
15 treatable early on; we have them dying from cardiovascular
16 treatable conditions, diabetes. Again, late recognition,
17 late onset.

18

19 I use this sort of term that the Royal Australia and
20 New Zealand College have used about sort of diagnostic
21 shadowing, because I think it's a problem both in mental
22 health and physical health. I think in mental health the
23 mental health diagnosis can sort of overshadow the physical
24 diagnosis, so that we have staff who don't see it.

25

26 We also have problems with physical health services
27 about the different ways they need to engage people coming
28 from a mental health background, who may not be easily
29 engaged in the usual sort of model of care, so we have to
30 have more creative ways of managing this, but I think it's
31 a terrible dilemma that we have people dying so many years
32 earlier and it's really because of treatable physical
33 illness that we're not managing appropriately.

34

35 Q. In relation to the forensic components of the system,
36 are there adequate facilities to provide treatment to
37 prisoners with serious mental illness problems?

38 A. No, there are not, there certainly aren't. I probably
39 need to explain for people who don't understand the system,
40 that if you're a prisoner, obviously involuntarily
41 sentenced to prison, you can't receive mental health
42 treatment in a prison against your will.

43

44 So, to receive the sort of treatment, if you're
45 refusing treatments, you have to be transferred to our
46 forensic secure hospital called Thomas Embling, and you
47 become what's called a security patient. So, it means

1 you're a prisoner under the Mental Health Act.

2
3 Our dilemmas with that are that we're in no way
4 meeting the demand. So, if we think it's bad in our acute
5 inpatient units in health services where we have delays of
6 24-hours, for in some cases in our prisons, prisoners can
7 wait up to three months before they're - so they're
8 untreated. These are usually people who are severely
9 unwell, people who are suffering conditions like psychosis,
10 so they're very, very unwell.

11
12 So they arrive, if they eventually get to Thomas
13 Embling after having had three months without any
14 treatment, or even more concerning I suppose is that
15 sometimes the prisoners are reaching the end of their
16 sentence, so they're being released from prison and because
17 they're so unwell they're being put on an assessment
18 order under the Mental Health Act and they're sent to
19 whichever is their closest hospital.

20
21 I'm sure Dr Ruth Vine would have comments to say about
22 that because her hospitals are geographically located to
23 some of our prisons so that's more likely to happen. So
24 we're expecting then our acute mental health services to
25 take these people who are ex-prisoners who should have been
26 treated early on during their prison stay but are ending up
27 on their doorstep through the emergency department with
28 three months or more of untreated serious mental illness.
29 So obviously very hard to treat when we're getting them so
30 late in the situation and this is something we could so
31 easily do differently.

32
33 Q. We could so easily do differently, by doing what?

34 A. Having access to beds. I think, to have the same
35 expectation that we have for someone who's in the
36 community, we don't expect them to wait three months if
37 they're severely unwell because they can't get access to a
38 bed, although they do sometimes wait 24 hours which is
39 terrible. But we should have that same expectation for
40 prisoners in our community; they should be able to get
41 ready access when they require.

42
43 So, they do get access to treatment in prisons when
44 they accept treatment, and we have a robust forensic system
45 of in-reach into prisons but it's really at the pointy end
46 when they need inpatient psychiatric care that we really
47 struggle.

1
2 Q. Dr Coventry, we've asked you some questions about how
3 the system has got to the point at which it now exists, and
4 you've said that:

5
6 "One of the factors is that growth in
7 demand has increased at an unexpected
8 rate."
9

10 Has that led to higher thresholds for consumers
11 seeking access to services?

12 A. Look, I certainly think it has. The way that people
13 are managing this high demand is really, instead of triage
14 being, as we heard earlier this morning, it should be no
15 wrong door approach, so if someone makes contact with a
16 triage service we work out what we need to do. Instead,
17 it's really trying to work out, I think, how this can be
18 someone else's problem because we just have no capacity to
19 manage this. So, the bar is getting higher and higher.
20

21 It concerns me that we have not a consistent approach
22 across our mental health service. So, I'll give you two
23 examples, and I should say, I'm coming as a child and
24 adolescent subspecialty psychiatrist as well in my role as
25 Chief Psychiatrist.
26

27 So, we have conditions, as we heard from our previous
28 witness, eating disorders such as anorexia nervosa, and
29 what we call pervasive developmental disorders which really
30 covers a group of disorders but includes autism spectrum
31 disorder. Child and youth services would regard those two
32 types of problems as being their core business and would
33 have staff that are very skilled in diagnosing and
34 assisting families and young people with those sort of
35 conditions.
36

37 However, once they turn 18 and move into the adult
38 service, autism would be regarded as a disability and would
39 not be seen as core business of the adult community mental
40 health service, nor would they necessarily have clinical
41 staff who are well trained and experienced to manage this.
42

43 Similarly with eating disorders: while we have a few
44 inpatient - state-wide inpatient beds and regional beds for
45 inpatient eating disorders, the majority in the community
46 are managed in private community services, such as private
47 psychologists under the Medicare arrangement.

1
2 So this is really concerning that we have these
3 discontinuities, particularly with these conditions which
4 aren't episodic in the way that other conditions might be
5 and eating disorders may need treatment over a number
6 of years. Autism obviously will need treatment over
7 many years or the lifetime to assist.
8

9 So it's concerning that we have these discontinuities,
10 I think, in the level of care we provide which is very
11 difficult to explain to consumers and their families why
12 they were eligible.
13

14 I even have an aversion to the term "eligibility",
15 which sounds incredibly restrictive, that people are being
16 told "you're not eligible for our service" or "you're not
17 sick enough to need our service", when we should be really
18 aspiring to our rhetoric, which is, early in life, early in
19 illness and early in episode. We know the best outcomes
20 are from prevention, early intervention, so to actually set
21 up these barriers and say that someone's not sick enough to
22 get our service is a terrible blight, I think, on how we
23 offer.
24

25 Q. Dr Coventry, we've heard that quite a bit from
26 consumers who have said that's what they're told and I
27 gather you as the Chief Psychiatrist agree that that is a
28 refrain that's often heard in the system, that people are
29 not sick enough?

30 A. Yes. Look, we hear this in various ways. One of the
31 extreme examples, just getting back to eating disorders,
32 is, "You haven't lost enough weight to be really so
33 dangerously unwell", when all of our research shows that
34 the earlier you can treat a disorder like anorexia nervosa,
35 the better outcome.
36

37 So it's terrible to hear that someone, when they make
38 that attempt - and we also need to remember, it takes an
39 enormous amount of courage for either consumers or their
40 carers to actually contact a triage. Not only is it
41 difficult to navigate your way through our system, to
42 actually have that capacity to make that first contact is
43 often very, very challenging, so it's an opportunity really
44 and we're wasting that opportunity if we don't provide that
45 sort of response.
46

47 Q. We've asked you, as I said before, about how the

1 system has got to where it is now, and one of the things
2 you have said is that:

3
4 "The funding system is unresponsive to
5 demand."
6

7 What do you mean by that?

8 A. It's quite challenging to explain our strange system
9 of funding. I think perhaps my colleague, Dr Ruth Vine,
10 did a good job when she was talking about the block
11 funding. So, we're not funded against what we call
12 activity funding, it's block funding.
13

14 We're also sort of cross-supporting services when we
15 have our expensive inpatient services that aren't funded at
16 the actual real cost, so it means there's diversion of
17 funds from our community, which paradoxically makes the
18 problem even worse because it means that we're not managing
19 and helping people at the right stage in the community that
20 might actually prevent them needing to access the acute
21 pointy end of inpatient care.
22

23 So that's what I was meaning, that we don't have that
24 capacity and I think we've got to be looking across the
25 whole system. So that would be my plea to the
26 Commissioners in terms of recommendations, that we need to
27 see this hopefully as a much better integrated system and
28 we need to be supporting both community and inpatient care
29 because they go hand-in-glove, I think.
30

31 Q. Thank you. You've also said that:

32
33 "Planning and demand forecasting mechanisms
34 are not able to access information required
35 to deliver targeted capital and workforce
36 infrastructure investment."
37

38 When you talk about "planning and demand forecasting
39 mechanisms", what do you mean?

40 A. Well, look, I'll give a practical example.
41 Unfortunately, we sometimes get stuck in sort of historical
42 arrangements in mental health that don't necessarily
43 reflect the current demographics.
44

45 So, you've heard quite a bit this morning, I think,
46 about some of the bed blockages and when people are in
47 emergency departments for unreasonable lengths of time.

1 When I look at how this gets mapped across the state, the
2 sort of hot spot areas are all the areas in growth
3 corridors where clearly the demand for services,
4 particularly inpatient bed access, hasn't been matched by
5 the actual number of beds. So we're stuck in the
6 historical perspective of the beds that might have been
7 adequate for a different period a decade or more ago, but
8 clearly are not adequate for what we now know about the
9 growth corridors and the mix of people coming in, and the
10 families and the age demographics.

11
12 So, that's what I was meaning, that we're not sort of
13 scanning the horizon to be aware of these hot spots where
14 we could actually anticipate, if we don't invest, we're
15 actually going to have a problem because the beds stock and
16 the other services don't match the demographics and the
17 population.

18
19 Q. Yes. We've asked you about what you think are the
20 most critical of the unmet needs and I think you've
21 mentioned some of them already. In your statement you
22 mention:

23
24 "Unmet needs for children and young people
25 living with dual disability."

26
27 Can you say a little bit about that?

28 A. Yes, I was alluding to that before. So, dual
29 disability, these are somewhat confusing terms. But we
30 talk about dual diagnosis, dual disability. Dual diagnosis
31 means patients/consumers who have a substance use problem
32 as well as a mental health problem.

33
34 Dual disability is talking about the group I was
35 mentioning before, the consumers or young people who have a
36 mental illness and also have a coexisting disability, so it
37 may be an intellectual disability, it may be a disability
38 like autism, spectrum disorder, which is what we call again
39 a confusing name, pervasive developmental disorder.

40
41 So my concern with that particular group, both
42 children and adults who have that diagnosis of autism, is
43 that at times they absolutely need to be able to access
44 inpatient assessment; that we know that there are
45 significant other mental illnesses that could be comorbid -
46 coexist with conditions like autism.

1 However, what can often happen is that the community
2 service, and particularly accommodation, is stretched
3 beyond their capacity to cope or it may be a young person
4 and their family where the family are stretched beyond
5 their capacity to cope.
6

7 So what can sometimes happen is that there's a crisis,
8 but it's really a crisis on a sort of chronic deterioration
9 really, so it's not necessarily an acute crisis. Usually
10 coming to the emergency department, sometimes after hours,
11 the person gets admitted to hospital, and I'd say our
12 inpatient services can be very good at doing reasonably
13 quick assessments to see if there's a coexisting other
14 mental illness that needs a different sort of treatment.
15

16 But what can happen in reality is, these people have
17 no exit plan to be discharged because there's no
18 accommodation. And, even with the best will in the world,
19 an acute inpatient unit is not the best environment to try
20 and manage and help people. In fact, in some cases it
21 probably makes their behaviour worse with the sort of
22 approach and the mix of patients.
23

24 The sort of situations I get involved with as Chief
25 Psychiatrist is then trying to work out some way of joining
26 up the dots and getting an exit plan, and usually it's
27 around providing stable accommodation or a non-government
28 agency that will be able to care and working out the
29 funding mechanism to assist that. Sometimes we use MACNI,
30 the Multiple and Complex Needs Initiative as well.
31

32 Unfortunately, even with the best will in the word, it
33 usually takes me weeks-to-months to get an outcome, in
34 which case I'm also seeing some deterioration. I think
35 there's a degree of complacency, that obviously for these
36 very vulnerable people, no-one would want them to be
37 homeless, no-one wants them to get involved with the
38 criminal justice system, so people do everything to avoid
39 that. That sometimes means they're then occupying an acute
40 inpatient bed when that's not really what they need or it
41 might actually be making their behaviour deteriorate, if
42 that makes sense.
43

44 I get very concerned about the fact that we don't have
45 the right mix of services for this particular vulnerable
46 group, both as children and adolescents and as adults,
47 inappropriately having them in our acute inpatient units

1 and then we don't seem to have good mechanisms to actually
2 be able to discharge them safely into a wrap-around service
3 with the appropriate level of accommodation and service
4 input.

5
6 Q. In asking you about the key drivers of unmet need you
7 said this:

8
9 "Overall insufficient acute beds and
10 community treatment capacity which can
11 provide evidence-based psychological
12 interventions and intensive support are the
13 key system drivers of unmet need."

14
15 You go on to say that:

16
17 "Substantial investment is required in
18 these areas to resolve demand pressures."

19
20 What is the scale of investment that's required, if
21 you can describe it?

22 A. Look, I'll try. I'll go to the pointy end about the
23 beds. It's not easy to actually think what this is or what
24 the number is, because I think we need to rethink our mix
25 of beds: so I'm not just talking about acute beds, I think
26 we need acute and subacute because we will use our beds
27 differently depending on what else is available. This is
28 why sometimes the comparisons with other state
29 jurisdictions is a bit confusing because they don't
30 necessarily have the same mix of beds.

31
32 I think we need to be looking at our models of care,
33 our subacute bed mix, and our acute, and how we're using
34 both of those. As an example, thinking about the PARCs
35 that you've heard about today.

36
37 We need to be thinking that the subacute services can
38 be both step-up and step-down. We shouldn't only be using
39 them as a step-down from our acute inpatient units as a way
40 of managing the beds, they should actually be a step-up,
41 and one would hope we'd be able to help people much earlier
42 in their stage of episode and illness where they don't
43 necessarily need the intensity of an acute inpatient unit,
44 and we've heard that some of our consumers would far prefer
45 to be admitted to a PARC than an acute inpatient unit.

46
47 So, I think it needs considerable investment to try

1 and have sufficient stock that we can actually provide
2 ready access, that we can get to an occupancy rate
3 somewhere around the 80-85 per cent with the flexibility,
4 and that we need to fund those inpatient services so
5 they're not stealing money from the community mental health
6 services. I think that will then drive a different model
7 of care so that we can start to do much more early
8 intervention, early in episode community care which one
9 could hypothesise would hopefully diminish to some extent
10 the need for acute care, that we would actually be able to
11 treat people earlier in the community in their stage of
12 illness.

13
14 So I think there would be a flow-on. I think then we
15 would also have the capacity to offer a variety of
16 different sorts of interventions. One of the things we
17 don't want to do is, we don't want to be a mental health
18 specialist service that only provides what we call
19 pharmacotherapy or medication, we need to provide a whole
20 variety, and there's an enormous wealth of evidence-based
21 interventions, as we were hearing earlier, if we think
22 about different psychotherapies for conditions like
23 personality disorder or trauma. We've got a wealth of
24 treatment that we should be offering in the community to
25 people who are experiencing those sorts of disorders.

26
27 So, I think there needs to be considerable investment
28 but it's not just investment, it really needs - like, it
29 shouldn't be more of the same, in other words. While I
30 think our bed stock is inadequate, I would certainly
31 suggest we need to look at the mix of bed stock and have a
32 variety and really seriously consider the mix of subacute
33 and acute beds, and also then look at our model of care
34 that we have in the community that we can do much better
35 and differently.

36
37 Then I'd also like to look at integration between
38 physical health and mental health so that we don't have
39 this problem of our patients with physical illness not
40 getting diagnosed and treated.

41
42 Q. And so, when you say in the context of answering our
43 question about how the Royal Commission could make more
44 than incremental change, you say that:

45
46 "The specialist mental health system needs
47 to be rebuilt and it will take time and,

1 once the core system elements have been
2 stabilised and strengthened, then there is
3 enormous scope for reform."
4

5 Is that what you mean when you talk about stabilising
6 the core elements?

7 A. Yes, look, I do, and it's interesting thinking about
8 the other speakers and the other witnesses and the
9 questions asking about, are we talking about incremental,
10 are we talking about transformational change, and I think
11 it's actually both.
12

13 Clearly, even if we had huge investment tomorrow, to
14 actually create extra beds takes a long period of time to
15 actually get that. But we shouldn't think we will be
16 complacent over that time without looking at models of
17 care.
18

19 So, I think there's a lot of work we need to be doing.
20 I guess what I see as being incremental and
21 transformational, we need to sort of not throw the baby out
22 with the bath water, and remember, we still have a
23 responsibility to be assisting vulnerable consumers while
24 we rethink this, so we can't stop providing care and
25 compassion and treatment for people while we redesign.
26

27 I think it's transformational in the sense that I
28 think there's much more we can do about putting consumers
29 at the core of all our treatment decisions, and we have
30 done that to some extent. But that's the big
31 transformational change for me, to actually do that in
32 partnership and really do it in a - talking this morning
33 about power and power inequalities - I think to actually do
34 that with sharing of power and I think that will actually
35 guide us with the advice from consumers and carers to new
36 models.
37

38 So, I think it's got to be incremental or
39 transformational, and we need to think about the whole of
40 the system, not just one aspect of the system. I'm
41 probably not quite answering your question, I'm sorry.
42

43 Q. That's alright. Is it right then that in your view
44 the system can't be transformed or improved without dealing
45 with the inadequacy of beds problem?

46 A. I think that's the foundation but I don't think that's
47 the only thing.

1
2 Q. No.

3 A. So for me that would be absolutely the foundation, to
4 look at beds, both acute and forensic beds and subacute
5 beds as a foundation. But the other aspects that go on
6 with this, I think we need to absolutely look at our
7 workforce and our workforce capabilities, because it would
8 be ludicrous to open up more capacity with inpatient beds
9 if we can't staff it. We know there are dilemmas with our
10 current workforce, it's an ageing workforce, so we need to
11 be anticipating, succession planning.
12

13 We need to think about the mix of the workforce. We
14 know across health generally people are struggling with
15 insufficient numbers of trained nursing staff, for example.
16 So, I think we need to consider a mix of disciplines, the
17 model that we want to have, and also the competencies and
18 capacity.
19

20 I think probably over my career I've seen that we've
21 perhaps deskilled our workforce to some extent by needing
22 to focus on a crisis model of care, so I think some of the
23 core capacities and competencies that our staff had maybe a
24 generation ago we've actually lost to some extent, so we
25 need to have a workforce that's well and truly well
26 trained.
27

28 I think we also need to see - this is a specialist
29 skill. It's a bit like, you know, you don't send a nurse
30 to a coronary care unit and think they're going to be a
31 coronary care expert. It takes years and years to develop
32 that and they need appropriate training and professional
33 development and supervision and on-the-job mentoring,
34 et cetera. That's what we need to do for our mental health
35 workforce, I think, and we need again to be making sure
36 that - hopefully the Royal Commission will be an
37 opportunity - that this is the best time ever to be
38 thinking about a career in mental health and we will
39 support people through this as a career so that they
40 develop the right skill mix that we expect.
41

42 Q. Can I go back to a more particular question and that
43 is about triage, changing topics for a moment?

44 A. Yes.
45

46 Q. You've explained that triage services are managed on
47 an area basis and so what is in place in any particular

1 area will vary with the demographics and so on. We've
2 asked you about some of the constraints on triage services
3 recognising that they are different in different places.
4

5 You have said, among other things, that:
6

7 "Demand for triage services is resulting in
8 extremely long wait times and high
9 abandoned call rates. Feedback from health
10 services, consumers, carers, emergency
11 services and referral services is that
12 there are often long waits."
13

14 And that your office itself often experiences long
15 wait times. When you say "long", what do you mean?

16 A. Well, very long; hours in some cases. This is
17 particularly a challenge I think for after hours, as I was
18 explaining before, where the telephone triage function may
19 also - in fact many times - is managed and organised
20 through the CAT Team or the ECATT team who are the
21 clinicians providing emergency assessments in the emergency
22 department of a hospital.
23

24 So, I think it's incredibly problematic, when people
25 are trying to juggle these dual tasks that they need to do,
26 and it's easy to see why the telephone triage task will be
27 given a lower priority than the patient/consumer that's
28 actually in the emergency department. So, I think that's a
29 problem.
30

31 I think the system sometimes gets overloaded. From my
32 experience ringing triage services where they may not have
33 the capacity to take a number of calls simultaneously, so
34 the calls just drop out. So, I hear that from consumers
35 and their families saying they give up because they've
36 tried a few times and the call just can't get through; or
37 there's a recorded message and they don't feel comfortable
38 leaving a contact number on a recorded message, they want
39 to speak to a real live clinician. So, I think that's a
40 problem in terms of the demand.
41

42 It's done a bit differently across the age spectrum.
43 So, aged/mental health tend to do their own triage; to some
44 extent the child and youth will do their own triage in a
45 different way, so there are different models that you need
46 to do.
47

1 Ideally, one would like triage workers to have the
2 right amount of time to be getting the assessment that they
3 need to be able to do over the telephone to work out what
4 is the best outcome. And to make sure that anyone ringing
5 triage feels listened to and supported and, if it wasn't
6 the right door - but we should say there is no wrong door -
7 but if it wasn't the appropriate door, that they get
8 assisted into accessing what would be the most appropriate
9 service.

10
11 Q. The things you've been describing in the last few
12 moments are prefaced with your statement that ideally
13 that's what you would like. Can we infer, from what you've
14 just said, that that's not what's happening by and large?

15 A. I don't think that's what's happening, and I know
16 triage telephone services are being overloaded because I
17 need to ring them at times in my work, in hours and
18 sometimes after hours, and it's very challenging and
19 sometimes I need to escalate when I need to speak to
20 somebody after hours because I can't be on the phone for an
21 hour or longer waiting for a call. But I do understand
22 that the person who's actually taking on that task is
23 actually trying to juggle two diverse tasks really and how
24 they prioritise.

25
26 Q. You've said that:

27
28 "Some individuals may be appropriately
29 triaged but they're not accepted into the
30 services to whom they're referred by
31 triage."

32
33 So, what's the disconnect that's going on there?

34 A. I think it's, again, part of our dilemma about demand
35 management, so that, basically we're putting the bar up to
36 let as few people in, because we know the mental health
37 services are so overwhelmed they're not able to cope, so
38 this is really giving people the wrong messages to people
39 who ring in.

40
41 They're being referred to services that may not have
42 the expertise to manage. So, we're sometimes referring
43 people to primary care, where it's been primary care that's
44 actually referred them to the specialist service, so
45 they're bouncing back. And primary care, without some
46 in-reach from the specialist mental health service, doesn't
47 have the expertise to be able to manage that sort of

1 person.

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At other times we're referring people to other services and, because it's a telephone triage, we don't actually facilitate that referral process. We could do that much better because I think that is our responsibility. If it wasn't the right door that they entered, we need to really assist the person to be able to access more appropriate services and we should actually be doing that referral process, not expecting our consumers and carers to do that; which again takes time, but I think that's what our role should be at triage.

Q. In relation to people who need to speak to someone through an interpreter, what services are available for telephone triage, do you know?

A. It's pretty poor, in my experience. In having tried to use that myself in my clinical role, it's incredibly challenging to have a telephone interpreter service with someone who's on the telephone; an interpreter service where the interpreter may not necessarily have any expertise about mental health and the language. There can also be other cultural issues about the appropriateness of the particular interpreter that's being used because of their cultural issues.

So, I think that's poor generally, I wouldn't say just with triage. I think our use of appropriate interpreter services across our whole mental health system is not ideal. We're not funding that appropriately and we're not encouraging people to use that when they really need to, so it means that sometimes our consumers or their carers are acting as interpreters and that's not appropriate. We shouldn't have family members acting as interpreters.

Q. You pointed out that other jurisdictions, apart from Western Australia, have a single point of contact for triage. Do you think that's something we should have in Victoria?

A. I don't probably know enough information about that. We have changed our triage system, so many services have a sort of 1800 number.

However, what we don't want to do is to have a whole series of triages, and I think that can be the case when you have a totally centralised number that takes some preliminary information then refers you onto another

1 process, and we hear from our consumers and carers, the
2 most frustrating experience they have is having to tell
3 their story over and over and over again.
4

5 I think, whatever triage service, we should assist
6 them to do the job they have to do rather than actually
7 refer on to anybody else. So, regarding having a
8 state-wide triage, I probably just don't know enough
9 information, and I would struggle to see how in reality
10 that's not just putting another layer of triage that would
11 be challenging, I think, for our consumers and carers.
12

13 Q. Just a couple more questions. We've asked you about
14 the data analysis capacity that your office has and you've
15 said the office collects a range of data that could be
16 usefully analysed and interpreted.
17

18 But we gather, from what you've said, that you don't
19 have sufficient capacity to do that. Is that right and
20 what additional resources would you like?

21 A. Resources are improving, but one can always have more
22 capacity, and I think our responsibility is to get
23 meaningful data and then analyse that in partnership with
24 services and give that back to services, because the data
25 is really for the purpose of driving service improvement,
26 quality and change.
27

28 So, having said that, we do have a much better data
29 collection system than we had when I first came into the
30 department, but it probably needs some tweaking. We would
31 like to be able to make sure that people can enter the data
32 in as efficient a way as possible from the field.
33

34 We partner with organisations like VAHI; this is the
35 Victorian Agency for Health Information who publish now, in
36 collaboration with us, what's called Inspire Mental Health
37 Report, where we select a number of the areas of data and
38 KPIs that we collect, or they collect, and publish the
39 variance data so that people can actually look at this and
40 do benchmark comparisons and actually have their services
41 named. This is really important I think to drive change.
42

43 I think there's lots more we could be doing, there's
44 no point collecting this sort of data without analysing and
45 giving it back. So, while I've got some increasing
46 capacity in my service to do that, I think it's probably
47 been a shortfall generally, but I'm pleased that we've

1 addressed it to some extent through partnership with VAHI.
2
3 Q. Can I just go back to quite early in your statement
4 where you were describing your role, and you said your role
5 is to:
6
7 "Intervene at a system level through
8 promotion through cultural and clinical
9 practice improvement."
10
11 And you:
12
13 "Operate as a resource for the specialist
14 mental health system to drive continuous
15 improvement and embed the principles of the
16 Act."
17
18 Given the pressures on the system that we've been
19 talking about this afternoon, how difficult is it for your
20 office to drive continuous improvement and embed the
21 principles of the Act?
22 A. Quite challenging, I have to say. One of the
23 challenges really is Victoria's geography and having the
24 resources. So, I really try and do this engagement at a
25 number of different levels. At the most basic level it's
26 actually being visible and going out to services; not
27 sitting at the department's ivory tower, we've actually got
28 to be actively engaging with services, and that means
29 actually going out to visit.
30
31 So, we do a lot of visits and at the moment I've got a
32 rolling program to do visits to Aged Mental Health Services
33 and also to services that provide ECT, electroconvulsive
34 treatment. But we would like to do much more if I had the
35 resources; it's very time-intense but incredibly valuable
36 to do that.
37
38 So, I have the sort of pointy end of my role where I
39 can give directions and instructions and Chief Psychiatrist
40 guidelines, but to actually drive service improvement it's
41 got to be much more than just publishing a document that
42 you hope people actually read at the end of the day.
43 You've actually got to be seeing how people are complying
44 with it, what are the barriers to doing that, what's the
45 training needs that are required, what's the feedback that
46 we're getting?
47

1 So, it's got to be a really comprehensive suite of
2 different ways with engaging with the service to make sure
3 that, you know, I'm fulfilling my function, which is to
4 drive safety and quality improvement at the broader systems
5 level, as well as using some of the specific instances to
6 do a much more detailed analysis to see if, from an
7 individual situation, we can get some learnings as well and
8 making sure that gets disseminated widely.

9
10 I do this to an extent with my annual report, which is
11 a requirement under the Mental Health Act, to try and give
12 some transparency to the work that my office does and
13 provide some of the data, so it's a summary of the lot of
14 the activity that we do, but with more resources obviously
15 one could do this in a much more robust way.

16
17 Q. Understanding you do a lot of visits and engage in a
18 lot of activities, focusing rather on the features that
19 exist in the system that you yourself can't change, are
20 there problems in the system that mean it's really, really
21 difficult to drive change and improvement?

22 A. There are lots of challenges, and one of the
23 challenges can be having really experienced staff to be
24 taking on leadership roles. We have leaders who, you're
25 hearing, are very stressed at the sort of work we're
26 expecting to do around a crisis model. I think anyone
27 going to an inpatient unit, if you were responsible for
28 running that and having to work out who is your least
29 unwell person to discharge, is incredibly stressful. So,
30 I'm worried that we're burning out our leaders and we don't
31 have enough people in terms of succession planning.

32
33 We're also probably not training them for the sort of
34 skill set that they need to have to take on these tough
35 roles as leaders and how to make that better, and also, how
36 to actually have a really robust quality and safety
37 framework that people can use, despite the pressures of
38 their work.

39
40 So that's a concern when we see there are gaps in
41 particular disciplines. Sometimes this can be around
42 senior medical staff, particularly outside Metropolitan
43 Melbourne where we can struggle, when someone leaves, to
44 actually have a suitable person to step in and replace.
45 And, at times my office has actually needed to help out as
46 an interim to provide some stability whilst some
47 recruitment happens. So, that's probably one of the

1 biggest challenges.

2
3 I think the other challenge we see is the need to
4 provide more robust teaching and training to our workforce;
5 as we expect them to do more and more in a different way,
6 we've got to make sure they have the right skills to
7 actually do this.

8
9 I guess the other thing I try to do in my work is sort
10 of model the importance of having the consumer and the
11 carer at the centre of everything we do. So, when I do
12 visits, when I do investigations, when I set up Chief
13 Psychiatrist committees, we always have consumers and
14 carers with lived experience and we will model that to the
15 services to say that's what we expect services to be doing
16 as well.

17
18 MS NICHOLS: Thank you, Dr Coventry. Chair, do the
19 Commissioners have questions?

20
21 CHAIR: Q. I just have a number, please. Dr Coventry,
22 thank you very much for your comprehensive overview. We've
23 heard a lot about some of the pressures on the system that
24 are, in your words, compromising the quality of care that
25 sometimes can be covered and the impact that has.

26
27 I guess I'm drawn to a point in your witness statement
28 where you talk about planning, policy and service
29 development. So, obviously anticipating, planning for,
30 doing the modelling about what the level of need is
31 et cetera.

32
33 I note in your statement you say that these are
34 functions that are separate to your office and are
35 undertaken elsewhere in the department. Can you just
36 confirm where else in the department the planning, policy
37 and service development occurs and, for example, who has
38 responsibility for developing a capital management plan for
39 mental health?

40 A. I actually wish I could answer that question. The
41 department's a very complex organisation. So, I'm part of
42 the Mental Health Branch, so I bring the clinical expertise
43 and the clinical knowledge to the Mental Health Branch.

44
45 But there's another part of the department which I'm
46 not involved with which looks at the sort of
47 epidemiological study, looks at the demographics, and I

1 would have to say I'm not sure how much mental health is
2 actually configured in that; I think they take a much
3 broader general health perspective. So, I think that it's
4 important that we should be using that sort of data and
5 considering how it's relevant for mental health and mental
6 health planning to try and see where the future development
7 needs to be.
8

9 So, I'd have to say on a sort of daily basis, while I
10 feel I contribute the clinical perspective to inform that
11 through the Mental Health Branch, outside of the Mental
12 Health Branch I'm not involved in that sort of planning.
13

14 Q. Thank you. For example, we've also heard about the
15 importance for people, if they do require inpatient care,
16 consumers have talked to us about the physical design of
17 those; collocating, shared accommodation, and certainly
18 some of the observations about the standard of
19 infrastructure is pretty minimal in terms of what we've
20 been hearing.
21

22 When you do your reviews and find shortfalls in terms
23 of practice that might be able to be possible and some of
24 that being limited by physical infrastructure, how do you
25 influence the design principles for our future mental
26 health infrastructure?
27

28 A. What I tend to do in practice is give immediate
29 feedback, and sometimes that's involving a significant
30 piece of work. Sometimes it's not, sometimes it's just
31 creating an atmosphere that's much more welcoming and
32 inviting.
33

34 I'm often intrigued that people who work in an
35 environment that's substandard over time will accept that
36 as being the norm. And we come in with fresh eyes - and
37 particularly with my consumer and carer colleagues with
38 lived experience - to actually point out sometimes very
39 simple things that could be done to make the environment,
40 right from the first point of entrance, more effective.
41

42 So that's what I would do on-the-spot. I'd also
43 follow that up with services, in some cases directly with
44 their leaders and in some cases with the CEO to actually
45 say, this is a very important priority that needs to be
46 addressed.
47

In terms of your second part of the question which is

1 around sort of future planning and design: that's pretty
2 fluid, I'd have to say, because I don't think we have
3 necessarily the perfect ideal design sort of structure that
4 we want to do.

5
6 What I will get involved with is when services
7 themselves might be coming up with a particular proposal to
8 provide some oversight to look at whether that looks like
9 it's sensible, whether it's safe, whether it's practical,
10 whether it would still meet the requirements under the
11 Mental Health Act in terms of space.

12
13 So, I guess that's not trying to micromanage that, but
14 also to be thinking at the end of the day, while we have to
15 manage level of risk, we need to make services that are
16 warm and welcoming to, not only the consumers, but their
17 family and friends who come to visit. And I think as much
18 as possible trying also to have services going out to visit
19 other services to see examples of really good practice and
20 good standards.

21
22 As I say, sometimes I think people have blind spots
23 and accept something that really shouldn't be tolerated,
24 sometimes because they have never worked in a different
25 sort of service.

26
27 Q. And one final point, Dr Coventry. In your statement
28 you talked about the fact that you don't have jurisdiction
29 over private mental health services. But we've heard many
30 examples whereby consumers move between the public and the
31 private system.

32
33 How is the oversight function that you have and the
34 requirement to drive continuous improvement compromised by
35 your inability to look at those transition points?

36 A. I'm assuming you're talking about when we've actually
37 had people that have needed to access beds in the private
38 sector?

39
40 Q. Or when someone's moved out of a private facility into
41 a public system or the other way round, and you don't have
42 an opportunity to look at the continuity of care or the
43 handover, for example?

44 A. Sure. What I try to do at a systematic level is link
45 in the department with my colleagues, who have the
46 responsibility of oversight for private hospitals, to talk
47 about what we do in the public sector, the sort of levels

1 of governance, how we go about investigations of serious
2 incidents, to sort of give them a model of how they can
3 improve safety and quality.
4

5 We have to remember that the system in private
6 hospitals is very, very different to the system in public
7 mental health services. So, my line of authority in public
8 mental health services is with the clinical lead who's the
9 authorised psychiatrist under the Act, so I have certain
10 powers that lead up or devolve through that person.
11 Private hospitals function in a very different sort of
12 manner, so that sort of model wouldn't work in that sort of
13 environment.
14

15 So, I think it's something that's worth obviously
16 thinking about, and it was a change in the previous Mental
17 Health Act where I had jurisdiction over ECT, for example
18 in private hospitals, which isn't the case now.
19

20 So, I don't have an easy solution to that, but it does
21 trouble me, when people move, about the level of oversight
22 that I should be able to provide to ensure that they get
23 the same quality of care regardless of where they might be.
24

25 CHAIR: Thank you.

26
27 MS NICHOLS: May Dr Coventry be excused?
28

29 CHAIR: Yes, thank you.
30

31 MS NICHOLS: That concludes the evidence for today.
32

33 **AT 4.05PM THE COMMISSION WAS ADJOURNED TO**
34 **TUESDAY, 9 JULY 2019 AT 10.00AM**
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