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

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

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

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

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

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

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

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

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

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

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

(Video played.)

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

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

MS NICHOLS: Q. Yes, Professor Stafrace, are you the Director of the Mental Health and Addiction Program at The Alfred?
A. Yes. The title, by the way, is Associate Professor.

Q. I beg your pardon.
A. That's all right.

Q. I've been promoting you for some time now.
A. That's all right.

Q. Have you been the Director of that program since 2006?
A. Yes, I have.

Q. Was it previously known as Psychiatry?
A. Alfred Psychiatry, that's correct.

Q. Have you got responsibility for the delivery of services across 12 locations across southern Metropolitan Melbourne?
A. Yes, I do.

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

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

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

Can I ask you briefly about The Alfred Mental Health and Addiction Service: do its programs include infant, child, youth, adult, liaison, emergency and aged care mental health services?
A. Yes, they do.

Q. Also a research centre managed in partnership with Monash University?
A. Yes, it did does.

Q. Does your network include seven clinics, two hospitals and three residential units?
A. Last time I counted, yes.

Q. Do you also have a series of partnerships with community providers including Launch Housing, Wellways, Odyssey, Headspace and South East Melbourne Primary Healthcare Network?
A. Yes, we do.

Q. Is your adult community mental health service based in a clinic in St Kilda Road?
A. Yes, it is.

Q. Does that service deal with the needs of adults between the ages of 25 and 64 living in the inner south of Melbourne?
A. Yes, it does.

Q. In relation to that service, can I ask you about the continuing care teams. Can you tell the Commissioners what they do?
A. Sure. So, we have two community mental health sites, but one of them is about to relocate to the St Kilda Road site; just to be clear, that's happening in about three weeks' time.

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

Q. Can I get you to elaborate a little bit on the Navigations Service so we can understand what it does and what its parts are, perhaps starting with its intake role?
A. So, just to perhaps put it in some context. There has been an increase in funding over the last two financial years, and in response to that we undertook a service planning activity.

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

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

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

Q. How does the Transitions Team provide that support and does it provide it directly to GPs or to the consumers themselves?
A. They work with a combination of the consumers and GPs. So, it might involve something like, for example, going and helping the consumer make appointments with GPs, perhaps attending an appointment or two; making sure that information is passed over, trying to understand what some of the barriers to continuing care might look like in that setting and working with the client in order to overcome some of those barriers. It's a slow process.

Q. And that service has been in existence since 2018?
A. Since 2018, yes.

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

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

Q. As far as you're aware, do similar services exist across the state?
A. I'm sure they exist, but you know, I suspect in a different form. There are many different ways in which these tasks can be undertaken.

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

Q. Does that include a community care unit and a prevention and recovery unit, otherwise known as a PARC?
A. Yes, it does.

Q. Just to be clear, can you tell the Commissioners what consumers Alfred Mental Health doesn't serve, leaving to one side your general primary care service dealing with young people?
A. So, I tried to sort of explain in the submission that, essentially the focus is very much on people with severe mental illnesses with urgent need and alternatively with those patients who may have been in that position and they are at risk of having those needs emerge once again.

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

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

for how long?

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

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

Q. You've given us a quite sophisticated analysis of all of the inputs to that in your statement. We won't go through all of the parts of that, but making the assumption that supply is acute inpatient care for patients who are severely ill and at imminent and high risk of harm to themselves and others, and also includes community-based services that are able to provide early intervention or short-term therapies or continuing care for patients with non-urgent but complex needs: with that assumption, you have identified that demand is increasing, and can I ask you to elaborate on what you say about the trends in demand?
A. Look, one of the points that I've tried to make is that, there are very different stories that emerge when you take a sort of an operational view on the one hand and when you look at this from the perspective of a patient and a family. I think both parties would say that supply is not keeping up with demand, but would have very different ways of communicating that and understanding that.

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

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

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

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

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

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

Q. You mentioned wait times; do you want to elaborate on what you say about how wait times are performing?
A. Wait times have been a bit of a focus of the work that we've done at The Alfred for a bunch of reasons, one of which is that the Commonwealth introduced national

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

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

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

Q. Is lack of capacity in community services contributing to the pressure on emergency services?
A. Yes, it does. So, the system is all interconnected, at least big parts of it are interconnected, and so, you can trace the difficulties that our clients are experiencing through from the lack of secure long-term extended care beds, through to the absence of subacute and non-acute shorter-term community care, through to community services, and by that I mean sophisticated community services that can deliver a range of treatment options, you know, all the way to the way in which emergency demand is handled sort of at the front-end in the emergency department.

Q. Can I ask you about discharge rates. You've observed in your statement that the number of discharges per month remained high. And, acknowledging that each patient's journey is different and there will be many factors that influence when and in what circumstances a patient is discharged, is discharging people as soon as you reasonably can one way of managing demand pressure?
A. It's one way, that's right. And I think in my submission I tried to make the point that, the questions about when to discharge patients are complex, they require the input of the patient, the input of the family; they

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

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

Q. What happens in those circumstances, where you feel the pressure to discharge someone when you otherwise might have kept them in?
A. Again, I mean, you know, we would not do that if we thought that the patient was at imminent risk, and so, you'll see from the data that I provided that in fact it's not uncommon at The Alfred that we would admit somebody with a mental health problem out of the emergency department into a medical bed, for example, in order to await their pending a transfer over into psychiatry. It's important to make that point.

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

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

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

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

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

Q. What do you do when you're faced with a person who has no place to live?
A. Well, our social workers work really hard. They work really hard, they ring around homeless shelters, they ring around crisis housing providers. For many of the crisis housing providers the way things work is, you've got to turn up on the day when you're ready to find accommodation, they will not take advance bookings, and so, this is really problematic when you're trying to coordinate the clinical care of somebody with complex needs and their housing requirements at the same time, and so, yeah, it's a very difficult, time-consuming and ultimately unrewarding for everybody - you know, not the least of which is the patient and anybody who cares about the patient.

Q. You said in your statement that:

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

What are you referring to when you say "driven by other factors"?
A. Driven by demand pressures, specifically.

Q. Yes.
A. Yep.

Q. Alright. In relation to non-hospital-based services, what's your opinion in relation to whether the mental health system is providing the things it was intended to provide?
A. If I remember correctly, the way I interpreted that was in relation to community services. I think that, when you look at the language of the framework documents in the 1990s and then the way in which in fact services were

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. So when your caseload is significantly reduced, just to give us an idea, what difference does that make in relation to the kind of care practitioners are able to provide?
A. Well, I think we're still exploring that to be quite honest with you because it's been such a long time since we've been able to do that. And when I say it's been a long time, for many of the clinicians who are in the system, they've never known a system to provide them with that kind of time, and so, this touches a little bit upon the workforce issues: that there is a real need for us to continue to support the workforce to develop the competencies and the skills required to deliver specific evidence-based interventions right across the board.

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

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

Q. To ask the question from a different perspective: what sort of pressures occur when caseloads are too high?
A. Oh, when caseloads are too high, clients get short - well, clients get short appointments, they get less frequent appointments, there's more work that's done on the telephone. The families may never see a case manager under those circumstances.

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

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

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

Q. You've also talked, and you mentioned earlier, about "the missing middle", and I think what you mean by that is to refer to patients who have moderate or severe illnesses whose needs are not urgent in that sense?
A. Urgent, yes, correct, and whose risks are not, you know, high.

Q. I think you have prepared an interesting infographic that illustrates what you want to say about that.
A. Yes.

Q. I'm going to ask for that to be shown, please.
A. Look, this was just a bit of indulgence on my part trying to put together the data. You'll find in the submission the data is presented in a narrative form and I found it hard to follow at times myself, so I put this up to try and make it a little clearer; you'll tell me whether I met that objective.

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

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

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

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

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

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

Q. Can I ask you about PARCs and what specific needs they --
A. Sorry, before you do that. And at some point I hope we'll be able to talk about this: that assessment really comes, I think, from our experience in the child and youth space, where we tried something a bit different and I think have slightly different experiences. We can come to that.

Q. Why don't I ask you about that now.
A. Within the child and youth space we've had the opportunity to be involved in the Headspace initiative and the national initiative, and we are the lead agency for a Headspace Primary Centre, and we're also the lead agency for a Regional Youth Early Psychosis Program, and the consequence is that we've been able to integrate within a single framework - a Headspace Primary, Youth Early Psychosis Program, and a state funded Child and Youth Mental Health Service.

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

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

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

Q. What benefits do you say that having this integrated into your system confers in terms of moving people through this system when their needs change?
A. Well, I mean, I think it has benefits both in terms of how the service system operates - it has benefits both in terms of patient care, but it also has benefits in terms of system reform as well.

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

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

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

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

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

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

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

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

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

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

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

Q. And is it connection between parts of the system via personal relationships that makes that warm referral possible?
A. Look, those personal relationships are absolutely - I was going to say indispensable - they're really important, they make a big difference to the degree to which these processes are undertaken or are experienced without too many barriers, yeah.

Q. Can I ask you about PARCs and what they're intended to achieve and whether you think they are achieving their intended goal on the basis of your experience.
A. Look, I think that that's a difficult question to answer because I'm not clear in my mind at times what their intended goal actually is.

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

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

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

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

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

Q. There hasn't been enough time to tell; is that right?
A. There's been a lot of time. You see, I think the gaps between some components of the system are so large that you can put something in to fill those gaps and in fact you'll only be dealing with a part of the demand and a part of the need, and so, the fact that PARCs have not necessarily had a massive impact on demand for acute psychiatric inpatient beds does not mean they are not required. These are two different questions.

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

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

Q. Yes. Can I turn now to ask you about crisis assessment teams. You've said that they were and are a very important feature of community-based mental health services.
A. Yes, they are for us, yep.

Q. You've spoken about the barriers that can limit the effectiveness of the CATs. What are they?
A. Look, I think, to the extent that the CATs act in order to provide a short period of intensive care as an alternative to hospitalisation, I think that there are features built into the model which do create some limitations. So, I think this is just something we've been thinking about, you know, how do we improve this.

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

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

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

Q. You received funding to implement that?
A. Yep.

Q. Is that program being trialed or is it permanent?
A. I think it's - to be honest with you, I can't quite recall, but I do think it has time-limited funding but, given that it was extended this financial year, I would say that the department's pleased with the results that it's getting so I would anticipate that it will continue but I can't know that for certain. It's being evaluated at the moment by a consulting group and I can't quite recall the details.

Q. I see. And, because it's currently being evaluated, are you in a position to say whether you think that program is going to make a real difference to patients who present to it, or are you reserving your judgment?
A. So, I think I can say with some confidence that the people who have used the service that we've provided, and who have in turn then provided feedback to us, have been very satisfied with the service.

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

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

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

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

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

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

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

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

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

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

Q. While you're there can I get you to say a little bit more about that. How do the rates in Victoria compare, for example, to New South Wales?
A. Look, I'm pretty sure, if I remember correctly, the figures are something like 19 - I think it's 19 per 100,000 versus 22 per 100,000, 23 per 100,000. I'd have to refer to some documents, I don't have that data off the top of my head.

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

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

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

Q. That is your phone this time.
A. I've just turned it off, thank you. Apologies.

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

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

Q. Yes. Is there a temptation from a systems perspective when considering how to resource it, to adopt an either/or mentality; to say, you either need to invest in community-based services or inpatient beds?
A. Look, there are problems occurring at a number of levels, or that have been occurring at a number of levels. So, at a programmatic level, we are required operationally to deal with the urgent and high risk problems that present to us on a day-to-day basis, and so, we have to have our emergency and acute services able to respond to that.

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

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

Q. Is what draws you to that, particularly the integration between primary and secondary?
A. What draws me towards it?

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

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

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

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

Q. I want to ask you now about the funding gap. Do you say there's a meaningful gap between the funding provided and the costs incurred in running an area mental health service?
A. Yes, and of course, you're asking me a question that the answer to which is changing because funding is changing and has done over the past two or three years now.

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

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

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

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

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

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

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

Q. Yes, indeed. We've asked you the question whether in your experience clinical mental health services are crisis-driven, and you've said in your statement that that's undoubtedly the case. To summarise, what in your view are the hallmarks of the crisis-driven services?
A. I suppose the key hallmark is an attitude that says, if you no longer have an urgent need and you are no longer presenting with a high risk of harm to self or others, and you are not likely to be at high risk of experiencing a relapse of illness that will put you in that position again, that we'll seek to transfer your care into the primary sector. And that doesn't necessarily reflect the complexity of the case, of the client's needs, the family's needs.

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

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

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

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

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

Q. So, are you suggesting that, if the system is crisis-driven, it doesn't really have time to ask itself how might it respond to someone in that sort of a situation?
A. I think one of the great things about this Royal Commission has been that it has generated lots of conversations about, you know, what should we be doing differently and how should we be doing it. The clinical system is not the only player in this space, and that's why a Royal Commission I think is so important, because we all need to understand how all of the different components of the system can operate collectively in order to make that person's - you know, the mum I was talking to, to make her life better and to improve the lot of the son who she was looking after.

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

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

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

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

Q. Can I also ask you about the role that falling investment infrastructure has played in getting the system to where it is now?
A. Well, we had the opportunity to spend some time reflecting over the last two or three years for a whole host of reasons, and one of the conclusions we came to very early on was that we were providing an inpatient unit, for example, that we thought was from a physical design perspective, you know, not fit for the purposes that we wanted it to be used for, for example.

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

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

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

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

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

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

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

Can you say a little bit about that?

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

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

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

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

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

> "... believe that the DHHS must provide epidemiological surveillance of psychiatric morbidity in the community, including suicide, and better reporting on service performance with a particular emphasis on the development of metrics for community practices in all aged groups."

Why do you put it that way in relation to surveillance

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

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

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

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

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

it's a really missed opportunity.

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

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

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

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

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

Q. Unfortunately, we are getting short of time.
A. That's all right.

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

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

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

Q. What's the implication of that, because it seems very much like your argument that you've just put, you can't really separate the mental health and addiction issues.
A. So, in the primary space I think these are different - one could make an argument for there being different needs. The problem that we're dealing with in the clinical services is that we get patients with undifferentiated problems. You know, by virtue of the fact that they are complex, they will have lots of things going on in their lives.

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

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

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

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

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

We've heard many times from particularly consumers and family members about their distress attending to an ED where they feel they're in need of urgent care and attention. Having that explained to them, that they don't meet the criteria, who does that explaining and how is that done, and how confident are we that they actually do get a referral on to other alternate forms of support?
A. Well, the people who do the explaining are the clinicians, and these are difficult conversations to have at the best of times. I think we like to think that people are being offered with a pathway forward irrespective of how they present.

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

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

Q. Or being actually recommended a pathway forward.
A. Yeah, yeah. So, we know from a lot of the work that's

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

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

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

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

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

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

What implication does that have for re-admission rates?

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

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

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

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

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

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

CHAIR: Thank you. Professor Fels.

COMMISSIONER FELS: Q. Thank you for your excellent witness statement and evidence. I just wanted, notwithstanding the time, if you could give us a short minute or so on what you said about the power situation and what you're getting at in terms of its implications for practice.
A. The new power reference?

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FELS: Thank you.

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

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

In your opinion, what do you see as the opportunities for leadership and, I guess, maybe hierarchy governance in the adult hub model that you've proposed?
A. I'm not sure I understand that question fully.

Q. Okay, I'll go again if I need to.
A. Yeah, see if you can.

Q. In your statement you describe one of the things that you would be interested in the Commission pursuing is adult hub community spaces.
A. Yes, built on the foundations of existing services but expanded, yes, absolutely.

Q. So, how do you see, in the complex world you've described, leadership, governance and those aspects being brought to bear?
A. Yeah, very good question, very good question. I don't have the answers and I think that's part of the challenge, is that, to be open to the fact that in fact the answers are to be explored and to be tested out.

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

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

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

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

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

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

COMMISSIONER COCKRAM: Thank you.

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

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

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

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

SHORT ADJOURNMENT

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

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

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

Q. I tender that statement. [WIT.0002.0002.0001]
Dr Vine, would you please briefly outline your relevant background and experience?
A. Certainly. I'm a consultant psychiatrist by training. My career has spanned, I guess, three major areas: I was a

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

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

Q. In your statement you've stated that in your role as Executive Director of NorthWestern, you attended Melbourne Health's board meetings which increased the visibility of NorthWestern to the board. Can you explain what you meant by that, please?
A. Yes. NorthWestern Mental Health is different from many other mental health services by reason of its size and geographic coverage. It covers a large chunk of north and western Metropolitan Melbourne.

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

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

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

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

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

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

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

Q. So, just speaking to this, can you explain the area that you cover and then the next slide deals with the population growth which we'll come to when you raise population growth.
A. Alright. Look, I almost can make no apology for the complexity of NorthWestern Mental Health, our coverage is

historical.

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Just to clarify, does NorthWestern record the number of people who contact triage but who are not provided with service?
A. Yes, we do, and so - I can't give you an exact number of the total incoming and outgoing calls, but it is considerable. The screening events is when we just look at the screening register on the client management interface, the database, as opposed to actually enter someone as a case managed client.

Q. We can take those slides down for the moment, please. I'd like to ask you questions about funding, Dr Vine. Can you tell us briefly how NorthWestern is funded?
A. It's a bit hard to be brief on this, but I'll do my

best.

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

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

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

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

Q. I have a couple of questions arising from that. You've referred to the fact that the block funding is historically based. Can you just elaborate on that?
A. Yes, and again, bear with me. When the area-based mental health services were first established, which is sort of back in the 1990s, there was a thing called the resource allocation formula. Basically, that took into account the numbers of beds and the population size and built into it some, I think a slight increase in funding for rural regions, a slight increase in funding for places

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

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

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

Q. You referred to the need to make savings. How has NorthWestern been making savings?
A. In a service where 85 per cent of the funding goes on salaries and wages, it becomes immediately apparent that it is hard to make savings without reducing staffing or changing the staffing model.

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

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

Q. You've also referred to the fact that the under-funding of inpatient units is cross-subsidised by community teams. Can you explain how that happens?
A. Indeed. I think the bed day rate in the current policy and funding guidelines is in the region of $850 per bed day. The actual cost of an inpatient unit is not quite twice that but perhaps nearly twice that.

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

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

Q. What is the impact of this insufficient funding on the amount and quality of NorthWestern's services?
A. Clearly we do our best to deliver a safe and clinically appropriate service.

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

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

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

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

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

service."

Can you just explain what you mean by that?

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

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

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

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

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

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

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

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

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

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

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

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

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

The beds, is it?

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

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

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

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

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

Q. Just before you go to EFT. In simple terms does that mean the basic bed numbers hasn't really changed, there's just been marginal change since the 1990s?
A. Yes, so an example there is that the Sunshine unit opened in I think the mid to late 1990s with 25 beds, it now has 29 beds, but in that time the population it's expected to cover has grown. So, the only way you cope with that, you do two things: you increase the throughput, that is, the length of stay goes down, so our length of stay is now ten days or less on average, which again is different from the Alfred's, and you maintain a higher occupancy.

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

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

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

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

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

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

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

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

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

You've referred to the fact that:

"This is because the amount of services that you can provide is capped by the funding available, creating a form of rationed service."

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

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

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

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

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

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

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

Q. And so, where do you send those people?
A. We try and make referrals to other practitioners, so to general practice or to private psychiatrists or private psychologists. We would try and provide people with appropriate information, but I think, this has been talked about earlier, that whether those referrals are actually followed up and whether they are successfully followed up, we don't know a lot of the time.

Q. So you don't have any visibility about whether those people received the treatment that they need?
A. We don't have that visibility. Of course, if they come back to us, then we would receive - we'd get their feedback as to whether it worked or it didn't work and whether they re-presented, but otherwise, no.

Q. You've referred to a number of barriers for receiving appropriate treatment. Are there any others that you want to raise?
A. I think that the separation between the Commonwealth and state funding is a real issue and the different models of funding, the different market pressures, if you like, are very important.

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

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

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

think that's a barrier to efficient access.

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

Q. You've said in your statement:

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

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

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

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

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

person's experience of the system considerably.

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

Q. You've referred to the fact of having an area-based mental health service is appropriate for people who need the protection of the Mental Health Act. Can you clarify who you think an area-based mental health service should be responsible for?
A. Yeah, so the rationale I think behind having an area-based system, which means of course that where you live geographically determines where you are going to receive a service - there's a planning rationale - but as I mentioned earlier, a significant proportion of people with severe mental illness perceive their problems as being external to them. So, they don't perceive that their experiences, their emotions, their thoughts, are part of an illness; they perceive it as having an external cause, if you like.

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

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

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

Q. Can I ask you now some questions about the mental health system more broadly. In your experience how does the system we have now compare to what was envisaged in the 1990s, and in particular what has been lost?
A. Yes, so people might be aware that Victoria - back in

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

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

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

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

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

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

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

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

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

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

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

There are two slides, so this first one is the mental health plans which outlines the number of plans [WIT.0002.0002.1004] And then this is also depicted in a graph format. We might go to the next slide with the same title. [WIT.0002.0002.1005]
A. Yes. The beauties of a Gantt chart.

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

> "We are in a constant state of consultation and distraction."

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

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

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

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

improvement.

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

Q. You've referred in your statement to bipartisan support; do you mean both at a state level and in between the state and Commonwealth governments in terms of going forward for mental health?
A. I do. Again, when the National Mental Health Policy was created back in about 1992, that was a policy agreed at both a state and Commonwealth level, but also back at that time there was bipartisan agreement about the general policy, and that general policy was around working towards mainstreamed and away from those stand-alone services.

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

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

Q. A separate issue you've raised is the loss of respect or regard for the expert in public clinical services. Can you explain what you mean by that?
A. Yes. Look, I think firstly, working in public psychiatry does bring its particular challenges, because a

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

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

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

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

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

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

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

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

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

Q. You raised the issue of your business case for Sunshine and not getting the funding. Can you tell the Commission in your experience what are the challenges for making a successful business case to government for reform of mental health?
A. Yes. Firstly, I do think it's a challenge, and just briefly to touch on the poor old business case for the Sunshine beds: at one level you'd think that just the population data would argue that you need more capacity.

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

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

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

of social - social inclusion sort of outcomes.

Q. You've referred in your statement to there being some compelling and costly areas to be considered in making that business case, and areas that are not necessarily mental health-specific; for example, homelessness, prison population, community safety. Can you clarify why you say these areas need to be part of the broader social policy?
A. Well, firstly, I guess they are very important areas. They're not health areas as such, so again, it's been a difficulty I think with some of the national mental health plans; the national mental health plans are the Health Minister's plan, but really, you need also need to consider some of the impacts on other government portfolios, and you've outlined a number of those.

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

Q. You've stated:

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

A. Yes, I have.

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

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

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

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

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

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

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

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

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

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

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

Q. Finally, are there any other matters that you want to raise in terms of lasting improvement to the mental health system that you haven't covered already?
A. Well, I think that stigma and discrimination has been a focus for this Commission already and I do think that the amenity in which people receive care absolutely needs urgent attention. Simon mentioned this as well, that it's a very different experience coming to a bright, warm, safe, welcoming environment than it is to coming to a place that's poorly looked after, poorly maintained, and so, our ability to invest in infrastructure - and I don't just mean now new buildings or more buildings - but just to invest in improvement and amenity has been also very constrained in recent years and I think that impacts enormously on the feeling a person has when they come to the service, but also the morale and wellbeing of staff.

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

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

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

did notice in your description of NorthWestern you introduced something I hadn't heard about before which was that you said some of the accommodation was rented from private hospitals, can you explain what that was?
A. Yes, and the terminology's not quite right. In the context of no bed capacity, the State Government provided funding for us to effectively buy six beds in the private sector: so some in Melbourne Clinic, North Park and Wyndham Clinic. They've done that previously, at times of very constrained capacity.

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

Q. Thank you. The other thing that you did talk about when you focussed on reform that I thought would be worthwhile just making sure we're clear about your intent around this, is you did say about the business cases and the approaches that we need to make to the sort of reform you think's required. You said it should be incremental but steady. Why do you give the emphasis on incremental?
A. Well, I think it comes back a bit to my comment about, it can't happen in a single electoral cycle.

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

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

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

COMMISSIONER McSHERRY: Q. Dr Vine, I think you've set out very clearly how some people want access to the mental health system, can't get it, some people are in the system but don't want to engage. I'm just wondering in your opinion what might help perhaps to lessen compulsory treatment under the Mental Health Act?
A. Firstly, as I mentioned, I think often, partly because of the constraints of the system, we are seeing people late, and also, when a person is under a compulsory phase of treatment, because we don't have capacity for really strong engagement and assertive treatment, when that person stops the compulsory treatment they stop treatment and then they will come back again late. And indeed, it has to be said that, for illnesses like schizophrenia, if you have recurrent relapses your overall prognosis overall gets worse. You know, with each relapse there is a loss of functional ability and the recovery may not be as complete.

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

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

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

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

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

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

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

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

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

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

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

So, levels of training, the skills expected of a

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

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

MS BATTEN: Thank you, no further questions?

CHAIR: No, thank you.

MS BATTEN: May Dr Vine please be excused?

<**THE WITNESS WITHDREW**

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

CHAIR: Yes, it is.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

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

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

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

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

Q. And you move to Mildura and did Year 12 in Mildura?
A. M'hmm.

Q. Then you got into university?

A. Yep.

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

Q. Can you please start from that point, your first year of Uni, and tell the Commission about your experience with the mental health system?
A. For brief context: as you said, I have a complex trauma background which I think informs my experience with the whole system. But basically five years ago I was 17 in my first year of Uni and I started to experience kind of like anxiety and depression symptoms that I didn't really know what to do with. So, yeah, I would get really anxious, my mood was quite low.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. So, where was that admittance? Don't name the hospital, but that was a hospital other than Orygen?
A. Yeah, that was at a separate hospital other than Orygen.

Q. Can you tell the Commissioners about that inpatient

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

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

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

Q. Were you on a general ward at that point?
A. I was on a general ward at that point, yeah.

Q. Was there treatment for your eating disorder at that point?
A. No, I never received any treatment for my anorexia. So, I didn't end up getting a transfer upstairs to the eating disorder ward and I physically got worse and worse and worse until the private hospital was afraid that I was physically deteriorating too much for them to be liable to care for me.

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

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

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

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

Q. Sorry, we just need to slow down a little bit. You were in the ED for about 14 hours, and then what happened after you were in ED?
A. After that I was transferred to Orygen inpatient unit, and from there, I think just with the help of the team at Orygen, even though they don't have any facilities to treat anorexia, my treating team was just amazingly - astoundingly supportive of my recovery, and I think they just really pushed for me to get physically well while I was at Orygen's inpatient unit, and so I eventually recovered from the anorexia while I was with Orygen, even though Orygen don't have the formal facilities to treat anorexia in the first place.

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

Q. You said you were re-admitted to Orygen in late 2018?
A. That's correct.

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

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

Q. You said you were very unwell at that point. Did you try to leave Orygen?
A. Yeah. I absconded from Orygen four times. I think that's a serious, like, infrastructure issue. I was able to climb over the fence on four different occasions, and I was brought back by police and physically detained with handcuffs each time, and with each time I was leaving with the intent to commit suicide, so it was very lucky that emergency services were kind of made aware of my situation as it was happening.

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

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

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

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

Q. Then you were eventually discharged home after this admission?
A. Yep.

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

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

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

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

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

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

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

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

happened to me a couple of times.

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

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

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

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

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

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

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

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

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

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

Q. Thank you, Erica. Along the way you've identified different areas where there is room for reform. Were there any other matters that you wanted to touch on that you think are in dire need of reform?
A. I think, coming from my perspective as somebody with a diagnosis of borderline personality disorder, I think that the way the system understands this illness probably needs a lot of reform. I think it's often regarded as something that's frightening or something that people don't want to diagnose and treat, and I think the treatment of the illness is often shrouded in stigma rather than actual treatment.

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

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

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

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

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

CHAIR: Professor McSherry.

COMMISSIONER McSHERRY: Q. Erica, thanks very much for telling us your story. Just one question: when you were in the High Dependency Unit did you ever meet an advocate, a human rights advocate or a peer worker who could help support you?
A. No. No, in other units definitely, but in this particular High Dependency Unit, yeah, we were never offered, even if there would be legal counsel, let alone legal counsel ever occurring at all. We didn't know, yeah.

COMMISSIONER McSHERRY: Thank you very much.

CHAIR: Q. Thank you, Erica. Just one thing from me: I noticed in your witness statement you say that Orygen had been your primary source of support since late 2017 and you had your GP, psychologist, psychiatrist and case manager all in one place.
A. M'hmm.

Q. You also then went on to explain how they helped and persisted - you said, persisted with you even when things were very severe. And so, I guess it's helpful for us to have that understanding, what was it about their persistence that you found so important to you?
A. I think having a service that keeps faith in you even when you're very unwell was very, very important. And also

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

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

Q. Thank you. One other thing you talked about was what happened when you were discharged from hospital and your partner and friends provided the support role. Can I just confirm, did you have any follow-up from the hospital at that time and were they given any guidance on how to care for you?
A. Um, we had a little bit of guidance. So, I was discharged from Orygen. So, Orygen always had contact with us, especially in my second admission, because I think as a service they really learn and they don't keep making the same mistakes that they made before with you again.

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

CHAIR: Thank you. Thank you very much for sharing that with us.

MS BATTEN: Thank you, may Erica please be excused.

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Dr Neil Coventry, I call him now to give evidence.

<**NEIL DOUGLAS COVENTRY, affirmed and examined: [2.32pm]**

MS NICHOLS: Q. Dr Coventry, have you prepared a statement, with the assistance of the VGSO, which is in response to a request by the Royal Commission that you do so?
A. Yes, I have.

Q. I tender the statement. [WIT.0003.0004.0001] Dr Coventry, are you Victoria's Chief Psychiatrist appointed under the Mental Health Act?
A. Yes, I am.

Q. Noting that your role is defined under the Act and described in some detail in your statement, in summary do you have a strategic system-wide role with responsibilities for clinical leadership, quality assurance and improvement in the delivery of mental health services?
A. Yes, I do.

Q. Do you have a particular role in promoting the human rights of people receiving mental health services?
A. Yes, I do.

Q. Commissioners, I note that at a later phase in the Commission's work we may ask some further matters of Dr Coventry, but we're concentrating particularly on access issues today.

Dr Coventry, it's not your role, is it, particularly to investigate and resolve individual complaints?
A. No, I don't. Under the new Mental Health Act - well, it's not new, but 2014, complaints management changed. So, it was quite appropriately thought that that should be managed independently, so there was a Mental Health

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

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

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

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

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

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

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

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

change management process.

Q. So, is it fair to say that you've got a pretty good working knowledge of Victoria's mental health services?
A. Yes, I think I do.

Q. Does your office gain input from consumers and carers?
A. Yes, we do, and I've been fortunate I think in my long career over 40 years to see the involvement of consumers and carers which has been, I'd have to say, the single most important driver of improving safety and quality. We have to do this in partnership.

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

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

Q. Do you also engage with the Department of Health and Human Services?
A. Yes. Well, my office sits within the Mental Health branch, so there's another team that's involved with engagement with lived experience and, as I said before, we also engage with the peak bodies as well and we have them represented on all of my advisory committees so that I'm always having that lens.

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

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

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

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

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

Q. You've said in your statement that:

"The specialist mental health system includes both clinical and non-clinical services."

What do you mean when you say "specialist" in this context?
A. Yes, good question. So, we've heard from the other witnesses. The specialist mental health service is the area-based designate - what are called designated mental health services under the Mental Health Act which, probably the simplest way to understand that is, under the Mental Health Act, they have the capacity to provide care and treatment for people in a voluntary or in an involuntary capacity.

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

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

mental health part of the service system.

Q. Do the non-clinical services engage clinicians to work in --
A. Yes, they do and need to when they take consumers with significant mental health complexity. I also have jurisdiction and oversight of those services when they have mental health patients/consumers as part of their clients.

Q. And both clinical and non-clinical aspects of the system have peer work?
A. Yes, this is a really interesting and innovative approach. We now have quite a number, I'm not sure how many totally in Victoria, but it's quite a considerable number and growing. To add value to our existing clinical workforce, with people with lived experience previously these people have been employed as consultant positions. Now we have them as peer workers working alongside the clinical service with a different sort of role and function.

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

Q. I asked you about the difference between acute and subacute in the context of those definitions.
A. When we talk about acute, or when I'm talking about acute, I'm meaning the acute inpatient beds that we have that are in health services. So, that's about, something like half or a bit over half of our bed stock.

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

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

We also have our acute forensic hospital, which is

Thomas Embling Hospital.

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

Q. You make a point in your statement that:

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

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

What kinds of difficulties do you see consumers facing when they get themselves into that situation where they are falling in between one catchment and another?
A. Look, it's very challenging and I'm thinking particularly, this was challenging during the terrible bushfires, where our catchment areas didn't make sometimes a lot of sense for where people were actually living - or where people's houses had been destroyed.

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

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

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

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

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

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

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

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

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

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

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

Q. You used the words both "integrated" and "diluted" when you were answering my question.
A. Yes.

Q. Is it correct that really what you were saying was, the functions have been diluted because staff are trying to fulfil more than one role at one time?
A. Yes, I think that's certainly the case, and as an example we see that, I think, particularly with after hours triage which is done by staff who are also covering the emergency departments and dealing with those sort of crises, so it's very difficult for them to balance the priorities of a telephone triage role with providing support to the emergency department, and I think we've also diluted our capacity to provide the sort of safe outreach service that we used to provide.

Q. I'll ask you more about triage shortly, but can I just get you to explain what you mean by the capacity to provide the safe outreach service?
A. I think, if you don't have a team with a low caseload - I think we've gone to a situation where we have generic teams with what we call generic case managers, and I think that's created some difficulty to provide a number of the subspecialty areas such as the mobile outreach support in a safe way. It really needs a team that has, as we heard this morning, low numbers of consumers that they are involved with so that they have that capacity to be available to do that sort of outreach.

And we know that, for some of our consumers and carers, having an office-based approach is never really going to cut it for them.

Q. Can I get you to explain what you mean by generic teams, and firstly, can you contextualise it? What level of service are you discussing in this context?
A. Well, I'm talking about community, so these are the mental health specialist teams that are in the community. And when I say "generic", what I'm meaning really is, we aspire to multidisciplinary team work and that's what we should be doing.

What's happened is, positions have been recruited as generic positions so they haven't been discipline-specific. It's quite complex but it's also due to some industrial

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

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

Q. Is that something that you see right across the state in relation to community-based mental health clinical services?
A. To an extent, yes, I think it's pretty much the case in many adult services. I don't think it's the case in Child and Youth Services and Aged Mental Health Services, they still aspire to having multidisciplinary teams and have the variety if disciplines.

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

Q. Can I ask you a question about community support services. You have discussed in your statement the provision of continuity of support for clients of programs that are transitioning to the NDIS where the program is no longer funded. What kind of gaps have you observed occur for consumers whose service is no longer funded under the NDIS?
A. Yes, this is an absolute headache for my office and for myself really.

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

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

isn't really well defined.

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

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

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

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

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

Q. Can I just get some clarification about that. So, does the gap arise where a consumer has been a client, if you like, of a service which is no longer being funded because of the change in the funding structure, but the consumer has not yet or will not at all get a package under the NDIS?
A. Look, it's quite complex. People who were previously on packages were meant to roll over. NDIS involves the consumer being active in determining what their wishes are. Some of our mental health consumers struggle with that and

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

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

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

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

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

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

> "On the one hand the principles are becoming embedded in the philosophy of treatment."

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

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

So my question is, when you say "may be compromised", are you in fact saying that there are aspects of the Victorian mental health system that do not in fact reflect the 12 principles embodied in the Act?
A. I would hope that every service does aspire to that. I guess what I was meaning there, in terms of the practice - maybe if I give some examples about this.

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

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

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

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

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

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

One of the things you say is that:

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

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

Q. In what ways does that not reflect the principles embodied in the Mental Health Act?
A. Well, look, certainly our principle is to have voluntary treatment and decision-making, voluntary decision-making wherever possible, so it's not too difficult to hypothesise, if we're not seeing people early in their stage of their illness early in their episode, we're running the risk of people getting more and more unwell and probably, because of their illness, having less capacity to be making informed decisions about the sort of treatment that they would want, so that's really very concerning.

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

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

be able to be discharged.

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

"... slower to occur than desirable."

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

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

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

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

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

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

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

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

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

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

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

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

extent to which carer involvement should occur under the Act?
A. I think we are falling short in adult psychiatry, adult mental health. Clearly in child and youth, that's a key part of the treatment, and I think in aged mental health as well.

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

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

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

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

Q. Are the demand pressures making it more difficult to involve carers to the extent as is expected under the Act?
A. Look, I think it's partly that. I don't think it's totally that. I think we have moved to a culture that's much more crisis-driven.

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

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

Q. You said in your statement that:

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

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

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

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

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

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

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

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

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

Q. And to what extent are the demand pressures on the system allowing those warm referrals to occur in your observation?
A. I think that's right and I think it's particularly with the rapid throughput and discharge, that it can be a sense of just, let's link in with the support services by giving someone the information and hoping that they will engage, rather than taking the time to actually assist in that engagement process which I think is our responsibility to do.

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

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

A. Yes.

Q. You've gone on to say that:

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

In what ways do you see that?
A. Well, again, the Commissioners have heard frequently I think over the last few days, the concern that in the 90s when we went into the cycle of mainstreaming, I think the aspiration was very worthy and to try and bolster community services because the previous era of the institutions was focused very much on the stand-alone institutions rather than community care.

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

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

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

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

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

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

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

Q. Yes, sure?

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

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

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

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

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

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

Q. What models of care does high occupancy rates drive?
A. One of the particular concerns I think with the high occupancy is the need to be discharging people far too early in the course of their treatment, in a way that we would never do in general health.

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

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

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

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

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

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

> "evidence-based psychological interventions which assist with longer-term recovery."

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

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

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

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

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

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

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

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

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

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

female, up to 10 years.

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

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

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

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

Q. In relation to the forensic components of the system, are there adequate facilities to provide treatment to prisoners with serious mental illness problems?
A. No, there are not, there certainly aren't. I probably need to explain for people who don't understand the system, that if you're a prisoner, obviously involuntarily sentenced to prison, you can't receive mental health treatment in a prison against your will.

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

you're a prisoner under the Mental Health Act.

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

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

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

Q. We could so easily do differently, by doing what?
A. Having access to beds. I think, to have the same expectation that we have for someone who's in the community, we don't expect them to wait three months if they're severely unwell because they can't get access to a bed, although they do sometimes wait 24 hours which is terrible. But we should have that same expectation for prisoners in our community; they should be able to get ready access when they require.

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

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

> "One of the factors is that growth in demand has increased at an unexpected rate."

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

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

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

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

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

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

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

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

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

Q. Dr Coventry, we've heard that quite a bit from consumers who have said that's what they're told and I gather you as the Chief Psychiatrist agree that that is a refrain that's often heard in the system, that people are not sick enough?
A. Yes. Look, we hear this in various ways. One of the extreme examples, just getting back to eating disorders, is, "You haven't lost enough weight to be really so dangerously unwell", when all of our research shows that the earlier you can treat a disorder like anorexia nervosa, the better outcome.

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

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

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

> "The funding system is unresponsive to demand."

What do you mean by that?

A. It's quite challenging to explain our strange system of funding. I think perhaps my colleague, Dr Ruth Vine, did a good job when she was talking about the block funding. So, we're not funded against what we call activity funding, it's block funding.

We're also sort of cross-supporting services when we have our expensive inpatient services that aren't funded at the actual real cost, so it means there's diversion of funds from our community, which paradoxically makes the problem even worse because it means that we're not managing and helping people at the right stage in the community that might actually prevent them needing to access the acute pointy end of inpatient care.

So that's what I was meaning, that we don't have that capacity and I think we've got to be looking across the whole system. So that would be my plea to the Commissioners in terms of recommendations, that we need to see this hopefully as a much better integrated system and we need to be supporting both community and inpatient care because they go hand-in-glove, I think.

Q. Thank you. You've also said that:

> "Planning and demand forecasting mechanisms are not able to access information required to deliver targeted capital and workforce infrastructure investment."

When you talk about "planning and demand forecasting mechanisms", what do you mean?

A. Well, look, I'll give a practical example. Unfortunately, we sometimes get stuck in sort of historical arrangements in mental health that don't necessarily reflect the current demographics.

So, you've heard quite a bit this morning, I think, about some of the bed blockages and when people are in emergency departments for unreasonable lengths of time.

When I look at how this gets mapped across the state, the sort of hot spot areas are all the areas in growth corridors where clearly the demand for services, particularly inpatient bed access, hasn't been matched by the actual number of beds. So we're stuck in the historical perspective of the beds that might have been adequate for a different period a decade or more ago, but clearly are not adequate for what we now know about the growth corridors and the mix of people coming in, and the families and the age demographics.

So, that's what I was meaning, that we're not sort of scanning the horizon to be aware of these hot spots where we could actually anticipate, if we don't invest, we're actually going to have a problem because the beds stock and the other services don't match the demographics and the population.

Q. Yes. We've asked you about what you think are the most critical of the unmet needs and I think you've mentioned some of them already. In your statement you mention:

"Unmet needs for children and young people living with dual disability."

Can you say a little bit about that?

A. Yes, I was alluding to that before. So, dual disability, these are somewhat confusing terms. But we talk about dual diagnosis, dual disability. Dual diagnosis means patients/consumers who have a substance use problem as well as a mental health problem.

Dual disability is talking about the group I was mentioning before, the consumers or young people who have a mental illness and also have a coexisting disability, so it may be an intellectual disability, it may be a disability like autism, spectrum disorder, which is what we call again a confusing name, pervasive developmental disorder.

So my concern with that particular group, both children and adults who have that diagnosis of autism, is that at times they absolutely need to be able to access inpatient assessment; that we know that there are significant other mental illnesses that could be comorbid - coexist with conditions like autism.

However, what can often happen is that the community service, and particularly accommodation, is stretched beyond their capacity to cope or it may be a young person and their family where the family are stretched beyond their capacity to cope.

So what can sometimes happen is that there's a crisis, but it's really a crisis on a sort of chronic deterioration really, so it's not necessarily an acute crisis. Usually coming to the emergency department, sometimes after hours, the person gets admitted to hospital, and I'd say our inpatient services can be very good at doing reasonably quick assessments to see if there's a coexisting other mental illness that needs a different sort of treatment.

But what can happen in reality is, these people have no exit plan to be discharged because there's no accommodation. And, even with the best will in the world, an acute inpatient unit is not the best environment to try and manage and help people. In fact, in some cases it probably makes their behaviour worse with the sort of approach and the mix of patients.

The sort of situations I get involved with as Chief Psychiatrist is then trying to work out some way of joining up the dots and getting an exit plan, and usually it's around providing stable accommodation or a non-government agency that will be able to care and working out the funding mechanism to assist that. Sometimes we use MACNI, the Multiple and Complex Needs Initiative as well.

Unfortunately, even with the best will in the word, it usually takes me weeks-to-months to get an outcome, in which case I'm also seeing some deterioration. I think there's a degree of complacency, that obviously for these very vulnerable people, no-one would want them to be homeless, no-one wants them to get involved with the criminal justice system, so people do everything to avoid that. That sometimes means they're then occupying an acute inpatient bed when that's not really what they need or it might actually be making their behaviour deteriorate, if that makes sense.

I get very concerned about the fact that we don't have the right mix of services for this particular vulnerable group, both as children and adolescents and as adults, inappropriately having them in our acute inpatient units

and then we don't seem to have good mechanisms to actually be able to discharge them safely into a wrap-around service with the appropriate level of accommodation and service input.

Q. In asking you about the key drivers of unmet need you said this:

> "Overall insufficient acute beds and community treatment capacity which can provide evidence-based psychological interventions and intensive support are the key system drivers of unmet need."

You go on to say that:

> "Substantial investment is required in these areas to resolve demand pressures."

What is the scale of investment that's required, if you can describe it?

A. Look, I'll try. I'll go to the pointy end about the beds. It's not easy to actually think what this is or what the number is, because I think we need to rethink our mix of beds: so I'm not just talking about acute beds, I think we need acute and subacute because we will use our beds differently depending on what else is available. This is why sometimes the comparisons with other state jurisdictions is a bit confusing because they don't necessarily have the same mix of beds.

I think we need to be looking at our models of care, our subacute bed mix, and our acute, and how we're using both of those. As an example, thinking about the PARCs that you've heard about today.

We need to be thinking that the subacute services can be both step-up and step-down. We shouldn't only be using them as a step-down from our acute inpatient units as a way of managing the beds, they should actually be a step-up, and one would hope we'd be able to help people much earlier in their stage of episode and illness where they don't necessarily need the intensity of an acute inpatient unit, and we've heard that some of our consumers would far prefer to be admitted to a PARC than an acute inpatient unit.

So, I think it needs considerable investment to try

and have sufficient stock that we can actually provide ready access, that we can get to an occupancy rate somewhere around the 80-85 per cent with the flexibility, and that we need to fund those inpatient services so they're not stealing money from the community mental health services. I think that will then drive a different model of care so that we can start to do much more early intervention, early in episode community care which one could hypothesise would hopefully diminish to some extent the need for acute care, that we would actually be able to treat people earlier in the community in their stage of illness.

So I think there would be a flow-on. I think then we would also have the capacity to offer a variety of different sorts of interventions. One of the things we don't want to do is, we don't want to be a mental health specialist service that only provides what we call pharmacotherapy or medication, we need to provide a whole variety, and there's an enormous wealth of evidence-based interventions, as we were hearing earlier, if we think about different psychotherapies for conditions like personality disorder or trauma. We've got a wealth of treatment that we should be offering in the community to people who are experiencing those sorts of disorders.

So, I think there needs to be considerable investment but it's not just investment, it really needs - like, it shouldn't be more of the same, in other words. While I think our bed stock is inadequate, I would certainly suggest we need to look at the mix of bed stock and have a variety and really seriously consider the mix of subacute and acute beds, and also then look at our model of care that we have in the community that we can do much better and differently.

Then I'd also like to look at integration between physical health and mental health so that we don't have this problem of our patients with physical illness not getting diagnosed and treated.

Q. And so, when you say in the context of answering our question about how the Royal Commission could make more than incremental change, you say that:

"The specialist mental health system needs to be rebuilt and it will take time and,

once the core system elements have been stabilised and strengthened, then there is enormous scope for reform."

Is that what you mean when you talk about stabilising the core elements?
A. Yes, look, I do, and it's interesting thinking about the other speakers and the other witnesses and the questions asking about, are we talking about incremental, are we talking about transformational change, and I think it's actually both.

Clearly, even if we had huge investment tomorrow, to actually create extra beds takes a long period of time to actually get that. But we shouldn't think we will be complacent over that time without looking at models of care.

So, I think there's a lot of work we need to be doing. I guess what I see as being incremental and transformational, we need to sort of not throw the baby out with the bath water, and remember, we still have a responsibility to be assisting vulnerable consumers while we rethink this, so we can't stop providing care and compassion and treatment for people while we redesign.

I think it's transformational in the sense that I think there's much more we can do about putting consumers at the core of all our treatment decisions, and we have done that to some extent. But that's the big transformational change for me, to actually do that in partnership and really do it in a - talking this morning about power and power inequalities - I think to actually do that with sharing of power and I think that will actually guide us with the advice from consumers and carers to new models.

So, I think it's got to be incremental or transformational, and we need to think about the whole of the system, not just one aspect of the system. I'm probably not quite answering your question, I'm sorry.

Q. That's alright. Is it right then that in your view the system can't be transformed or improved without dealing with the inadequacy of beds problem?
A. I think that's the foundation but I don't think that's the only thing.

Q. No.
A. So for me that would be absolutely the foundation, to look at beds, both acute and forensic beds and subacute beds as a foundation. But the other aspects that go on with this, I think we need to absolutely look at our workforce and our workforce capabilities, because it would be ludicrous to open up more capacity with inpatient beds if we can't staff it. We know there are dilemmas with our current workforce, it's an ageing workforce, so we need to be anticipating, succession planning.

We need to think about the mix of the workforce. We know across health generally people are struggling with insufficient numbers of trained nursing staff, for example. So, I think we need to consider a mix of disciplines, the model that we want to have, and also the competencies and capacity.

I think probably over my career I've seen that we've perhaps deskilled our workforce to some extent by needing to focus on a crisis model of care, so I think some of the core capacities and competencies that our staff had maybe a generation ago we've actually lost to some extent, so we need to have a workforce that's well and truly well trained.

I think we also need to see - this is a specialist skill. It's a bit like, you know, you don't send a nurse to a coronary care unit and think they're going to be a coronary care expert. It takes years and years to develop that and they need appropriate training and professional development and supervision and on-the-job mentoring, et cetera. That's what we need to do for our mental health workforce, I think, and we need again to be making sure that - hopefully the Royal Commission will be an opportunity - that this is the best time ever to be thinking about a career in mental health and we will support people through this as a career so that they develop the right skill mix that we expect.

Q. Can I go back to a more particular question and that is about triage, changing topics for a moment?
A. Yes.

Q. You've explained that triage services are managed on an area basis and so what is in place in any particular

area will vary with the demographics and so on. We've asked you about some of the constraints on triage services recognising that they are different in different places.

You have said, among other things, that:

"Demand for triage services is resulting in extremely long wait times and high abandoned call rates. Feedback from health services, consumers, carers, emergency services and referral services is that there are often long waits."

And that your office itself often experiences long wait times. When you say "long", what do you mean?
A. Well, very long; hours in some cases. This is particularly a challenge I think for after hours, as I was explaining before, where the telephone triage function may also - in fact many times - is managed and organised through the CAT Team or the ECATT team who are the clinicians providing emergency assessments in the emergency department of a hospital.

So, I think it's incredibly problematic, when people are trying to juggle these dual tasks that they need to do, and it's easy to see why the telephone triage task will be given a lower priority than the patient/consumer that's actually in the emergency department. So, I think that's a problem.

I think the system sometimes gets overloaded. From my experience ringing triage services where they may not have the capacity to take a number of calls simultaneously, so the calls just drop out. So, I hear that from consumers and their families saying they give up because they've tried a few times and the call just can't get through; or there's a recorded message and they don't feel comfortable leaving a contact number on a recorded message, they want to speak to a real live clinician. So, I think that's a problem in terms of the demand.

It's done a bit differently across the age spectrum. So, aged/mental health tend to do their own triage; to some extent the child and youth will do their own triage in a different way, so there are different models that you need to do.

Ideally, one would like triage workers to have the right amount of time to be getting the assessment that they need to be able to do over the telephone to work out what is the best outcome. And to make sure that anyone ringing triage feels listened to and supported and, if it wasn't the right door - but we should say there is no wrong door - but if it wasn't the appropriate door, that they get assisted into accessing what would be the most appropriate service.

Q. The things you've been describing in the last few moments are prefaced with your statement that ideally that's what you would like. Can we infer, from what you've just said, that that's not what's happening by and large?
A. I don't think that's what's happening, and I know triage telephone services are being overloaded because I need to ring them at times in my work, in hours and sometimes after hours, and it's very challenging and sometimes I need to escalate when I need to speak to somebody after hours because I can't be on the phone for an hour or longer waiting for a call. But I do understand that the person who's actually taking on that task is actually trying to juggle two diverse tasks really and how they prioritise.

Q. You've said that:

> "Some individuals may be appropriately triaged but they're not accepted into the services to whom they're referred by triage."

So, what's the disconnect that's going on there?
A. I think it's, again, part of our dilemma about demand management, so that, basically we're putting the bar up to let as few people in, because we know the mental health services are so overwhelmed they're not able to cope, so this is really giving people the wrong messages to people who ring in.

They're being referred to services that may not have the expertise to manage. So, we're sometimes referring people to primary care, where it's been primary care that's actually referred them to the specialist service, so they're bouncing back. And primary care, without some in-reach from the specialist mental health service, doesn't have the expertise to be able to manage that sort of

person.

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

process, and we hear from our consumers and carers, the most frustrating experience they have is having to tell their story over and over and over again.

I think, whatever triage service, we should assist them to do the job they have to do rather than actually refer on to anybody else. So, regarding having a state-wide triage, I probably just don't know enough information, and I would struggle to see how in reality that's not just putting another layer of triage that would be challenging, I think, for our consumers and carers.

Q. Just a couple more questions. We've asked you about the data analysis capacity that your office has and you've said the office collects a range of data that could be usefully analysed and interpreted.

But we gather, from what you've said, that you don't have sufficient capacity to do that. Is that right and what additional resources would you like?

A. Resources are improving, but one can always have more capacity, and I think our responsibility is to get meaningful data and then analyse that in partnership with services and give that back to services, because the data is really for the purpose of driving service improvement, quality and change.

So, having said that, we do have a much better data collection system than we had when I first came into the department, but it probably needs some tweaking. We would like to be able to make sure that people can enter the data in as efficient a way as possible from the field.

We partner with organisations like VAHI; this is the Victorian Agency for Health Information who publish now, in collaboration with us, what's called Inspire Mental Health Report, where we select a number of the areas of data and KPIs that we collect, or they collect, and publish the variance data so that people can actually look at this and do benchmark comparisons and actually have their services named. This is really important I think to drive change.

I think there's lots more we could be doing, there's no point collecting this sort of data without analysing and giving it back. So, while I've got some increasing capacity in my service to do that, I think it's probably been a shortfall generally, but I'm pleased that we've

addressed it to some extent through partnership with VAHI.

Q. Can I just go back to quite early in your statement where you were describing your role, and you said your role is to:

> "Intervene at a system level through promotion through cultural and clinical practice improvement."

And you:

> "Operate as a resource for the specialist mental health system to drive continuous improvement and embed the principles of the Act."

Given the pressures on the system that we've been talking about this afternoon, how difficult is it for your office to drive continuous improvement and embed the principles of the Act?

A. Quite challenging, I have to say. One of the challenges really is Victoria's geography and having the resources. So, I really try and do this engagement at a number of different levels. At the most basic level it's actually being visible and going out to services; not sitting at the department's ivory tower, we've actually got to be actively engaging with services, and that means actually going out to visit.

So, we do a lot of visits and at the moment I've got a rolling program to do visits to Aged Mental Health Services and also to services that provide ECT, electroconvulsive treatment. But we would like to do much more if I had the resources; it's very time-intense but incredibly valuable to do that.

So, I have the sort of pointy end of my role where I can give directions and instructions and Chief Psychiatrist guidelines, but to actually drive service improvement it's got to be much more than just publishing a document that you hope people actually read at the end of the day. You've actually got to be seeing how people are complying with it, what are the barriers to doing that, what's the training needs that are required, what's the feedback that we're getting?

So, it's got to be a really comprehensive suite of different ways with engaging with the service to make sure that, you know, I'm fulfilling my function, which is to drive safety and quality improvement at the broader systems level, as well as using some of the specific instances to do a much more detailed analysis to see if, from an individual situation, we can get some learnings as well and making sure that gets disseminated widely.

I do this to an extent with my annual report, which is a requirement under the Mental Health Act, to try and give some transparency to the work that my office does and provide some of the data, so it's a summary of the lot of the activity that we do, but with more resources obviously one could do this in a much more robust way.

Q. Understanding you do a lot of visits and engage in a lot of activities, focusing rather on the features that exist in the system that you yourself can't change, are there problems in the system that mean it's really, really difficult to drive change and improvement?

A. There are lots of challenges, and one of the challenges can be having really experienced staff to be taking on leadership roles. We have leaders who, you're hearing, are very stressed at the sort of work we're expecting to do around a crisis model. I think anyone going to an inpatient unit, if you were responsible for running that and having to work out who is your least unwell person to discharge, is incredibly stressful. So, I'm worried that we're burning out our leaders and we don't have enough people in terms of succession planning.

We're also probably not training them for the sort of skill set that they need to have to take on these tough roles as leaders and how to make that better, and also, how to actually have a really robust quality and safety framework that people can use, despite the pressures of their work.

So that's a concern when we see there are gaps in particular disciplines. Sometimes this can be around senior medical staff, particularly outside Metropolitan Melbourne where we can struggle, when someone leaves, to actually have a suitable person to step in and replace. And, at times my office has actually needed to help out as an interim to provide some stability whilst some recruitment happens. So, that's probably one of the

biggest challenges.

I think the other challenge we see is the need to provide more robust teaching and training to our workforce; as we expect them to do more and more in a different way, we've got to make sure they have the right skills to actually do this.

I guess the other thing I try to do in my work is sort of model the importance of having the consumer and the carer at the centre of everything we do. So, when I do visits, when I do investigations, when I set up Chief Psychiatrist committees, we always have consumers and carers with lived experience and we will model that to the services to say that's what we expect services to be doing as well.

MS NICHOLS: Thank you, Dr Coventry. Chair, do the Commissioners have questions?

CHAIR: Q. I just have a number, please. Dr Coventry, thank you very much for your comprehensive overview. We've heard a lot about some of the pressures on the system that are, in your words, compromising the quality of care that sometimes can be covered and the impact that has.

I guess I'm drawn to a point in your witness statement where you talk about planning, policy and service development. So, obviously anticipating, planning for, doing the modelling about what the level of need is et cetera.

I note in your statement you say that these are functions that are separate to your office and are undertaken elsewhere in the department. Can you just confirm where else in the department the planning, policy and service development occurs and, for example, who has responsibility for developing a capital management plan for mental health?

A. I actually wish I could answer that question. The department's a very complex organisation. So, I'm part of the Mental Health Branch, so I bring the clinical expertise and the clinical knowledge to the Mental Health Branch.

But there's another part of the department which I'm not involved with which looks at the sort of epidemiological study, looks at the demographics, and I

would have to say I'm not sure how much mental health is actually configured in that; I think they take a much broader general health perspective. So, I think that it's important that we should be using that sort of data and considering how it's relevant for mental health and mental health planning to try and see where the future development needs to be.

So, I'd have to say on a sort of daily basis, while I feel I contribute the clinical perspective to inform that through the Mental Health Branch, outside of the Mental Health Branch I'm not involved in that sort of planning.

Q. Thank you. For example, we've also heard about the importance for people, if they do require inpatient care, consumers have talked to us about the physical design of those; collocating, shared accommodation, and certainly some of the observations about the standard of infrastructure is pretty minimal in terms of what we've been hearing.

When you do your reviews and find shortfalls in terms of practice that might be able to be possible and some of that being limited by physical infrastructure, how do you influence the design principles for our future mental health infrastructure?

A. What I tend to do in practice is give immediate feedback, and sometimes that's involving a significant piece of work. Sometimes it's not, sometimes it's just creating an atmosphere that's much more welcoming and inviting.

I'm often intrigued that people who work in an environment that's substandard over time will accept that as being the norm. And we come in with fresh eyes - and particularly with my consumer and carer colleagues with lived experience - to actually point out sometimes very simple things that could be done to make the environment, right from the first point of entrance, more effective.

So that's what I would do on-the-spot. I'd also follow that up with services, in some cases directly with their leaders and in some cases with the CEO to actually say, this is a very important priority that needs to be addressed.

In terms of your second part of the question which is

around sort of future planning and design: that's pretty fluid, I'd have to say, because I don't think we have necessarily the perfect ideal design sort of structure that we want to do.

What I will get involved with is when services themselves might be coming up with a particular proposal to provide some oversight to look at whether that looks like it's sensible, whether it's safe, whether it's practical, whether it would still meet the requirements under the Mental Health Act in terms of space.

So, I guess that's not trying to micromanage that, but also to be thinking at the end of the day, while we have to manage level of risk, we need to make services that are warm and welcoming to, not only the consumers, but their family and friends who come to visit. And I think as much as possible trying also to have services going out to visit other services to see examples of really good practice and good standards.

As I say, sometimes I think people have blind spots and accept something that really shouldn't be tolerated, sometimes because they have never worked in a different sort of service.

Q. And one final point, Dr Coventry. In your statement you talked about the fact that you don't have jurisdiction over private mental health services. But we've heard many examples whereby consumers move between the public and the private system.

How is the oversight function that you have and the requirement to drive continuous improvement compromised by your inability to look at those transition points?
A. I'm assuming you're talking about when we've actually had people that have needed to access beds in the private sector?

Q. Or when someone's moved out of a private facility into a public system or the other way round, and you don't have an opportunity to look at the continuity of care or the handover, for example?
A. Sure. What I try to do at a systematic level is link in the department with my colleagues, who have the responsibility of oversight for private hospitals, to talk about what we do in the public sector, the sort of levels

of governance, how we go about investigations of serious incidents, to sort of give them a model of how they can improve safety and quality.

We have to remember that the system in private hospitals is very, very different to the system in public mental health services. So, my line of authority in public mental health services is with the clinical lead who's the authorised psychiatrist under the Act, so I have certain powers that lead up or devolve through that person. Private hospitals function in a very different sort of manner, so that sort of model wouldn't work in that sort of environment.

So, I think it's something that's worth obviously thinking about, and it was a change in the previous Mental Health Act where I had jurisdiction over ECT, for example in private hospitals, which isn't the case now.

So, I don't have an easy solution to that, but it does trouble me, when people move, about the level of oversight that I should be able to provide to ensure that they get the same quality of care regardless of where they might be.

CHAIR: Thank you.

MS NICHOLS: May Dr Coventry be excused?

CHAIR: Yes, thank you.

MS NICHOLS: That concludes the evidence for today.

AT 4.05PM THE COMMISSION WAS ADJOURNED TO TUESDAY, 9 JULY 2019 AT 10.00AM

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