ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Tuesday, 9 July 2019 at 10.00am

(Day 6)

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

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

1 MS NICHOLS: Good morning, Commissioners. The first
2 witness this morning is Dr Caroline Johnson who's been a GP
3 in Surrey Hills for a number of years. Dr Johnson has a
4 particular interest in mental health and has also been
5 involved in training general practitioner registrars in
6 mental health.
7
8 The next witness is Dr Sika Turner who is a clinical
9 psychologist who works in a publically funded service
10 attached to Monash Health that receives referrals mostly
11 from the emergency department and from triage.
12
13 The next witness after that is Dr Gail Bradley who's
14 held very senior management and leadership responsibilities
15 in area and mental health services.
16
17 We will hear from Janet Butler who is a mother whose
18 son at the age of 22 developed severe mental illness issues
19 and spent time in and out of hospital. She will speak
20 about the devastating impact of mental illness on their
21 whole family and with their engagement with the system
22 which she describes as severely lacking.
23
24 Dr Paul Denborough is the final witness and he's the
25 head of the Child and Young Person's Mental Health Service
26 at Alfred Health and also Headspace Alfred.
27
28 I call Dr Caroline Johnson.
29
30 <**CAROLINE LOUISE JOHNSON, sworn and examined: [10.03am]**
31
32 MS NICHOLS: Q. Dr Johnson, have you prepared a
33 statement, with the assistance of the Royal Commission,
34 that addresses the questions we've asked you to answer?
35 A. Yes, I have.
36
37 Q. I tender the statement. [WIT.0001.0019.0001]
38 Dr Johnson, are you a general practitioner?
39 A. Yes, I am?
40
41 Q. Have you practised in Surrey Hills from about 1997?
42 A. That's correct.
43
44 Q. Have you been a GP since 1993?
45 A. Yes.
46
47 Q. Have you lived in Surrey Hills for most of your life?

1 A. Yes, I have.
2
3 Q. Did you complete your PhD in primary mental health
4 care?
5 A. That's right.
6
7 Q. What was the subject of your PhD thesis?
8 A. I looked at the experience of GPs, patients and carers
9 in monitoring depression in the general practice setting.
10
11 Q. Do you have a particular interest in mental health in
12 general practice?
13 A. Yes, I do.
14
15 Q. Are you a member of various committees and advisory
16 groups?
17 A. That's correct.
18
19 Q. What work did you do in relation to the Medicare
20 benefits schedule and its application to mental health in
21 general practice?
22 A. So, I was lucky enough to be a GP representative on
23 two committees: one was looking at the MBS item numbers for
24 psychiatry, so I was one of two GPs giving the GP
25 perspective there. And I was also the only GP on the
26 mental health reference group which was looking at the
27 funding of allied mental health and the GP mental health
28 item numbers.
29
30 Q. I see, I'll ask you a bit about that in a while. Are
31 you also involved in the education of general practitioners
32 in mental health?
33 A. Yes, I am.
34
35 Q. Have you been involved in the development of the Royal
36 Australasian College of GPs mental health curriculum?
37 A. Yes, I have in the past done that.
38
39 Q. Are you still involved in teaching GP registrars about
40 mental health?
41 A. Yes, indeed.
42
43 Q. What level of competency is a GP expected to have in
44 mental health according to the curriculum?
45 A. So, GPs are meant to be able to recognise the risk
46 factors for someone developing mental illness and certainly
47 some of the early symptoms. They're also meant to be able

1 to diagnosis specific mental illnesses and also engage in
2 the treatment, or at least appropriate referral for those
3 conditions. They're also trained in understanding these
4 health conditions from a bio psycho-social perspective, so
5 they're meant to understand the social determinants of
6 health and the population health issues around mental
7 health as well.
8
9 Q. Most of your exposure in terms of education has been
10 to training registrars. Can you say, do GPs do continuing
11 professional education in mental health?
12 A. They do. In fact, we know that since the Better
13 Access initiative came in and GPs were encouraged to do
14 mental health, that well over 85 per cent have done formal
15 training in mental health, and now for many it's integrated
16 into their general practice training when they're preparing
17 for fellowship.
18
19 Q. Are there any surveys or other benchmarks that measure
20 the competency of general practitioners in mental health?
21 A. Like most CPD for professionals, they're not so much
22 measuring their competence, a lot of it is about behaviours
23 and attitudes and skills, but we certainly have a lot of
24 data that shows that they're doing a lot of work in that
25 area.
26
27 Q. The Australian Institute of Health and Welfare has
28 data that indicates that GPs are most often people's first
29 port of call in dealing with the mental health system.
30 You've described GPs as both gatekeepers and stewards of a
31 system that, at times, has to be rationed. Can you say
32 what you mean by "GPs in their role as stewards" and what
33 it is that's being rationed?
34 A. We are certainly trying to use the word "steward" more
35 in my advocacy work because I find people see gatekeepers
36 as a barrier. They often say, you have to go to the GP
37 just to get a referral and I think that really dumbs down
38 the notion of what a GP is capable of if the system's
39 working well.
40
41 On the other hand, we know that since Better Access
42 was introduced the help seeking has increased significantly
43 and we can see that in the national mental health surveys,
44 that more and more people are seeking help and certainly
45 their access to psychologists has improved a lot. What
46 that means is there's concerns about the cost of those
47 services and so there's been a lot of conversation around

1 things like stepped care models, introducing interventions
2 that are less expensive but equally effective. So, for
3 example, online interventions, although that's not the only
4 example.
5
6 And so, when a patient comes in to see a GP and we
7 recognise they have a mental health problem, if they see us
8 as the gatekeeper it will be pretty much, I've been told I
9 have to get a plan and I need to go on and see a
10 psychologist, whereas I see our role as more letting them
11 know that there are other interventions that might be
12 appropriate, that might be more cost-effective, but of
13 course at the end of the day it's very much dependent on
14 what the patient's wishes are and so there's often a
15 negotiation about that and I think that's entirely
16 appropriate and the GP is well placed to do it because of
17 course we don't profit in any way from the pathway that we
18 choose.
19
20 Q. I might ask you to try and slow down a little for the
21 transcript writer. What is the Better Access framework,
22 briefly?
23 A. So, the Better Access framework is meant to be a
24 structured system of care for people who have a diagnosable
25 mental illness using ICD 10 criteria and it enables the GP
26 to do a mental health treatment plan with the patient's
27 consent, which is more than just making a diagnosis, it's a
28 more holistic assessment including things like providing
29 psycho-education, providing crisis planning, making sure
30 that there are family members or other significant others
31 who can support the person, but it also allows access to
32 more psychological services that are funded through
33 Medicare.
34
35 Q. I'll ask you about that shortly, but is it necessary
36 for a person to have a plan under that framework in
37 order to get access to certain services?
38 A. That's right.
39
40 Q. You've said in your statement that one of the things
41 that general practitioners can do for a patient is that
42 they can be focused on early intervention in mental health.
43 Can you say something about what that looks like on an
44 individual patient basis?
45 A. Well, it's so varied at an individual level. Often
46 it's more about just checking the wellbeing of families as
47 they come to care for other things. So, families bring

1 children in for immunisation or with simple things like
2 coughs and colds, and I think an astute GP gets a good idea
3 of the wellbeing of the family generally and often is a
4 source of wisdom for families who are uncertain about
5 things like making choices about schooling and childcare
6 and all kinds of things that you wouldn't think necessarily
7 fit into the health realm.
8
9 At the time GPs might then notice families who are
10 struggling so they can make some sensible suggestions based
11 on the experience they have of seeing many people who have
12 had similar adversity and coped. But then they also have
13 the opportunity, if they see someone developing clear signs
14 of mental illness, they might offer some very simple
15 strategies, for example things like teaching patients about
16 mindfulness, relaxation strategies; if they're anxious is
17 one example.
18
19 And then setting in place a system of monitoring
20 because of that notion of continuity of care that a family
21 doctor can provide, keeping an eye on someone and making
22 sure that things aren't progressing early rather than
23 waiting until someone reaches a crisis.
24
25 Q. You mentioned a family doctor approach. Do you have a
26 view about the extent to which Australians are seeing their
27 GPs as family doctors who provide continuity of care, or
28 whether the trend is more to seeing GPs episodically and at
29 different places in different times?
30 A. Look, I certainly think in the more than 20 years I've
31 been a GP, I think the notion of continuity of care hasn't
32 been as strong as it was when I was a young GP. So, when I
33 was a young GP practices were smaller and often provided
34 24-hour care. That's obviously changed and I might say for
35 good reason because it wasn't necessarily healthy for
36 people to be on-call 24/7.
37
38 But with the larger group practices and the greater
39 mobility of the population, it's harder to maintain
40 continuity of care. I don't think that means it's not
41 beneficial I just think it's harder, and there aren't many
42 incentives to encourage people to keep going to the same
43 practice. Although we do know that probably 85 per cent of
44 people would identify with one practice as being their main
45 practice.
46
47 Q. Thank you. Can I ask you about your practice as a

1 basis for then asking you some later questions about the
2 way that GPs manage patients with mental health issues. At
3 the Surrey Hills Clinic, do you see patients with a range
4 of different mental health issues with differing complexity
5 and severity?
6 A. Yes, I do.
7
8 Q. Can you give some examples of the types of issues that
9 you would treat?
10 A. Well, certainly far and away the most common mental
11 illnesses as diagnosed would be depression and anxiety and
12 then various sub-types within that, so within anxiety
13 there's generalised anxiety, posttraumatic stress disorder,
14 et cetera, and within depression there's different types of
15 depression.
16
17 But I also see people who have more complex mental
18 illness, including diagnoses like bipolar disorder or
19 schizophrenia, and I also have large numbers of patients
20 who probably in the system would be classified as having
21 personality disorders, although I think that's not always
22 that helpful to frame it like that, because GPs, we really
23 work from what I call a dimensional perspective, so we see
24 people with symptoms who might not have yet crossed a
25 categorical diagnostic line as per ICD 10 or DSM, but we're
26 often in a position where we're not going to say, let's
27 wait until you cross this line before we provide you any
28 help.
29
30 So, in that sense labels are useful in some ways
31 because it informs the kind of treatment pathways, but
32 labels are less useful when you're dealing with the
33 individual because we often find that some labels work
34 better for some people, and also labels evolve over time as
35 an illness becomes more clear. So, trying to work with a
36 patient and help them understand that labels are useful but
37 they also have their limitations is part of that complex
38 work.
39
40 Q. Can I just ask for an understanding at a general level
41 first about the other types of practitioners and services
42 to whom you will refer patients with mental illness issues?
43 A. Well, there's a very broad range. Certainly the
44 commonest would be psychologists and psychiatrists, but I
45 also have some patients who see mental health social
46 workers or mental health OTs, they're a much smaller part
47 of that mental health workforce pool.

1
2 I have to acknowledge, too, that many patients are
3 very resourceful in finding help in other ways, so some of
4 them will use online services, and some patients also
5 choose to get help outside what I would call the kind of
6 mainstream medical system: they might see alternative
7 health practitioners, they might use spiritual counsellors
8 or church groups, those kinds of things as well as the
9 medical system.
10
11 Q. In relation to mental health social workers and mental
12 health occupational therapists, if you're referring a
13 patient to someone like that, where do you or they find
14 those people?
15 A. Well, it's harder to find them; usually I find them by
16 word-of-mouth. So, someone for example has already been in
17 hospital and been recommended someone through the hospital
18 and then they're already seeing them and then they come and
19 say, "I'd like to keep seeing this person", so then I
20 usually try and find out who they are and what their
21 qualifications are, and if it's helping I then refer, and
22 if it's successful that increases the chance that I might
23 use them again in the future.
24
25 Q. Can I ask you about access to private psychologists.
26 Firstly, from your perspective, reflecting on your own
27 patient group, how affordable do you think access to
28 private psychologists is for patients?
29 A. Well, look, keeping in mind that I work in a fairly
30 well resourced suburb, I think for people who are working
31 psychology is a relatively affordable investment for their
32 mental health.
33
34 Sometimes patients don't see it that way, they see the
35 out-of-pocket costs as very expensive, so I try and
36 encourage them in framing it in the sense of the benefits
37 they get from that compared to other things they spend
38 their hard earned income on.
39
40 But I do think there's a large number of people, even
41 in my area, who can't afford the out-of-pocket gaps:
42 particularly young people or students or even people who
43 seemed quite well resourced, they might seem to come from a
44 fairly well off family, but because of the stigma they
45 choose not to tell anyone that they're seeking help and
46 they have to try and self fund and sometimes those people
47 don't have as much spare income as you might think.

1
2 Q. Even if you assume that the services are affordable,
3 are there a sufficient number of psychologists for patients
4 to be referred to?
5 A. Well, certainly in my area I would say there's a
6 fantastic sufficiency of psychologists; it's more the issue
7 of finding the right psychologist for the right person.
8 There's a lot of variability in what psychologists offer.
9 It's not just a quality issue, it's a sort of an interest
10 and capability issue; it's also about a match. You know,
11 when you're trying to refer someone to talk about emotional
12 problems, sometimes it's also about the interpersonal
13 relationship, so that can take a bit of time to develop.
14
15 So it's not so much that there's not enough names on a
16 book to refer to, but it's more about getting the right
17 person for that individual.
18
19 Q. What about access to private psychiatrists; what kinds
20 of patients would you be wanting to refer to a private
21 psychiatrist?
22 A. Look, I tend to use private psychiatrists when I'm
23 unclear about the diagnosis and, as I instruct other GPs
24 who are in training, be very cautious about giving someone
25 a potentially serious diagnostic label like bipolar
26 disorder or schizophrenia unless you've got expert help,
27 whereas sometimes with conditions like depression and
28 anxiety the diagnosis is much clearer. Also if someone's
29 not responding to treatment, then I would use
30 psychiatrists.
31
32 I also have a group of patients who have really
33 complex long-term mental health problems. They're the
34 group that often fall into patients who have experienced
35 complex trauma, which I'm sure you'll hear about, and those
36 groups sometimes benefit from long-term psychotherapy and
37 that can often only be provided by a psychiatrist because
38 it often means an hour a week for 50 weeks of a year.
39 Unfortunately, it's getting much harder to find
40 psychiatrists who can do that kind of work but there's
41 definitely a need for that as well.
42
43 Q. How affordable do you consider referrals to
44 psychiatrists to be, at least in your patient group?
45 A. Well, I know very few psychiatrists who bulk bill but
46 I do know many psychiatrists who are happy to reduce their
47 fee by negotiation, so if they are looking after a patient

1 for a long time, they will make a graded decision based on
2 the person's income of what's reasonable, but overall I
3 would say the affordability is not that great.
4
5 I certainly think, since we've had more access to
6 psychologists and psychiatrists through some of these
7 changes, I still have a large group of patients who just
8 see me because I'm willing to bulk bill them and they can't
9 get bulk billed services anywhere, and I'm quite happy to
10 do that but it does create a bit of a burden because I
11 wonder whether I'm providing the optimal service that they
12 could get if they saw someone with more specialised skills.
13
14 Q. You mention in your statement the benefit of Medicare
15 benefit schedule item 291 which is the assessment and
16 management plan; what is that?
17 A. Item 291 is an item number that the psychiatrist uses
18 whereby the GP refers a patient, saying we'd just like this
19 to be a one-off assessment. It's in the consultation
20 liaison model of psychiatry. So the psychiatrist will then
21 see the patient for one or maybe two visits and provide a
22 detailed report back to the GP.
23
24 I find that very useful because I'm in an area where
25 we're very well resourced with expert psychiatrists so I
26 use it quite often, and I have two or three psychiatrists
27 that I use for two or three different types of clinical
28 problems. But I'm very aware from my colleagues and from
29 the young doctors I train that accessing that service is
30 not as easy in other parts of Australia as it is for me in
31 Surrey Hills in Melbourne.
32
33 Q. When you have mental health patients who are in a
34 crisis, where do you send them?
35 A. It depends on the nature of the crisis. If it's
36 someone who I think is actively suicidal and at immediate
37 risk, I would normally involve the hospital's crisis team,
38 or occasionally if they've already been connected with one
39 of the local private hospitals, I might ring the private
40 hospitals and see if an urgent admission is possible, but
41 more commonly the state funded crisis services.
42
43 Q. How do you get access to those? Do you mean the
44 telephone triage line or something different?
45 A. Yeah, so you ring the CAT Team and you ask to speak to
46 someone. It's a tricky thing to do because usually you're
47 already running about an hour late, because the general

1 practice is a busy environment, someone presents in a
2 crisis, assessing the crisis and giving them the time to
3 agree that that's an appropriate thing to do. And then to
4 get on the phone and wait another 15 or 20 minutes while
5 you've still got, you know, all the pressures building up
6 in the waiting room, it's quite a difficult service to
7 access.
8
9 Having said that, it's an important service because
10 when someone's at immediate risk - the only other option
11 you really have is to call an ambulance and in my
12 experience that's usually not that helpful for the person.
13
14 Q. You said in your statement that you tell your patients
15 who you consider to be at risk of self-harm or suicide, if
16 they are speaking to a crisis line themselves, to tell the
17 crisis line how sick they really are. So, why do you give
18 that advice?
19 A. Just because in my experience I've seen patients in
20 practice who I know are really quite at risk, they've got
21 quite strong suicidal ideation, we've put a safety plan in
22 place and they know what they're doing but there's always a
23 risk that in the next few days things could get worse.
24 I've had experience where patients ring the crisis team and
25 they come back and say the crisis team didn't think that I
26 was sick enough.
27
28 I think that's probably because people tell me as
29 their GP in the privacy of a consulting room a lot of very
30 personal stuff that they're very unlikely to tell someone
31 that they've never met on the end of a telephone, and I
32 think I understand that. But in so doing they might come
33 across as less at risk than I believe they are. This is a
34 common story that young GPs have because they haven't yet
35 learnt how to be more assertive when they ring a crisis
36 team on behalf of a patient of the kinds of words to use
37 that are likely to get a response, and I think that's a
38 problem because really decisions about clinical care
39 shouldn't be made just on verbal cues necessarily; it's
40 much more complex than that.
41
42 Q. Is what's missing there the connection between the
43 services?
44 A. Well, that's certainly my biggest bugbear as a GP
45 working in the community. I know all these services exist
46 but to me they really feel very much like separate silos.
47 So, I don't necessarily know the people working in the

1 service or, even if I do, by the time I'm formed a
2 relationship with them they've moved on. Certainly a
3 crisis team is very unlikely to then contact me or let me
4 know what's happened to a patient. Sometimes that will
5 happen, but much more likely it feels like the patient's
6 gone into a big black hole and here I am quite keen to help
7 them and quite concerned, and sometimes I'll even ring the
8 hospital and say, "I'm trying to find out what happened to
9 this patient", and it can take actually lots of my time and
10 lots of the receptionist's time before we get an answer
11 that often says, "Oh no, it's all turned out fine, they've
12 gone." But there's not that linkage. So really it's a big
13 potential for someone to fall through the gap.
14
15 Q. In dealing with that gap, is it the patient themselves
16 and their family, if they have one, that manages the gap?
17 A. Well, I think that's right, although I tell them I'd
18 like to hear what's happening, I'd like them to get back to
19 me and to leave a message. Now, because I work part-time
20 that can be a little bit more tricky but in my practice I
21 work well with the other doctors in the practice and say,
22 if I'm not here, here's another name of someone you can
23 contact.
24
25 The problem is that for people in crisis, the last
26 thing they're thinking about is telling their doctor what's
27 happened, they're dealing with the crisis, so they really
28 need a bit more support from the system to make sure
29 they're connected back in, and that's not as easy as it
30 sounds. When you're in a crisis it's pretty tricky.
31
32 Q. I'll ask you a bit later about your ideas about how
33 the system can provide some more support. In relation to
34 the eligibility criteria for some services you say that
35 some but not all mental health services are available to
36 people without a diagnosis and it's necessary to have a
37 diagnosis in order to obtain some services. How does that
38 work?
39 A. Well, certainly with regard to the Better Access item
40 numbers and the mental health treatment plan, it says quite
41 clearly in the MBS schedule that this is for people with an
42 ICD 10 diagnosis.
43
44 Q. Can you say what's an ICD 10 diagnosis?
45 A. So the international classification of diseases.
46 You've probably heard in these hearings about the DSM which
47 is the American Psychiatric Association classification.

1 The ICD 10 is a slightly more GP-friendly version of
2 classification. Unfortunately a lot of the young GPs were
3 trained in the hospital system so they learned DSM, so I
4 just introduce it to them as an option of another
5 classification system that they can use, and it does have
6 slightly looser definitions that are useful in general
7 practice, like mixed depression and anxiety. It even has a
8 category called "mental disorder not otherwise specified",
9 which we all find amusing because it kind of becomes a bit
10 of a catch-all bag for things we can't quite label.
11
12 The reason it's important is that technically Medicare
13 expects you to have made a diagnosis to refer someone. But
14 if someone comes to see you and they're in a lot of
15 psychological distress and you might use an objective
16 measure like the K10 and confirm that they are in deep
17 psychological distress, but they don't yet fall into a
18 clear category because you've only just met them and you
19 don't want to label them prematurely, or they're actually
20 seeking help because they've experienced violence or some
21 other crisis, it's not really appropriate to say, first we
22 have to make a diagnosis and then we can put you on this
23 pathway.
24
25 On the other hand, if you make a mental health plan
26 without a diagnosis, there is a risk later on that someone
27 could come back and say this person had a mental health
28 item number therefore they must have had a diagnosis and
29 therefore they might not be eligible for things like life
30 insurance or travel insurance, or even later on if they're
31 applying for a job in something like the military service
32 or a pilot, that they'll be discriminated against because
33 someone's used this item number.
34
35 So, there's a few complex decisions to be made there
36 about it. But in general I think it's better to encourage
37 people to seek help, so again, working from a dimensional
38 perspective if we can find a label that will meet the MBS
39 criteria but also help the patient get care, then I think
40 that's a reasonable outcome. But, as you can see, it's
41 quite a complex discussion if you really want true informed
42 consent for the person seeking help.
43
44 Q. Can I get some clarification about what services are
45 not available unless there is a diagnosis?
46 A. Well, really, technically any of the allied health
47 Better Access things are not available, so any patient who

1 wants to see a psychologist under Medicare. I guess
2 technically anyone can see a psychiatrist even without a
3 diagnosis because psychiatrists are funded by the MBS as
4 long as a GP refers, but certainly psychologists, social
5 workers and OTs are meant to be referred by someone who's
6 deemed eligible for a mental health treatment plan.
7
8 Q. Is one of your points that, it may not be
9 therapeutically helpful to go down the diagnostic path at a
10 particular time, but at that time you think the patient
11 really does need some help?
12 A. Well, that's true but it's also true that sometimes
13 early intervention is important. So a good clinical
14 example is if someone comes in quite distressed, they're a
15 husband and wife and they're having relationship
16 difficulties and everyone seems distressed, I would say
17 it's a normal reaction to a relationship conflict; it's
18 good to assess and see whether any of them meet the
19 diagnosis of ICD 10, but even if they don't it seems very
20 sensible for the sake of the whole family that they should
21 access a psychological service.
22
23 And then say to them, well, because you haven't
24 crossed this line you're really eligible to see a
25 psychologist off your own bat as a private patient and
26 that's going to cost you twice as much, I don't think
27 that's ideal.
28
29 Having said that, of course there are state funded
30 services that they can access, but again it's hard for the
31 GP then because it's broadening the number of people that
32 you have to involve in your patient's care and it's
33 therefore harder to build those interprofessional
34 collaborations that are usually more effective in helping
35 people.
36
37 Q. You've said that you have some patients who have quite
38 severe symptoms but they manage, they have jobs and
39 families, but they really manage effectively outside of the
40 mental health system because they don't quite fit into one
41 part or the other.
42 A. I think this came up in the conversation of talking
43 about the missing middle, and I kind of thought, they're
44 not missing to me, I see them all the time and they're
45 fantastic people. I mean, I learn a lot from them in terms
46 of how to be resilient despite a lot of adversity.
47

1 Some of them unfortunately are not seeking help
2 because they've had a very bad experience when they've
3 sought help in the past, and that's obviously very
4 disappointing. So, some of my work is getting them into a
5 space where they might trust the health system again to
6 engage in help again. And that takes time and I think
7 that's a really important role of the GP, to be there over
8 time so that you've got someone you trust in the health
9 system who can be a touch point for you. And sometimes
10 that'll be safety netting, so saying to a person, "Look,
11 it's great you're coping now but if these things happen,
12 then I want you to come back and revisit this", so leaving
13 the door open.
14
15 But yes, these are people who are working in the
16 community, they certainly struggle with things like
17 employment, and sometimes when there's family conflict they
18 struggle, but again, they have other ways of managing that
19 that are outside the health system.
20
21 Q. What kind of complexities in your experience, and I'm
22 really asking you about your observations of GPs generally
23 if you can, what kind of presentations will be too complex
24 for many GPs?
25 A. Well, I certainly think people who have experienced
26 complex trauma and have had then many diagnostic labels
27 over many years who also had much exposure to the formal
28 mental health system, it would be very hard for a GP to
29 manage them on their own. Having said that, many GPs do
30 because these patients don't go anywhere else and I think
31 their main job there is to provide that constant safe
32 support.
33
34 Q. How challenging do you think it is for the average GP
35 who doesn't have a special interest in mental health to
36 navigate pathways for referral?
37 A. I think it's really, really, really challenging
38 because even for me with a special interest, I find it
39 challenging, I find it really - because I am a generalist,
40 I don't just do mental health and I think the pathways to
41 access for care are really messy.
42
43 When you think about the way the MBS is set up, it's
44 funded fee for service and as a business model it
45 definitely favours short consultations. When you're faced
46 with a person who's come in with a 15-minute appointment
47 and they're in crisis and they're saying, do something now,

1 you can imagine that sometimes you'll choose a pathway
2 that's adequate but it's maybe not the very best pathway
3 for that person because that takes a bit more time to nut
4 out.
5
6 Q. What about the complexity of the parts of the system
7 and how they interrelate; how does that affect
8 navigability?
9 A. Certainly in my experience it's one area of the health
10 system where having private insurance really helps. So, if
11 you have someone who's really unwell and you think they
12 need to see a private psychiatrist and they might need to
13 do some inpatient care or outpatient group care, if you've
14 got private health insurance you can get in quite quickly
15 and there's a wide array of services.
16
17 If you don't have access to that, then you really - in
18 my experience the state services are really for people who
19 are really quite unwell and not that kind of - I guess
20 that's what they're talking about when they mean "the
21 missing middle", the people who have got a lot of symptoms
22 but can't quite get - you know, they don't have psychosis
23 for example or they're not acutely unwell, they're the ones
24 who it's quite hard to get into services.
25
26 Q. Staying with GPs for the moment, are there any tools
27 that make navigation of the system easier, and if not
28 should, there be?
29 A. There are lots of tools that have been tried over
30 the years and I've certainly been involved in trying to
31 review tools that various health systems have created.
32
33 So in my area there's the Eastern Health Mental Health
34 navigation tool. They're quite clunky, they're hard to
35 find. I certainly have colleagues of mine who ring me and
36 say, "You know about mental health; where do you find the
37 tool?" And I go, "Oh, yeah, I remember, I'll just show
38 you", and ten clicks later I'm still struggling to find it,
39 and I think that's just the nature of general practice, we
40 don't just deal with the mental health system, we deal with
41 the physical health system, and that has then many
42 subparts.
43
44 So every time someone makes a change, that change has
45 the potential to lose that connection, but much more
46 importantly it's the coming back into general practice
47 after receiving that other care, and in that respect I

1 think the communication back to general practice about
2 what's happened to patients is still seriously lacking.
3
4 Q. Is it even more difficult for patients to navigate
5 themselves if it's difficult for GPs?
6 A. I think it's a really big problem. We talk in the
7 advocacy space about the "no wrong door model" but the no
8 wrong door model doesn't always work. If you go to a door
9 and they say, "Thank you for seeking help but this isn't
10 quite the right door for you, here's another door to go
11 through"; that's not quite the same as that kind of joined
12 up care.
13
14 Q. One of the ideas that you've discussed in your
15 statement to overcome some of the problems caused by the
16 disconnected parts of the system is case conferencing
17 between GPs and other mental health professionals. What do
18 you mean by that?
19 A. Case conferencing is something that does exist on the
20 MBS and it sounds like a fantastic idea but it's just about
21 impossible to implement using a fee for service model.
22
23 It's the notion that professionals with a mutual
24 interest in the care of a patient would meet together and
25 talk about that care. In the real world it happens much
26 more pragmatically by telephone calls and conversations,
27 often after hours and early in the morning when clinicians
28 are free to talk to each other. But you can imagine that's
29 a very difficult thing to structure in some way that the
30 time can be remunerated or compensated, so a lot of a GP's
31 work is outside the fee for service but there's no fee for
32 it and that creates tensions for GPs about how much of
33 their working day they'll be doing that kind of work.
34
35 Q. You've spoken about, in this connection,
36 "incentivising collaboration". Is one way of doing that to
37 provide a scheduled item for conferrals with other
38 practitioners?
39 A. I think there already is that item, I think it's more
40 than just item, you have to make the item with flexible
41 enough rules that it actually works in the real world and I
42 think that's the challenge. We have over the years tried
43 to do other things to improve collaboration between mental
44 health professionals at a national level.
45
46 One example of that is the Mental Health Professional
47 Network. So, I belong to a group that represents the four

1 major groups of mental health professionals: so GPs,
2 psychiatrists, psychologists and mental health nurses.
3 Through that we got government funding to run this network
4 and that's an opportunity for mental health professionals
5 to meet and discuss cases.
6
7 I think that's worked really well at a national level.
8 They have webinars that over 700 mental health
9 professionals come on to. What's much harder is getting
10 that collaboration happening at a local level where you
11 know who your providers are and you work together for the
12 better outcome of a patient. At the moment in the real
13 world it's more, well, this didn't work, so let's try this
14 or let's try this, and I don't think that really makes
15 sense.
16
17 If you had cancer you'd have a multidisciplinary team
18 meeting where they'd all sit around the table and
19 say, "This is a complex cancer to treat, what does everyone
20 think we should do?", everyone agrees and then the plan is
21 implemented. Unfortunately in mental health that doesn't
22 really happen, at least not in the community setting that I
23 work in.
24
25 Q. Do you have some views about how that can be
26 encouraged and incentivised?
27 A. Yeah, I certainly think, first of all, we want the
28 state funded health systems to get into general practice.
29 The biggest problem here is the Commonwealth/state divide
30 and it's very easy, even with the best intentions, to pass
31 the buck between what's paid for by the Commonwealth and
32 what's paid for by the state.
33
34 In my career I've seen some of those difficulties
35 overcome. For example, now I can refer my patients to a
36 public hospital outpatients and it's MBS funded, but there
37 are other aspects where I can't and I would prefer that
38 these experts came into the practice. And we have had
39 examples of that in Victoria. We used to have the Primary
40 Mental Health Team where you could invite a mental health
41 professional from an experienced team to come to your
42 practice, see the patient there with you, actually tell you
43 what they thought was going on from their perspective and
44 give you extra help. That had the advantage that it was
45 close to home for the patient, stigma-free in general
46 because they're already coming to the practice, but also
47 the unmeasured and unrealised benefit it has for the GP in

1 upskilling us that if we meet a patient with that problem
2 next time, we have a better idea of what to do because
3 we've formed those relationships and we've got those
4 connections.
5
6 That doesn't happen any more in my area.
7
8 Q. Can I just stop you there. What kind of practitioners
9 were coming into the general practice and where did they
10 come from?
11 A. Well, my experience was with St Vincent's Primary
12 Mental Health Team, and I only accessed them a couple of
13 times and they would have been either mental health nurses
14 or mental health occupational therapists, but they did have
15 other members in their team and they allocated them as
16 appropriate.
17
18 Q. Was that a service that occurred on request by you?
19 A. Yes.
20
21 Q. Is that what you call the Mental Health Nursing
22 Practice or is that something different?
23 A. That's a separate initiative but I can talk about that
24 as well. The Mental Health Nursing Practice initiative was
25 probably one of the greatest unrealised dreams of the
26 mental health system, in my view. It was actually set up
27 to fund just what epidemiologically speaking was estimated
28 to be about 50,000 people who weren't accessing acute state
29 funded mental health services but probably needed them, and
30 they said wouldn't it be good if that 50,000 could get care
31 in general practice.
32
33 They set up a system where mental health nurses were
34 funded to work with GPs in general practice, but they put
35 very severe limitations around it, budgeting as they
36 reasonably did as bean counters, that there's going to be
37 50,000 people and this is what we'll do.
38
39 The nurses came into our practice and they were
40 fantastic. They would see patients with us. They had a
41 bit of trouble too in navigating the system but they at
42 least gave us a better chance of navigating the system. It
43 was evaluated and shown that GPs loved it, nurses loved it,
44 consumers loved it, but interestingly also carers loved it,
45 and I don't know many other programs where everybody says
46 this is a good idea.
47

1 I think it was not well realised, the vision of it
2 wasn't well realised because of the strict boundaries and
3 the rules around it. But if you think about it, that
4 program was funded just by a sessional fee for the nurse
5 and the general practices actually gave up their consulting
6 rooms for free.
7
8 So, in general practice, it's a small business, if you
9 have a consulting room, someone might pay rent to use that
10 room, like a pathology service or an allied health
11 provider. GPs were very happy to give that room up for no
12 cost, so there was a loss to the business, because they
13 could really see the huge benefit in having the nurses in
14 our practice.
15
16 The saddest thing about that initiative is it's been
17 restructured and refunded and moved around and nobody knows
18 exactly how it's going to work in the future, and what that
19 means is the relationships that we've built up over a
20 number of years have been lost, but also for all those
21 mental health nurses who took the brave step of stepping
22 out of hospital to work in the community, probably for a
23 small income loss but because they believed in the model,
24 they're now all in great difficulty in terms of job
25 security and they're forced to go back to the more secure
26 and better funded hospital system. So, they've kind of in
27 a way regressed back to a system that we had before, we had
28 the MINIP which was, again, I think a really important
29 initiative.
30
31 Q. How was this nursing practice funded, do you know?
32 A. It was funded through the Commonwealth and it was
33 administered through the Medicare locals.
34
35 Q. When did it stop?
36 A. When the Medicare locals transitioned to PHNs they
37 transitioned the funding to other models of care which
38 again we're yet to see how they work. I want to make it
39 clear, they're not saying that we've just completely gotten
40 rid of a service, it's just been restructured, remodelled
41 and you have to then start again with forming those
42 relationships.
43
44 Q. You've spoken more generally in your statement about
45 capacity constraints in the fee-for-service model, which of
46 course general practices are fee-for-services. What are
47 the disincentives to spend time with mental health patients

1 that are built into the fee-for-service model?
2 A. Unfortunately, a fee-for-service model breaks up
3 consultations in time blocks. So, less than 5 minutes,
4 6-20 minutes, 20-40 minutes. And the Medicare fee for that
5 amount of time - and there's also other criteria about
6 complexity, but predominately a time-based concept, and the
7 Medicare fee is the same. So as a GP if I spend seven
8 minutes with a patient I can actually claim the same fee
9 from Medicare as if I spend 19 minutes with a patient.
10
11 I want to make it clear, I don't think the GPs are
12 solely focused on income, but I think that if you're
13 running a business and you're noticing that your costs are
14 going up and the Medicare rebates have not gone up over the
15 last few years because of the rebate freeze, at some point
16 you're going to say, well, either I have to see more
17 patients per hour to meet the same financial goals I've set
18 for my practice, or I'm in trouble.
19
20 I think that's a problem. It's a problem for me
21 because I quite like doing long consultations and it's more
22 for me to convince other GPs to do this work when they face
23 those financial barriers.
24
25 Interestingly, the government has done some things to
26 try and help with that, for example chronic disease
27 management item numbers and mental health item numbers.
28 But I think a lot of people don't realise, when you look at
29 what those item descriptors require you to do - a mental
30 health treatment plan for example compared to a chronic
31 disease management plan - it's actually a lot more complex,
32 more time required, but the rebate is significantly less,
33 sort of $50 to $100 less. So, you're basically saying to
34 GPs, we want you to do this work but actually
35 dollar-for-dollar we are paying you a lot less than you
36 would be getting for some of the other physical health care
37 item numbers and I think that sends a wrong message to GPs
38 about the importance of this work.
39
40 Q. Can I ask you a bit more about the primary health care
41 networks. They're intended to assist general
42 practitioners. You mentioned some of the challenges that
43 their introduction has brought. What role are they
44 intended to play and can you address your remarks to the
45 context of mental health?
46 A. I think they're really meant to sort of say, well,
47 this is the population we serve in this geographical

1 region, where are the gaps, what are the things that are
2 missing and how can we help provide those services. So
3 really the PHNs is just the third iteration of that process
4 that started with the divisions of general practice and, in
5 my experience, they've gotten bigger and more complex and
6 at the expense of their relationship they can provide with
7 the local primary care providers.
8
9 In mental health that's challenging mainly because
10 every time a system changes you have to then reeducate the
11 whole of the primary care system about how it works and
12 there's still an awful lot of confusion out there about how
13 each system works. If you're unlucky enough to be on the
14 boundary between one PHN and another, then you often have
15 to work with two different systems, different sets of rules
16 for referral, and then there will be different sets of
17 rules for referral to the local hospital, to the private
18 hospital, to the consultants that you use, and that kind of
19 complexity doesn't encourage people to spend time making
20 decisions about what good care looks like.
21
22 Q. Does the length of the funding cycle play a role in
23 the complexity and the lack of continuity?
24 A. Yes, it does. I mean, unfortunately the way - in
25 fact, the way a lot of the mental health sector is funded -
26 and I'm sure you'll hear in this commission about many
27 different pilots that happen. They're often very
28 short-term. And the challenge here, it comes back to a
29 problem even with research, you know, randomised controlled
30 trials are the gold standard of proving something works,
31 but unless you test it in an actual community, you're not
32 going to really know if it works, and even then it can
33 take months or even years for the relationships to form and
34 the system to be bedded down so that people can actually
35 work well together.
36
37 And that's why I'll have more success than junior
38 colleagues in dealing with the system because I've just
39 been in the same chair for more than 20 years and so I've
40 just been around long enough to know this is how it works.
41 It shouldn't take that long for someone to form those
42 relationships, but of course very short funding cycles like
43 the PHNs have really work against that.
44
45 Q. What role do you think self-stigma plays in preventing
46 people getting access to help?
47 A. I think it's a big part of the difficulty people face.

1 I still think that most people find it very difficult to
2 admit they have a mental health problem. It's definitely
3 better than it was 20 years ago when I started. I
4 certainly think that stigma in the community seems to be
5 getting less for common conditions like depression and
6 anxiety and I know you'll hear from other experts who will
7 talk about the ongoing problem with more serious disorders.
8
9 But I do have a lot of people who come in - this is
10 also part of the nature of some conditions. So, for
11 example, if you have depression, part of the illness is to
12 have low feelings of self-worth or feelings of guilt, and
13 that obviously translates into feelings of, well, I'm not
14 really important enough to justify this treatment. So,
15 those kind of patients do need a lot of extra encouragement
16 and support to get the help they need and I think that's
17 just part of their illness.
18
19 Q. You say there would be merit in developing
20 "collaborative care models" which has been a model adopted
21 in several parts of the world. Can you say what you mean
22 by "collaborative care models" and why they would help?
23 A. So, in an international sense, the term "collaborative
24 care" really means a more complex intervention. So, the
25 story's really interesting when you look at how it started.
26 It started in the 90s in Seattle in Washington where a GP
27 and a psychiatrist who'd trained together met and said,
28 let's train GPs to be better at mental health. Tried to
29 train GPs and it didn't really make the difference they
30 hoped.
31
32 So then they said, let's move from training GPs to
33 actually getting a bit of extra help for GPs in the clinic.
34 We'll actually help them to screen for mental illness
35 better, and then if they find mental illness we'll actually
36 give them a case manager, someone who can help the GP make
37 sure the person's followed up, and if the person isn't
38 getting better we'll bring in an expert, psychiatrist, who
39 will come in and know the GPs in that clinic and help them
40 navigate the system. That's in a very simple term.
41
42 But the story is beautiful because it is very similar
43 to what we've had in Australia: let's just train GPs more,
44 let's then get more help in there, but it's closing the
45 loop which is following up in the practice and saying, what
46 else can be done to help this person get better.
47

1 It's certainly been very useful in areas for people
2 who have multi-morbidity. The most bang for buck there is
3 for people with other conditions like diabetes or cardiac
4 disease and depression, they often benefit from those
5 models, but they haven't been extensively tested in the
6 Australian context.
7
8 Q. Finally, you say in your statement that:
9
10 "A good touchstone of how well the system
11 is functioning is to ask, if this was a
12 physical problem, what would happen?
13 There's still a lot of stigma; a lot of
14 judgment around mental health. I always
15 wonder: is this person who has a mental
16 health problem getting at least [as] good
17 [a] deal as a person with a physical health
18 problem? The answer is almost always no."
19
20 In addition to the things we've discussed this
21 morning, are there any things you want to tell us about the
22 way in which the system could be changed to get a better
23 deal for people with mental health problems?
24 A. Well, the simple answer is just fund mental health
25 systems according to the burden of the disease that they
26 create. If it was in proportion to the burden of disease
27 that physical health creates we would get a bigger slice of
28 the pie for mental health. I think that's the simple
29 answer.
30
31 I also think, another thing I reflect on a lot as a GP
32 is, we've improved help-seeking, but just getting someone
33 to get help doesn't mean they're automatically going to get
34 better. These are quite complex conditions often to treat.
35 So, yes, it's true that they're treatable, but you won't
36 necessarily get better the first time you seek help.
37
38 So to create a system where there's continuity, so
39 it's not like, well, you've tried this, you've tried that,
40 you're not better, so back you go back to the GP. We
41 should then be looking at, well, what are the barriers, why
42 is it that some people are getting better and some people
43 aren't? And I think you'll find a lot of that has to do
44 with the social determinants of health, and so we can't
45 just spend in the health system, we have to spend in that
46 area as well.
47

1 MS NICHOLS: Thank you very much. Chair, do the
2 Commissioners have questions?
3
4 CHAIR: No, thank you very much.
5
6 MS NICHOLS: May Dr Johnson be excused, please?
7
8 CHAIR: Yes.
9
10 <**THE WITNESS WITHDREW**
11
12 MS BATTEN: Commissioners, the next witness is Dr Sika
13 Turner. I call Dr Turner.
14
15 <**SIKA TURNER, affirmed and examined: [10.49am]**
16
17 MS BATTEN: Q. Dr Turner, have you prepared, with the
18 assistance of your legal team, a witness statement for this
19 Commission?
20 A. I have.
21
22 Q. I tender that statement. [WIT.0002.0012.0001] Could
23 you briefly outline for the Commission your relevant
24 background and experience, please?
25 A. So, I've got an undergraduate degree in psychology
26 from the University of Oxford and I've got a postgraduate
27 doctorate in clinical psychology from the University of
28 Melbourne. I've been a registered psychologist since 2002,
29 and I've got a clinical psychology endorsement with APRA.
30
31 Q. Could you please explain your current role as
32 Discipline Senior, Adult Mental Health in the Mental Health
33 Program at Monash Health?
34 A. Sure. So, as Discipline Senior, my role is - I've got
35 three main roles. So, the first one is, I do some clinical
36 work within the Agile Psychological Medicine clinic, APM
37 clinic. I do some professional leadership with other
38 psychologists within the adult mental health program and
39 some supervision of other psychologists.
40
41 Q. You referred to the APM clinic, can you please explain
42 what that clinic is and what services it provides?
43 A. Sure. The APM clinic is a clinic that was set up - I
44 should say "clinics", we have several of them - set up to
45 provide first-up treatment, so close to the time when
46 people first present to the mental health system in a way
47 that responds to their needs and that provides them with

1 evidence-based treatment as soon as they present; in a way
2 that, we're hoping to respond to them as an individual and
3 less as a diagnosis.
4
5 Q. I'll have some more questions about that, but first I
6 want to understand, how do people come to your service, how
7 do they access your service?
8 A. Sure. So, there's two main access points which are
9 the two kind of emergency access points for mental health
10 within Monash Health. So, they either present to
11 emergency, in which case they would be assessed by an ECATT
12 clinician.
13
14 Q. Sorry, what's ECATT?
15 A. So that's Emergency Crisis Assessment Treatment Team,
16 so it's a CAT Team but with a clinician placed in
17 emergency. So, they would be assessed in emergency and, if
18 appropriate, they'd be booked straight into our APM diaries
19 and they'd be told, for example, you've got an appointment
20 with Sika on Wednesday at 11 o'clock.
21
22 The other access point is through the psychiatric
23 triage service. So, people might ring up, or their friends
24 and relatives might ring up or their GP or other concerned
25 individuals in their life. Then PTS would triage them over
26 the phone and they again would book them straight into our
27 calendars. We then see people within 72 hours of that
28 initial contact.
29
30 What we would do when people come through the door is,
31 we try very quickly to start the treatment. So, we try
32 very quickly to do a joint formulation with the person of
33 what the issues are, and then we come up with some joint
34 treatment goals and start working on those as soon as
35 possible.
36
37 Q. Who can access the service? Are there catchment
38 limitations for your service?
39 A. No. So, although we operate within Monash Health, we
40 will see anyone who's booked into our diary. The main
41 issue is that they have to be over 18, but other than that
42 we will see anyone who's booked into our diary.
43
44 Q. Do you turn people away?
45 A. No. So, we might - occasionally we might have people
46 who, after a couple of sessions, we think they might be
47 better off somewhere else, but we'd never do that without

1 meeting the person and having several sessions with them if
2 we can.
3
4 Q. You referred to the fact that you try and provide
5 treatment straight away, can you elaborate on what you mean
6 by that?
7 A. Often, as I'm sure has been heard before, the main
8 thing that's offered first up is a crisis response, so a
9 crisis management or crisis mitigation. Our ethos is that
10 we try to start the actual treatment. I guess our belief
11 is that the key to resolving risk is to try to treat the
12 underlying issue and we try and start that straight away.
13
14 We were concerned with the number of gates that people
15 had to go through before they got to the specialist
16 treatment, rather than having the specialist treatment at
17 the front end of the service. Often people have to go
18 through several kind of - many assessments for example
19 before they get to the actual treatment component if they
20 get there.
21
22 Q. Can you describe the make-up of your patients in terms
23 of mental illness severity and complexity?
24 A. Sure. So, primarily we would see people with high
25 prevalence mood disorders, but really, we'll see anyone who
26 comes through the door. So, we've had referrals, you know,
27 people who are acutely psychotic and if they're booked into
28 our diaries we would see them. But I guess primarily we
29 would see people with the more high prevalence disorders.
30 Also a lot of trauma and we've responded to that by setting
31 up a specific trauma treatment to that.
32
33 So we kind of have - I guess, they're not official
34 streams, but kind of three different outcomes that we might
35 be working on. I guess one of them is more where we see
36 people for around say four sessions and that's more in
37 response to a situational crisis. So, someone might come
38 in with, you know, they've lost a job or a relationship
39 issue, financial issues, issues often in response to
40 relationship issues and often there's an underlying mental
41 health issue, and so, we might see them relatively
42 short-term to try and help them mobilise some resources to
43 deal with their crisis.
44
45 We find that when people come in a situational crisis,
46 they're often not very well placed to try and find
47 resources to deal with them.

1
2 The other sort of two categories, I suppose - I don't
3 really like to use that term because we try not to think
4 about people in those categories, but just to explain it:
5 we might see people with the high prevalence mood disorders
6 and we might see them for sort of 10-ish type sessions.
7 Then we have a specialised treatment program for PTSD
8 because we were finding we were getting a lot of them come
9 through, so that's a 12 session treatment for PTSD
10 specifically.
11
12 I've mentioned session numbers, but actually our
13 number of sessions is not set in stone and we don't kind of
14 say, oh, your ten sessions are up, kind of thing. So, we
15 try very much to respond to the issues that people come
16 with and we work from the goals that we've set with them.
17
18 The other thing that we very much try to do is to, (a)
19 provide evidence-based treatment, and (b) provide
20 feedback-informed treatment. So, that is, we routinely ask
21 people throughout their time with us whether they're
22 getting the things out of the treatment that they wanted,
23 whether the goals are being met through the relationship,
24 and we would monitor that as we go and respond to that.
25 So, if that's not the case, then we would rethink what
26 we're doing.
27
28 Q. I'll ask you some more questions about that, but first
29 I want to understand the demand for your service. You've
30 said:
31
32 "Our analyses actually indicate that the
33 number of people who could benefit from our
34 service hugely outnumbers the actual
35 referrals we receive"?
36
37 A. Yes.
38
39 Q. Can you just explain to us what analyses have been
40 undertaken?
41 A. Sure. We've tried to understand what the demand might
42 be for our service, and so, to do that we've looked at just
43 purely the people who present to PTS and to emergency with
44 mental health issues. So, emergency with mental health
45 issues or PTS, and we've looked at what they're presenting
46 with essentially.
47

1 Basically, with PTS, it's a little bit tricky because
2 they don't necessarily record a diagnosis, so the
3 indicators are fairly general. With ECATT they will record
4 a diagnosis, and so what we can see from that - and I'll
5 use ECATT, so these are people who are presenting to
6 emergency as an example.
7
8 So in 2018 we had about 4,000 people who would fit, on
9 the surface of it, looking through the file and what
10 they've presented for, would fit into what we could treat
11 within the APM clinic. So, they're people with depression,
12 they're people with some suicidal ideation and sometimes
13 some history of self-harm as well. So, there's about 4,000
14 of those, and in fact we've had 75 referrals from ECATT in
15 2018, so that's just under 2 per cent.
16
17 Q. Why do you think that is? Why do you think there's a
18 greater number of people who could benefit from your
19 service than the people you're actually getting referrals
20 for?
21 A. So my guess about that is that the system is very much
22 geared towards looking where the highest risk is and trying
23 to mitigate that risk, and also, the system is really
24 stretched and it's concerned with trying not to get
25 flooded, and so, there's some resources that, on the
26 surface of it at least, look like they're geared towards
27 keeping people out rather than actually getting them in.
28
29 What we would like to see is that people are assessed
30 on the basis of how much they could benefit from treatment.
31 So, the guesstimate that we have about those numbers, and
32 we look at those diagnoses, these are the kinds of people
33 who we have evidence to show could benefit from the kind of
34 treatment that we offer.
35
36 Q. You've observed that the mental health service is
37 crisis-driven - this is what you've just been saying as
38 well - "and that we often manage the crisis rather than
39 provide the treatment". Can you elaborate on what you mean
40 by that?
41 A. Sure. Because you often have to express quite a lot
42 of risk to get seen in the public mental health system, we
43 have this - so we have this belief that actually we know
44 how to predict suicide, and actually unfortunately we don't
45 really. So, in terms, we have some risk factors that we
46 understand but we don't know how to predict from those risk
47 factors which people will actually suicide. But in spite

1 of that we still use a risk assessment to determine who
2 gets help.
3
4 Q. When you say "we still use", who are you referring to?
5 A. Within public mental health generally, yep. And so,
6 the help that is then offered to the people who kind of get
7 through that is often around how to get through this
8 crisis. So, it's typically making a crisis plan or a
9 safety plan, rather than necessarily looking at what's
10 driving that crisis underneath and how can we kind of help
11 people deal with that rather than how can we try to guess
12 what might keep them safe.
13
14 Another issue around this is that some of the safety
15 plans that we make with people when we've just met them for
16 the first time are actually not necessarily that useful to
17 people because they're very general and not very specific
18 to that person, whereas we might be better placed - and we
19 do within APM, we do work with risk and safety - but when
20 you know people you can make a much more useful kind of
21 risk plan.
22
23 Q. You referred to the fact that the research shows that
24 we're not good at assessing risk and we're not able to
25 reliably predict. Are you able to elaborate on that?
26 A. So basically I mean, what that means is that, when you
27 look at the people who have suicided, many of them have not
28 declared their risk in the way that we think people do, if
29 that makes sense. So, we have some risk factors, but it
30 seems like we're not able to know how to use those risk
31 factors to actually predict who is going to suicide,
32 unfortunately.
33
34 Q. Is it the case that the clinic still looks at risks,
35 or do you not look at risk at all?
36 A. Absolutely, absolutely. I mean, the risk is part of
37 the picture, and I guess I sort of see, say, suicidal
38 ideation is very much an indication that someone really is
39 in need of help, and of course we listen to that, that's
40 what we're there for, and so we would very much have that
41 be part of the treatment. But the goal of the treatment
42 isn't just to provide - to get people through the crisis,
43 it's to hopefully set them up to have a better quality of
44 life and towards recovery.
45
46 Q. Does your clinic have the capacity to treat anyone who
47 presents with suicidal ideation?

1 A. Yes. I mean the only - yes, the only "but" around
2 that is the 72-hour sort of thing. So, if someone is at
3 immediate kind of risk, then we wouldn't be the service,
4 but other than that, absolutely. And in fact, if we look
5 at our data, it shows that we do hold people with quite a
6 lot of risk within the APM clinics.
7
8 Q. You have stated that:
9
10 "We use risk assessments as the main access
11 point to services and a system, and the
12 cost of this is that we do not provide
13 mental health services to some people who
14 have a lot of distress because they do not
15 express the right type of risk or enough of
16 it."
17
18 Can you elaborate on what you mean here?
19 A. So, I think there are a lot of people who are really
20 struggling with long-term complex - some of the complex
21 trauma that we heard about before: ongoing or recurrent
22 depression, anxiety issues, sometimes personality issues,
23 who are living with their symptoms in an ongoing way and
24 who might be getting by okay some of the time and they have
25 times when they're really struggling, but they don't
26 necessarily express the risk in the way that the system
27 tends to listen to; those people are not getting what they
28 need within the public health system.
29
30 Q. You also state:
31
32 "Another cost is that, by focusing on risk,
33 we often do not spend enough time
34 understanding the person and providing them
35 with appropriate treatment."
36
37 What is the appropriate treatment in that scenario?
38 A. So that would really depend on the person I think.
39 So, to me appropriate treatment is about what I mentioned
40 before about trying to kind of formulate with the person
41 what's going on for them, why are they presenting now, and
42 trying to understand what's going on for that person at
43 that point in time, and then setting some treatment goals
44 and then using the tools that we have, which might be, you
45 know, it might be CBT or it might be IPT or it might be
46 medication, so using the various tools that we have to then
47 try and work towards those goals.

1
2 Q. You just used two acronyms, CBT and IPT; can you just
3 explain what the are?
4 A. CBT is cognitive behaviour therapy and IPT is
5 interpersonal therapy.
6
7 Q. You've highlighted the importance of the therapeutic
8 relationship. Can you just elaborate on that in terms of
9 treatment outcomes and recovery focus for the patients?
10 A. Sure. So, one of the things we know, and this is
11 generally from sort of psychotherapy research I suppose, is
12 that, it matters less what kind of therapy I might be
13 doing, whether I'm doing CBT or IPT or something else
14 altogether. When you pick apart what actually works in
15 psychological therapy the technical content of what I'm
16 doing actually matters a lot less than the relationship I
17 have with my client, and this is a well-known kind of fact
18 around psychological therapies.
19
20 One of the things that really worries me actually as a
21 psychologist within the mental health system is that the
22 therapeutic relationship in some ways is the most powerful
23 tool that we have. If you look at the research around
24 that, it explains more of the variants in who does well
25 than what kind of therapy I'm using, so it's one of the
26 most powerful tools that we have.
27
28 But when we have people go through many assessments
29 with many different clinicians, which is often the case,
30 it's like we're throwing out the most powerful tool that we
31 have
32
33 Q. Is it correct that the modal number of sessions with a
34 particular clinician is one session?
35 A. Yes, so that relates to research, again sort of
36 globally in terms of psychological treatment, which is that
37 the modal number of sessions attended is one. That means
38 that many people just come in once. Now, we don't know why
39 that is, and actually that's also the case within our APM
40 clinics which is something that we've looked at because we
41 want to increase that number.
42
43 What we don't know is, because we can't ask them
44 because they've left, is why they've just come the once.
45
46 I think within APM sometimes it's to do with the fact
47 that we see them in a situational crisis and the crisis has

1 shifted. Other times it might be because we have this sort
2 of intact model - and I'm not just talking now about APM,
3 I'm talking more generally - where we often will spend the
4 first session taking a very detailed history and going
5 through a lot of details and not necessarily giving the
6 person who wants help any help in particular.
7
8 And so, as was mentioned by the previous witness, it's
9 very hard for people to get themselves to that situation
10 where they're asking for this kind of help often and I
11 think people will get demoralised quite quickly if they
12 can't see any sign of hope that something is going to
13 shift.
14
15 Q. You said that it's quite hard for people to get
16 themselves to this position of seeking help. Can you
17 outline some of the barriers people face in accessing
18 psychological services?
19 A. So, I guess within the public mental health system
20 psychological services are often very patchy. So, some
21 teams might have a psychologist and some teams don't.
22
23 I guess at Monash Health we have the APM team which is
24 meant to be a kind of, yeah, as I said, very close to the
25 presentation. But over and above that, so if we take that
26 out of the equation because it's probably a bit of an
27 exception in some ways, it's very hard to get access to
28 psychological treatment and it just depends on who's in
29 that team, yeah, that you happen to be presenting to.
30
31 Q. You've referred to the fact that people can't
32 necessarily access the treatment at the time that they need
33 it. Is that in terms of availability of psychologists?
34 A. So, sometimes, but it's also, in terms of availability
35 of psychologists within given teams. I think it's also
36 that psychological treatments, can I say in spite of the
37 evidence, are often not thought of as first line treatments
38 for common mental health treatments.
39
40 Q. Why do you say "in spite of the evidence"? Does the
41 evidence point the other way?
42 A. No, the evidence points to the fact that it should be
43 a first line treatment, along with, say, medication for say
44 a depression, but within the public mental health system it
45 isn't necessarily offered as a first line treatment.
46
47 Q. Can I turn to the issue of the impact of not getting

1 treatment. You've stated:
2
3 "Ultimately when people attempt to get help
4 and do not get any or they get insufficient
5 help or the wrong kind of help, they may
6 end up worse than before they tried to get
7 help."
8
9 So, there's three different parts there. In which of
10 those scenarios can they end up worse?
11 A. Well, I think unfortunately they can end up worse in
12 all three, but perhaps most in the one where they ask for
13 help or don't get any, or where they get the wrong kind.
14
15 Q. And why do they end up worse?
16 A. I think there's a number of reasons why that might be
17 the case. Sometimes it might be, as I mentioned before, a
18 loss of hope in the sense that, you've got yourself to the
19 point where you're asking for help and then it's not
20 forthcoming, and so, you think, well, where else can I
21 turn?
22
23 The other issue is really around, sometimes people
24 then might mobilise other coping resources that might end
25 up causing other problems for them in the future. So, for
26 example, they might manage their symptoms in ways that
27 might cause problems for them down the line, so through
28 drugs or alcohol or other ways of managing; self-harm,
29 et cetera.
30
31 Q. You've referred in your statement to collaborating
32 with other parts of the system. Can you explain the
33 difficulties with trying to collaborate and refer patients?
34 A. Sure. So, it's very difficult to refer - so anyone
35 that I see, to refer them to another part of the service.
36 And actually it doesn't really matter whether I'm trying to
37 refer them to an external service outside of Monash Health
38 or internally, I still have to go through the same gate.
39 So, you can't just go from one service to another, say
40 within Monash Health, easily or indeed to an external
41 person.
42
43 So what that means for the person is that, I might
44 work with them for a little while and then I might go,
45 okay, well maybe they need this thing over here that I know
46 one of my colleagues within my service is offering, I then
47 send through a referral and there might be phone calls

1 backwards and forwards, the person might be waiting for a
2 little while, and then they go and have another assessment
3 there, in spite of the fact that I've already assessed
4 them, and then they may or may not then get in. So, they
5 might say, no, this person is not appropriate for our
6 service.
7
8 Every individual service within a public mental health
9 bigger service has to assess and decide whether or not to
10 see a person, which means that there's gates all along the
11 way, people can't move smoothly from one service to
12 another, and again, it's that multiple handovers where
13 people have to re-tell their stories which they explicitly
14 tell us they really don't want to do, and we ask them to do
15 that many, many times over, and often to kind of end up
16 back at square one.
17
18 Q. You've said that in that scenario where you have to
19 repeatedly go through intake processes there's a risk of
20 losing people; is that because they don't want to keep
21 telling their story?
22 A. I think so. Yeah, I think so. And look, people have
23 said that to me over the years when I've floated with them,
24 maybe you could go to this service or how about this? And
25 they go, do I have to tell my story again, because really,
26 quite frankly, that's not appealing to me.
27
28 Q. You've said in summary, there's lot of activity, but
29 ultimately very little treatment.
30 A. Yeah. So, when you look at the - so we've been able
31 to kind of track the amount of clinical activity for a
32 person within our mental health system, and often there's
33 many, many, many - a lot of activity logged in our system,
34 so lots of phone calls and lots of people who have spoken
35 to someone, but when you look at the content of what's been
36 offered, not very much of it, if any, is actual
37 evidence-based treatment. A lot of it is checking in and
38 perhaps some crisis management, et cetera.
39
40 Q. You've observed that the consequences of that can be
41 tragic, the lack of treatment?
42 A. Yeah.
43
44 Q. You've been able to track that with certain analyses,
45 can you explain those analyses?
46 A. So basically it's looking at sort of a patient
47 journey. So, it's picking out some patients, either

1 randomly from, say, a group of people who are accessing CAT
2 or other services, and also, picking outpatient journeys
3 where there's been a tragic outcome, and actually looking
4 at what services were they getting along the way: so, how
5 many phone calls, who spoke to them, who spoke to them the
6 next day and the following day, so actually tracking
7 exactly what services people were offered.
8
9 Q. Is that services and treatment or just services?
10 A. Services, which could include treatment, yeah.
11
12 Q. You said this at the outset, it would be helpful if
13 you elaborate on it: turning to the system as a whole, and
14 you mentioned this in terms of psychology services, "It
15 should be designed to facilitate treatment as soon as
16 possible when the person first presents." Can you explain
17 why that's important and why the system should be designed
18 that way?
19 A. It's really I think around this idea that, when people
20 bring themselves, say, to emergency or they ring PTS
21 because they're having problems that are so significant
22 that that's where they're getting themselves, that they
23 should get the treatment straight away. Like, if I go to
24 emergency with a broken leg, I don't have to wait, you
25 know, a long time before getting the actual treatment for
26 the broken leg; I get that treatment pretty close to when I
27 present.
28
29 I guess my sense is, it should be the same for mental
30 health. There's too many kind of hoops that people have to
31 jump through to get that treatment.
32
33 Coming back to my point before about the modal number
34 of sessions being one, we often don't - we don't have many
35 chances with people because it is so hard for people to get
36 themselves there that, if we miss the opportunity, it might
37 be very hard for them to come back.
38
39 Q. You've referred to the benefit of feedback in that
40 scenario and trying to ascertain if treatment is working
41 for people. Can you expand on why you think that's so
42 important?
43
44 Q. So there's sort of two things I think with that; one
45 of them is more just on a sort of fundamental ethos level.
46 I guess, with mental health, the only indicator we have as
47 to whether people are benefitting really from our treatment

1 is to ask them. I can't do a scan or a test or whatever to
2 sort of work out, you know, is this working; it's the only
3 way I have of asking them. I think, you know, we want to
4 make sure that the stuff that we do with people actually
5 works. So, it's getting them better quality of life,
6 moving them towards recovery, and it seems like there'd be
7 no point in all the things that we do if we don't know that
8 what we're working towards is actually helping, so that's
9 kind of more on a theoretical level.
10
11 There is also quite a lot of research around
12 feedback-informed treatment that actually shows that it
13 really enhances sort of psychological therapies. Routinely
14 asking people, how is your life generally, how are you
15 finding the work that we're doing together, is our
16 relationship working for you, actually improves the
17 efficacy of psychological treatment and it reduces the
18 relapse rate and it reduces the length of admissions.
19
20 Q. In your view, what are the key issues with the mental
21 health system?
22 A. So, I might just have to quickly refer to this. I
23 think, so there's a couple: one of them is really a focus
24 on outcomes for clients rather than necessarily having KPIs
25 around activity. So, we really want to measure the things
26 that we value, which is quality of life and recovery for
27 the people who use our systems, rather than making sure
28 that we do lots of things and that we move people around in
29 the right way and get the right flow of people. We
30 actually want to focus on the outcome; keep our eye on the
31 prize in some way.
32
33 Then I think, coming back to what I said before around
34 therapeutic relationship, we want to use the most powerful
35 tools that we have, which means really valuing that
36 therapeutic relationship.
37
38 I think we also want to move away from having this
39 crisis-driven risk mitigation model and actually looking
40 more at evidence-based treatment, what treatment should we
41 be offering, what are the most helpful things to be doing.
42
43 I think that kind of talks to another point, which is
44 to really be data driven, to look at the evidence, look at
45 what we're doing and what actually works and what doesn't
46 work and change accordingly, rather than being more focused
47 on kind of service as usual and being focused on making

1 sure the stretched system doesn't break, if that makes
2 sense.
3
4 Q. What's the available data at the moment, is it
5 sufficient to engage in this or are there holes in the
6 data?
7
8 A. I think, look, there are always holes in the data, you
9 can always get better data. But I think if we insist on
10 being informed by the data, then the quality of it will
11 also improve, if that makes sense.
12
13 And then a final point that I wanted to make is also
14 around looking after the workforce and the facilities
15 around mental health, in the sense that, we want to make
16 sure that our workforce feels safe to do the work that they
17 do, that they have the right professional development to do
18 the work that they do, and that the facilities are
19 conducive of the treatment that we're trying to provide,
20 both for the workforce and for the people who use the
21 system.
22
23 MS BATTEN: Thank you very much, Dr Turner. Chair, are
24 there any questions for Dr Turner?
25
26 CHAIR: Dr Cockram.
27
28 COMMISSIONER COCKRAM: Q. Dr Turner, I just want to step
29 through some of your evidence so I can understand then why
30 you think it's happening. First of all, my understanding
31 is that APM is presenting evidence-based interventions for
32 the people that it is supporting.
33
34 The PTS and the ED, or ECATTs, are the ones that are
35 referring?
36 A. Yes.
37
38 Q. They're all in the same service?
39 A. Yes.
40
41 Q. In the same health service?
42 A. Yes.
43
44 Q. And yet, you're describing, I think, that the PTS and
45 ECATT are gate-keeping and creating barriers to the
46 successful transfer to the evidence-based treatment.
47 A. Yeah.

1
2 Q. So, could you just again describe to us, what are the
3 mechanisms or what is going on that is creating that
4 barrier at that point between the ED and the PTS into an
5 evidence-based treatment?
6 A. Yeah. I think, to be honest with you, we don't
7 understand exactly why that bottleneck is there, and if we
8 understood exactly why that was there it would probably be
9 easier to unblock in some ways.
10
11 My guess is that it is around the sort of habit of
12 using the level of risk as the main way of getting access
13 into the treatment, into the service. So, people who on
14 the surface of it could clearly benefit from, say, an
15 APM-type service are not necessarily being sent away, they
16 might be told to, I don't know, to maybe go and see their
17 GP, or they might be told - I guess what I'm saying is they
18 might be actually turned away from the system as such,
19 yeah.
20
21 Q. So, the mental frameworks that the clinicians in PTS
22 and the ECATT are using in what you've described quite
23 clearly as being a very risk kind of framework --
24 A. Yes.
25
26 Q. -- isn't thinking about definitive evidence-based
27 treatment, it's thinking about managing that risk and - I
28 don't know if this is too harsh - but getting it out of the
29 system rather than coming in.
30 A. Yes.
31
32 Q. Is that your hypothesis?
33 A. That is my hypothesis, and I think - I just want to
34 make it clear that it's not the fault necessarily of the
35 clinicians who work in that system, it's more around, I
36 think, the fact that the system is so stretched and people
37 are concerned that it will be flooded, yeah.
38
39 COMMISSIONER COCKRAM: I understand, okay, thank you.
40
41 CHAIR: Q. I'd just like to follow that up a bit because
42 I, too, was interested in the evidence you gave around
43 that. You said that you looked at about 4,000 matters
44 where people had presented and asked for assistance but
45 where you thought they could have benefitted from your
46 service but they weren't referred, or a very small
47 percentage were referred --

A. Yes.

Q. -- and then you went on to talk about the fact that we turn away a lot of people who ring; you also said, we often turn away people who are not risky enough but we don't know and don't review what happens when they've asked for service and been turned away. Did you get any insights from that examination of the 4,000 matters where they were referred to and whether they were referred?
A. So, some of them were referred, so that's mostly around the level of risk. I think that's a big unknown, actually. PTS is even more of an unknown than ECATT. In terms of the number of people that do not get mobilised into Monash Health generally, is where do they get sent and why are they not getting service when other people are, so I think it would be really interesting to try and really understand that more, but I don't understand it fully at this point in time.
Q. You do, however, make the statement that:

> "We know that this hugely increases senses of hopelessness and demoralisation."

A. Absolutely, and I think in some ways that's not hard to imagine, that if you phoned a psychiatric triage service or you've rocked up to emergency and you are sent home or turned away, that that would not be a positive experience.

CHAIR: Thank you.

MS BATTEN: Are there any further questions, Commissioners?

CHAIR: No, thank you.

MS BATTEN: Thank you. May this witness be excused?

CHAIR: Yes, thank you. Thank you for your evidence.

<THE WITNESS WITHDREW

MS BATTEN: Is now a convenient time for a break?

CHAIR: Yes, thank you very much. Please adjourn.

SHORT ADJOURNMENT

1 MS BATTEN: Commissioners, the next witness is Ms Gail
2 Bradley. I call Ms Bradley.
3
4 <**GAIL MELANIE BRADLEY, affirmed and examined: [11.44am]**
5
6 MS BATTEN: Q. Thank you, Ms Bradley. Have you, with
7 the assistance of lawyers, prepared a witness statement for
8 this Commission?
9 A. I have.
10
11 Q. I tender that statement. [WIT.0002.0001.0001]
12 Ms Bradley, would you please outline your relevant
13 background and experience for the Commissioners?
14 A. Yes. I am a clinical psychologist and I've been
15 working in public mental health for 32 years. 25 of
16 those years have been in operational leadership roles, 15
17 of those years have been in community mental health, and
18 ten years as the area manager of the Inner West Area Mental
19 Health Service.
20
21 Q. Thank you. I might get you to move the microphone a
22 bit closer to you.
23 A. Is that better?
24
25 Q. Thank you.
26 A. I should also mention, for the last five months I've
27 been the interim Operations Director for NorthWestern
28 Mental Health.
29
30 Q. So you were doing that for five months but you've
31 ceased doing that role?
32 A. Yes. Back at the old role yesterday.
33
34 Q. And the old role is as area manager of Inner West?
35 A. That's correct.
36
37 Q. Could you outline for us your role and
38 responsibilities in that role?
39 A. Sure, so I have management of the financial resources
40 of the service; other operational functions, like
41 occupational health and safety, human resources,
42 infrastructure, but I guess a really important part of the
43 role is working with our leadership group to develop our
44 strategic directions and look for ways to improve our
45 services.
46
47 Q. I'll focus these questions on Inner West rather than

1 NorthWestern. I understand from your statement that there
2 is a section that relates to NorthWestern and a number of
3 the things that you've said in relation to NorthWestern
4 also apply to Inner West?
5 A. That's correct.
6
7 Q. Can you just explain to us what is Inner West Area
8 Mental Health Service and what services does it provides?
9 A. So the Inner West is one of 21 area mental health
10 services in Victoria. We cover the catchment of the City
11 of Melbourne and the City of Mooney Valley. And, because
12 we cover the catchment of the City of Melbourne, I guess
13 there are some features of that population, including high
14 rates of homelessness, particularly in the CBD of
15 Melbourne, and we also have two of the large crisis
16 accommodation services, Flagstaff and Ozanam House in that
17 area.
18
19 The population is 285,000 people and the services
20 include, like other area mental health services, we have an
21 adult acute inpatient unit that has 29 beds. There is an
22 emergency mental health team in the emergency department at
23 the Royal Melbourne Hospital. We have a consultation
24 liaison service also at the Royal Melbourne Hospital.
25
26 There are two community mental health teams based in
27 Moonee Ponds. We have another team based at the Royal
28 Melbourne which has a focus on homelessness, and we're also
29 in a partnership program with cohealth and other services
30 in a program called Homeless Outreach Mental Health
31 Service.
32
33 And we have a community care unit, so that has 20 beds
34 for residential rehabilitation, a prevention and recovery
35 centre which is ten beds, and we have two specialist
36 services: one is the neuropsychiatry service which is a
37 state-wide service for Victoria, and an eating disorder
38 service which is an eight bed service with outpatient
39 facilities as well, and that covers the North West of
40 Metropolitan Melbourne and Victoria.
41
42 Q. So it's quite a diverse service, but can you explain
43 to us how you access the service, how does someone come
44 into the service?
45 A. So, the main access points would be through the North
46 West Mental Health centralised triage service, so that's a
47 phone referral service which is manned from the morning

1 until late evening. We probably get around about a third
2 of our referrals that way.
3
4 Otherwise, they're through the emergency department,
5 so people coming directly to the ED, and then through there
6 into either an inpatient unit or into a community team.
7
8 We get community referrals from a range of sources: so
9 that might be from GPs and private practitioners, from
10 police, from prisons. We have the Melbourne Assessment
11 Prison in our catchment and we receive a number of
12 referrals from there and a number of self and family
13 referrals.
14
15 Q. You said the triage service ends in the evening, so
16 after the evening do you need to go to the ED to access the
17 service?
18 A. That's correct.
19
20 Q. Can you tell us about the criteria for accessing the
21 service. So, if someone presents, what do they need to
22 satisfy in order to be taken into the service?
23 A. So, they need to have a severe mental illness, by
24 which I mean an illness which has a long-term course and a
25 relapsing course, and that can include diagnoses of
26 schizophrenia and other psychoses, or a severe form of
27 another illness, so that might be mood disorder, it might
28 be a borderline personality disorder or an eating disorder.
29 They need to have a significant risk associated with that
30 presentation, either to themselves or to other people;
31 history of hospitalisation or presentation to emergency
32 department, and a significant impact on their ability to
33 live their usual life.
34
35 Q. Do they need to satisfy all of those criteria or just
36 some of those?
37 A. Pretty much all of those criteria.
38
39 Q. You've told us what a severe mental illness is for the
40 purpose of that criteria, you also said that Inner West is
41 only able to provide services to some but not all people
42 who have severe mental illness; is that right?
43 A. That's correct.
44
45 Q. Can you explain why that is?
46 A. So simply it's a case of funding, so our resources and
47 the population. So, at the Inner West and across Victoria

1 really it's estimated by academic epidemiologists that
2 we'll be seeing 30 per cent of people who have a severe
3 mental illness, and the other 70 per cent are not being
4 seen.
5
6 The other thing that has happened is that over time
7 our capacity to work with people over a long-term has
8 severely constricted, so we now see people for episodes of
9 care which would typically be from six to 12 months.
10
11 Q. What does that care involve?
12 A. So, that care would involve assessment, stabilisation
13 of acute symptoms and identifying recovery goals for the
14 person. Very unfortunately, by the time somebody's mental
15 state is at the point where they can actually start to
16 engage and work around their recovery goals, we are kind of
17 obliged to start looking at discharge and planning for
18 discharge, and so it does feel very much like we're
19 interrupting treatment just when we're getting started.
20 Because, I guess with severe mental illness, you do need a
21 longer period of treatment and care to effect change.
22
23 Q. Why do you say you're obliged to start thinking about
24 discharge?
25 A. I guess the issue is that, in order to take people in,
26 we need to have an exit point, and because the demand has
27 grown so much over the last 20 to 25 years, I guess we have
28 had to take more and more people out of the system to
29 accommodate people coming in.
30
31 Q. You've referred in your statement to the "revolving
32 door effect", what's the revolving door effect?
33 A. So that's something we're seeing more and more where
34 people come in for treatment, as I say, 6-12 months,
35 symptoms stabilised, referred out to a GP, and over time,
36 might be in the first year, might be over the second year,
37 relapse; come back to hospital via the ED or whatever way,
38 and then in for an inpatient stay, back out to the
39 community for another 6-12 months of treatment and then we
40 start all over again.
41
42 Q. And so, the episode of care is not sufficient for
43 recovery; is that what you mean?
44 A. No, it is not sufficient for recovery.
45
46 Q. Why is it insufficient?
47 A. As I say, you really need a longer period of time to

1 work with people who may be very demoralised, they may have
2 lots of issues around motivation, identifying recovery
3 goals and then starting to do some work to improve the
4 quality of life, particularly around relapse prevention;
5 that work is longer-term work.
6
7 You also need the opportunity for the person to start
8 to experience a relapse, which often happens with the
9 conditions that we treat, then to start to implement the
10 management strategies that we've suggested or that they've
11 identified are useful for themselves to thwart that
12 relapse, and that doesn't happen in a 6-12-month period.
13
14 Also, often people who are in our system have been
15 very isolated for a long period of time, and so, the work
16 is very gradual work getting them back into community, back
17 into services that they might be interested to use, and
18 yes, it just does take time.
19
20 Q. Can you describe an example, at a high level and,
21 please, in a way that doesn't identify anyone, of the
22 impact of this episodic nature of care?
23 A. Yes. So, I can think of a number of situations
24 actually where - and because I've been around for a long
25 time - where we've had a consumer who might have started
26 their work with the service, their treatment with the
27 service in their 20s; they've had a worker that they've had
28 a long-term relationship with, that might be for five or
29 more years. During that time, if there was the sort of
30 early signs of a relapse, that would have been picked up
31 really quickly and the need for hospitalisation wouldn't
32 have been there because there would have been adjustments
33 made to their treatment, extra support offered, and so,
34 there are numerous situations like that where people have
35 had five, eight years with maybe a two-week admission at
36 the most, and really that's a great outcome.
37
38 That person now, in the current regime, is still a
39 client of the service but they're referred out to the
40 primary care system. They'll see the GP for a while, they
41 might drop out of that treatment. They may start to
42 relapse and, because they may also be quite isolated,
43 that's not really picked up by other people. So, by the
44 time it gets to the point where maybe neighbours are
45 concerned, or the police have been involved, the person's
46 in a full-blown relapse, needs an admission to hospital.
47 They're often much longer admissions and often there's a

1 need for application of more restrictive interventions,
2 which we know are extremely traumatic for consumers, and
3 then they'll be referred after that longer admission back
4 for treatment and we start all over again.
5
6 So it's extremely difficult for consumers and it's
7 also very demoralising for staff to see people that they've
8 worked with for a long time in a kind of downward spiral,
9 with worse relapses, longer relapses and in more
10 deteriorated states.
11
12 Q. Just to clarify, how long ago was the first scenario
13 compared to the present situation?
14 A. Let's say, that's kind of 20 years ago.
15
16 Q. You also referred to the fact that some patients can
17 be treated by the service permanently.
18 A. Yes.
19
20 Q. What criteria do people need to satisfy to be a
21 permanent patient of your service?
22 A. So, they need to have what we would describe as
23 treatment-resistant symptoms, so that means that, despite
24 medication, despite ongoing support, they continue to
25 experience auditory hallucinations or delusions, and that
26 there's a risk attached to that, either to themselves or to
27 other people. They would typically have frequent relapses
28 and they would often have a lot of challenges with living
29 independently, and so for our client group that's about
30 10 per cent of our client group.
31
32 Q. Can you elaborate on why Inner West has very limited
33 capacity to treat people with milder forms of severe
34 illness or high prevalence disorders with acute
35 presentations?
36 A. The same issues, so it's around funding around our
37 resources and population growth.
38
39 We do have capacity, with the redesign of our
40 community service some time ago, we do have capacity to
41 offer what's described as a targeted brief intervention and
42 that's for people who might have an acute presentation or a
43 worsening presentation, and it's a support to primary care
44 providers in our area.
45
46 It means that the person will come in, they'll have a
47 comprehensive assessment that will cover a range of

1 different areas. We would try to have contact with any
2 family who were involved at that time. They would get some
3 support for a brief period, so that might be for four weeks
4 to three months, and they might have the opportunity to
5 participate in one of our shorter term group programs, like
6 our Wise Choices program which helps people with things
7 like emotional regulation, and then they'd be referred back
8 to the GP with a plan. But again, that is a very small
9 number of people compared to the people who are in the
10 population with high prevalence disorders.
11
12 Q. I do want to ask you shortly some more questions about
13 the community-based program, but before we get there can
14 you talk to us about supply and demand. So, you've said
15 supply is not meeting demand. What gaps and impacts have
16 you observed?
17 A. Okay, well, I'll talk about bed stock first of all.
18 So, I guess as a rule of thumb it would be suggested that
19 you would need 2.8 inpatient beds per 10,000 population.
20
21 Across NorthWestern Mental Health if you average it
22 out, we have 1.6 beds per 10,000 population, and at the
23 Royal Melbourne Hospital in the John Cade unit, we have
24 0.98 beds per 10,000.
25
26 So, bed resources are extremely restricted and as an
27 example of how that impacts on our kind of day-to-day
28 operations: every morning in the emergency department at
29 the Royal Melbourne Hospital there will be six to ten
30 people who have presented with mental health distress.
31 Probably about half of those will require an admission to
32 hospital. But we have very restricted resources so we've
33 got quite an elaborate arrangement now across NorthWestern
34 Mental Health where all of the services get together for a
35 conference call twice a day, one at 9 o'clock in the
36 morning and one at 3 in the afternoon, and so we have
37 between 15 and 18 people on the phone looking for, first of
38 all, how many beds have we got available, what's the demand
39 in each of the emergency departments and coming in from
40 communities, and then a kind of complex arrangement of
41 trying to work out who has the greatest priority to get
42 into a bed first.
43
44 Q. You said there's 15-18 people on that call?
45 A. Yes.
46
47 Q. What roles do they have?

1 A. They would be managers of - I should say, managers of
2 an inpatient unit, so they would be reporting on, within an
3 inpatient unit, how many vacancies there are or how many
4 discharges are coming up that day. They would be people
5 who are in the emergency mental health team reporting on
6 how many people are in the emergency department. There
7 would be area managers like myself and the bed access
8 coordinator and the interim - well, the Operations Director
9 for NorthWestern Mental Health.
10
11 Q. And the need is such that you need to have those calls
12 twice a day?
13 A. Twice a day.
14
15 Q. To try and place people in beds?
16 A. That's right. Then in addition to that we have, a lot
17 of the managers these days have an access portfolio, one
18 per service, and those people are involved in what we call
19 repatriating people. So, because things are so dire, I
20 guess when we have people who present who are not from the
21 area that the hospital is in, we will attempt to repatriate
22 them to the area they came from, whether that's another
23 part of Melbourne or whether it's a part of rural Victoria.
24
25 We also call on our neighbouring area mental health
26 services for assistance in kind of times of really acute
27 demand. So, for instance, there was closure of six beds at
28 Broadmeadows inpatient unit in the last couple of weeks,
29 and so, that meant we were really struggling. It is
30 actually really great to see the cooperation that you get
31 from other area mental health services when you're in a
32 situation like that and you need the beds, that people
33 often will put their hand up and try to assist.
34
35 But it's enormously - like there's a well developed
36 system and people do a really great job with it, but it
37 shouldn't have to be that hard.
38
39 I might talk a little bit about community next.
40
41 Q. Yes, we'll come to community, I want to ask you some
42 more about the beds though.
43 A. Sure.
44
45 Q. Of the six to ten people who are presenting each day,
46 who gets the beds, how do you decide?
47 A. So, it's a combination of, who has the greatest risk

1 and who has been there the longest, because we don't want
2 people staying there for a long time without treatment,
3 without having commenced treatment.
4
5 Q. When you say "there", do you mean in the emergency?
6 A. In the emergency department.
7
8 Q. So, the longer you've been waiting?
9 A. Yeah.
10
11 Q. And the risk to yourself and others?
12 A. Yes.
13
14 Q. Is a factor in terms of who gets the bed?
15 A. Absolutely. You can imagine, if you've got mental
16 distress and you're in an emergency department, that's not
17 a very kind of comfortable environment.
18
19 Q. You were talking about the beds in terms of gaps that
20 you observed. Can you talk to us about the culturally
21 responsible services being eroded. These are in response
22 to gaps that you've observed supply not meeting demand?
23 A. Culturally responsive?
24
25 Q. Yes, so particularly in relation to Aboriginal and
26 Torres Strait Islander people?
27 A. Thank you for that hint. Yes, so I guess we've
28 observed a number of clinical gaps. And amongst those a
29 real key one is Aboriginal and Torres Strait Islander
30 background people. So, we know that there's really high
31 rates of mental distress and suicide for indigenous people,
32 but we have very little developed that's actually
33 culturally sensitive.
34
35 There are a few services; so, the Northern Area Mental
36 Health Service for instance has some really great programs
37 that they've started there. But elsewhere there's been
38 very little done. At the Inner West we're trying to
39 recruit an Aboriginal mental health clinician for one of
40 our homeless teams at the moment; that's the first attempt
41 that we've made in that area, so there's a heap that needs
42 to be done in that area.
43
44 Q. You've also referred in your statement to there being:
45
46 "... insufficient resources and capacity to
47 work with people with comorbid alcohol and

1 others drugs issues, or forensic issues."
2
3 Can you talk to us about the gaps that you've observed
4 in those scenarios?
5 A. Sure. So, in relation to alcohol and other drugs,
6 probably around about 40 per cent of people who have a
7 severe mental illness also have a substance misuse or
8 dependence problem, and so, helping them with that problem
9 if they want the help is a really kind of important thing
10 to be able to do, but we don't really have the capability
11 amongst our mental health workforce.
12
13 At the Inner West, we have had a little bit of
14 community growth and we're able to use that to employ
15 alcohol and other drug clinicians who had, as kind of I
16 guess a blended role into our three community teams, and
17 that's been fantastic, it's great for capacity building.
18 But I know that doesn't happen universally; in fact the
19 other area mental health services within NorthWestern
20 Mental Health have access to a 0.03 position.
21
22 Q. A 0.3 FTE position, is that what you mean?
23 A. That's correct. It's simply not adequate. When
24 you've got a lot of complexity you need to be multiply
25 capable and we're not designed like that.
26
27 Q. You've also highlighted that a gap is the consumer and
28 carer peer support workforce and that's something you're
29 developing.
30 A. Yeah, so that's been a really great development over
31 the last few years, is expanding our consumer and carer
32 lived experience workforce because we know that's one of
33 the most powerful interventions that we can offer, but we
34 need to do more of that, we need a bigger workforce and we
35 also need good systems to sustain that workforce.
36
37 It's a very new workforce, and so, there's quite a lot
38 that we're learning as we're going along, but definitely we
39 need to develop those support structures.
40
41 Q. I will come to community services, but I just want to
42 focus on the demand and the unmet need before we get there.
43 Can you explain to the Commission, elaborate on the points
44 you've raised in terms of there being unmet need and which
45 needs are the most critical, starting with the issue of the
46 needing to provide services to a larger proportion of the
47 group of people with severe and enduring conditions for

1 longer periods of time.
2 A. That seems to be the most critical gap because, as I
3 mentioned, we're in this kind of revolving cycle at the
4 moment and people aren't getting the opportunity to make
5 their own kind of personal recovery with the support of a
6 clinical team.
7
8 So really, we need significantly more resources to
9 broaden the number of people that we can work with and to
10 be able to do that for the duration that's required and
11 with the frequency that's required.
12
13 I guess, as people are kind of terminating, coming to
14 the termination of their short episode of care we also tend
15 to stagger out the appointments so that they might go from
16 fortnightly appointments to monthly appointments, and
17 again, it's really not enough for somebody's who's been
18 acutely unwell for six months or in the last 12-month
19 period, so that's a really critical demand.
20
21 Q. One of the strategies you've adopted is to integrate
22 your Crisis Assessment and Treatment Team, the Mobile
23 Support and Treatment Teams and the Continuing Care Teams.
24 Can you talk about that integration and what impact that's
25 had in terms of accessing services?
26 A. So, in 2013 NorthWestern Mental Health undertook a
27 redesign of its community services, and that was in
28 response to feedback that we'd had from consumers and
29 carers that they didn't feel like they were being heard,
30 that there was lots of fragmentation and there was massive
31 duplication of assessment.
32
33 An example of that would be, if you're in a Continuing
34 Care Team and your mental state deteriorated and you needed
35 some more acute care, you'd be referred to the CAT Team.
36 It would be a completely different team of people. You
37 would have another assessment and then you would have a
38 period of treatment there, then be referred back to your
39 Continuing Care Team to continue on.
40
41 So, we felt that it was really important to have much
42 more consistent care with the same team of people, and so,
43 that was where we came to in terms of integrating our
44 services.
45
46 The other issue was that there was very variable
47 workloads between those teams. So, there might be a

1 caseload of 50 - total caseload of 50 in some of those
2 teams while the Continuing Care Team had a caseload of 400
3 people and caseloads of 40-plus people, which is really
4 just unsustainable. So, that redevelopment allowed us the
5 opportunity to smooth out some of that variability in the
6 work to the point that these days the highest caseload is
7 actually 18 people per worker, which means that there's
8 much greater capacity to do quality work.
9
10 In terms of the access issues though, it hasn't
11 significantly assisted us with that because we still have -
12 I mean, that's allowing us to provide better quality of
13 work but our resources haven't increased significantly over
14 probably ten, 15 years, so we still have a pretty static
15 resource.
16
17 Q. Does that mean that you're providing better quality
18 treatment to the existing client base?
19 A. That's correct.
20
21 Q. But there's no capacity to take on more people?
22 A. To do more, not without blowing out our caseloads
23 again.
24
25 Q. Okay, I follow. I'd like to ask you some questions
26 about the emergency departments. You refer to there being
27 a very significant increase in people seeking to access the
28 mental health system through ED?
29 A. Yes.
30
31 Q. First of all can you explain what the increase is?
32 A. Yes. So, in 2011 we had around about 700 people
33 attend the emergency department who were assessed by the
34 emergency mental health team. That figure has increased
35 substantially over time to - there was a big spike in 2015
36 and it went up to about 2,000 people, and then it's
37 increased year-on-year for the last four years by about
38 20 per cent. And at the close of this financial year it
39 was 3,900 people who were assessed in our emergency
40 department, which is a pretty staggering figure, without a
41 significant increase in our emergency mental health
42 clinicians.
43
44 Q. I was going to say, has there been a comparable
45 increase in workforce to deal with that demand?
46 A. No. What happened was that we used some community
47 growth a couple of years ago to create a program called

1 Engage, and that was for people who were attending the
2 emergency department with a suicidal crisis who, after
3 perhaps the next day; perhaps they'd been intoxicated,
4 perhaps the next day it was deemed that they were safe to
5 go home. In the past there was no follow-up for that
6 cohort of people which was a grave concern to us.
7
8 So, we used that community growth to create the Engage
9 program with the idea that the clinician will contact the
10 person the next day, check in that they're travelling okay,
11 see if they've got any support needs, make sure that things
12 are on track with connecting with a community service
13 provider.
14
15 So we had about four EFT attached to that team, but
16 because of the demand we've had to shift that to
17 assessments and we now have one clinician who just does
18 phone interviewing and he probably - or phone contact,
19 post-discharge contact, and he probably only manages to
20 catch about half of the people.
21
22 Q. Do you have a view about why there has been such an
23 increase in presentations to the ED?
24 A. I think it's probably a combination of population
25 growth. So, we know the City of Melbourne from 2011-2018
26 had a 60 per cent growth in population, so that's some of
27 it.
28
29 But I think otherwise I think it's just that it is, as
30 other people have said, an accessible way to get a mental
31 health assessment. You don't have to wait for an
32 assessment at a community clinic, you can pretty much get
33 assessed within the day that you present, and also for
34 people who have been rejected from clinics, that's a way
35 that they can get an assessment. So, I think word has kind
36 of got around about that, but it is the only place that is
37 open 24 hours a day, seven days a week.
38
39 Q. You said in your statement that EDs are not an
40 appropriate setting for assessing people who are seeking to
41 access the mental health system. Can you explain why you
42 hold that view?
43 A. So, they're very kind of cold, clinical environments,
44 they can be very noisy, and when you're having mental
45 distress being in that kind of environment is not conducive
46 to feeling any better about things. So, I guess that's
47 kind of the main issue.

1
2 There are some options that we're looking into. So, we have recently received funding for a crisis hub that will be at the Royal Melbourne Hospital and one of the things that we're going to implement is called the Safe Haven Café, which is a model that was developed in the UK, and there's a trial at St V's - it's not a trial, it's actually going on. Excuse me, I'll have a drink. That aims to provide a much more comfortable environment. So there are lounge chairs, there's soft lighting, there are peer clinicians, peer workers and mental health clinicians, and so, the person can be escorted from the emergency department over to the café to a much more comfortable environment and talk with the staff there about what's going on for them and trying to make some connections in the community.

That's proving to be a really kind of - I think a much better way and a much better environment to work with people.

Q. And that trial has started?
A. St Vincent's has been going for around about a year I think, and we'll be starting later this year.

Q. What hours will that operate, do you know?
A. At St Vincent's and for us, first of all it will be over the weekend when we know there aren't other services open, so that will be Friday, Saturday and Sunday, 2-8pm, but we're hoping to expand that to seven days a week.

Q. How are people who present to the ED with suicidal presentations supported?
A. So, at the moment they would typically wait for an assessment. They would have an assessment with the emergency mental health clinician. If it was deemed that there was a significant and imminent risk of suicide they would be allocated for admission to hospital.

If it was more in the context of a situational crisis or in the context of intoxication it would be looked at over time, so the person might stay a bit longer and, yes, may well be discharged home.

Q. Is the triage service coping with demand?
A. No. The centralised triage has also not had any growth over a long period of time, and so, there's a lot

1 of - there's been a lot of demand for calls. So, at the
2 moment it's a 30 minute wait is the average time to get on
3 to someone. You can imagine in a mental health crisis
4 situation that's not a very good situation, and we have
5 very high call abandonment rates.
6
7 Q. You've stated that the clinical mental health services
8 are increasingly crisis-driven. Can you please explain in
9 what respects it's increasingly crisis-driven and what
10 impacts that has on the type of treatment you're able to
11 provide?
12 A. I think, really, from community and then into the
13 inpatient unit. So, in our inpatient units there's been a
14 lot of demand there. So, another kind of statistic that's
15 of interest is that, back in 2014, I think, the length of
16 stay was 14.7 days. And 2018 it had gone down to 9.6 and
17 for Inner West our KPI from the last quarter was 9.1. So,
18 we have shorter and shorter admissions, which means that
19 people are coming out of hospital more unwell, and so, the
20 community service has necessarily needed to focus more on
21 that work, which means that recovery work kind of gets put
22 on the backburner. It takes longer to get to that.
23
24 I guess another impact is that sometimes, if there is
25 a lot of acuity happening in the community and there's a
26 need to do, say, a home visit, then that means grabbing
27 another worker and getting in a car, which often means
28 cancelling appointments that might have been recovery
29 appointments, so there's those kinds of effects.
30
31 Q. I'd like to ask you about community-based care. We
32 have a slide that is an "Adult Community Service Practice
33 Guide".
34 A. Yes.
35
36 Q. We might pull that up on the screen, please.
37 [MEH.0001.0001.0009] Can you tell the Commission about how
38 Inner West delivers community-based care?
39 A. Sure. So, I've talked about the integration of the
40 teams and that was a really important thing to do from the
41 perspective of having manageable caseloads, better
42 integration, consistency of clinicians. And it also
43 produced some significant culture change that was important
44 for the service.
45
46 But I think reflecting --
47

1 Q. Just before you go on, can you tell us about the
2 culture change, what kind of culture change?
3 A. I guess, we've had a system for a long time which was
4 kind of fit for purpose 20 years ago, but has over time
5 become - like, it was a great model when it started in
6 terms of having a team for doing some specialist rehab, a
7 team for doing some acute work. That worked for a time,
8 but over time those teams became very siloed and it
9 actually became very difficult to make an internal
10 referral. So, not only was it hard for consumers to get
11 in, it was hard for clinicians to refer between the teams,
12 so that's the kind of cultural change I'm talking about.
13
14 Q. Okay, thank you.
15 A. So, that has definitely shifted. But the bigger
16 change and more fundamental change was really around our
17 practice, and so, I guess the thing to say there is that,
18 there's a lot of evidence, there's a lot of concern, not
19 just in Victoria and Australia, but worldwide about poor
20 outcomes for people particularly with schizophrenia. We
21 know that there's poor physical health outcomes and
22 premature morbidity, there's workforce participation
23 issues, there's a lot of social isolation. Quality of life
24 is deteriorating, and of course in those situations there's
25 much higher suicide risk.
26
27 And at the same time we know that there are
28 evidence-based treatments that can support those things
29 that can help reduce relapse rates and improve quality of
30 life very significantly but - and again, it's a worldwide
31 thing - there's extremely minimal uptake of those
32 psycho-social interventions.
33
34 And so, I guess the point of the practice change for
35 us was to start to embed more of those psychosocial
36 interventions in the work that we are doing.
37
38 Q. Why has there been such a low uptake of the
39 psycho-social interventions, do you have any views on that?
40 A. I think implementation of any change is really hard in
41 mental health services, or in any health service, but I
42 think particularly the fact that we don't actually have a
43 framework behind things.
44
45 So a very typical scenario would be that you might
46 have one or two very enthusiastic clinicians who are keen
47 to start some program that had an evidence base, and they

1 get working on it and it would go on swimmingly for a
2 couple of years, but then the clinicians leave and the
3 program falls over. So, the problem is that there isn't a
4 framework, a foundation, that's embedded in the system that
5 keeps things going. And so, this is really our opportunity
6 to try to do something differently with that.
7
8 So, the document that I had --
9
10 Q. We might pull it back up on the screen, the practice
11 guideline.
12 A. The other thing is that there's lots of clinical
13 guidelines, international clinical guidelines that say we
14 should be doing more psychological work, we should be
15 working more with families and carers, we should be doing
16 peer work, and so the recommendations are there but, as I
17 say, not taken up. So, this guideline took into account
18 information from those guidelines, so it kind of condensed
19 it, plus our sort of practice wisdom and it was put
20 together by our most senior professional staff and academic
21 staff, and it's a fantastic resource.
22
23 So that's it there, it's a great document. From that,
24 we at the Inner West identified the practice domains that
25 we wanted to implement, and so, there are six domains. It
26 might be good to pull up the other slide now.
27
28 Q. If we may, the second slide, the "Working towards
29 recovery with evidence-based interventions."
30 [MEH.0001.0001.0122]
31 A. In this slide you can see that there are six areas of
32 intervention: psychological interventions, family and carer
33 work, health and wellbeing, vocation, lived experience and
34 overcoming hurdles, which really refers to working with
35 people with substance dependence issues and people with
36 forensic problems.
37
38 Q. Ms Bradley, can I just pause you. Would you mind just
39 going through each of the different evidence-based
40 interventions and just at a high level explaining what they
41 are and what you're trying to do?
42 A. Yes. You will see there's a heavy line through the
43 middle of that table and above that line are what we call
44 our core interventions and these are either conversations
45 or mini assessments that we want all of our consumers to
46 have exposure to in the first six to 12 weeks of treatment.
47

1 So, for instance, we want, in the area of family work,
2 we want contact with the family to occur within six weeks
3 of treatment. In the area of lived experience we want
4 there to have been a conversation with a peer support
5 worker about what peer support options are available within
6 the first few weeks of engagement.
7
8 There's the APQ 6, which is the activity and
9 participation questionnaire, which is a simple tool which
10 the clinician goes through with the consumer to identify
11 what their interests are, whether they've got an interest
12 in employment, those kinds of things.
13
14 And psychological interventions, the two kind of core
15 things there are Early Warning Signs Program and CBT
16 Fundamentals, Cognitive Behavioural Therapy Fundamentals,
17 which refers to a kind of mini suite of interventions that
18 all clinicians are trained in.
19
20 So we want all clinicians to deliver those core
21 interventions, and then depending on what comes from those
22 conversations, the interventions below the heavy line are
23 what we call our specific interventions.
24
25 So, within the psychological interventions area one
26 program is cognitive behavioural therapy for psychosis,
27 which helps people live with voices. There are therapies
28 for comorbid anxiety and depression which often occur with
29 psychotic illnesses.
30
31 In the family area we want everyone to have had a
32 single session of family consultation, so we have a
33 relationship with Bouverie Family Therapy. We've trained
34 our staff in those interventions which really is
35 identifying what are the family carer support needs that we
36 should be looking at.
37
38 We have an evidence-based multiple family group which
39 brings the consumer and their family together, six to seven
40 consumers, and they work looking at problem solving
41 together and psycho-education together, and there's a lot
42 of mutual social support, and that's been proven to be
43 effective in reducing symptoms and relapse rates.
44
45 In the area of physical health we have a range of
46 different programs, but I guess one thing that's been very
47 effective I think is a bunch of wellness activities. So,

1 there's things like a walking group that was very popular
2 so that's been duplicated, there are two walking groups
3 that happen every week. There's a swim/gym group. There's
4 soccer, there's a soccer club. So, I guess just kind of
5 opportunities for people to not only be looking at their
6 physical health but also having connection opportunities
7 with other consumers which has I think been a really
8 fantastic benefit of that program.
9
10 We work with people on their vocational goals. So, I
11 guess one of the issues for us is that we know trying to
12 refer to employment services; the employment services that
13 are out in the community aren't typically evidence-based.
14 The main evidence-based practice is individual placement
15 support, where you find a job that a consumer wants to do
16 and support them actively while they're doing that job and
17 you work with the employer. That's not available
18 externally so we brought that into the service.
19
20 We have our Lived Experience Program which includes
21 peer zone, that's an entirely peer led program developed by
22 Mary O'Hagan in New Zealand and it offers recovery modules
23 for consumers and we have individual support. Then there
24 are a range of things we can do around overcoming hurdles,
25 supporting people through motivation interviewing, those
26 kinds of things.
27
28 Q. For some of those, you said that you wanted the person
29 to engage with them in 6-12 weeks. What's the rationale
30 behind the 6-12 weeks?
31 A. Well, we want them to start early but we also
32 recognise that it takes a little bit of time to get to know
33 someone, so we want that relationship to have developed
34 sufficiently as the kind of recovery goals are being
35 discussed along the way.
36
37 Q. You explained at a high level the challenges with
38 implementing an evidence program from a frameworks
39 perspective. Have there become challenges at a practical
40 level trying to implement it on the ground?
41 A. Yes. So, this was a very ambitious program and so we
42 used reliability methodology and we made lots of system
43 changes.
44
45 So, as an example, in relation to workforce, one thing
46 I hadn't mentioned is that the main mode of kind of work in
47 Victoria is through medical appointments and case

1 management. And case management is very good at keeping
2 people in touch with services but it doesn't have an
3 evidence base around improving quality of life or relapse
4 reductions.
5
6 So, we as a kind of symbolic exercise, we have
7 rebranded the case management role to be a key clinician,
8 which is also acknowledging the professional background of
9 the staff that we employ. So, we employ psychiatric
10 nurses, OTs, psychologists, social workers who have a raft
11 of skills and expertise, but was being under-utilised in
12 the previous kind of framework.
13
14 We've changed all our position descriptions, so I
15 guess the overall plan with reliability methodologies is
16 that everywhere you look you should see something that
17 reflects the change that you're trying to implement. So
18 all of our position descriptions include the statement that
19 we work from an evidence-based framework and that way we
20 hope to attract people who are interested in that kind of
21 work, and we attach this poster to our position
22 descriptions.
23
24 Also around workforce, we have found it really useful
25 to recruit some other kinds of roles that can support the
26 domains. For instance, we've employed an employment
27 consultant who works within the team. We have an exercise
28 physiologist who's also a yoga instructor, and so, she does
29 exercise physiology work with consumers in the community,
30 but she also runs a yoga class on our inpatient unit.
31
32 We've employed a bunch of blended roles, so that is
33 where they have a mixture of a kind of mental health key
34 clinician role plus another speciality. So, that's what we
35 did with our alcohol and other drug roles, and we've also
36 done that for treatment of eating disorders. So, we've got
37 in people who are key clinicians but they also have the
38 portfolio of eating disorders. That supports both
39 provision of the treatment directly but also capacity
40 building within the teams.
41
42 We've recently recruited a dietician also to support
43 the program. Then there are some other people who have
44 kind of portfolios embedded in their position description.
45 Like, there is a psychologist who is responsible for our
46 Early Warning Signs Relapse Prevention Program.
47

1 So that's kind of some of the workforce changes. In
2 terms of the support to the staff, we knew that was going
3 to be a really important thing to invest in heavily, so we
4 recruited a practice development manager part-time, and we
5 also contracted experts in some of these interventions to
6 come in and provide monthly supervision groups for the
7 staff.
8
9 We've revamped our professional development calendar,
10 so that aligns with this, and we also have a clinical
11 showcase day where we show our work between the teams to
12 each other.
13
14 Then the next kind of raft of changes was around
15 monitoring and measuring how we're doing, so we introduced
16 a range of different ways of doing that. So, we monitor
17 both the core interventions to see how we're going over
18 time with implementing those, and also the specific
19 interventions, which we monitor through contacts and
20 that's - what happens is that, every time a clinician has
21 contact with a consumer or a carer, they are required to
22 document that contact and that's data that goes into the
23 department and we have research field in there that we use
24 with codes for each of these interventions.
25
26 Q. Sorry, why does it go into the department?
27 A. This is part of their general measurement of what's
28 happening in services. So, every area in mental health
29 services submits contact data to the department.
30
31 In addition to those monitoring systems we have done
32 quite a bit of qualitative evaluation as well. So, for
33 instance, the single session family consultations, we have
34 - some of our care peer support workers have done
35 qualitative follow up with people who've attended those
36 sessions to see how they've found it, and we get absolutely
37 fantastic feedback about that.
38
39 Then we've had a raft of accountability interventions
40 as well. So, myself and Ricky Yeatman, our Director of
41 Clinical Services, we meet with the program manager and
42 lead consultant for each of the programs and we do that on
43 a quarterly basis and we review their live data with them.
44 So, they can see, this is what we're looking at, this is
45 what's important for the service, and they get to give us
46 feedback about how they think it's going, where they might
47 need some support, those kind of things.

1
2 We also changed our clinical quality meeting so that
3 it is much more focused on the domain. So, at that meeting
4 each of the programs across the service have the
5 opportunity to talk about what's happening and they also
6 talk about what's going on in relation to these domains.
7
8 That's been one of the fantastic things over the last
9 12 months, is that, we started this in community and we've
10 kind of - we're about four years into that now. And it's
11 now kind of shifted over to our residential services and
12 our inpatient unit, so there's been a lot of - I think
13 people can see this makes a lot of sense and they want to
14 get involved with it, so that's been really fantastic.
15
16 I guess, just in terms of some outcomes, we are seeing
17 kind of progressive - and we know it's going to be slow
18 because we expect that, that's how it goes, we know these
19 things take time - but in relation to the core
20 interventions, they've been steadily increasing.
21
22 So at this point we know that 70 per cent of everybody
23 who comes in who has a family member involved, there's been
24 contact with that carer within the first six weeks. And if
25 you compare that to five years ago there was no way
26 anything like that level of activity was happening.
27
28 Our employment area: we had a 12 per cent employment
29 workforce participation rate, which was way worse than even
30 internationally, it's about 18 per cent. In the first year
31 that we had our employment consultant working, there were
32 30 people who got into paid employment, there were another
33 30 people who got into voluntary employment or training,
34 and a raft of people who are considering employment and can
35 participate in one of our pre-employment groups, which is
36 called The Works.
37
38 Our Lived Experience Program, that's been going really
39 well, we get fantastic feedback about that. I guess maybe
40 just a little story about one of the areas in terms of
41 psychological interventions, just the power of that.
42
43 So, our Early Warning Signs Program, there's a not
44 uncommon situation has occurred, I guess, where we might
45 have somebody who has had a lifetime of - adult lifetime of
46 relapses every 12-18 months, severe relapses requiring
47 hospitalisation. They do the Early Warning Signs Program,

1 model developed in the UK, which helps them identify
2 whether they have any vulnerable times of the year, whether
3 there's any seasonal things that affect them. We look at
4 exactly the symptoms that they experience, we know what the
5 common kind of prodromal symptoms are, we go through those
6 but then sort of individualise it to the person, and then
7 we work out the top three of those very early warning signs
8 and then what you do if that happens in terms of getting
9 extra support.
10
11 I know for at least two people who have had that
12 pattern of relapses every year, they did that program and
13 have never had another relapse, and are working and they've
14 repaired relationships with families, all those sorts of
15 things.
16
17 I guess that's the other point we need to be really
18 aware of, is that relapse has a really kind of powerful
19 impact, personal impact and cost for people in terms of
20 both hospitalisation risk, but also disruption of
21 relationships, disruption of work or study, so we want to
22 do as much as we can to prevent that.
23
24 Q. In terms of delivering this program, how have you been
25 able to deliver it in terms of the crisis demand? Has that
26 impeded on your ability to deliver it or is it immune from
27 the crisis demand?
28 A. So, we do our crisis work now within the team. So, as
29 I said, there are three community teams, and the two that
30 are based at Moonee Ponds, they take it in turns, so they
31 do a week - they alternate weekly. So, there are people on
32 between 8.30 in the morning and 9 o'clock at night, so
33 there will be two clinicians on each of those shifts and
34 they look at all of the crisis demand that's coming in to
35 the service. So, they might do outreach assessments, they
36 might see people at the clinic. The thing that works
37 really well with that is that, once that person's been
38 assessed by that team, they go straight into that team, and
39 so they're absorbed into the team for both that period of
40 acute work but also the ongoing work around recovery.
41
42 It is again, I think because of lack of resources,
43 there's no doubt that the recovery work can get disrupted,
44 and so I think we just do need more resources to be able to
45 do things more effectively without that acute disruption.
46
47 Q. I have two more topics to cover with you. The first

1 one relates to system and then the final one is reform.
2 First into systems: can you explain the key barriers to
3 appropriate treatment from a systems perspective?
4 A. So, putting aside resources, et cetera, one of the
5 things that has occurred for us is that, at the same time
6 we haven't received funding to support our service, there's
7 been a lot of community support withdrawn.
8
9 A really important area for us because we have a big
10 homeless population is in housing. Over time, perhaps last
11 10-15 years, a lot of rooming houses and things like that
12 have closed down because they were substandard so that's
13 fair enough, but nothing went in their place. So, we've
14 seen that there's been increasing homeless people in the
15 Melbourne CBD. So, we know from City of Melbourne street
16 count that number increases every year.
17
18 I heard a really startling statistic the other day
19 from one of our homeless agency partners, it's one of the
20 crisis accommodation access points, who told me that
21 they're sending away 218 people every night who need crisis
22 accommodation. So, that is a really big issue for us.
23
24 One thing that's worked really well for the
25 partnership program that we have is that we're bringing
26 some of that expertise and access into the team. So, the
27 HOMS program has clinical staff, they have cohealth, care
28 coordinators, there's a Launch housing worker, there's a
29 women's worker, and that means that we can make sure that
30 all of those things are embedded in the team and we get
31 quick access to it.
32
33 I guess the same is true for our practice domains.
34 Bringing in different things like the exercise
35 physiologist. That means that people who may have been
36 intimidated about going to a gym, they can go with a group
37 of people with the exercise physiologist and that's kind of
38 a bridge.
39
40 So I think the more that we can do around blended
41 teams bringing expertise in that we need, the better, so
42 that's a big kind of systems issue.
43
44 I guess the other thing is that, there was hope that,
45 with mainstreaming of services many years ago now, that
46 we'd have much greater integration of physical and mental
47 health support, but I guess that hasn't really happened and

1 that's been a little disappointing.
2
3 Q. You've referred to the workforce and the types of
4 roles that you need. Can you just comment on the budget
5 for capital infrastructure and where that comes from?
6 A. Yes. So, we have a capital budget. Unfortunately
7 18 months ago it was halved, and so, that's meant that -
8 well, first of all it's meant that our services are looking
9 really shabby. It was a bit shocking going back to Waratah
10 the other day and seeing the state of the carpet. And you
11 think, this actually doesn't imbue a sense of hope or
12 progress having kind of shabby buildings around you.
13
14 The other thing that's happened is that, when there's
15 really kind of expensive things that need to be done, that
16 has tended to come out of staffing resources because we
17 simply don't have the capital resources that we need. And
18 so it's meant things like, we have to hold back on filling
19 vacancies, hold positions over to be able to support both
20 our staffing and physical structure resources.
21
22 Q. The final topic I want to ask you about is reform.
23 So, first, can you give us your views on what trends have
24 impacted on community needs since de-institutionalisation
25 in the 1990s. So, what's been happening, what are the
26 trends?
27 A. I think the trend that I'm kind of most aware of is
28 the increasing complexity, which I think is just reflecting
29 the fact that we don't have good services available for the
30 duration that we need to support people with their
31 recovery. And so, when people get hopeless and
32 demoralised, then they turn to substances often, and that
33 creates all kinds of issues.
34
35 I think also we've seen a really big change in terms
36 of ice use and people presenting with all kinds of issues
37 around that. And then, once we've got people who have got
38 substance use issues, then often that results in them
39 getting into crime and ending up being incarcerated. So,
40 like in other parts of the world, increasingly we're seeing
41 people with mental health issues being incarcerated. And,
42 while they're in prison they often don't have any
43 treatment, so when they come out they're very often very
44 unwell, so that kind of situation is really pretty
45 appalling and feels like it's not going anywhere fast.
46
47 Other trends - I mean, people were talking earlier

1 about relationship, and that is certainly something that's
2 much harder to use as one of your kind of tools to support
3 people. The fact that we have these shorter episodes means
4 that people don't have the sort of support, they don't have
5 the long-term relationships with people who know them
6 incredibly well, who can pick up on things that might be
7 changing for them and respond appropriately to that, so
8 that's another big change.
9
10 Q. I want to ask you about accountability. You've said
11 in your statement:
12
13 "To support the shift in focus to, and the
14 implementation of, evidence-based practices
15 services need greater funding to enable
16 necessary changes to their workforce and
17 accountability structures."
18
19 You spoke a little bit about the accountability
20 structures that you've put in, in terms of the new practice
21 model. Do you have views about the accountability
22 structures at a system level?
23 A. M'hmm. So, it's been one of the most important tools
24 that we had, to start of let people know that this is what
25 we're paying attention to. We think that it would be
26 really useful for the department to have a much greater
27 role in relation to accountability with services, and by
28 that I mean both in terms of things like making investment
29 of resources dependent on services being able to
30 demonstrate that they're providing recovery-focused,
31 evidence-based care. That's a hugely powerful incentive
32 for services.
33
34 The other thing is that, some time ago we used to get
35 visits out from the department. So, the office of the
36 Chief Psychiatrist Team would come out and look at the
37 service about some issue or another, and it made us feel
38 like we were in connection, that they knew what was going
39 on. We don't really have that now, so I think that's
40 another opportunity that can come out of this Commission,
41 is thinking about a strengthened role for the department
42 with services and a real relationship where they understand
43 the challenges that we're dealing with and are able to
44 support us with that. But also, that we're more
45 accountable to them for actually what it is that we're
46 providing in terms of the quality of the treatment.
47

1 MS BATTEN: Thank you very much, Ms Bradley. Unless
2 there's anything further, I'll ask the Commissioners if
3 they have any questions for you.
4
5 Chair, are there any questions for Ms Bradley?
6
7 COMMISSIONER McSHERRY: Q. I was interested that you
8 mentioned the outsourcing of psychosocial services as a
9 trend that had occurred. Could you perhaps explain a
10 little bit about that?
11 A. Sure. Two issues: one is that, it must have been -
12 I'm not actually sure how long ago, at least 15 years ago -
13 there was a division whereby it was decided that the then
14 PDRS service, which is our kind of psychosocial support
15 service, would take over psychosocial treatment of people
16 with severe mental illnesses, and that the clinical
17 services would focus on the clinical interventions.
18
19 I think that was a very big backward step because it
20 meant that we had lots of professional staff who weren't
21 able to use their skills, and it meant that our service did
22 become far more pharmacologically driven, and that we lost
23 a lot of people along the way with that. Consumers kind of
24 disengaged from us because they didn't feel like they were
25 getting much more than pharmacology and medical support.
26
27 So, yeah, that feels like that was a big backward
28 step, and it's good to feel like we're kind of clawing that
29 back now. I guess the other thing that I guess is worth
30 mentioning and I haven't had an opportunity to address too,
31 is just the irregularity of funding.
32
33 About maybe two years ago that service - PDRS, which
34 then turned into Mental Health Community Support Services -
35 they were eventually defunded, because it was thought that
36 the NDIS would provide what was being provided by that
37 service. That hasn't proven to be the case. The NDIS is
38 very good with practical support, but complex psychosocial
39 support, not so much.
40
41 The department's realised that that's created a big
42 gap and they have funded a psychosocial response and those
43 organisations were able to tender for that. But the
44 funding is only for two years, and so, it's kind of well -
45 yeah.
46
47 The other thing that happens for us, is that, there

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1 was HOMS, our homeless program in the CBD; that was
2 initially funded Federally for four years. It demonstrated
3 that it was effective but, because the Federal Government
4 didn't continue on that funding, every year we have to have
5 a kind of massive lobby of the department to continue that
6 funding. And, that's happened for three years in a row
7 now: every year we've been able to get the funding - we
8 just heard last month that we'd be getting it for
9 another year.
10
11 It's very frustrating, it's also very risky because
12 one of the times that happened we lost nearly half of that
13 team, because they're not going to hang around and wait to
14 see what happens, they need employment and so they left,
15 and so we had to start from scratch, and so, this kind of
16 intermittent funding is quite problematic for services.
17
18 Q. Just one other question. You mentioned in your
19 statement that the acute inpatient unit has one of the
20 highest staff turnover rates in health services in
21 Victoria.
22 A. Yes.
23
24 Q. You've also mentioned that:
25
26 "As recently as three years ago we
27 experienced a maximum of 3-4 code greys,
28 that is, a psychiatric behavioural
29 emergency within the clinic per year, and
30 now that occurs 2-3 times per week."
31
32 A. Yes.
33
34 Q. So, what's the major driver of that change, because it
35 seems that you can't attract a workforce if it's --
36 A. It's very hard.
37
38 Q. -- going to be managing risk the whole time. Is it
39 because of increased drug use, or is it also because of the
40 lack of capital expenditure, that you just don't have
41 inpatient units that modify behaviour?
42 A. Yeah, I think it's a combination of all of those
43 things. Our inpatient service is really focused on just
44 getting on top of the most, most acute symptoms. We also
45 have, I guess, the issue of incarceration: we have a lot of
46 people coming out of prisons and being brought straight to
47 the inpatient unit. I think that has a really significant

1 impact, particularly when you have two people who have just
2 come out of prison at the same time need to be in a secure
3 environment, and they're very unwell and they may have a
4 history of violence or aggression. Then we have a very
5 young workforce, mostly female, it's really hard to hold
6 onto staff in that situation, because people get scared and
7 so they leave.
8
9 In the community I think again it's this kind of
10 gradual erosion of the quality of the treatment, that
11 people aren't getting better, people get demoralised. Some
12 people are on compulsory treatment, and they do not like
13 that, and so - and there's a lot of methamphetamine use.
14 And so, that's one of the main drivers actually,
15 particularly of community issues around either property
16 damage or other kinds of environmental emergencies, yeah.
17
18 CHAIR: Q. I just have one other question I'd like to
19 ask. You do note the fact that there has been, amongst
20 those changes I think linked to those psychosocial supports
21 and other things no longer being available than they had
22 been in the past, you talk about the closure of drop-in
23 centres that had been operated which were considered
24 marginalising and contributing to social isolation.
25
26 Can you talk about the role that drop-in centres have
27 played in the past and what the substitute is for them now,
28 if any?
29 A. Yeah, so I guess that was probably a disagreement that
30 clinical services had with some of our mental health
31 partners, community partners. I understand that they were
32 coming from the perspective of maximising people's
33 independence and trying to reduce marginalisation and
34 stigma, and so, therefore not having special centres for
35 people with mental health conditions.
36
37 And so, the idea there was that, so they stopped some
38 of those drop-in centres, and the thought was that people
39 could join neighbourhood houses or other places where they
40 could access those kinds of activities and services, but
41 that didn't kind of pan out in the most part. There's
42 usually cost attached to those neighbourhood houses to do
43 programs there which people can't afford.
44
45 But also, some people feel quite intimidated about
46 going along to somewhere they haven't been before. When
47 they're around their peers there's greater opportunities

1 for peer support at drop-in centres and it's a natural peer
2 network.
3
4 So, in some ways it's been a real shame that we've
5 lost that, some people have lost the social networks that
6 sustained them, and yeah, it would be great if we could do
7 something to develop a model along those lines again.
8
9 CHAIR: Thank you.
10
11 MS BATTEN: Thank you. If there's no further questions,
12 may Ms Bradley please be excused?
13
14 CHAIR: Yes. Thank you very much for your comprehensive
15 evidence today, thank you.
16
17 <**THE WITNESS WITHDREW**
18
19 MS BATTEN: Chair, is now an appropriate time to adjourn
20 for lunch?
21
22 CHAIR: Yes, thank you.
23
24 **LUNCHEON ADJOURNMENT**
25
26 **UPON RESUMING AFTER LUNCH:**
27
28 MS COGHLAN: The first witness this afternoon is Janet
29 Butler, and I call her now.
30
31 <**JANET BUTLER, sworn and examined: [2.01pm]**
32
33 MS COGHLAN: Thank you, Mrs Butler. You've made a
34 statement with the assistance of the Commission?
35 A. I have.
36
37 Q. I tender that statement. [WIT.0001.0002.0001] Around
38 five years ago your son, Christopher, began to suffer from
39 acute mental illness?
40 A. He did.
41
42 Q. You've made a statement about your family's ongoing
43 journey through Victoria's mental health system. One of
44 the things you say is that it's been marked by trauma and
45 difficulty with brief moments of help.
46 A. That's the case, yes.
47

1 Q. Can I ask you then about when Christopher was around
2 22 years of age back in 2013. If you could tell the
3 Commissioners what life was like for him at that point in
4 time?
5 A. Christopher was 22, he was happy, witty, calm. He was
6 in an up-and-coming band, he's a musician. He had two
7 jobs, one of which was a lifeguard, he was doing very well.
8
9 Then, in December 2013, he underwent some quite severe
10 stress and he became quite anxious. We took him to our GP,
11 who prescribed one of the new generation antidepressants,
12 which was Sertraline. Christopher's anxiety actually
13 worsened after that and we just thought it was because of
14 the situation we were negotiating with him.
15
16 So, he went back to the doctor and the doctor doubled
17 the dose of the Sertraline, and after that Christopher's
18 condition radically worsened until it became almost
19 completely out of control. He was sleeping four hours in
20 every 48, he was speaking very quickly, he was delusional.
21 He was engaging in risky, quite dangerous behaviour and we
22 became very concerned.
23
24 Q. And you had no prior experience, you and your husband,
25 of engaging with someone with mental health issues?
26 A. No, but we knew that something was terribly wrong.
27 You know, we had no idea, and didn't for quite a long time,
28 had no idea what was happening.
29
30 Q. You later came to understand that your son,
31 Christopher, had a predisposition to bipolar?
32 A. We did, and the stress that he was under and the
33 Sertraline that he was prescribed, and then the double dose
34 he was given are triggers, and he moved into first episode
35 psychosis, but we had no experience of it, so we didn't
36 know what we were looking at.
37
38 Q. I'll come back to ask you about that in a moment. Was
39 there also some drug use going on at the time for
40 Christopher?
41 A. There was. Yes, he was self-medicating, I think, you
42 know, what turned out to be quite a frightening illness.
43
44 Q. In around March 2014, you and your husband contacted a
45 hospital?
46 A. We did.
47

1 Q. What happened as a result?
2 A. We were concerned enough, and sure enough, that this
3 was something beyond anything that we'd experienced before,
4 that we contacted a CAT Team of our local hospital. We
5 were that sure that something was terribly wrong.
6
7 Christopher went in by himself and was assessed by the
8 CAT Team, and he came home to us with a referral to a
9 public drug rehabilitation unit that took three months to
10 get into.
11
12 Q. And so, at the time when he was assessed by the CAT
13 Team, it appeared that they couldn't see beyond the effects
14 of drugs?
15 A. No, they didn't. They didn't look behind the - once
16 they knew that drugs were involved - and this was a problem
17 that we found - the doors were just shut. They didn't look
18 behind the drugs and think, this presentation could also be
19 what it turned out to be, which was the onset of an acute
20 mental illness.
21
22 So, I took their word for it and spent a couple of
23 weeks trying to find somewhere else to get Chris into,
24 because his - he clearly needed immediate assistance. But
25 as those days went by, Christopher was becoming worse and
26 worse and worse, and we realised that it was a lot more
27 complex than they were saying, and I knew, you know, in my
28 bones that Christopher was suffering from a mental illness,
29 because we had seen the change and we knew where it had
30 begun, we could see the causes. We didn't know the role
31 that the antidepressant was playing, but we thought we
32 could see where the stress had kicked in, so we stopped
33 going down the road of the drug rehabilitation and started
34 to try again to get him help for mental illness.
35
36 Q. So he didn't receive, beyond that first assessment by
37 the CAT Team, he didn't then receive any treatment for
38 three or four months beyond?
39 A. No. I rang the CAT Team five times over that period,
40 increasingly frantic for help, and we were given no help
41 whatsoever. They described it as, they said one day that
42 it sounded behavioural, that I should sit him down and set
43 some boundaries. Christopher was by then in psychosis.
44
45 They thought it sounded like personality disorder, so
46 they said they didn't come for that sort of thing. And at
47 one stage I rang and they said, "Oh, we know Christopher,

1 he uses drugs. We don't deal with people that take drugs."
2
3 So no, from March until the middle of June, as I
4 begged them increasingly for help, no, we didn't receive
5 any help at all.
6
7 Q. And at times Christopher's behaviour was quite
8 frightening for you?
9 A. It was. Christopher was engaging in risky, riskier
10 behaviour, and he was becoming unmanageable in many ways.
11 I mean, looking back, it must have been terrifying for him.
12 He was delusional and paranoid, and we found him - you
13 know, it was a very difficult situation to manage.
14
15 There was once a time when somebody had given us
16 advice to just disengage, and Pete and I just fled the
17 house and actually went to the hospital that we'd been
18 asking for help, went to the acute ward, said, "Look, we've
19 got this terrible situation, we have no idea how to deal
20 with it, can you help us?" And they said, "No, we can't
21 help you, you have to go home and you have to ring the CAT
22 Team."
23
24 So I went home, Pete didn't come home with me. I went
25 home and I called the CAT Team and after half an hour when
26 I hadn't heard back from them I called them back and I was
27 told by the receptionist that there was a two-hour call
28 back time.
29
30 By this stage I - I'm sure that people listening have
31 been faced with somebody who is spiralling into mania and
32 in psychosis, but you need help right then. You need
33 somebody who is an expert who can give you advice and,
34 hopefully in the best scenario, come. And, what he needed
35 - what he needed - was somebody to come, recognise what
36 could possibly be going on; he needed to be sedated, he
37 needed to be admitted, and he needed to take antipsychotic
38 and mood stabilising drugs.
39
40 But there was a two-hour call back. When they finally
41 called back, that is when I got the advice about it being
42 behavioural and that I needed to sit him down and set some
43 boundaries.
44
45 Q. So, Christopher received no help at that time?
46 A. No. No, we never received help.
47

1 Q. And, after that, he became essentially homeless?
2 A. He did. He was in many ways difficult to have in the
3 house. He couldn't be there either. He was couch-surfing.
4 He would randomly come home at odd times, sicker every
5 time.
6
7 Once he came home and told us a story about him being
8 taken to another hospital in an ambulance because a
9 bystander had called an ambulance because he was fitting in
10 the street, and he told us that he had been taken to the
11 hospital, that he had run away, that the police had picked
12 him up, they had let him go somewhere. And I knew that
13 some of that story, that terrible story, was true.
14
15 I could see that Christopher was processing that
16 information in a way that I couldn't really understand;
17 that he was telling the story, and in his mind it was
18 probably slightly different than - I could see it in his
19 eyes, but I knew that enough of it was true that this was a
20 nightmare that we - we had no idea what to deal with, and
21 he left then.
22
23 I remember Pete and I sitting on the couch listening
24 to the crickets chirping in the mental health system and
25 wondering if we were ever going to see our son again.
26
27 Q. There was another occasion in June 2014 where
28 Christopher was picked up by the police?
29 A. He was, and thank heavens for it. He was picked up by
30 the police late one night in June and the sergeant in
31 charge of the police rang me at 4 o'clock in the morning,
32 and he told me that he knew Christopher was over age, but
33 if they were under 26 he always tried to call a parent. He
34 said, "Your son hasn't done anything wrong, but his
35 behaviour is bizarre, what's going on?" And I told him, I
36 told him about what had been happening, what we had tried
37 to do, and he said to me, "What do you want me to do?" And
38 I said to him, "Could you please take him to a hospital."
39 It was out of our area, a big inner city hospital, "Could
40 you please take him there and we will meet you there", and
41 that's what happened. We met the police there at, you
42 know, 4 or 5 clock in the morning.
43
44 Q. In your statement you say:
45
46 "When I arrived I experienced one of the
47 worst moments of my life."

1
2 A. That's the case. We arrived there at 4 o'clock in the
3 morning, after months of this trauma, and looking back, I
4 can't ever remember it being daylight. For those months
5 that we tried to get help for Chris and we lived through
6 that nightmare, it was night to me all the time looking
7 back.
8
9 We got there and we got out of the car, and I heard my
10 son, saw my son, the boy that I had tried to get help for
11 since March, dragged screaming and terrified out of the
12 back of a divvy van. It was - it should never have been
13 allowed to get to that state.
14
15 Q. And, he was seen by a psychiatric registrar and the
16 head of emergency and a psychiatric nurse when he was
17 there?
18 A. Yes.
19
20 Q. And there was a diagnosis made?
21 A. Yes. They knew what was wrong. A diagnosis was made
22 of first episode psychosis bipolar. My son is bipolar,
23 type 1. That's what was wrong with him all the time.
24
25 Q. And there was no suggestion at that time that his
26 presentation was drug-related in any way?
27 A. No. In fact, I raised that with the nurse. I said to
28 her, "We have been trying to get him help for months but
29 the suggestion has been, it's all drug-related" and I got a
30 flat "no" in return. The nurse said to me, "No, your son's
31 bipolar."
32
33 Because by that stage they had sedated him, they
34 wouldn't let me see him. I wanted to see him because he
35 was terrified, but they wouldn't let me see him. They said
36 it was for my sake. They heavily sedated him, and they'd
37 said, "Come back tomorrow. When the sedation wears off
38 then we will see", and I'm assuming, I don't know, that if
39 it was drug-related then they'd come out of whatever was
40 causing it but Christopher was as he was.
41
42 Q. He was admitted as an involuntary patient at that
43 time?
44 A. He was. They were very sensitive about it but they
45 came and said, "Look, he's so at risk we need to take his
46 rights away." He was admitted to the acute psychiatric
47 ward. He was in seclusion for three days.

1
2 They told us that they couldn't keep people for longer
3 than ten days, but he was there for 31 days.
4
5 Q. And he was ultimately discharged in July 2014?
6 A. He was.
7
8 Q. At which stage you observed him to still be unwell?
9 A. He was very unwell still. He looked to me to still be
10 in the tail-ends of psychosis when he was released. There
11 was some discussion at the hospital about them finding
12 accommodation for him.
13
14 But Christopher turned up, when he was released, on
15 our doorstep. We had no warning that he was coming, we had
16 no advice about how to support him. He had the remainder
17 of his belongings in a Coles supermarket bag, and his
18 discharge papers - we weren't told that he was coming.
19
20 He had seven days worth of medication, no script for
21 the medication, and these were heavy duty antipsychotics
22 and mood stabilisers. There was no script. His discharge
23 papers were sent to the GP, who also didn't know that they
24 were coming, and that was it. That was the end.
25
26 Q. What happened then when Chris ran out of medication
27 after his first week at home?
28 A. He asked his father to take him back to the hospital
29 who had treated him for a month, who had diagnosed him,
30 treated him for a month, and then had only released him
31 seven days before. So, my husband took him in there, and
32 Chris was still pretty hot-wired. He asked that he be
33 dropped off, that he go to the hospital.
34
35 He asked them for more medication or a script and they
36 refused to treat him because he was no longer living in the
37 geographical area that he served, so he left, and I have no
38 idea to this day what they thought happened to him.
39
40 Because, in order to solve that situation that he was
41 in, my son would have had to find somebody to tell the
42 story to, a medical practitioner who was qualified to
43 prescribe those heavy duty drugs. He would have had to
44 make an appointment, tell his story, get a script, go to a
45 chemist, pay for those drugs, and I can tell you honestly,
46 my son would have been unable to do a single one of those
47 things. And, if he didn't have us, he would be unmedicated

1 and on the street.
2
3 Q. You mentioned before that his discharge papers were
4 sent to his GP?
5 A. They were.
6
7 Q. And the expectation was, as you understood it, he was
8 to be referred to a private psychiatrist?
9 A. Yes.
10
11 Q. Which you found was nearly impossible?
12 A. It was nearly impossible, because we had absolutely no
13 understanding of how the system worked. Somebody as sick
14 as Christopher is treated in the public system, not the
15 private system, and they're usually released, I believe,
16 with support: a psychiatrist, a social worker, a
17 caseworker, a psychologist. Christopher had nothing.
18
19 So I had to find a private psychiatrist who would
20 treat somebody newly diagnosed with bipolar, and it was
21 almost impossible. I tried, I contacted psychiatrists, I
22 sent them his discharge papers. They were very good about
23 it. One of them I sent to said, "Send me the discharge
24 papers." He read them. He said, "I'm semi-retired, I
25 can't take on a case of this level." He passed it along to
26 one of his associates and she rang me and she said, "I'm
27 terribly sorry I'm part-time, I can't take on a case like
28 this." To her credit she rang me in a month and said,
29 "Have you found a psychiatrist?" And I said, "No." And
30 she said, "He needs to be eyeballed", that's what she said,
31 "And I'll do it."
32
33 I rang Headspace because Christopher was inside their
34 parameters, he was 22, and they said he was too high end
35 and too high risk, and anyway, they were a psychiatrist
36 down. And so, I just - I just called on people that I knew
37 who worked in the area, they gave me recommendations, and
38 finally somebody agreed to take him on. Because, he said
39 to me, "I read it and I realised something had gone
40 terribly awry from reading the discharge papers." That
41 was September.
42
43 Q. So it look you from July to September to find a
44 psychiatrist?
45 A. Yes. Christopher was completely untreated from March
46 until June and he was completely unsupported from July
47 until September. And, we weren't even told how to speak to

1 our son, and if you've got somebody with a tail-end of
2 psychosis, you have to be sensitive about how you engage
3 with them; it can go terribly wrong.
4
5 We were just ordinary people, without any kind of
6 mental health training at all, and we had been
7 substantially in charge of somebody moving into psychosis
8 and bipolar since March of that year, with a brief 31 day
9 stint when the hospital actually said to us, "Go home and
10 get some rest." But we were in charge, despite our best
11 efforts.
12
13 My husband and I are educated, we are articulate, we
14 were committed to find help for our son, we were determined
15 and we had resources, and we couldn't get help for him at
16 either end of his hospital admission.
17
18 Q. There was a period of time where Christopher went to a
19 private hospital?
20 A. He did.
21
22 Q. And he spoke highly of his experience there?
23 A. He did. The hospital had programs, the days were
24 busy. They used all kinds of different therapies and all
25 day long. It was a purposeful way of getting better. He
26 spoke very highly of that hospital and we had a good
27 experience of it.
28
29 But one thing that did happen there, is that,
30 Christopher, once when he was admitted there, began to
31 become unwell. He'd already begun to become unwell before
32 he moved in there and I had rung them because, in
33 conversation with Christopher, I realised that he was
34 actually becoming quite unwell.
35
36 I tried to get into contact with them. One of the
37 problems that we have in the current system is that the
38 people who are caregivers aren't really listened to, and
39 it's also very difficult under the Privacy Act to get any
40 information. So, although everything is landing in our
41 lap, we're getting no hearing and we're getting no advice.
42
43 When I spoke to the head of the unit - things did go
44 very wrong - when I spoke to the head of the unit she said
45 to me, "If Christopher becomes unwell, we can't keep him
46 here." And I said, "But what will I do?" And they said,
47 "We will send him to a public hospital."

1
2 And I knew, my understanding was that he probably
3 wouldn't be sick enough. He would be too sick for the
4 private hospital, but not sick enough to get into the acute
5 ward of the public hospital, so our boy, who would be too
6 unwell for a private hospital to cope with, would be home
7 with us.
8
9 Q. One of the things you say in your statement, which
10 I'll read to you because it's expressed so well, is this:
11
12 "My experience of the mental health system
13 felt like opening a door and seeing a
14 yawning abyss because of the lack of
15 support and help."
16
17 A. That's exactly how it felt. I was shocked because I
18 think, we know we've got a physical health system, although
19 we complain about it but it works, it's there, we've got a
20 transport system. I think everybody assumes that there's a
21 mental health system, but there isn't one.
22
23 We opened that door and there was nothing behind it,
24 absolutely nothing, until the police intervened when my son
25 was so ill that he had begun to burn resources in this
26 state. He was taken to hospital in an ambulance, police
27 were picking him up.
28
29 When he was at the hospital where he was finally
30 treated, he had two security guards at the end of his bed.
31 He had a designated nurse. Surely, this money could have
32 been put into preventing it from getting to that stage,
33 because by that stage he was using up the resources anyway.
34
35 Q. And that's one thing that you see needs to change in
36 terms of the importance of accessing early intervention?
37 A. Yes. I think there are gaps in our system. Early
38 intervention's critical. I actually believe that my son
39 was damaged by the extent to which his illness was allowed
40 to get.
41
42 When he was taken to the hospital he had a short-term
43 memory of 30 seconds. He was not eating, he was not
44 drinking, his lips were cracked from dehydration. He was
45 terrified and he was delusional, and it is a long way back
46 from that.
47

1 And, to be in that level of mania is dangerous. He
2 was at risk that entire time that we were trying to get him
3 help. If, when he'd gone to the CAT Team, they had said,
4 yes, there's drug use, that could be an explanation; but it
5 could also be, at this age, it could be with the stress and
6 the antidepressant, it could be the start of bipolar, we
7 need to monitor this, we need to keep an eye on it to see
8 if that is in fact what is happening and the drugs are
9 being used as some sort of dependence to medicate, you
10 know, his own terror of what was happening to him.
11
12 We also found that the CAT teams would not come
13 because Christopher's illness had become so extreme. But
14 then, if they're not coming, who is going to come? I think
15 with early intervention it's not going to get to that
16 stage, but at the moment that's the stage it's at: that you
17 can't get help until you're acute. But, if you're acute,
18 the CAT teams won't come, so who's going to come?
19
20 There needs to be some sort of body who is educated
21 and able. I can understand the CAT Team's fears of putting
22 themselves in a dangerous situation. But there needs to be
23 somebody who can manage that situation, some sort of team
24 that's got somebody in it that can manage a situation that
25 can get a little bit out of control, but also needs the
26 psychiatric expertise to recognise what this might be and
27 to work out what to do, and we need the beds to take them
28 to. Christopher needed to be an inpatient well before he
29 was.
30
31 We also need a body - when Christopher was released
32 from hospital he was still at risk. Without us - he was
33 still very ill. We were never contacted by that hospital
34 that treated him, or by the hospital that we begged for
35 help, ever again. Now, nobody is responsible for what
36 happens to somebody, even with Chris's level of illness.
37
38 We need, either within the hospitals or an external
39 body to the hospitals that they send their discharge
40 information to, we have somebody newly diagnosed with
41 bipolar, they have now been released to this address.
42 There needs to be follow-up, there needs to be oversight.
43 Maybe a week later, how are they travelling? Are they
44 taking their medication? Are they able to access
45 medication? Can they afford to buy it? Are they living
46 anywhere? Are they supported? If they're homeless, is
47 there some sort of contact that can be made?

1
2 There's nothing, there's no oversight of the people
3 who are still quite ill because of the very short hospital
4 visits, there's nobody looking out for them, they're just
5 out there and they're not in the right frame of mind to be
6 able to be taking care of this by themselves. Chris had
7 us, but we could see what would happen if he didn't, and
8 there are many people out there that haven't made it safely
9 home in the way Chris did, and that's why we're here today.
10
11 Q. You say in your statement that you're proud of your
12 son and you see --
13 A. I am.
14
15 Q. -- the efforts that he's made climbing the mountain to
16 wellness.
17 A. Yes, he has, it's an enormously difficult task to come
18 back from a situation like that. I am proud of him, I see
19 the efforts he makes, and it is hard, there are dips. He's
20 got to contend with the fallout from what happened when he
21 was so incredibly unwell. He has to deal with the heavy
22 duty medication that he's on and the way that it affects
23 his life. He has a Parkinson's tremor from his medication,
24 it's heavily sedating. It has side-effects, he has to deal
25 with the difficulties of getting work, of being without
26 money, of negotiating with Centrelink, which is a whole
27 other area where there needs to be some kind of compassion
28 for the mentally ill.
29
30 But yes, I am proud of him. He is trying. He is a
31 musician and he has that saving grace, that he can pour his
32 feelings into his music. He's very open on stage about
33 what's happened to him, but yes, we are very proud of him.
34 It's almost awe-inspiring, because I don't know how I would
35 have been able to come back from that great blow.
36
37 My son said to me that he woke up in a psych ward and
38 he couldn't remember the last six months of his life. He
39 rang his girlfriend and he found out they'd broken up
40 three months before. He lost everything. He lost his
41 girlfriend, he lost the band that he was in, because he was
42 allowed to get so unwell. It's an alienating disease to
43 the people around you. He lost his part in the band, and
44 the night that he was dragged out of that divvy van, he
45 lost his human dignity. It shouldn't have got to that
46 stage.
47

1 We were trying to get help, he wasn't a person not
2 trying to get help. We were begging for it, and it just
3 wasn't forthcoming. And every time I think he slides back
4 because of the extent of the illness in the first place.
5 It was huge.
6
7 Q. Just lastly, how are things for him at the moment?
8 A. He's ill at the moment, he is. It's a cyclical
9 disease, it's very hard to come back. We're currently
10 going through the same thing again: how do we get him into
11 hospital? The psychiatrist he goes to is away.
12
13 The psychiatrist, the private psychiatrist costs $320
14 an hour, and Christopher's on Newstart. So, there is an
15 impact, it's a financial impact on our family as well. He
16 wants to go into hospital every year, and he can get
17 support depending on the unit he goes into in the private
18 hospital. They will release him with some sort of support,
19 but every year in January the excess clicks on with the
20 health insurance and he has to come up with another $500.
21 He gets $500 a fortnight, he has to pay $190 of that for
22 his health insurance. You know, in common with a lot of
23 mentally ill people, he smokes and, you know, the money to
24 get help in the private system's not there.
25
26 Another thing that we do need that, if I could say, as
27 a family we need access, we need quick and better access to
28 willing professionals that we can ring up and say, "This is
29 our family situation, he was diagnosed then, this is what's
30 been happening, what would you suggest, you know, what
31 advice can you give us that we can actually do now?", and
32 hopefully there will be the infrastructure in order to put
33 that through if he needs to go into hospital.
34
35 At the moment there is nobody to ask. Both of the
36 psychiatrists that Christopher has seen has made it
37 absolutely clear that they are not to be rung in a crisis,
38 that is not what they are for. And, we've not had good
39 results when we have rung the CAT Team, so we have only
40 ourselves to fall back on, and we knew nothing. We know
41 things now.
42
43 But even now, like right now, we're back in that state
44 of, where do we go? What do we do? Who can we ring? And
45 it's not a matter of, you know, in a best possible world we
46 would be able to ring somebody who would say, "Okay, I
47 think this is going a bit wrong, we're going to come, we'll

1 have a look, we'll have a chat with him. If we think he
2 might need a bit of time in hospital, we might do that,
3 we'll check the medication levels, we'll give him a bit of
4 space. We'll assess what's going on." That's what we need
5 and it's an almost impossible thing to find, unless you are
6 very well resourced.
7
8 MS COGHLAN: Thank you, Mrs Butler. Chair, do the
9 Commissioners have any questions?
10
11 CHAIR: Q. I would just have one. Thank you very much
12 for telling us that experience, it sounds like there were
13 some great many challenges that both your family and
14 Christopher had to overcome. I'm interested in, you talk
15 about the fact that even now after the experience you've
16 become more informed about the system through necessity,
17 obviously, and great challenge.
18
19 On the basis of that you're saying, would you reach
20 out to the CAT Team and the triage again with an
21 expectation of --
22 A. No, absolutely not.
23
24 Q. It's put you off seeking help in that way?
25 A. Absolutely. I dealt with the CAT Team at two
26 different hospitals. When Christopher came out of hospital
27 he was still very ill, and things got very difficult, and I
28 rang the CAT Team at the hospital who treated him. And,
29 he'd only recently been released, they had all the
30 information; they refused to help me. They said, "We can't
31 come, you're out of our area. You need to ring the CAT
32 Team in your area." And I told them the experience we had.
33 But she convinced me to ring them, and I rang them, and
34 they were as bad as they ever were.
35
36 They said to me, "Is he violent?" And I said, "No."
37 I said, "He's a bit shouty." And she said, "Well, that's
38 completely inappropriate, we can't come." And I was only
39 concerned to get him help.
40
41 It was years later that I realised, they'd left me in
42 that situation, and they'd left Chris in that situation.
43 Doesn't our safety matter too? I understand that their
44 safety matters, but there's a gap: if they can't come, we
45 need somebody who can, or we need the system changed so
46 much that we don't get to the situation where that's
47 necessary, and I think that will happen.

1
2 I think, if the emphasis is placed on early
3 intervention, people will not be getting as sick as that,
4 and we won't be in those situations anymore where a parent,
5 with a non-compliant, delusional psychotic person at home,
6 has a choice between nothing and ringing the police, which,
7 you know, could also - it looks behavioural and there's
8 that fear, that that could go terribly wrong. If you
9 invite an armed response team to your house and you've got
10 a terrified, delusional person there, we need some kind of
11 integrated team.
12
13 The other thing we need is a recognition of the fact
14 that there needs to be an integrated look at drug use and
15 mental illness. At the moment they're separated. We've
16 tried to get help for the drug side of what's going on, but
17 they're in completely separate units, and at times
18 Christopher has still been mentally unwell and has asked to
19 go into the general part of the hospital and that's not
20 been possible because there's been no beds.
21
22 They need to be treated together with a recognition
23 that they can present together as well; that there's
24 probably a reason why these people are medicating
25 themselves like this. It's a chicken or the egg kind of
26 situation. At the moment the separation of that is very
27 unhelpful and the geographical basis of the treatment of
28 the mentally ill is something that affected us very badly.
29
30 CHAIR: Thank you very much, Mrs Butler.
31
32 MS COGHLAN: Thank you. May Mrs Butler be excused?
33
34 CHAIR: Yes, thank you.
35
36 <**THE WITNESS WITHDREW**
37
38 MS COGHLAN: I call Paul Denborough.
39
40 <**PAUL MICHAEL DENBOROUGH, affirmed and examined: [2.37pm]**
41
42 MS COGHLAN: Q. Thank you, doctor. You've made a
43 statement for the Royal Commission?
44 A. Yes.
45
46 Q. I tender that statement. [WIT.0002.0015.0001] Doctor,
47 I'll just ask you to sit forward a bit closer to the

1 microphone, if that's okay, so we can hear you.
2 A. Sure.
3
4 Q. You are the Clinical Director of Alfred Child and
5 Youth Mental Health Service, or CYMHS?
6 A. Yes I am.
7
8 Q. And also of Headspace at Alfred Health?
9 A. Yes, the primary Headspace and the Early Psychosis
10 Service as well.
11
12 Q. I'll ask you about them in a moment. Just in terms of
13 your background qualifications and experience, you have a
14 Bachelor of Medicine, Bachelor of Surgery from University
15 of Melbourne?
16 A. That's right.
17
18 Q. You have a Master of Medicine, University of
19 Melbourne?
20 A. Yes.
21
22 Q. You also started at Alfred Health in 2002 as Clinical
23 Director of Alfred CYMHS?
24 A. Yes.
25
26 Q. And Headspace, and that's continued to be your
27 position?
28 A. That's right.
29
30 Q. So you've held that for a number of years?
31 A. I have. Long time.
32
33 Q. You just need to speak up just a little bit?
34 A. Sorry, a long time, yeah.
35
36 Q. Thank you. Also, you're a child and youth
37 psychiatrist?
38 A. I am.
39
40 Q. With extensive experience otherwise working in the
41 public health system?
42 A. I am.
43
44 Q. You mentioned before your responsibility for CYMHS,
45 but also Headspace Primary and Headspace Youth Early
46 Psychosis. That's the case?
47 A. That is correct.

1
2 Q. But you have that responsibility in partnership with
3 Glenda Pedwell?
4 A. That's right.
5
6 Q. And so, Glenda is the operations manager?
7 A. Yes.
8
9 Q. And so you see it that you're the clinical lead and
10 that she's the operations lead?
11 A. That's right, so we work in partnership.
12
13 Q. What you try to achieve is an effective and accessible
14 mental health service?
15 A. That's right.
16
17 Q. I want to ask you individually about CYMHS, Headspace
18 Primary and Headspace Youth Early Psychosis Program, just a
19 little bit about each, we won't spend much time on that,
20 just to provide some context.
21
22 You say in your statement that:
23
24 "The CYMHS at Alfred Health provides a
25 coordinated mental health service for young
26 people and their families."
27
28 A. That's right.
29
30 Q. Can you just describe the integrated nature of the
31 service that it provides?
32 A. Okay. So, the mental health system, ideally it's a
33 tiered system, so that there's a primary mental health
34 system which Headspace fits under, Primary Headspace, and
35 there's also a secondary system which is often the private
36 system and people working on their own, professionals on
37 their own, and then there's the tertiary system which is
38 the state mental health services. But we also have an
39 early psychosis service which functions like a tertiary
40 mental health state system although it's funded federally.
41
42 Really what we hope to achieve is that, if someone
43 rings us for help, we're able to provide them help in one
44 of those tiers, one of those services. So, it's not like
45 they have to justify that they meet criteria. We assume
46 that if someone's going to ring us up or want help, they
47 need help from somebody, so our decision-making is about

1 who sees them, not whether they're seen.
2
3 Q. One of the things that you mention in your statement
4 is that you're seeking to avoid people bouncing around the
5 mental health services. Can you just elaborate on that?
6 A. I think the previous witness talked about - it was a
7 bit of a thing about the missing middle, where people are
8 either seen as too sick for say the Headspace or primary
9 system and not sick enough for the tertiary system.
10
11 So, we try not to have that happen, we try and - not
12 try - make sure that doesn't happen, that people are too
13 sick for one and not sick for another.
14
15 Q. You mention in your statement that the CYMHS struggles
16 to meet demand, but is able to maintain a no waiting list
17 policy but that is becoming increasingly challenging.
18
19 Can you just expand on how it is you seek to maintain
20 the no waiting list policy and what the challenges are?
21 A. Yeah, well, I guess it is a help having a Headspace
22 service, because it's a very busy service which sees over
23 2,000 people a year in our catchment, so we are able to -
24 as long as we support and back up that Headspace system, a
25 number of clients that might be perceived as being too sick
26 for Headspace, we can work in partnership and support the
27 Headspace to manage those families.
28
29 But I guess, it's a very busy - state mental health
30 services is very busy and I think the main way we manage
31 the demand is by really trying to focus on getting a good
32 start, so that is involving the whole family at the first
33 meeting and putting some of our most experienced and best
34 staff, taking that first phone call. So, we reduce
35 inefficiencies about people having to tell their story more
36 than once and that we can get off to a start with the whole
37 family network. So it may sound intensive, but I think
38 we're able to do it by being as effective and efficient as
39 possible at the beginning.
40
41 Q. Are you mentioning there essentially a triage service
42 of a kind?
43 A. So, the triage that I think that we do differently is
44 potentially working out how to best help someone as
45 effectively and quickly as possible, rather than asking a
46 lot of questions about whether they're eligible or not and
47 trying to make diagnoses or understand things like that at

1 the first phone call. Rather, it's how can we help you
2 best and most quickly and who's going to be involved.
3
4 Q. You mentioned earlier that the assumption is, if
5 someone's calling, they need help?
6 A. Yeah, you've probably heard many stories, there's a
7 lot of stigma around mental illness and it usually takes
8 people when they call to be pretty desperate to call, so
9 it's pretty unusual for someone to call when they don't
10 have a serious problem, to be honest with you.
11
12 Q. The idea is that, from that first call, they are given
13 help?
14 A. Yes, so the other thing that we've been told by many
15 families and many young people is, they only really want to
16 tell their story once or to the same person who's going to
17 actually help them, so not having a separate assessment and
18 then be treated or helped by somebody else. So, we do a
19 lot of work over the phone to set up that first appointment
20 and that first meeting with the whole family network with
21 somebody who can help them in an ongoing way.
22
23 I think that does help us treat problems more
24 effectively and efficiently which is one of the reasons I
25 think that we're able to maintain a no waiting list for our
26 CYMHS.
27
28 Q. One of the themes that emerges from your statement is
29 a support of recovery-oriented practice. You see it as
30 your job to essentially implement that in the areas over
31 which you're responsible; is that right?
32 A. That's right.
33
34 Q. Can you just explain what is meant by
35 "recovery-oriented practice or approach"?
36 A. Yeah, so there's a whole framework document which was
37 done by the department in 2015 which really goes into a
38 great deal of detail about it. But essentially I suppose
39 it's different to the traditional biomedical model in some
40 ways and it's more of an approach which wants to find out
41 what's happened to someone rather than what's wrong with
42 them. It's about, I suppose, collaboration, so it's
43 valuing families' lived experience or their knowledge of
44 the problem and partnering with a mental health
45 professional.
46
47 So, the cliché or the jargon word is that mental

1 health is on tap, not on top, is the sort of thing, and
2 that you wouldn't do anything in a mental health service
3 without involving young people and families in the design
4 and delivery of the service.
5
6 So, it really focuses on choice, providing hope and
7 empowerment, and I guess the key thing is collaboration,
8 which is using the wisdom of the family with the wisdom of
9 the professional to find solutions together, rather than it
10 being some sort of prescribed thing from above or on high,
11 that mental distress or mental illness is different for
12 everybody and different for every family and it requires
13 both sides of the wisdom or knowledge to get a quick and
14 appropriate solution to the problem.
15
16 Q. And so, just expanding on that, it's about drawing on
17 the lived experience, people with lived experience as
18 experts on their lives, and experiences with the
19 professionals; they're drawing on their expertise to assist
20 them?
21 A. I suppose it's also an attitude, so it's walking in
22 seeing a family and making the first assumption that this
23 family has a lot of strength and knowledge about their
24 young person and their family, and the job of the mental
25 health professional is to tap into that. Sure things are
26 going awry at the moment, but this family is the best
27 placed - has a lot of knowledge that can be used in
28 partnership in a collaboration.
29
30 So, you go in feeling curious, feeling hopeful, and
31 trying to, I suppose, utilise the strengths of a situation
32 rather than spending a lot of time looking at deficits or
33 problems.
34
35 Q. I want to ask you about some specific examples of
36 recovery-oriented practice, I guess, moving on from the
37 theoretical. Five examples in particular and I'll take you
38 to them one-by-one.
39 A. Sure.
40
41 Q. The first is a single session program, and that's
42 something that the CYMHS has. Can you just explain,
43 please, first of all what it is?
44 A. If I just back one step. So, delivering - actually
45 making sure recovery-oriented practice happens on the
46 ground. Even though people read the document and think
47 that's a no-brainer, it's really obvious, actually having

1 it happen is actually extremely difficult, and there's lots
2 of reasons for that which we could go into if you want.
3
4 But single session is one way that helps embed those
5 principles that I talked about into a service.
6
7 Q. Can I just stop you there. You've talked about why
8 it's so difficult. Can you explain why, at least just give
9 some examples of why it's so difficult?
10 A. Yeah, well, often people think that recovery practice
11 is about being, I don't know, supportive or kind, which are
12 all good things; it's about hoping for the best, but
13 actually when you truly deliver it, you have to actually
14 change your paradigm which is actually believing that
15 there's not so much difference between the person in front
16 of you and you. That it's sort of, things have happened to
17 people which have led them to come to this situation and
18 it's that sort of respect for their - I don't know - their
19 past experience and their wisdom of the situation and
20 working in true partnership with somebody is actually not
21 something that used to happen in mental health services, so
22 actually making that shift and change is actually
23 difficult.
24
25 Q. Sorry, I interrupted you, you were about to describe
26 the single session program.
27 A. It's probably an unfortunate name because people get
28 very skeptical that it's possible to fix serious problems
29 in one meeting. But the principle of it is that, when
30 someone calls in with a problem, that you work with the
31 family to get everyone possible there to the first meeting.
32 What you do is, you work on what they want to work on. You
33 haven't got a pre-described sort of assessment pro forma
34 that you go through.
35
36 So, just an example, the usual common things that
37 present to a CAMHS are kids who are suicidal or kids that
38 are not going to school or kids that are not eating, kids
39 with psychotic symptoms. You work with the whole family
40 about trying to - sure, you do need to understand the
41 meaning and different perspectives on how this has come
42 about, but the whole purpose and driver of that meeting is
43 to find solutions and to change, and having a working thing
44 on the problem, rather than necessarily focusing on an
45 assessment, if that makes sense.
46
47 You're really led and directed by the family about

1 what they need. There's a pro forma we send out. We ask
2 them if there's specific questions they need to know, we
3 give them a report at the end with recommendations about
4 what needs to happen. And I guess it's a very respectful
5 and solution-focused, strength-based meeting with the whole
6 family, and it is surprisingly successful.
7
8 Q. I'll come back to ask you about how successful it is
9 in a moment, but just in terms of understanding what it
10 actually involves, you say in your statement:
11
12 "We use a one-way mirror during the session
13 and after an hour of talking with the
14 family the participants swap places."
15
16 A. Yeah, so probably to think of it, we set aside two
17 hours, but to be really honest there's quite a lot of stuff
18 done on the phone before they come, and that's about
19 prepping the family for what to expect, and also how to get
20 the most out of the meeting. And then what happens is that
21 we - let's just say they fill in a questionnaire which is,
22 what's the main thing you want to work on today, what's the
23 second thing, and we get all family members to fill that
24 in. We obviously do a bit of an introduction and get to
25 know each other a little bit.
26
27 But then we sort of get into trying to fix the
28 problem, and we have a team behind a mirror of about three
29 or four people who, after about an hour and a quarter, swap
30 places with the therapist and the family who are in the
31 room and their job is to think of ideas or suggestions, or
32 make positive strengths-based comments on ways forward for
33 the family, and it's quite powerful to have people just
34 sitting back listening and offering advice and suggestions.
35 So, it's transparent, these things are not done in secret.
36
37 The families often feel quite validated or empowered
38 by having people that they've sort of forgotten are there
39 come in and make really quite usually positive and
40 reinforcing comments about things that they've already
41 tried or things they can do more of to try and fix the
42 problem.
43
44 Q. And so, who would be in that meeting, for example,
45 from the CYMHS?
46 A. Yeah, so it's a generic team, a multidisciplinary
47 team. We have psychiatrists, we have social workers,

1 psychologists, OTs. We do, to be honest - it's part of our
2 training program in terms of, one of the things that we
3 have which I might get onto later is that the workforce we
4 have often haven't had much experience with working with
5 families, they often get in their undergraduate training a
6 lot of training on assessment, diagnosis, working with
7 individuals and a lot of theory, but often come to us with
8 no experience of working with families.
9
10 And because we're a family-oriented service, we
11 usually try and - everybody we see we just see their
12 family, often they're not confident or experienced in doing
13 that. So, part of being involved in a team like this is
14 that the more inexperienced people get to learn about the
15 culture and the type of family work that we do.
16
17 So, there is someone behind there taking notes, and so
18 that there's a report that summarises what's been discussed
19 and recommendations that's given to the family at the end,
20 so they go away, that whole idea that people only sort of
21 take in about 20 per cent, or remember, of a sort of
22 emotion-charged meeting like that. The families report
23 back feeling incredibly validated to have something, a
24 record of what's happened given back to them.
25
26 Q. Where and how did the Single Session Program model
27 originate?
28 A. Well, it actually originated in America, where a
29 psychologist was doing some research and following up
30 people who only came once to a service, and the assumption
31 was that these were treatment failures or drop-outs, that
32 the service didn't actually meet the needs of these people.
33 But when he called them, about 60 or 70 per cent of those
34 people said, "No, no, we didn't come back because we got
35 what we wanted, it was really helpful", and that was in a
36 service which wasn't offering a Single Session Program, it
37 was just one session with a counsellor.
38
39 His idea was, if people are gonna come once and find
40 that helpful, why not try and make the most of that first
41 meeting, because even for efficiency or for common sense
42 really, that if you can actually get results with one
43 meeting, why not really go for it.
44
45 Q. What is it about the one session model that means the
46 teenagers or adolescents, are more likely to anticipate?
47 A. Yeah, that's the common reason for offering.

1 Unfortunately, we only offer it about a fifth of families
2 that are referred to CYMHS, just because of our resourcing,
3 I guess is the main reason.
4
5 Often mums ring up and say "I want help for my kid"
6 and they often don't want to come. But it gives the mum or
7 the dad a lot of power to say, "Well, you'll come in once
8 at least." Because people have this idea that coming to a
9 mental health service will be ongoing and chronic, and they
10 don't want to commit to something like that. Whereas, you
11 know, it's pretty hard for a kid to refuse to come once.
12
13 Q. What's the importance of the intensive intervention
14 involving the family?
15 A. I guess it's getting back to that idea of, it's a
16 really a recovery-oriented approach, in terms of, it's
17 collaborative, it's a working meeting, it's not - I guess
18 one of the things that we're struck with, at CYMHS anyway,
19 is that people often feel a lot of shame and blame. They
20 feel like their going to be blamed or they're feeling in a
21 really bad place.
22
23 So, this is a really respectful approach where we're
24 actually rather than spending - in the old days we often do
25 long protracted, problem-saturated assessments, asking
26 about a lot of things from the past which may or may not be
27 relevant. Whereas this is here and now, done straight
28 away, we're going to work with you to help sort out your
29 kid's problems.
30
31 I think what's effective about that is, it's the
32 inherent respect in that model and the inherent, I guess,
33 practicality and pragmatic nature of it which is not doing
34 a whole lot of esoteric things which may seem irrelevant,
35 it is working on what's in front of you at that moment.
36
37 Q. Are most of the adolescents that you see live with
38 their families?
39 A. Yeah, definitely. Our program goes up to 25, so even
40 in the - I think it's still 80 per cent of our young
41 people, even up to the age of 25, are still living with
42 their family.
43
44 Q. You were talking before about how successful these
45 sessions are, and in that sense you mean the family are
46 satisfied with the outcome and additional help is not
47 sought.

1 A. Yeah. So basically, to have a single session, you're
2 in our system. So you don't have to - you know, it's not
3 taking mild cases, or things that are seemingly suitable
4 for a single session, it's taking cases that would be
5 standard for our service.
6
7 Our studies show that about 70 per cent of those
8 families are satisfied with that meeting, which no-one can
9 believe. But around the world actually where this practice
10 is very common - in Canada in particular it's sort of the
11 standard thing that happens - about 50 per cent of people
12 are generally satisfied with one meeting. And, you might
13 be surprised to know, the commonest number of sessions to
14 come to a mental health service is actually one.
15
16 Q. And what about the other 30 per cent?
17 A. Yeah, well, they get followed up in the system. So,
18 probably the only slight risk of implementing a program
19 like this is, you have a very powerful emotion-charged
20 meeting and the problem might be that you have to start
21 again with somebody else in the system. But because we
22 have a bigger team like that almost always we are able to
23 have someone who's been present for that meeting, even if
24 it's not the actual therapist in the room, but somebody
25 who's been part of that team is able to continue with that
26 family in an ongoing way.
27
28 I guess one of the beauties of this model is that it
29 is efficient, so that, there's more time that you can have
30 for people who need longer and some people stay in our
31 system for five, six years. I mean, there are cases that
32 need that sort of long-term intensive involvement.
33
34 Q. Can I ask you about a couple of specific examples
35 within some CYMHS programs. The Eating Disorders Program,
36 for example, and how this single session might work in that
37 context?
38 A. Yeah, so we've adapted our Single Session Program
39 which I think is in a very exciting way, and so, we have a
40 very more targeted single session for people that present
41 with problems with anorexia, and we have a
42 multidisciplinary team which is much more targeted.
43
44 So we have a dietician, we have a nurse, and the nurse
45 is very much focused on the physical state of the person,
46 because obviously with anorexia there can be severe
47 physical complications of not eating.

1
2 We have a parent who's had a daughter with anorexia
3 before, so she's on every team as a parent carer consultant
4 or peer worker. We have a couple of generic workers,
5 including myself, as someone whose expertise is more around
6 running family sessions; you don't really need a
7 psychiatrist for that problem, but you need a couple of
8 people who are familiar with working with families and
9 managing that system.
10
11 It's a much more focused single session on trying to
12 help - anorexia's usually not a diagnostic problem, it's
13 pretty obvious, and so the focus is very much on getting a
14 really fantastic start to starting re-feeding, and that
15 usually involves family members. So it's about empowering
16 parents and getting the advice from the experts for the
17 family: so, a dietician, peer worker, a nurse right at that
18 first meeting that wrap around.
19
20 With anorexia - I think we might be talking about it
21 later - but it's a condition that it's essential to have
22 early intervention and get on top of the problem quickly
23 otherwise it can become very difficult to help.
24
25 Q. We'll come back to that. Can I just move on just
26 quickly to ask you about an example of, again, the single
27 session in the context of the Youth Early Psychosis
28 Program.
29 A. We have, in our Early Psychosis Program we started
30 using open dialogue, which I know that's coming, but
31 there's a link to what I'm saying. An open dialogue is
32 another model that's been used overseas which is very much
33 an exemplar of providing recovery-oriented practice,
34 because it's immediate help, it's at home, it's with the
35 family system, it's continuity, it's responsibility.
36 That's some core elements of it, but it's really talking,
37 trying to understand meaning and involving families and
38 networks in the solution to the problem.
39
40 What we've found, we've tried to adapt that slightly
41 at our Early Psychosis service, have a bit more structure
42 around that first meeting. So, the open dialogue is open,
43 which is great and it's a really great model, but our
44 system, we've decided to adapt it to have a bit more
45 structure and use some of the single session principles to
46 get the most out of that first meeting.
47

1 Maybe the other thing to say - and this is in relation
2 to that previous witness as well - was that, the biggest
3 thing that we want to do is try and have the right people,
4 and including the family and other people, at the first
5 meeting. That's something that's of highest priority to us
6 because if you don't have - and this is for any age, or
7 we're up to 25 - the time to do that is at the beginning.
8
9 Because, as soon as you start with the young person on
10 their own, or a young adult on their own - and sometimes we
11 do because there's no alternative - it becomes difficult to
12 involve the family, and the family's often then brought in
13 later, and they're supported to some degree but they're not
14 actually front-and-centre in actually fixing the problem at
15 the beginning if they aren't invited to the first
16 appointment.
17
18 Q. We talked briefly about waiting lists earlier. How
19 does a single session help to maintain the "no waiting
20 lists" that you've been able to achieve so far?
21 A. Yeah, I think it's part of the success of having a
22 "no waiting list", and part of that is just the
23 effectiveness of it, in that, if you're able to help a
24 fifth of your referrals and help them recover in one
25 meeting - even though it's not correct to say that it's two
26 hours, it's more like an hour beforehand, two hours and a
27 follow-up afterwards for sometimes up to an hour, so it's
28 really like a 4-hour intensive thing, so it's not just one,
29 1 one hour session.
30
31 The other thing that I think happens, and I can't
32 prove this, but I think because we have so many of our
33 staff involved in a Single Session Program, that the work
34 that they do outside of that program, I believe, cannot
35 help but be influenced by that practice. So, they're still
36 always working trying to make the most out of every meeting
37 that they have, and that philosophy of working on what the
38 family wants to work on rather than some idea of what the
39 service want information for, I think that sort of filters
40 across the whole service, to be honest.
41
42 Q. Can I move on to ask you about an outcome-based
43 measurement tool. I just ask you about that.
44 A. Yeah, so that's the other thing, that part of changing
45 our open dialogue and adapting it to what we're calling a
46 collaborative adaptive network approach, is that we're
47 using an outcome measure - it's developed by Barry Duncan

1 and Scott Miller which is called the ORS and the SRS now.
2
3 I don't know how much detail you want me to go into
4 it, but it's really, really important for us to be able to
5 deliver a recovery into a practice by using this measure.
6 Because, it runs on the predication that what we're really
7 trying to do is get outcomes that we're going to be an
8 outcome-focussed service. So, if we're going to be meeting
9 with you, we want to be noticing change or making a
10 difference to your life. It's not just coming, hoping for
11 the best sort of thing, we're really going to be looking
12 closely at whether we're making a difference. And, it's
13 not based on diagnosis.
14
15 So, what this ORS is, is that, whenever you talk to
16 families, they say what they want is, they want to feel
17 better, they want to have better relationships with their
18 friends and family, and they want to have something
19 meaningful to do, like work or school, and they want to
20 have an overall better quality of life. And, when they say
21 that, we say, "Well, that's what I want as well." So, it's
22 no different to what anyone wants, so what we decided to do
23 was measure that rather than using symptoms scales for
24 different diagnoses.
25
26 And so, you get a measure of how people are going in
27 their life, and you do it session-by-session and it's rated
28 by the young person and their family, so it's not rated by
29 the professional, it's rated by them, so they're judging
30 their own improvement, it's not us.
31
32 But it goes hand-in-hand with another measure which we
33 use at the end of each session, which is them rating us
34 about how effective our therapeutic relationship is with
35 them. So, they rate us on whether they felt listened to,
36 whether we talked about what they wanted to talk about,
37 whether the therapist is a good fit for them and overall
38 was there something missing in the session.
39
40 So, the whole idea of that tool is, what you're doing
41 in terms of your clinical practice is, you're prioritising
42 getting the therapeutic relationship with the family right;
43 that's the priority. And, if they're able to be honest and
44 give you some feedback about ways you could improve, then
45 you change and you adapt your work to them, rather than
46 them having to adapt to you, which is the old sort of way.
47

1 Why that's effective, why that's recovery-oriented, is
2 really about ensuring that there's great collaboration
3 between the therapist and the family, and it's about
4 equalising that power and also making sure that the
5 therapist is taking responsibility for outcomes. It's not
6 about, oh, this person's - the family's resistant, or
7 they're dysfunctional or whatever. It's my job as a
8 therapist to ensure that we're making progress, and that,
9 if it's not working, what am I doing that's not working?
10 Not what are they doing that's not working.
11
12 If you get enough trust and respect between the two
13 parties, the family will tell you - hopefully it's not not
14 listening, although it could be. But it's commonly about,
15 "I don't want to talk about that, I want to talk about
16 this", or, "Your approach is too - you're not giving enough
17 advice." If they can actually be really honest and be
18 up-front about giving you feedback, it's a really great
19 thing.
20
21 Q. Other than informing the individual about how they can
22 change their practices, can it be used in any other way?
23 A. Yes, it can. The idea of it and implementing it is
24 really about making sure that the clinicians on the ground
25 and the families find it useful to help them improve.
26
27 But a side-effect of it is that we are able to report
28 to our funding bodies about how many people we have that
29 are improving, how many people are getting worse, how many
30 people are staying the same. But, more importantly I
31 suppose, it helps direct team reviews so that we focus our
32 multi-disciplinary discussions on the clients that are not
33 improving or deteriorating.
34
35 So, if a family and a therapist or a team are working
36 well together, we just leave them alone, you know, keep
37 going that's great. But if they're not, then what do we
38 need to do, how do we help this situation? It's efficient
39 in terms of focusing the team discussions on the clients
40 and the families that are not doing well.
41
42 But I don't think there are any mental health services
43 who can actually report on their outcomes, and I think we
44 are able to report on - and we don't have every family
45 where that's happening, it's really difficult to implement,
46 honestly, but we are three-quarters of the way there I'm
47 going to say, but we have a renewed push to make sure that

1 every family is, we're using these tools.
2
3 And it is about being accountable to our fundholders
4 but it's also about ensuring that the recovery-orientated
5 focus is happening on the ground.
6
7 Q. The next recovery-oriented practice I want to ask you
8 about is the Discovery College.
9 A. Yeah, so we've had a Discovery College for about four
10 or five years and it's based totally on the Recovery
11 College idea in the UK. So, in UK I think there's now
12 about 80 Recovery Colleges and we have, I think, the only
13 youth Discovery College. The reason why it's called
14 "Discovery College" is, when we co-designed our service,
15 the young people told us that, "If you call it Recovery
16 College, we won't come", so we thought that's probably a
17 good idea not to call it that, so they named it Discovery
18 College.
19
20 The idea of a Discovery College is that it's an
21 educational approach to managing mental health problems.
22 So, courses are co-produced, usually with family members,
23 young people and professionals on different topics. And
24 then they always have to be co-facilitated, which means you
25 have to have a professional and a person with lived
26 experience delivering the course, and there's co-audience,
27 so the audience is professionals, family members and young
28 people.
29
30 So, we've got about 24, I think it is, current courses
31 and they're things like understanding self-harm, managing
32 medication. We did one the other night which is called
33 "The ripple effect of mental illness", which is really not
34 predominantly pitched at family members but also
35 professionals, but young people are welcome; in fact,
36 everybody's welcome at a Discovery College course.
37
38 It's a fantastic initiative, but what it does do is,
39 it allows for much greater participation of young people
40 and family members into the service because they are part
41 of the co-production, they are part of facilitating
42 courses.
43
44 But the other thing it does is, it's great for the
45 service's culture because it's really about, what's valued
46 in the service it's co-produced and co-delivered courses,
47 not professionally run courses, if that makes sense.

1
2 Q. And so, how is it facilitated at the moment? Like, is
3 it in a seminar kind of environment or how does it happen?
4 A. In our Early Psychosis service it's spread across the
5 whole southern region. So, for example, the course I did
6 last week was in Hastings in a Community Centre.
7
8 So, even though we have a hub in Bentleigh, it is
9 actually staffed by a very few number of people; I think
10 there's a total of about three EFT. But when I say that
11 that's actually misleading, because we have a lot of
12 contracted people who come in and are part of - this is
13 mainly young people - but also professionals who come in
14 and help co-produce and design and facilitate courses. But
15 they are run predominantly from our Headspace centres, all
16 of them, but their main hub is at Bentleigh.
17
18 Q. You've mentioned, in the course of describing what the
19 Discovery College does, the idea of people with lived
20 experience, and you've also previously mentioned the peer
21 workforce. Can you just elaborate on the peer workforce
22 and the idea of recovery-oriented practice?
23 A. Yes, I think that's one of the things also I think
24 where the UK is slightly ahead of us, the importance of
25 having employed peer workers in your service.
26
27 We have a combination of youth peers and parent peer
28 workers. I think I alluded to the idea before, we have a
29 specialist peer worker for eating disorder for anorexia.
30 And, it's quite embarrassing, but usually the family says,
31 "The most important information we got and the most
32 valuable information we in that meeting we had was from the
33 parent." So, it's about truly understanding the
34 therapeutic nature of what peer workers provide, which is
35 humbling for a start, but it is very, very powerful for
36 families to be able to work with people who have been
37 through something before.
38
39 Particularly this parent of a daughter with anorexia,
40 I mean, she's had so much experience now of the system and
41 what needs to happen, that's sort of - that's priceless,
42 basically. We also have other mechanisms involving young
43 people: we have youth participation programs, we have
44 advisory groups for Headspace.
45
46 I think, to be honest, I think our parent peer
47 workforce is really state-of-the-art, if you like, but

1 there's still more we can do in the youth peer space. We
2 don't have a youth peer worker at our CYMHS, for example,
3 which I think is a massive gap and we need to be looking at
4 that.
5
6 Q. Can I ask you briefly, just in relation to early
7 interventions, what do you understand the term to mean?
8 A. Yeah, well, I suppose it's confusing because people
9 have different - how I use it is trying to help people as
10 quickly as possible with an identified problem.
11
12 I think I used the example before of anorexia, that
13 how I understand early intervention is that - because it
14 can be a bit of a secret problem, some of the young people
15 are very good at hiding the fact that they're losing weight
16 and there can be delay in picking it up anyway.
17
18 But, if there's a whole circus of trying to get help:
19 if you go and see your GP and they say "Let's watch it for
20 a bit", or if you go and get some medical check and if
21 there's any delays in actually doing something about it, it
22 is very, very dangerous to not act immediately and get the
23 whole family together and provide the intervention I
24 previously described. So, for me, that's the classic
25 example of early intervention, is that you're providing
26 help and treatment to someone at the first sign that
27 there's a problem.
28
29 Q. Just on that topic, you see that particularly the
30 treatment of anorexia should be part of a general mental
31 health system rather than a specialised service?
32 A. That's my opinion, and obviously we're running that
33 service for eating disorders within our general CYMHS.
34 Obviously, we have now built up quite a bit of expertise in
35 it. I'm not saying you don't want to have people who have
36 seen other cases like this before - you do. But the beauty
37 of having it within our system is that it allows for early
38 entry, that we say "yes" to that problem, you don't have to
39 wait. There's always delays getting into a specialist
40 program that might be regionalised or something. If it's
41 part of your local CAMHS, and the CAMHS actually knows what
42 they're doing, it's a much better way to get people in when
43 they're in a milder situation and they can be helped
44 earlier.
45
46 I guess the other reason I feel passionate about that
47 is that, really, the skill that's needed is a

1 recovery-oriented approach working with the family. It's
2 not any different. It's about empowering the parents to
3 help get the kid back to eating again.
4
5 I'm making it sound really simple, it isn't, but it's
6 not a difficult concept. The skill is how to do it, and
7 I'm not for a minute saying it's not hard at home to get
8 kids out of this problem, but the principles around a
9 working alliance with the therapist and empowering parents
10 is something that we really use for all of our conditions.
11
12 Q. So, in terms of what's been done well in Victoria in
13 early intervention, you'd say youth psychosis?
14 A. Yes, I think, I mean that idea of helping young people
15 with psychosis was developed in Victoria, I believe at
16 Orygen, so I think that's been a really good thing. I
17 think we do eating disorders in Victoria pretty well in
18 terms of young people. Of course, we could do better
19 still.
20
21 I think the whole - my opinion, I know it's a
22 contested area - but the whole idea of going up to 25 which
23 is happening in parts of Melbourne. When I go overseas, I
24 mean, when I go to England and America, I go, "Oh, we
25 should be doing that as well." I'm quite envious of the
26 fact, because everywhere in western countries it seems to
27 be that countries are struggling with those young adults
28 not fitting into the adult mental health system and not
29 getting appropriate, I think, family wrap-around care which
30 can be provided in a 0-25 system.
31
32 Q. And so, you're contrasting there the CAMHS services
33 that have only 0-18?
34 A. Yeah, what I'm thinking in those areas - and I
35 probably shouldn't speak outside of my area - but I think
36 for 19-year-olds and 20-year-olds in that area - and this
37 is true across the world, not just in Melbourne - but it's
38 difficult for them. Adult services are not usually very
39 well set up, I don't think, for that age group.
40
41 Q. Can I just ask you about some other initiatives that
42 are occurring in the rest of Australia: these are things
43 that you refer to in your statement that you comment could
44 be well implemented here in Victoria. One of them is, in
45 Queensland there's a mental health support for young people
46 in youth justice. Can you just elaborate on that?
47 A. Yeah, I'm a bit mindful that one of the Commissioners

1 knows a lot more about this than me. We've recently just
2 got an initiative in Victoria where we've got a really
3 embryonic team of 1.4 EFT of running specialist forensic
4 services to support the mental health service in the
5 eastern part of Victoria.
6
7 In Queensland, they have a very comprehensive - which
8 I visited and I haven't worked there - but they have
9 something like 40 EFT which are able to do intervention in
10 CAMHS, they're able to work with courts, and it's a much
11 more comprehensive system of support. I think we're just a
12 bit behind and that would be something I think would be
13 reasonably easy to expand what we're doing.
14
15 Q. What about the Foyer model?
16 A. Yeah, I'm very excited about that model and we do have
17 three Foyers in Victoria: there's one in Broadmeadows,
18 there's one in Glen Waverley and there's one in Shepparton.
19 But it's a model where it's mainly directed at young people
20 who are suffering from homelessness, and obviously many of
21 those young people have associated mental health issues.
22
23 The idea is that the young person does a deal where
24 they have to agree to attend TAFE and doing some course as
25 part of being able to stay in the Foyer. But, having
26 visited a few, they do have recovery-oriented practice
27 happening in those Foyers. I think we could easily have -
28 obviously I'd love one in the southern region because
29 there's a real gap in the system there for homeless young
30 people, particularly around Frankston, even in our area,
31 where you could have a Health First Foyer as something
32 where you have mental health practitioners as part of the
33 Foyer team.
34
35 The Foyers are generally run by - the Brotherhood of
36 St Laurence is operating some of them here - but I think in
37 partnership with a mental health service, say like us, we
38 could offer something in-reach or in-house to really target
39 some of those kids with more significant mental health
40 issues who are also homeless.
41
42 Q. Just in terms of further recommendations for reform or
43 change, one of the matters that you touched upon is the
44 idea that people must be welcomed into the mental health
45 system. Can you just elaborate on that?
46 A. You learn a lot when you co-design a service, and the
47 really key issues that were told to me at that meeting was

1 that, "Rather than having to bash down the door and prove
2 that we're ill or prove that we need to come in or answer a
3 whole stack of questions, why can't we be welcomed in?"
4 And, I thought that was a pretty decent question.
5
6 So, we are trying to do that, and I suppose we can do
7 that to some degree because we have a suite of services
8 that can handle a sort of more mild-to-moderate-to-severe,
9 so we can confidently, on the phone, welcome people in.
10
11 The other thing that they told us pretty clearly is
12 that, "What's most frustrating is telling your story to
13 more than one person." Now, that's not always possible,
14 but I think we try our very best to do that. Because it's
15 so demoralising I think and humiliating sometimes to really
16 open up with a lot of personal and heart-felt stuff and
17 then never see that person again. It just doesn't make
18 sense.
19
20 So, those are two things that I think, I suppose it's
21 my responsibility to try and have a system where that's
22 minimised as much possible; that people be welcomed in and
23 that they get to actually meet with a person who can keep
24 seeing them.
25
26 Q. Slightly off topic but something that you are
27 passionate about: can I ask you about your views on a root
28 cause analysis in relation to suicide?
29 A. Yeah, I'm glad you asked me that question. But no,
30 it's a really serious problem at the moment, because at the
31 moment - you may or may not be aware, and certainly in
32 other countries it's a problem as well - that sometimes
33 when there's a tragedy of a suicide it can be worsened by
34 having - the way that that's investigated, if you like, and
35 sometimes that's taken outside of or away from the people
36 who have been involved in the case and the methodology
37 that's used is called a "root cause analysis". I think
38 it's come from the airline injury or something where it's
39 quite helpful to know what's happened in a crash.
40
41 In this context what can happen, if you're trying to
42 look for a cause of why someone's ended their life, it can
43 be very fraught, particularly if you're not even actually
44 talking to the people who were involved. It can lead to a
45 lot of blame culture within the mental health service, and
46 also lead to a lot of loss of confidence and fear in
47 clinicians, which actually increase - ironically, I think

1 really increases the chances of suicide.
2
3 Because what we want in our - I've told you, I think
4 it sort of works counter to the recovery-oriented practice,
5 where we're wanting professionals to feel confident that,
6 if they operate in this way, that they're welcoming, that
7 they collaborate, that they involve the families, that they
8 treat people with respect and empower people; if we then
9 use a methodology to look back on something which doesn't
10 use that same methodology, it's incredibly demoralising.
11
12 There's much better ways to review the tragedy of
13 suicide. I mean, we're trialling one at the moment where
14 we have a sort of - it's a bit like an open dialogue: we
15 don't read the file, we don't forensically examine exactly
16 what happened, we meet with the people and try and
17 understand exactly what's happened.
18
19 Because clinicians also become traumatised after
20 deaths and that's not something that's - well, sometimes
21 it's not acknowledged and it can lead to a situation where,
22 particularly you can see some services where they'll want
23 doctors to see people because it feels that it protects
24 them if something goes wrong, rather than actually having
25 doctors for their expertise in trying to - medication or,
26 you know, things --
27
28 Q. Sorry just there, are you talking about in the
29 workforce?
30 A. In the workforce I'm talking about. The problem with
31 these root cause analyses is, it can lead to very defensive
32 or lack of confidence in particular - I mean, doctors as
33 well, everybody - but sometimes then doctors are used
34 purely to sort a ticked box thing to make sure that the
35 doctor's seen them so they won't be in trouble and it's
36 really detrimental to the culture.
37
38 Q. Can I ask you about your concern or criticism at the
39 lack of online presence for particularly youth mental
40 health services?
41 A. Yes, I'm talking about, probably my own service, is
42 that, if you tried to Google us or, like anything else, you
43 would find it pretty hard and also, if you did find us, it
44 would be a very rudimentary website. And I know why we do
45 it, is because we're afraid of getting a lot of referrals,
46 but that's not a good enough reason.
47

1 Because nowadays I think there's so much stuff we
2 could put on a website that would be helpful to people,
3 including parent support, chat forums. I mean, links to
4 people, and some of the things that were raised before by
5 the previous witness, it would be a much more transparent
6 and accessible system if there was a greater presence
7 online, which I think most people are these days, so I
8 think we're well behind there.
9
10 Q. Can I ask you finally, you've talked about
11 recovery-oriented practice and that model a lot. You say
12 in your statement that:
13
14 "A truly effective system would be one that
15 is recovery-oriented and outcome-focused.
16 This does exist in some places but is not
17 widespread."
18
19 Do you suggest that there needs to be that fundamental
20 change in order to have an effective system?
21 A. Yes. I think what's been potentially exciting about
22 this Royal Commission, I mean, there's a lot of tragic
23 stories, but there seems like a willingness to say the
24 system's broken and we need to do something differently;
25 that the way we have been doing things is not working.
26
27 And I guess this way of doing things, which is I think
28 on the face of it looks pretty sensible, but is actually
29 very hard to do, and so, I think that would be - it's not
30 going to solve everything, but I think that would be the
31 transformative change that is required.
32
33 And I think that services should be reporting on their
34 client-related outcomes. You know, it's difficult, but we
35 should be held accountable for whether people that are
36 coming to us are improving.
37
38 Q. Doctor, is there anything else you'd like to address
39 in your evidence today?
40 A. I don't think so.
41
42 MS COGHLAN: Thank you. Chair, do the Commissioners have
43 any questions?
44
45 CHAIR: Q. Thank you very much, Dr Denborough. I'm
46 interested - I know that in your Early Psychosis Program
47 you said that one of your aims is to prevent

1 hospitalisation. I guess, in light of the earlier
2 witnesses too that we've heard from, what happens if you
3 aren't able to avoid hospitalisation? What's the role of
4 your service? Do you continue to engage with those
5 children, young people and their families?
6 A. Absolutely, and I think that's the shift hopefully.
7 We see ourselves as primarily responsible, that the
8 hospital is there to back us up, rather than they go there
9 and then something happens to them and they come out or
10 something.
11
12 So we visit people in hospital if we're still managing
13 them. So, if we've referred them in we'll visit and we'll
14 actually have family meetings in hospital. Because the way
15 we're operating with that sort of network-family approach,
16 it's still wanting to continue that going while they're in
17 hospital.
18
19 So, yeah, absolutely, and we do have kids in hospital.
20 Unfortunately, in our area the ones who are over 18 go to
21 an adult ward, there is no youth ward really in our area,
22 which that would be a great thing to have because I think
23 18 to 25-year-olds are very vulnerable, I believe, in the
24 adult wards.
25
26 Q. So, would you in-reach to those young people while
27 they are in inpatient care?
28 A. Yes, absolutely. Sometimes unfortunately that is the
29 first place that someone might present and end up being
30 admitted before they even come to us, which is what we're
31 trying to avoid but does happen. So, we will be going in
32 and seeing them while they're in hospital and we will be
33 taking them out.
34
35 CHAIR: Thank you very much. Thank you.
36
37 MS COGHLAN: Thank you. May Dr Denborough be excused?
38
39 CHAIR: Yes, thank you very much for your evidence.
40
41 **<THE WITNESS WITHDREW**
42
43 MS COGHLAN: Thank you, Chair, that concludes the evidence
44 for today.
45
46 **AT 3.31PM THE COMMISSION WAS ADJOURNED TO**
47 **WEDNESDAY, 10 JULY 2019 AT 10.00AM**

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