ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Thursday, 11 July 2019 at 10.00am

(Day 8)

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

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

MS NICHOLS: Good morning, Commissioners. We have seven witnesses today. The first witness will be Dr Ainslie Senz, who is the Director of the Emergency Department at the Footscray Hospital.

The second witness is Ms Tracey Morgan who is the Community Mental Health Services Manager at the Casey Area Mental Health Service and she will talk about the Enhanced Crisis Assessment Team and its work at the Casey Hospital.

Next we have Assistant Commissioner Glenn Weir from Victoria Police, who will discuss Victoria Police's engagement with people presenting with mental health problems and the mental health system.

Next we have Ms Sally Jennings, who is a community witness and carer for her teenage son, and she'll be giving evidence under that pseudonym.

We have Mr Simon Thomson, who is the Regional Director for Barwon South West Region Ambulance Victoria, and he will discuss the management of 000 mental health presentations.

We have Ms Louise Glanville, who is The Chief Executive Officer of Legal Aid, whose clients of course are among the most disadvantaged in the Victorian community, and a high proportion of them present with mental health conditions.

Finally, Ms Vrinda Edan is the Acting Chief Executive of the Victorian Mental Illness Awareness Council. She will be speaking about the role of consumers and carers in the mental health workforce.

Commissioners, I now call Dr Ainslie Senz to give evidence

<**AINSLIE LYNEA SENZ, affirmed and examined: [10.03am]**

MS NICHOLS: Q. Dr Senz, just make yourself comfortable. If you need to stand at any stage because you are uncomfortable, please just do that and we'll manage.

Are you the Director of the Department of Emergency Medicine at the Footscray Hospital?
A. Yes.

Q. Are you an emergency physician and in the course of that work you deal directly with patients?
A. Yes.

Q. Do you have quite some experience in working with alcohol and drug abuse?
A. I do, within my role as an emergency doctor and I have previously held a role of alcohol and other drugs portfolio within the Emergency Department.

Q. Thank you. With the assistance of the Royal Commission, have you prepared a statement which answers the questions we have asked of you?
A. I have.

Q. I tender the statement. [WIT.0002.0016.0001] Can I ask you about the Footscray Emergency Department. About how many patients present there annually?
A. So it's a 40,000 per year Emergency Department, which is kind of a medium-sized Emergency Department, meaning about 115-120 patients a day.

Q. About what percentage of patients present with mental health problems or apparent mental health problems?
A. The data would suggest about 5 per cent of the population, or 5 per cent of the presentations. I will clarify that to say that the data searches are really a little bit tricky. They do depend on particular search terms being able to be defined. Some of the search terms might be "suicide", "self-harm", "intentional", "section 351" might come up as a search term.

But if someone presents with a laceration and it's actually not defined anywhere in any of the search terms that that was intentional, then they may be lost to the data search, so 5 per cent is what we can gather at the moment.

Q. Speaking generally, what kinds of mental health conditions do you see in patients who present to the Emergency Department?
A. So, we see a range of mental health problems and a range of severity as well. So, there are acute exacerbations of chronic problems. So, the chronic problems might be schizophrenia, bipolar, depression, and the exacerbation triggered, usually by alcohol and drug

either acutely or chronically, non-compliance with treatment and other triggers.

We see self-harm and suicide attempts that range from very, very superficial lacerations with intent to harm, right through to quite significant overdoses and injuries. We can see just baseline chronic conditions, so people who are not in an acute exacerbation but are requiring help with anxiety, depression, schizophrenia and personality disorders within that group as well.

We see alcohol and drug use triggering acute mental health issues in people who don't have chronic mental health conditions, and we see a range of other things on a sort of less frequent basis.

Q. What have you observed about the trends in the types of presentations?
A. So, Emergency Department presentations are increasing in general and I would say that mental health presentations are increasing as well and the data would suggest that. The severity of presentations is not increasing, so in fact the rate of admissions for people presenting with mental health problems is reducing. It's probably multi-factorial, but the severity of presentations would be part of that, and the presentations related to alcohol and drug abuse, or use or intoxication, are increasing.

Q. Can I ask you how mental health services are provided at the Footscray Emergency Department?
A. So, Western Health, which Footscray is part of, does not own its own mental health service. So, Footscray is serviced by Werribee-Mercy Mental Health Service.

Q. Can I just get you to say what is Western Health before you go on?
A. Sorry. So, Western Health is a multi-campus health service: so Footscray Hospital, Sunshine Hospital and Williamstown Hospital, as well as a few other day - so Sunbury Hospital and a few other centres. Sunshine Hospital is the largest of them now, especially because it's got a new Joan Kirner, and Footscray Hospital is the smaller of the two emergency centres.

Q. So --
A. So, Western Health itself doesn't own its own mental health service. So, Footscray is serviced by

Werribee-Mercy, and Sunshine Hospital, the other major campus is serviced by North-West Mental Health.

Q. How does the servicing occur in a practical sense?
A. Not very well, to be honest. So, what happens from an Emergency Department point of view, is that we have staff within the Emergency Department who are employed by Werribee-Mercy, they are our Emergency Mental Health staff, and that part works very well.

But then, because the next step is actually provided by a completely different service, the lines of communication and the accountability are quite problematic.

Q. Can I just take you back. So, you have staff and what kind of roles do those staff fulfil?
A. So, they're called our Emergency Mental Health staff or EMH staff. They range in qualifications and they're usually mental health nurses or allied health staff such as psychologists, and what they do is they provide mental health assessments within the Emergency Department. On a shift basis we have one of those per shift 24 hours a day, so that's three per day.

Q. That arrangement works well, you say?
A. Yes, that actually does, they're part of the Emergency Department team.

Q. Does that mean you are able to give relevant directions when you need to about who needs to see which patient?
A. So, that's not as easy, and I suppose this is one of the reasons why owning our own health service might be a little bit better, and it's nothing to do with the staff themselves, I might say, it's just about the systems that go around it.

So, I'll provide the example of the medical and surgical teams which Western Health does own; that dialogue is very easy, there are very clear systems around that, including policies and procedures which they have to follow; and so, we all know where we stand and we all know what our responsibilities are.

When you're dealing with a service that's not provided by you, that responsibility and the lines of accountability are not there, so we sometimes don't have the same

relationship and the same systems that we would have for our internal services.

Q. You started with the mental health staff and you were about to move up to the next level.
A. Yes, so the mental health staff are managed by an EMH manager. So, that role is again employed by Werribee-Mercy and, up until recently, was completely off-site. We do have now the capability to have them have some office space, not five days a week, but temporarily at Footscray. Also that role has been vacant quite a lot and has just been re-appointed to, literally just recently.

Then above that they obviously have their own off-site managers within the mental health service. One of the things that Western Health did do to create a little bit more of a relationship between the two health services, was to make a liaison role; it's called the Service Development and Operations Manager, and that was a Western Health role that was responsible for liaising and opening the dialogue between the two different health services and trying to break down some of the barriers and also trying to help with some of the accountability piece or the governance piece within there.

That role has been quite important, and has been there for about two years. However, it has had periods of vacancy and is currently vacant.

Q. Thank you. Can you say briefly how is the Emergency Department at Footscray funded?
A. So, EDs in general are funded on projections of activity based on previous numbers and also projected numbers, so we get sort of a lump sum of money to do what we do. It doesn't actually take into account any kind of complexity of care.

There are obviously projections about complexity of care but it doesn't really - unlike other parts of the hospital which will be managed on the type of patient that they eventually get and the complexity of the surgery, et cetera, we don't have anything like that in ED.

Q. Can I change topics now and ask you to go back to the presentation of patients to the Emergency Department. How are mental health patients presenting at triage?
A. So there are two different components to triage for

mental health patients: so there's a general triage for all patients which divides patients into categories 1-5 based on the life-threatening nature of their condition. So, category 1 is immediately life-threatening, imminently, possibly, and then down to potentially serious and then not serious. So, that's a triage criteria based on urgency to be seen; not necessarily on severity of the condition.

Then there's a mental health triage that goes alongside that which puts people into, like, a risk category in terms of their harm to their self or their harm to other people, and then along with that gives some advice on what level of supervision they might need. So, a level 1 would be that they're very high risk to themselves or a risk to other people and they need a high level of supervision, right down to no risk and no supervision required.

Q. Which patients will the mental health staff see?
A. So, generally speaking the high acuity, so the higher end of the triage, as in the 1s and 2s. Just to explain that a little bit more, we really don't have a service that can provide a lot of assistance to the really low acuity patients.

So, if you really need an admission and you're obviously very unwell, then that's not an issue. But the people who are presenting for help or assistance but don't have - I'll give some examples - don't have active suicidal ideation and don't have active acute mental health issues, it's very limited what we do for those patients.

Q. Once you've got through triage, if you are a low acuity patient and you're assessed as not being a risk to yourself or to others, what happens next after triage?
A. You'll be seen by a doctor, a nurse as well as a doctor, but if you're a low acuity patient without risk, then you won't be seen by the Emergency Mental Health staff.

Q. Once a person's been seen by a doctor, are they then discharged into the community?
A. Yes, if there's no other reason for them to stay.

Q. Is there any availability of information that can be given to patients about seeking out help once they go back into the community?

A. Yes, so we have information about 24-hour help lines, we have a card that we can give people about the service, yes.

Q. Is that essentially how you provide that support, by giving information to people?
A. That's right.

Q. What about patients who are perhaps more unwell but they don't need to be admitted to a bed?
A. So, they'll be seen medically as well by nurses and doctors to assess the medical state, and the people who are more unwell will be seen by Emergency Mental Health. The Emergency Mental Health staff will then determine whether an admission is required or not, and then if in the scenario you're suggesting they're not required, then they'll arrange some kind of community follow-up for them.

Q. Can I ask you about the process for admitting people to a bed: who can make that decision and how does it occur?
A. So, the Emergency Mental Health staff make that decision, and this is a unique area within my workplace. So, for every other type of patient I am empowered to make the decision about admission as a senior doctor in the Emergency Department. The way that it works: if I think someone needs an admission under a medical team and they don't think so, they need to come and see the patient themselves and then manage the care and either agree with me or disagree with me and manage the ongoing care of that patient, and that's very clearly written in Western Health policy and is very common amongst Emergency Department practice.

Within psychiatry I do not have that power. I can only refer to the Emergency Mental Health staff and then they will do the assessment and then they will make the decision about whether the patient needs an admission or not.

Q. What's the reason for that difference between mental health and general health?
A. I think for us one of the biggest reasons is that we don't own the mental health service.

Q. What do you say about the availability of beds, even though it's not within your control, what have you experienced in terms of the availability?

A. So availability of mental health inpatient beds is at crisis point, is what I would say. So, bed availability for all types of patients is really tricky and we do have some targets that are set nationally about how quickly we're meant to be able to find those beds, and let's just say that we're not perfect at that for any particular patient group. But the mental health group stay longer in an Emergency Department waiting for an inpatient bed than any other group of patients do.

So, if I just give you some examples: 70 per cent of the patients requiring an inpatient bed under mental health will stay more than eight hours and 20 per cent will stay more than 12 hours, whereas for all the other groups of patients it's actually half that number.

The other part about this is that there's a 24-hour rule, so essentially no patient is allowed to spend more than 23 hours and 59 minutes in an Emergency Department. That's very clearly set and it is not breached at any point for any patient other than mental health patients. And so, what that does is it means that mental health patients can breach that 24-hour mark, and unfortunately it's not very pleasant to say but they can breach a 48-hour mark and a 72-hour mark as well.

Every month we have around two or three patients breaching a 24-hour mark; sometimes it's zero a month. The worst month that we've had in the last few years that I've been Director is 14 in a month.

The longest length of stay we've had in the Emergency Department for a mental health patient is five days.

Q. What happens when you don't have a bed available and a person is waiting for 24 hours or more? What happens to the patient?

A. Essentially nothing. So, this is another area within health provision within the Emergency Department that's completely different for mental health patients and other patients. So, again, if you've got a medical or surgical patient in the Emergency Department, the inpatient teams would come and review that patient. So, even if there's no bed available and there's waiting in the ED, there's a collaborative care for that patient, they will receive their treatment, their antibiotics, their oxygen and their pain relief, whatever it is that they need and they will be

reviewed by the team who is essentially managing them with me in the ED.

Q. Can you give an example by reference to a general health condition?
A. So, if someone has pneumonia, then I will be giving them the oxygen and the antibiotics and the IV fluids if they require whilst they wait for a bed in the ward, and their team, the general physicians, will come and see them, they will admit them, which is essentially a process on paper, and then they will come and review that patient whilst they're still in the Emergency Department. So, they see that they are actually - they own that patient.

If there's something that goes wrong, so just say that patient with pneumonia deteriorates and needs some higher level care, then I will manage that in conjunction with the team, the general physicians, who will come down from the ward to do that. That is the not the case in psychiatry.

So essentially a patient waiting in the Emergency Department for a mental health bed will get medications charted by me in the Emergency Department. They will get reviews by the Emergency Mental Health staff, but they won't get any psychiatry care, and they definitely don't get anything therapeutic, so there's nothing that they get in terms of an intervention for counselling or therapy, there's just medications.

They also don't get meals, they don't necessarily get showers - this is something that we from the Emergency Department are trying to work on, but if you can imagine we're geared towards fast turnover of patients, most patients don't need meals or showers, and we're not very well geared to patients who are staying there for a really long time, so things like meals and showers can actually be overlooked for this group of patients unless they're actually asking us.

Q. And so, are there really two parts to the problem, one is that there's no capacity for them to go where they should be going, and that the Emergency Department being an Emergency Department is not equipped to manage people on a longer-term basis?
A. And a third component which is that the psychiatry team is not involved in their care during their stay. So, I gave the example of the pneumonia patient deteriorating

before. If a patient with mental health problems deteriorates the usual course for that or the usual scenario would be a behavioural crisis in which they get quite agitated and need management of that, and that will all be up to the Emergency Department to manage as well.

Now, we're very well trained in de-escalation and behavioural crisis management, so the skill set is there, it's just that I don't manage anyone else's deterioration without the other team involved, but I do manage the deterioration of a mental health patient without the involvement of psychiatry.

Q. Just returning to the question of wait times. The National Emergency Access Target, or NEAT, is eight hours; is that right?
A. It's four hours for the general population.

Q. Sorry, four hours. And is it different for mental health?
A. It's set at eight for the mental health population.

Q. Is it set at eight officially according to that target?
A. It's a bit complicated but that's the one that we run on.

Q. Can you explain that?
A. The four-hour one is pretty much for every other part, but the eight-hour one is giving it a little bit of flexibility for the mental health system.

Q. Is it explicitly intended or designed to give flexibility for mental health patients?
A. Yes.

Q. You referred to 24-hour breaches before: does a breach occur when a patient has been in the Emergency Department for 24 hours?
A. Yes, for 24 hours or more, yeah.

Q. And that applies whether or not they're a mental health patient?
A. That's right.

Q. In the case of 24-hour breaches for non-mental health patients, what are the consequences of a breach as far as

the hospital is concerned?
A. We don't breach 24 hours, it creates a very significant investigation, including the management of the hospital need to report to the Department of Health to explain what happened. That doesn't happen in the breach of a mental health - let me say, it's not as rigorous, there's not as much fear around a 24-hour breach in the mental health scenario.

Q. Can I just draw you out on that little bit, about not being as rigorous where there is a breach of the 24-hour rule in relation to a mental health patient: what do you mean by not as rigorous?
A. It's probably best said that we tolerate the 24-hour breach in the mental health patient because we know that the system is much more difficult and also because, at Western Health in particular, we know that we have little control over the system of getting the beds. So, for the non-mental health patient it's very much in our control to make that bed happen, and so, therefore if it doesn't happen the accountability is with us and there is a very, very detailed investigation that goes into what happened.

With the mental health patients, there's less - or there's no control over finding a bed, and so therefore, I think it's felt that we could investigate and find out that we couldn't do anything extra. I think there is also this idea that, if you breach, it will be sending a message that the system is broken rather than hiding it.

I'll just explain that a little bit more. So, there used to be a practice where for some of the lower risk patients who needed admission to an inpatient mental health bed, we would put them in our short stay area or waiting a bed. Now, there's lots of reasons to do this: so it frees up the bed in the Emergency Department to use for other patients. Our Emergency Observation Unit is a nicer ward environment with a nicer bed, and it's a bit quieter, so from the patient perspective - it's got a TV, it's a bit nicer. But it also had the effect of stopping the clock, which means that you could never get to 24 hours.

That practice was stopped for lots of reasons, one of them being that we also need to use our short stay beds, so we can't actually have a patient in there for 24/72 hours, which was happening. It's also because some of the behaviours of the patients were difficult within our short

stay area, especially after they have to wait for 24 or more hours, and the other thing is that we realised that hiding the problem wasn't actually solving the problem.

Q. So, who are 24-hour breaches reported to?
A. So, me and sometimes --

Q. Beyond you?
A. Yes, so then upwards through the hospital to the CEO. The CEO or the Executive Director of Operations will then have to answer to the Department of Health.

Q. On the basis of your knowledge, when you say the 24-hour or more breaches in respect of mental health patients aren't rigorously investigated: firstly, do you mean at a hospital CEO level?
A. I'm sorry, I can't really comment on that. I just know that I don't have to do the investigation that I would for another patient.

Q. I see.
A. I imagine, but I don't know, that the CEO still has to have a dialogue with the Department of Health about it, there's an understanding that these will happen.

Q. So your knowledge only goes so far as your involvement?
A. That's right.

Q. And your experience is such that you don't have to do the same kind of investigation or reporting at your level that you understand would occur if a 24-hour breach happened for a non-mental health patient?
A. That's right.

Q. Thank you. Can I ask you about what occurs with patients who are brought to the Emergency Department under section 351 of the Mental Health Act?
A. These patients are brought in - essentially they're brought in against their will to have a psychiatric or a mental health assessment within an Emergency Department; they're usually brought in by police with ambulance assistance as well. So, these patients can - not really want to be in the Emergency Department and may be quite angry at the fact that they are there, hence why the police are involved.

Q. What management issues arise for you in the Emergency Department?
A. These type of patients are managed very similarly to someone who is coming in with quite an urgent medical condition, so they need very quick attention from medical nursing and Emergency Mental Health staff. They are quite resource-intensive usually, and they also involve our security staff. We obviously need to get the police back out to the community, and so, our security staff will take over some of that role.

What happens with some of these patients - so there's a few different groups within this: the first group would be people who are easily de-escalated, and by that I mean they become calm and they realise that they're in the Emergency Department for a reason, they're agreeable to having a mental health assessment.

Obviously you have the other spectrum where people are not agreeable to be there, and that can either be because they intentionally don't want to be there, or it can be because they're actually quite unwell and they're not thinking well enough to actually make a decision about whether they should be there or not. In those situations people can be incredibly agitated and violent and require behavioural management and usually chemical restraint. So, by that I mean we give people medications to help facilitate them to be calm, and unfortunately in some situations we also have to physically and mechanically restrain people, and I do mean by that that we have to strap them down to the bed.

Q. What are the challenges that your staff face in dealing with that sort of situation?
A. So they're very challenging I think for any staff member, no matter how experienced you get with dealing with behavioural crises, they're quite confronting. There's always the risk of violence and injury to staff. There's also quite a lot of disruption to the remaining - the other patients and other relatives within the Emergency Department and it's quite distressing for them.

It's not easy to hide what's going on from the rest of the department, and at Footscray in particular we don't have a behavioural assessment room yet, it's being built, but it's not there so most of this happens in front of everybody else, and that can be very distressing.

Violence is a big risk within there scenarios, or injury is a big risk within these scenarios, and we do have staff being injured. I'm happy to report that our staff injury rate is actually quite low and we've got some other structures in place to help with that, but these particular crises can end in injury.

Q. The bringing on line of the behavioural assessment unit, do you think that will provide real assistance in that respect?
A. It provides it - so, you're talking about the behavioural assessment room?

Q. Sorry, room, I beg your pardon.
A. Yeah, no, that's fine. Yeah, so it provides a different space. So, the idea of the behavioural assessment room is to provide a space in a place that's more conducive to the patient's dignity and the distress levels of the other patients and relatives. So, you're usually a little bit out of the way, closer to the emergency and the ambulance entrance of the Emergency Department and a bit more soundproofed.

Q. Can I ask you a bit more about the physical makeup of the Emergency Department. You say in your statement that the environment of the Emergency Department is not suited well to mental health patients. Can you elaborate on that?
A. So, Footscray Emergency Department itself is very old, it's very small and cramped and low ceilings, and it sounds really silly to make that point, but it is actually really impressively small. And it's also very busy and it's a 24-hour business, and so, the lights are on all the time and there's lots of noise and there's lots of stimulation, so none of those things are very good for patients who are acutely unwell with mental health issues and they're also not good for other patients who are not as well but still needing to be there.

Q. You've made the point in your statement that Western Health is in the process of implementing a crisis hub at Sunshine Hospital. What's your view about the utility of those hubs and how compatibly they sit with the practice of emergency medicine?
A. So, I think one of the things about all of the different types of strategies that people use is, everyone wants to make the Emergency Department better for every

single patient group, and one of the things that I always say is that, my environment is designed to see patients quickly and to institute their immediate and urgent care, and then move them on to the next place.

And so, I would prefer to manage the number of patients who are coming to me and the need for the Emergency Department, but also then manage getting them out of the Emergency Department to actually the destination they need to go to, rather than create an environment that is better for people to stay longer in an Emergency Department. So, I'd prefer the process and the system to be fixed rather than to make the environment better to stay longer, if you understand.

So, from the crisis hub point of view, I think there's some elements of that that are really, really useful, but the problems that I have with it are that they, again, make the Emergency Department seem like the centre of care for all of the community, whereas I don't actually think that that's what we're there for, and it feeds into that idea of a one-stop shop, and that's the concern that I have, is that, the other part of this from my Emergency Director point of view is that I could do this for all different patient groups.

So, the same concept happens for the elderly population, that I should make an Emergency Department that's beautiful for the elderly population to be there for longer than anyone should ever be in an Emergency Department, so how about I just fix the scenario of moving the patient through to their actual appropriate destination and we could make that environment appropriate for the elderly population rather than the Emergency Department.

Q. Can I ask you about discharge planning: what's involved in discharge planning insofar as that occurs with mental health patients?
A. So, as a doctor I'm not involved in much of the discharge planning, the Emergency Mental Health staff are involved in the discharge planning. I imagine that it's community follow-up, some of that will be general, as in go back to a psychologist, here's the way you can do that; some of that will be coordinated through the community strategies such as having a caseworker.
Q. So, you don't do it yourself?
A. I don't personally arrange the follow-up.

Q. But is it ultimately your responsibility as the Director?
A. This is again a difficult space. So for the mental health patients, no. For every other patient, yes.

Q. Can you say one way or the other what the options are for discharge if a person is homeless, do you know?
A. So, the homeless patients, we do actually provide a safety net for. So, homelessness is slightly different to mental health, and so our social workers will be involved in managing the discharge of the homeless patient.

Q. I probably asked the question a bad way. If a person has presented with mental health issues but has no place of residence to be discharged to?
A. So, we don't discharge those patients home until we have sorted out something that we can do for them. So, the typical scenario is if someone is after hours, or overnight, then they won't go home until we've been able to sort something out for them in the morning.

Q. And, by sorting something out for them in the morning, do you mean you will put them in touch with the social worker who is at the hospital?
A. So, social worker input, yes, and also crisis centre, Homeless Crisis Centre contacts. I'll say, most of the homeless people actually have all of those contacts in the first place.

Q. We've asked you a question which is addressed in your statement which is, what are the most critical areas of unmet need? You have said, firstly, that low acuity patients represent a group suffering unmet need: what do you mean by that in the context of an Emergency Department?
A. So, Emergency Departments provide very, very little, if anything, to the low acuity patients. Unless you really meet criteria for seeing an Emergency Mental Health staff member, which usually means some kind of risk to self or risk to others, then you won't be seen by them and you'll really have little, from my point of view. I will just be making sure that you haven't taken the overdose you haven't declared yet or harmed yourself in some way, but other than that I can't provide anything.

So, I really feel like I do nothing for that group and I've said, I think everybody who comes to an Emergency

Department should get some kind of value-add, and that's not necessarily what the patient thinks that they were coming for, so it's not necessarily a diagnosis, but it can be reassurance, it can be education, it can be a diagnosis, it can be symptom management.

For mental health patients, especially in the low acuity, I provide nothing. I might provide a card for a phone number, but that's about all.

Q. We've already addressed, I think, the needs of patients requiring admissions. Can I ask you your views about how demand on the Emergency Department, at least in your area, is changing?
A. So, we're growing; I think every Emergency Department is growing. The rate of growth at the moment for Footscray Emergency Department is about 5 per cent, and that's been consistent. Sometimes it goes a little bit higher than that but it's consistently about 5 per cent over the last few years. That's higher than the population growth rate, and I think that's probably reflected around a lot of Emergency Departments, that the growth of Emergency Department presentations outstrips the population growth.

Q. You've mentioned the growing use of drug and alcohol in the community: does that impact on Emergency Department presentations, do you think, in terms of trend?
A. Yes.

Q. The college, our Emergency Department College does research on alcohol in itself and says at least 10 per cent of presentations to Emergency Departments are alcohol-related, that's not including other drugs at all, and the trend is, yes, that they are increasing.

Q. We've asked you about your ideas for reform and you have already mentioned Western Health needing to have its own mental health service, which is I think your number one recommendation?
A. Yes.

Q. You've mentioned the need for additional capacity which we've already discussed. In terms of the changes outside of Footscray Emergency Department, what do you think are the important changes that need to be made?
A. So, I do think there needs to be a lot more community-based resources. I actually think that it's

probably an untapped - I think there's an element of untapped demand in there, because we're not meeting the needs of the community at the moment, I don't think, because they're coming to the Emergency Department and not being admitted, so clearly not acute. But also, I think that there's a lot of - we've talked about the stigma and the discrimination around mental health and I think there's actually an untapped demand for community services as well.

I did mention in my statement that I think one of the things the Royal Commission could do was - is very powerful around the awareness of mental health and the way that employers and insurers could actually manage mental health risk. I made the point that mental health exclusions at insurance levels is actually not based on any type of risk assessment or severity level, unlike any other kind of illness, and I think that that's a form of discrimination. And, although that does not impact on Footscray Emergency Department at all, I actually think it's a very powerful thing that the community could benefit from.

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

CHAIR: Yes, please, Professor McSherry.

COMMISSIONER McSHERRY: Q. Thanks very much for your comprehensive statement. Just a couple of questions. Would you have any data about how often patients would be transferred and treated on a compulsory basis?
A. I'm sorry, I don't. It's not an uncommon request that patients are brought to the Emergency Department because they're on a compulsory treatment order; that would be one of the main reasons that someone would be referred to the Emergency Department by the community teams, but I'm sorry, I don't have that data on me.

Q. Okay. You've described some circumstances that might lead to the use of physical or chemical restraint. Can you perhaps explain what chemical restraint means in this context?
A. So we do use it as a bit of a broad term and it can be, at the lower end of it, using oral sedation, so tablet forms of sedation such as Valium, or there's another one that's commonly used which is called Olanzapine. To take an oral medication a patient has to be fairly compliant and cooperative with that, and so that's the lower end of

things and we generally use that after de-escalation, or talking with the patient is what we mean by that, addressing their concerns, and then we'd offer something like Valium to say, look, you're probably going to be waiting a little while, do you think that this would help you to manage your symptoms and your anxieties whilst you're here? So that's the lower end of the spectrum.

In the behavioural crisis that we were talking about before involving a lot of security guards and the idea of mechanical restraint, we're usually giving an injection of a sedative.

Q. And, what happens then?
A. So then the patient is asleep. So, there's a few different combinations to what happens then. So, what happens then is the psychiatrist has to be informed that that has happened. There are a whole lot of compliance things that we need to do as Emergency Department staff: so, regular observations, regular checks of the restraints to make sure that they're not causing injuries.

The patients are actually managed in resus, which is a one-on-one nursing area so that we can identify if there's any problems. Because the other side of things is the sedation part, so the drugs are very powerful and we need to continue to monitor them like an unconscious patient essentially.

And then what happens is that we wait for the medication to wear off; during that time we may have released the restraints and, when they wake up, we do a further assessment. Some patients wake up and that's really all they needed, was a really good sleep and sort of removing all of that anxiety and the really high crisis state and the time under the medication has actually helped that occur. Other people wake up and they're still very unwell and, depending on what goes on, people unfortunately could require further sedation.

Q. How often would that occur, that extreme circumstance?
A. So, we're doing much better at this now. When I say "much better at this", we have a system in Footscray Emergency Department where we actually identify behaviours of concern proactively, so we're trying to reduce the number of times that patients get to a crisis point.

Our code greys, which is the crisis point, have reduced about 11 per cent via this new process that we've got, and the proactive way of managing it has increased above 60 per cent. So we're actually seeing a reduction and probably about once in every two days would we have a crisis point.

Not every crisis point or code grey requires someone to be retrained or to be given injections of medication, so that might occur two or three times a week. It does depend, we get peaks and flows.

Q. Just to clarify, so two or three times a week a patient might be sedated to unconscious levels?
A. Yes. It might be more than that on some occasions, it might be less. The other part of that is that some patients require it repeatedly.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Q. Thank you. Dr Senz, thank you very much for the overview, I think you've given us a very good illustration of how an ED department works and the challenges in managing it. I'd like to clarify: you do say:

> "'Ice' is a particular problem with mental health as its harmful effects are more immediate and it has a significant relationship with psychosis."

You have referenced that a few times. Can you describe for us what in fact occurs in relation to that and if there are any particular management challenges you face that are --
A. With psychosis or with ice?

Q. Both.
A. Patients who have acute psychosis have, in layman's terms, lost touch with reality, they're very difficult to rationalise with: so, some of them are not a problem at all, their delusions are really internal and they're not distressing to them, and so, they're very easy to work with and manage.

Some patients with psychosis are paranoid, and if their paranoia is very real for them and they think that

people are actually out to get them they can be incredibly agitated, as you can imagine, and scared.

There's obviously variations on a theme within that, but ice can trigger a psychosis, and again, that could be a spectrum but it tends to be very acute. Most of the pharmacological psychoses are very real and very acute and patients are incredibly scared or angry.

Q. Thank you. We have heard from a number of witnesses already before the Royal Commission about their experiences of going to Emergency Departments, and I think that fear that you've talked about is very often what they will describe.

They have also talked about though the impact of the waiting times in an Emergency Department, and hence, eight hours might seem a very, very long time for someone in acute mental health crisis, let alone the other extremes you've talked about, and so, we do hear from time to time people have talked to us about the fact they just can't wait in that environment, they find the loss of dignity, the noise that you've described very eloquently, the lack of privacy overwhelming and they leave and don't seek the assistance that they've come to get. Would that be your experiences in terms of the impact of those wait times?
A. Absolutely. I think all patients do a good job waiting, the level of time that they have to wait. And obviously, if we could make it a shorter wait, we would. But I think for mental health patients in particular it's very challenging to wait that long, and, like you've just explained, the stimulating environment is not conducive to them waiting, and also, if they're very acutely unwell, they're actually not as well understanding what's going on.

So I think it is very challenging, and I'll say, even once they get in and if we're waiting for a bed, one of the biggest reasons for a behavioural crisis or an escalation of behaviour is just waiting.

Q. And that might mean a response with security guards as a result?
A. Absolutely, yeah, and it's just awful. It's especially awful because we can't do anything about it. We feel powerless as well, but it's a trend that patients do get to - and most patients I'm going to say, most patients would get frustrated, but the behavioural crisis is a

reality for this particular group of patients with respect to waiting.

CHAIR: Thank you very much.

MS NICHOLS: May Dr Senz be excused?

CHAIR: Yes, thank you very much for your evidence today, Dr Senz.

<**THE WITNESS WITHDREW**

MS BATTEN: Commissioners, the next witness is Ms Tracey Morgan. I call Ms Morgan.

<**TRACEY LEE MORGAN, affirmed and examined: [10.42am]**

MS BATTEN: Q. Thank you, Ms Morgan. Have you, with the assistance of Monash Health's legal advisors, made a witness statement to this Royal Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0002.0013.0001] You are the Community Mental Health Services Manager of the Casey Area Mental Health Service; that's right?
A. That's correct.

Q. Could you please outline what that role involves?
A. So, Casey Area Mental Health Service is part of the Monash Health Service. We have a number of sites and area-based services, Casey being one. My current role involves oversight of the CAT teams, the Continuing Care Teams, our PARCs units and our psychiatric triage service, and I've previously as well been involved both in a manager's position and in this position, and as a clinician in working in our Emergency Department services.

Q. Previously you were involved in overseeing the Emergency Department, could you just elaborate for us what that role involved?
A. Yes, so I was the manager of the ECAT services, so the mental health clinicians that were based in the Emergency Department providing assessment and treatment for clients that presented.

Q. What is the ECAT service?
A. So, ECAT is the Enhanced CAT TEAM. So essentially CAT

Team level clinicians or acute community mental health clinicians who are based in the Emergency Department, to be able to provide that assessment in that Emergency Department space.

Q. You've said they're clinicians: can you just clarify what roles people occupy in that team?
A. Yep, so we have a mixture; the majority are usually mental health nurses or psychiatric nurses. We do have social workers, we do have OTs, we do also on occasions have psychologists, so it's usually a mixture.

Q. Referrals are made to the ECAT Team by Emergency Department staff; is that right?
A. That's correct, so someone may present to the triage window, describe having a mental health issue and then that referral can come directly to the ECAT clinicians, or it may be that people have presented for something different altogether, but in the course of investigating that, medical staff in the Emergency Department have discovered that there's a mental health component and as a consequence they have made a referral to the team.

Q. People may also come to the ECAT Team through the psychological triage service, which is a phone service?
A. That's correct, yeah.

Q. People can ring that service and be referred to the ED and come to you that way?
A. That's correct, so that's our 24-hour contact service, so it may be that people have called that phone number, there's been a concern about their level of risk, so that they don't feel that people can wait to be seen in the community and they may be directed to present to the ED and present to that triage window, but will be contacted to be advised that they're coming and what information's been discussed so far.

Q. Can you clarify for us, what's the criteria to be referred to the ECAT Team? What do you have to satisfy to come to your team?
A. Look, we are I think probably more flexible than some other services. So, for us - I know we were hearing before, that very acute sort of end of the service. We would tend to see anybody in our Emergency Department that presents with a mental health issue. So, we don't wait for a criteria that's about risk or suicidality or the acuity.

If you've presented with a lower acuity presentation, it doesn't mean that we won't see you, so we will see people in those circumstances where there's a mental health component irrespective of the identified risk.

Q. You've stated:

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

Can you first just clarify, what crisis support services are you referring to there?
A. So in that circumstance I'm talking about either potentially admissions, or CAT Team follow-up as a specific community treatment team. We have clients that will present that we may refer to other services as well outside of that particular crisis space. So, it might be - we don't tend to refer very much to our Continuing Care Teams directly from the Emergency Department, but we might use programs like The Way Back who provide sort of three months support in the community but it's more psychosocial in nature. We might use other non-government organisations, we might send people back to GPs for referrals to psychologists or private psychiatrists, so we look at a number of options in terms of what's available in the community.

Q. You've referred to the objective criteria for those services: are criteria for those higher than getting to the ECAT Team?
A. Yep. Sorry, can I just check: so, you're asking about the criteria of how people would be referred to the CAT Team, what that would look like?

Q. Yes.
A. In doing the assessment people would be presenting either as at risk but able to work with us in terms of being kept safe in the community and having support, or they may be very psychotic or very unwell but their risk is otherwise manageable, so they're not acutely suicidal per se but still very unwell and able to engage with us in treatment.

Q. In reference to the Emergency Department you have stated:

"There is a growing need for mental health services and waiting times are increasing."

Could you outline for us what the growing need is?

A. Yep, so Casey is based in a growth area of the catchment; we sort of have a large amount of housing development in an area that doesn't have lots of existing infrastructure necessarily in terms of other services that you can access in crisis. It also has its own stressors with people moving into these sorts of areas, they may be a long way from family and other supports, they're often taking on mortgages that place them at financial stress. We see a lot of people, probably more than I would have five or ten years ago, who are presenting maybe with suicidal ideation but in psychosocial crisis: they're not being able to make their mortgage payments, they may have lost their jobs, they are having relationship difficulties or relationship breakdowns, more domestic violence, and so, the build up of those stressors has led them to a point where their mental health is then compromised and they're at risk.

Q. When you say "the waiting times are increasing", waiting times for what do you mean?

A. Across the board really, so the waiting times in the Emergency Department when people present there just to see people are increasing. For Casey Hospital the average over the last 12 months would be five hours, but that's the average, some people may wait an hour, some people may wait eight or nine. It's a 20-bed department and it's very small. Casey over the last four months has averaged about 360 mental health presentations a month, so it's a lot of people to sort of move through what's a fairly small Emergency Department.

But also, as community services are put in place, so any of those non-government organisations for example, there will be an influx of referrals as they start and then things will get to the point where there are waiting lists and it's difficult to access those services.

There are also a number of community-based services that exist, but they're tendered, so they're only there for short periods of time, and after a couple of years they may change names or location and it's very difficult to track that, so if you're in the community trying to find support

before you get to a crisis, it can be very hard to know where to go and what to do.

Q. In the Emergency Department you've said that clients can wait - the average is five hours, is that what you said?
A. Yes, and that's just for the initial assessment, to see a mental health clinician, that's the average, but it can be much longer than that.

Q. In your statement you said:

> "When I was first working with ECAT over 10 years ago I saw more patients with depression and psychosis but now we see patients with a wider range of mental health issues."

Can you elaborate for us what are the wider range of mental health issues that you're seeing?
A. Yes, so I think we're seeing a lot more clients who are, as I say, in that psychosocial crisis and have mental health impacts as a result of that. We're seeing a lot of clients whose behaviour and mental health has been impacted with substance use. It's not that those clients weren't there before but I think the increase in the use of stimulants has meant that we get a lot more presentations, I think, with quite agitated and behaviourally disturbed clients who then have mental health impacts as a result of that substance use.

We still do see clients obviously who are either psychotic or having more traditional presentations like bipolar disorders and more chemically driven depression, but I think we have a greater number of people whose mental health has been impacted by what's going on within their lives, as well as a behaviourally/biologically presented illness.

Q. Are you able to comment on what proportion of patients who come to the Emergency Department are involuntary patients?
A. I couldn't tell you off the top of my head the number. I know that we work very hard to try and keep as many people as voluntary as possible, but there certainly is a component of people who are brought there against their will either by the police under the section 351 that we

were talking about before; we do also have clients who are sent to the Emergency Department by our community teams: by psychiatrists, by GPs, on an assessment order or on a variation of their treatment orders.

Q. Staying in the Emergency Department, when someone's come to the Emergency Department and they've been triaged, where are they physically waiting then?
A. So it sort of depends on how they've presented and where they present. If they've presented themselves to the window, unless they're triaged as being at high risk, they'll most likely be waiting in the waiting room. For those clients who may present with police or ambulance, the ED staff will do a triage of their presentation, and again, depending on their risk, they may go directly through to a cubicle or it may be that they go to the waiting room to wait as well.

Q. You said in your statement that the ED environment is not helpful for patients who present in crisis or who are exhibiting mental illness. Can you elaborate on why it's not helpful?
A. I think very much, as we were hearing before, Emergency Departments are very busy places, they're fully lit 24 hours a day. You know, they might turn some lights off at night, but it's never not lit up there. They're noisy, they've got a lot going on.

Some of the noises that you hear and the voices that you hear across the Emergency Department are not only loud but very distressing. You'll have families in there who are in the process of being given the news that their family member's not going to survive; you've got people coming in with trauma incidents and that's noisy and quite chaotic; you've also got people coming in behaviourally disturbed either because they're substance intoxicated or because of other things that are going on for them at the time, or because of pain, and so all of those noises are sort of constant and 24 hours.

And when you've come in in crisis and you don't know quite what's going to happen, and you're scared and overwhelmed and you're in this environment where you're not necessarily going to get any sleep, your support people or your family may or may not be there, and people aren't in a position to spend a lot of time with you to provide any reassurance. I mean, we will provide what we can in terms

of medication and treatment, but you were already feeling pretty terrible before you got there and to spend potentially 24 hours or more in an environment like that isn't doing anything a lot - to any degree that offers you any help or assistance or gets any better, it's very overwhelming.

Q. When someone sees the ECAT team, where is the assessment conducted?
A. It's usually in a cubicle. Cubicles in Casey Hospital, some have physical walls, there are some specific rooms that are there, but the majority of cubicles are sort of paper curtains and things that you can draw around to get at least a little bit of privacy. Casey, unlike some of the other departments, doesn't have a specific interview area that we can use to see people, so we're reliant on a cubicle being available.

Q. Can I turn to the issue of treatment. You've stated that ECAT does not turn anyone away.

What does that mean? Does that mean everyone who is referred to ECAT gets assessed?
A. (Witness nods).

Q. Do they also receive treatment?
A. Yeah, so what we will do is we'll do an assessment; to do an assessment properly in terms of an ECAT assessment, so that means talking to the client, talking to their family or next of kin, their stakeholders that are taking care of them for those that you can get hold of depending on the time of day and actually writing that up, it's about an hour and a half. Everyone will get that assessment. Some of those people will go on to then need admission to hospital, some may be able to be linked in with our community teams. For others where we may not be picking them up for treatment, we will still look at what options are available and try and provide some specific plans and ideas to put in place.

Q. I'd like to go through each of the options but just at the outset can you clarify what they are: one option is admission?
A. Yes.

Q. One option is linking to community services?
A. Yep, so that would be more primarily our acute CAT

Team kind of follow-up, or we have an option through Monash Health which is our APM clinic which is a psychological service that's available that I can book an appointment through a diary at the time.

Q. I will ask you some questions about that. But in terms of the options, is the only other option discharging people?
A. By and large they're the sort of acute options. We do have Continuing Care Teams, but when people have presented in crisis that's not normally the sort of treatment that's best suited. It may be that you get followed up by our CAT Team initially and then we look at those longer-term sort of referrals at that point.

Q. Can we turn first to the option of admission. What proportion of people who present to ED with mental health issues get admitted?
A. Look, I think it is sort of between about a third and 50 per cent, and then we get skewed a little bit because some of those people coming to the Emergency Department are coming specifically for a bed because our community services aren't able to provide them with that support in the community any more, but that would be the number from the Emergency Department that goes through to wait for a bed.

Q. You've stated:

> "The biggest driver in assessing whether someone should be admitted to hospital or treated in the community is their risk to themselves and to other people, especially a family member."

Can you explain to us, why is that the assessment criteria for whether someone gets a bed?
A. Admission to hospital at the moment, so our inpatient unit stay, is around about nine days. The inpatient unit does a great job and they provide containment and support.

But there's also acute community treatment options in the community. So, if we think that we can work with you and keep you safe, you've got the support of family or friends or people that can come to offer you support, then that's often a better option for people when they're in their own environment. We can come and see them at home,

they can come and see us depending on what suits best, but we're able to provide the sorts of treatments for people who are acutely unwell in the community to at least get things started and get them on the path to recovery; that doesn't have to happen in a hospital.

But if we can't keep you safe at home or if you've got to a point with your family and your loved ones, because it's taken quite some time for them to be able to get to a point of getting treatment and support, they are just not in a position to be able to continue to offer that support and we can't keep you safe, then we would again look at hospital and that option.

Q. When the person is admitted on that risk criteria, is the underlying condition treated or is the crisis just managed?
A. So look, they will be started on treatment for the condition itself, but that treatment won't reach a point where we'll see whether it's going to resolve the symptoms or not. For most medications and treatments that we start, and it's really that medication treatment that we're looking at initially, it will take a couple of weeks before I even start to see whether it's having much impact on your symptoms. Mostly I'll know if it's giving you side-effects, that if it seems like the right kind of choice, it will take quite some time from there to see resolution of symptoms.

So people aren't going home from hospital, you know, with a full recovery of their illness, but medication will be started.

In terms of the more psychological kind of treatments, again you might speak to somebody during your inpatient stay but that's longer-term work that will happen in the community.

Q. I'd like to turn to the issue of suicide. You have stated:

> "Admission is necessary where there is a risk of suicide or a high risk of self-harm or harm to others."

Does Monash Health have experience of people who present to the ED who are suicidal who are not admitted?

A. Yes, we do.

Q. Why aren't all people who present as suicidal admitted?
A. So, suicidality and the experience of that for people is very different. For some people, it may be the first time they've experienced this, it may be in the context of either their first onset of symptoms, their first onset of illness, their first experience of being psychosocially in a position where they're feeling really stuck and they don't have options. That presentation of suicidality may be very different to somebody else who has, over a period of time, developed what we call maybe a chronic path of, they may have had a life where they've had a lot of trauma or a lot of distress, and part of the way that they experience that is that suicidality may be with them all the time, they may not ever get relief from it, but there may be a capacity to distinguish between, I'm feeling suicidal and I want to do something about it right now, versus I'm feeling suicidal which is always there but I'm looking for help to be able to work through that and get assistance with that.

So, suicidality in and of itself isn't the same for everyone that presents, and so you need to assess what that's about, what the risks around that are, and try and do the best that you can to try and work with the client about that and find some plans that help them to maintain safety and to access the kind of treatment that's going to try and help to either reduce or resolve that.

Q. If a person is suicidal but is not admitted, what treatment or support is provided in that scenario?
A. So some are referred to our acute community team, so they may go to a CAT Team for follow-up. For some where the suicidality may be about that more chronic kind of picture but not an acute experience of it, it would be looking at what the best sort of treatment is for that.

In a number of those cases it's psychological treatment and support around developing different behaviours, which is longer-term working. It can also be quite difficult to access so it's not necessarily an easy path to link somebody into, but there are certainly a variety of options like that that you would look at.

Q. Does Monash Health have experience of people who

present to the ED, who are suicidal, who are not admitted, and then who die by suicide?
A. Yes, we do.

Q. Have you been involved in reviews of those situations?
A. Yes.

Q. Have there been systematic changes as a result of those reviews?
A. Yep, yep.

Q. Could you outline for us some examples of the types of systematic changes?
A. Yep, so we've done a variety of different things, I guess, over the years. One of the more recent ones is quite extensive review about how we do risk assessment and how we capture sort of what I was talking about before, that difference between that very acute picture of suicidality and then a picture of chronic suicidality that may have become more acute, so we've done quite a bit of work in terms of working with our staff and our documentation around trying to be able to predict those sorts of factors better than what we had.

We've also looked at, for clients who are in our Emergency Department, and as we were hearing they can be there for 24 hours, rather than being in a position where we do the assessment and then it's like, alright, well, then you'll go on to a bed. We have asked our clinicians to be making sure that they're going in regularly and doing mental state and risk assessment.

So, if you're sick enough to stay there and wait for a bed we should be checking how you're doing. We've got our medical support for - our ECAT teams going in and starting treatment, rather than waiting to start treatment when they get to the ward. We're getting those staff involved earlier in trying to get those things rather than waiting for people to get to the next stage in their treatment.

Q. And so, there's been a change to the assessment process, that's been implemented?
A. Yes.

Q. Since that change, has anyone presented to the ED suicidal, not been admitted and then died by suicide?
A. Yes.

Q. In your experience, is that situation unique to Monash's ED?
A. I don't believe so, no.

Q. We were talking about the options when someone presents to the Emergency Department and we were talking about admission. Can we now turn to the issue of when someone is not admitted: what happens in that scenario?
A. Yep, so where someone is not admitted they will often go onto our CAT teams for community support, so that's a community-based team, usually geographically located. They will go out and either see people at home or have people come into a clinic to see them. That's sort of the primary team that we offer.

We also have the APM service, our psychological service, that we can make a referral to, or alternately we can look at what other services are available in that local area that people may be able to access: it may be a program that we're currently involved with called The Way Back where a non-clinical person provides three months worth of support in a catch up with people and also helping them to work through some of the psychosocial challenges that are contributing to their mental health distress.

It may be other non-government organisations who are able to provide sort of follow-up and support for periods of time.

Q. One of the options you just referred to is the Agile Psychological Medicine. The Commission has heard evidence that the number of people who could benefit from that service hugely outnumbers the actual referrals they receive; are you aware of that?
A. Certainly at the beginning, yes, I was, and I'm aware of the evidence, yes, earlier.

Q. Can you explain for us what is the barrier, why aren't the referrals making it to the Agile Clinic?
A. I can sort of talk to the Casey experience of it probably more than anything else. I know that certainly initially it was a bit of a challenge for people to think about things in that different way, and triage is probably the other area I'm aware of in terms of how they can refer directly into this clinic.

I think initially there was a challenge for our clinicians to think about those treatments in a different way. I think also, as they got more familiar with it and started to use it - you know, what I would say at the moment, our issue is more about being able to get access to appointments and resources more so than an unwillingness to refer, so it is something that's changed over time.

Q. You also refer to the fact that you manage a PARC?
A. Yes.

Q. You've said in your statement:

"PARC performance is not tied to KPIs of any kind but occupancy need is directly linked to hospital demands."

Can you please explain what you mean by that?
A. So I think PARC is - I know there's been a previous witness during the week as well - PARC is a residential recovery service that's available for people to use for a sort of two to four week period depending on the nature of their presentation and their recovery goals.

What we are finding is that, because of the pressure on beds at that end of the service, we're finding that the kinds of clients that we're having come, is what we call a step-down. So, there's always been the option of people to come from hospital to a PARC to continue to have support, working to integrate back into their home life or going back to work and those sorts of things, that's always been available.

What we're finding I think more is that people are coming to PARC as well because we needed some place for them to go to be able to create acute beds for people who are coming from Emergency Departments or who need that more sort of contained environment, and that means that some of the clients that we've got are not as engaged in the recovery progress and the referral is more about having some place for them to go to reintegrate to going back home. So it sort of compromises the program to a degree. But people need some place to be, they need that support. There are still things that we can help them with and work on but it just means that things are not exactly the same and the stay is shorter than what it may have been, you know, if I compared it to a couple of years ago.

Q. Can I turn to the issue of homelessness. In relation to patients who are homeless you've stated:

> "If the patient does not need treatment or admission, we keep them in the ED until accommodation somewhere is found or they are able to be linked to a crisis accommodation service."

Can you give us an indication of how many patients that you see would fit into this category, how many patients are homeless?

A. Yeah, it's unfortunately a growing number. Our information so far suggests I would think probably around about a third are experiencing homelessness, but we consider that quite a broad category, so it's not just people who don't have a home full stop although there are a number of people in that circumstance.

What we're finding is more and more clients who either financially are not able to afford the housing options that are available, they may have been displaced from home either again because of mortgage stress, relationship breakups, domestic violence. They're not able to return there but they can't afford accommodation to go anywhere else.

There's also people who, because of the nature of their illness they're just not in a position where they have the skill to sort of manage being in what is some fairly unpleasant accommodation services that are out there. I was hearing the other day of a client who had been sent to an accommodation through an accommodation service to some place that didn't actually even have a door on the room that they could close.

So the nature of the accommodation services that are available if you either don't have access to any kind of Centrelink or any kind of financial support, or you're not able to return to a home for other reasons, whether it be an AVO or a relationship breakup, your options are very, very limited.

From an Emergency Department and from an ECAT perspective we can link you with an accommodation crisis service but they still have difficulty actually accessing

accommodation services - you know, suitable accommodation. People will be put up in hotels for a couple of days which is not sustainable.

What we find is that, while people are struggling with those sorts of issues, it's incredibly difficult to make a plan about how to engage with a psychologist or a counsellor or anyone around your psychological needs when you're trying to figure out where you're going to sleep safely tonight. And, by the time people get to us, they've often worked their way through couch-surfing and staying with friends and families, and that's no longer a viable option for some of these people either and makes it really difficult for them.

Q. You've said in your statement that you have staff on the phones in the ED trying to find a place for people in the community. What staff do that role, who's performing that role?
A. Primarily it's trying to contact crisis emergency services, and that's ECAT primarily. We've had discussions with our social work services in the Emergency Department but they don't have any better options either, so essentially if we were to ask them for support, they would be providing the emergency accommodation service phone numbers.

Q. You've also referred to the ED being a stressful place and the pressure on staff. Can you elaborate on the pressures that are experienced by staff in the Emergency Department?
A. Yep. So, look, from an ECAT perspective, there isn't ever not really people with a mental health issue in the Emergency Department. I know when I look through, I get a text every morning that tells me how many people are in the Emergency Department, and every morning you start your day with six or seven people in the department that have been there from the night before, some are there waiting for beds, some are there waiting for reviews, some are there waiting for us to try and help with accommodation or linkage to other services because they're being discharged.

That's sort of where you start, and so, you start working your way through those clients, but in the meantime you've got other clients continuing to come into the department.

So, for us we've sort of changed our - where we place our resources. We've got two clinicians in the morning as well as our medical staff support, two in the afternoon and one person at night. But in a 20 bed department you can have a lot of clients in there that are either waiting for ECAT, waiting for transfer somewhere else, waiting for us to hear back from people so that we can tie up a plan that keeps them safe. That's incredibly frustrating for clients, for the Emergency Department staff, and so, you know, there's only one or two of them and you're trying to assess people, you're trying to absorb their stories, you're sometimes talking to clients that don't want to talk to you and that can be quite confronting when people are agitated and angry and frustrated.

You've got a department and staff that are also kind of saying, what are you doing? Why are people still here? Where are they going? It's not an easy place to work.

Q. Finally, Ms Morgan, what changes to the system do you think would help ECAT better meet its objectives?
A. Look, I think there is a big gap in terms of people being able to access services before they get to the Emergency Department. I mean, things have been added: we have things like our PACER units which is where clinicians go out with police to try and see people, where things have got to a point where 000 has been called because of emotional distress or the situation in terms of containment, but a clinician who can go out and assess situations there and make direct links to our CAT teams and admission beds as well to try and support people not having to come to the Emergency Department for that assessment.

But I think, you know, I speak to a number of families and a number of clients who talk about being - you know, knowing that things aren't going well, but not being able to access help, there's a huge gap in terms of being able to identify services who can provide help before it gets to that crisis point.

And, whilst it was a service that we used to be able to offer in our community teams, the demand at that crisis end now means that we don't get as involved with people in those earlier stages where you could avoid people getting to crisis point.

And, in terms of the non-government organisations,

because they're tendered, because they move, because they change; I know they're there and I have trouble finding them and figuring out who it is and who doesn't have waiting lists. If you don't know the system and you're going to look, it's really, really hard to find people.

Then, you can look at GP and private psychologists and private psychiatrists, but that's not necessarily financially sustainable. There are not many that actually do bulk bill. So, even though there is government support for accessing those services, it's not necessarily enough sessions or long enough to address the kind of issues that people are trying to deal with, and they don't have the capacity to financially sustain those gap payments and trying to access the treatments and services that would help them to develop better coping strategies or help people to understand their illness better and how to manage it, you know.

That middle part of the system has kind of disappeared and families understandably are very distressed, that they know that their family member is going unwell, the family member might not think they are, but they know that they are and they don't have capacity to get help for them in the way that they think would be useful.

MS BATTEN: Thank you very much, Ms Morgan. Chair, are there any questions for Ms Morgan?

CHAIR: No, thank you very much, Ms Morgan, for your overview this morning.

MS BATTEN: May Ms Morgan be excused?

CHAIR: Yes, please.

<**THE WITNESS WITHDREW**

MS BATTEN: Thank you. Chair, is now a convenient time for a morning break?

CHAIR: Yes, thank you very much.

SHORT ADJOURNMENT

MS NICHOLS: Commissioners, the next witness is Assistant Commissioner Glenn Weir, I call him now to give evidence.

<**GLENN CHARLES WEIR, sworn and examined:** **[11.46am]**

MS NICHOLS: Q. Mr Weir, do you have the rank of Assistant Commissioner within Victoria Police?
A. Yes.

Q. Are you responsible for the eastern region of Victoria?
A. I am.

Q. Can you describe what that encompasses geographically speaking?
A. So I'm responsible for all police operations from the City of Monash in the south up to and including Wangaratta, and then as far east as the Shire of East Gippsland, so to the New South Wales border and encompassing all the border areas along Wangaratta, down to Shepparton and Gippsland, and back through to Knox and Boroondara, so a large part of Victoria.

Q. A very diverse region?
A. It is diverse in terms of community, demographic and requirements for policing.

Q. How many police are there assigned to the eastern region?
A. I have just on 2,800 sworn police and Victorian public servants.

Q. Before I go any further, have you prepared a statement which answers the questions the Royal Commission has asked you?
A. I have.

Q. I tender the statement. [WIT.0003.0002.0001] Assistant Commissioner Weir, can I ask you to explain briefly the role of Victoria Police that is set out in very general terms in s.19 of the Victoria Police Act?
A. Sure. So, Victoria Police has a range of responsibilities that are articulated in the Victoria Police Act. In particular, a number of it obviously focuses on detecting and preventing offences and apprehending those who commit. But more particular, I think, in this context is around helping those in need of assistance and that's certainly one of our key roles.

Q. Police are often the first responders to situations involving people with mental health issues and their needs; that is right?
A. That is true.

Q. Will those situations include times where mental health issues are explicitly called out when police are contacted but also times when it is not?
A. Yes, so there's generally three ways that we come into contact with people, and that is either those people who we come in contact through the criminal justice system; there are those that we come across by virtue of calls for assistance, that can be from members of the public, family members, or people in the medical sector; or those that we just come across in everyday policing, including random connections in the street, through traffic intercepts, through attending people who might be victims of crime, road policing intercepts, or attending accidents. There is a broad range of ways we come into contact with people experiencing mental health.

Q. Do mental health clinicians sometimes ask you to do welfare checks?
A. Often. That is a duty that we perform many times every day and to varying degrees of severity, and varying outcomes and varying ways that we would respond dependent on what we know or find out during that contact.

Q. You've said in your statement that police are not mental health clinicians but are nevertheless expected to make decisions about an appropriate response in those circumstances you've just described, including whether or not to engage other services?
A. Yes. In my experience of 38 years, whilst we're not mental health clinicians, you quickly become experienced in recognising attributes of mental health for those people experiencing mental health. Our experience level and our structure around supervision, risk assessment, seeking information prior to engaging someone, in particular when we're called for a planned response to, in particular from a mental health clinician or from the health sector varies, but we try and obtain as much information as we can, and we make assessments based on the facts as they present and take a course of action as those circumstances dictate.

Q. Is there a protocol between the Department of Health and Human Services and Victoria Police which is intended to

provide guidance to police about how to interact with mental health clinicians?
A. There is. The Mental Health Act provides us with legislative powers to do certain things in response to certain incidents. The practice guide, the protocol, has been developed to inform what the legislation allows us to do in a more prescriptive and assisting manner and it's used daily and it's of great assistance.

Q. Is one way that the Police Act is a conduit between people in the community and the mental health system, by making a referral under the Victorian Police e-Referral system?
A. It is. So, there's two streams here, and one enables us to - I suppose we have three options: one is to do nothing if the circumstances dictate that there's no requirement; (2) is to make a referral for a non-crisis issue through the Victoria Police Electronic Referral System, and I'll explain that a bit further in a moment. The third option, of course, if the circumstances present, is for us to enact our powers under the legislation and take that person to a place for assessment or further treatment.

Q. We'll go back to that in a moment, but can we return to the e-Referral system?
A. Sure.

Q. Sure. So, we have a system, an Electronic Referral System, that is utilised for 26 different circumstances, excluding family violence which has its own particular referral system. For mental health referrals, people experiencing mental health, we gather data, fill in a form, and that is transmitted to Monash Health which has the contract and responsibility with us to receive, triage and action those referrals.

We have a "no wrong, door approach." By that I mean, the referral may be for someone who has a drug and alcohol issue, as the non-clinically trained police would attend and think that might be the issue, and that might be referred off, but then it might turn out that there's actually a mental health issue, so there's a re-referral.

And Monash Health certainly work the other way: if they receive a referral for someone who's experiencing mental health and through their contact realise that, well,

actually this person has a significant drug and alcohol issue or there's other factors of comorbidity that might need a re-referral, they certainly do re-refer on. So, it doesn't matter how people get there, as long as they get there.

Q. So, this as consent-based system for non-urgent situations?
A. Yeah, correct, and that can be problematic, is that it has to be consent-based. However, with respect to people's privacy and their human rights we make that call that we don't refer people if they don't consent.

Q. So essentially, the police officer involved, with the consent of the person, will take their details?
A. Yeah.

Q. And enter them into the portal and then Monash Health will contact the person?
A. That is, in essence, what happens.

Q. Is another more direct way in which the police are involved in connecting people with the mental health system the one you mentioned before, which is where they are called to apprehend someone under section 351 of the Mental Health Act?
A. Yes, so that particular provision in the Act, it gives us the legislative power to apprehend people and to take them for assessment. However, that power is not used lightly and it is often the end point of a considerable period of engagement, discussion, intelligence and information gathering from as many areas as we can before we take that decision to apprehend someone, which can be quite traumatic for the person, for their family, for observers, for the police, and to then take them by either police transport, which is not ideal, our preferable method is that they are transported by ambulance if possible.

Of course, some people experiencing mental health are extremely violent and are extremely, by nature of their illness, irrational and are not able to be talked into going to an ambulance. We would never put ambulance at risk and we have quite good discussions and we have a really good relationship with Ambulance Victoria around what happens.

In the past there have been significant issues with

delays in ambulances attending and the decision has often been made, and still is, that we will transport people in police vehicles, in divisional advance. That is not deal, that is a last resort for us.

Q. Is the objective of doing so, in order to get them more quickly to an Emergency Department?
A. Yes, but it's also - it's often done for a couple of reasons. One is that sitting and waiting with a person experiencing mental health issues can sometimes be fine and you'll build up great rapport and assist the family. Other times it heightens their stress, and so we do that.

There's a practicality too to our service demand requirements. Whilst the police are there dealing with that person, they're not doing all their other duties. It shouldn't be our core duty to be a transport for people experiencing mental health, but practically we realise that sometimes that will always happen, just like we shouldn't be the agency of first resort rather than last resort, we seem to have become the agency of first resort over the years.

Q. Just following that journey, if you are dealing with a response to a section 351 situation - and we'll go back to the criteria for that in a moment - one option you have is to seek the attendance of the Mental Health Police Response Unit, otherwise known as PACER, to conduct an in-field assessment, and the other alternative is to arrange a transfer to the Emergency Department. Are those the two pathways?
A. Those would be and then the sub-pathway to the transport is either us or ambulance, yeah. But the attendance of a clinician through the PACER program is absolutely beneficial, which I'll expand on in due course.

Q. Yes, we'll get to the PACER in due course. When you get to the Emergency Department, what, if you can say, is the experience of the police in terms of wait times?
A. It varies and it has improved, I'd like to say significantly but I can't say that. We work really well with hospitals and Emergency Departments who do their best in a really difficult situation to give priority to police who have presented at their facility with someone needing assessment who's been detained under section 351 of the Act.

It is not unusual for police to be waiting two hours. It is not unusual for multiple police units to be at one ED with multiple people needing assessment, and the service delivery impediments for the rest of the community, by us having all our available resources tied up there, is significant.

One of the barriers is that, the legislation dictates that when we apprehend someone under section 351, we cannot discharge our duty that we've enacted under that section until a person is seen and assessed by a medical practitioner or a qualified mental health practitioner, and appropriate handover and transfer of relevant information has occurred.

Reading that in isolation you think, oh, that sounds simple enough, but it is a timely, impactful process. I sort of outline sometimes there are multiple police there with multiple patients. We cannot transfer between the police. Once you enact that power, then you must stay there until that is discharged.

A lot of EDs, of course, are not designed to have police and people needing assessment sitting there with other patients. Some do have areas where they go. You know, they all have security that we can't discharge that responsibly to but do assist, but it's impactful and it doesn't de-stigmatise the experience that mental health patients have because, if the police are there with them, everyone's looking: everyone's looking and I'm not sure what impact that has on other patients, what impact it has on that person themselves. We don't want to be there doing that.

We realise there is always going to be a role in dealing with people experiencing mental health for the police, we realise that. However, I'm not sure that, as things have changed over time, that there's been a broader more strategic piece of thinking done about what all the impacts are.

Q. Just collecting the thoughts there for a minute, what are the particular gaps in the system that you see that mean police are performing that role when you really would prefer not to be?
A. So, the significant gap I think is that people often go from low-level - "low-level?" - that go from

experiencing mental health issues and dealing with that and living in the community, to crisis with no intervention.

So, the first time often that police will have any involvement, is when it's reached crisis level. So, the missing middle as it's been described is a significant issue, in my view.

People who have the ability to engage with practitioners and clinicians and avoid taking that step to crisis generally function and live really well, and we don't know what we don't know because we don't have a lot to do with people who aren't at crisis. So, that is a significant gap, I think.

The other gap is where we are engaged with people through a whole variety of means: be it a call for welfare assistance or we come into someone who's in crisis at the top end, right back to where people are experiencing issues with family members and, you know, we're the default agency, and we're a 24/7 agency, we have a leadership role in community, I think that's really important, so people come to us. So we will make the referral through the referral system, but sometimes it needs more than that.

But the ability for us to have one single point of entry into the system that allows us to find out what that person's particular issues, history, needs are, is not there.

The PACER program that you mentioned before is a classic example of something that works sometimes, in some places at some level, but again it's piecemeal.

Q. Can I just take you back to what you said a moment ago. You mentioned one single entry point into the system: did you have something in particular in mind when you said that?
A. So, depending where the incident occurs, where the police are, where the person experiencing mental health that you're dealing with is, it means a completely different system or process depending on where you are.

Q. You mean, where you are geographically?
A. Yes, so there's no consistent integrated model across Victoria. All the mental health areas work incredibly hard and are incredibly professional and compassionate people in

my experience of dealing with them. But it's different; every time you engage with a service it's different.

The ability for us to have one point of entry into the system, to then be appropriately referred to the appropriate area for the appropriate clinician to give you the appropriate advice that helps you risk assess or provide assistance to those needing it is vital, in my view. It is far too complex and inefficient at the moment.

Q. By one point of entry, do you mean a consistent way of entering the system?
A. Yeah.

Q. Or one portal or both?
A. I think so, how it looks practically I think is something that could be done as a piece of work, but at the moment we've got six or seven silos all working really hard and professionally and trying to do their best, but there's no horizontal strategic join up, top-down driven, that would allow me if I was working at St Kilda or if I was working at Mildura to access the same process.

Q. And so, would it be fair to say that, as a police force you are trying to meet people's needs and work in with a system that's quite fragmented?
A. It is, and we often make it work, but we don't always get it right. You know, there's examples where we haven't got it right. And there's systematic fails or process failures and there's human failures, and we make human failures like everyone.

But if we had an efficient, consistent, integrated, one service entry across the state that all police, ambulance, clinicians understood and were able to access it would be highly efficient, lessen the stress on consumers of those services; de-stigmatise mental health, because you're not standing around for ages; or you're unsure who to ring, so the person's heightened stress is exacerbated because the police or the other service providers are trying to figure out what's the best possible solution here. If we had a well understood, coordinated system, that would lessen that impact I think.

Q. Thank you. Can I ask you about the PACERs, which are the Police, Ambulance and Clinical Early Response program. Can you say in short form what that program involves and

how it works?
A. Yes, sure. It's been around in different iterations for a number of years, since about 2012, where a police member and a clinician will work together to provide secondary response but high level information/advice to police on the road responding to incidents involving people experiencing mental health.

Again, in 2012 it was kicked off as a sort of a pilot. In 2014 there was an evaluation done by Allen Consulting to look at what was happening and whether it was a good idea and worth expanding, and as a result of that review a submission was put to government, and DHHS were funded to roll out progressively more programs in more police areas.

So, today we have 19 police areas that operate a PACER model, but it's only one shift a day, eight hours, generally 2-10pm, 1-9pm because that was seen as the key peak periods.

Part of the proposal was, when that funding was provided, was that an evaluation would take place by DHHS to see if the roll out was successful, if the operating model was the best it could possibly be.

We've been trying to get that evaluation underway with our partners at DHHS. Safe to say, we haven't had the level of success in getting that evaluation to happen that we would like.

Q. What would you like to see happen?
A. Well, I would like to see the evaluation take place. However, today we've received a letter from DHHS to the Chief Commissioner that indicates that they're keen to undertake the review and that will kick off shortly, so that's a good thing.

Q. Alright, have you been given a date for its commencement?
A. No.

Q. And I take it, you'd like a date for its commencement?
A. I'd be very much liking a date, and I'm sure that will happen, we'll now engage and get that to progress, because we see the benefit of PACER; there are numerous examples where it has proved to be extremely efficient, but they are all different models, they all work slightly different, so

to get an understanding of what is the absolute best practice so that we might advocate for funding. We weren't funded anything to PACER, we supplied the police resource because we think it's a really good idea, but that's 19 police constables or senior constables each day who are performing that duty across Victoria that aren't doing other duties, which is fine because we see it as absolutely vital.

I think the need to potentially expand it to a 24/7, 365 model --

Q. Yes, and you mentioned that it's in 19 regions?
A. Yes.

Q. Out of how many?
A. So, there's 21 police divisions across Victoria, so we have four regions of which I command one, and there's a number. Depending on sizes, the models are all different, some work in a police service area which is aligned with local government areas. Others work more broadly across two or three, and again, that's why we really need the evaluation, to see what's the level of operating that we need to have.

Q. I see, but your operating premise is that PACER is effective and needed, and you would like it to be enhanced and expanded?
A. Well, potentially without getting ahead of any evaluation.

Q. Subject to that review, yes.
A. We would need to see the evidence that falls out of the evaluation, but I would be really surprised if that wasn't an outcome.

Q. Can I ask you about the Enhanced Critical Response Program. Can you say firstly what is that program?
A. So, that's a program that has been developed between NorthWestern Health and our Critical Incident Response Team to deal with high-end critical incidents involving persons experiencing mental health.

It's a service that actually provides exactly what I just described: a one-stop shop where our trained negotiators who form part of that team can have instant access to a clinician, who can then provide detail of the

subject person experiencing mental health, if there are any details known; or can provide advice around some strategies and tactics that might be used by our negotiators given what's been presented as the behaviours by that person.

It's been really successful, it's been going since 2014. It's seen as a really effective tool. In fact last year it was awarded the Minister of Health's award for excellence in helping people with mental health, so it's seen by our key tactical operators, the Critical Incident Response teams and the Special Operations Group who deal with people who are barricaded or high risk or armed with significant weapons, that's seen as a really good model and we look forward to that continuing for a long time.

Q. Is it available wherever the Critical Incident Response team works across Victoria?
A. Yes, it's aligned to that group rather than a geographic area, because it is one clinician - you know, they wouldn't have the capacity to deal with enquiries from all over that don't reach that threshold for the intervention by the Critical Incident Response people.

Q. Can I ask you now some questions about the amount of time spent by Victoria Police in responding to situations involving mental health issues, people with mental health issues. In your statement you have said that there is certain data that is captured, you don't capture everything but you capture certain data.

Can we start with this: in 2017-18 police officers were dispatched to approximately 43,000 events coded as "psychiatric crisis and suicide attempt or threat", which averaged across the year means Victoria Police responded to a mental health callout of this nature approximately every 12 minutes during 2017-18.
A. Yes.

Q. Can I ask you about the trends in relation to these numbers. Sorry, you go ahead.
A. It's increasing. I just got a note of caution I suppose, our data capture and our data integrity around these issues is getting a lot better, but to compare year-to-year-to-year going back would be a little dangerous, I think.

But we are certainly seeing an ongoing and consistent

increase in the number of those types of events that we are being dispatched through and we record that through our computer aided dispatch and through our Comms Centre.

Obviously Victoria's population is growing, so there needs to be that recognition, that it is in line with population growth, but even taking that into account and even taking into account we have more rigorous governance, supervision and oversight of our data collection now, so that's going to increase as well. Even taking those two things into account, the number of incidents that we're attending is increasing incredibly and it is one of the, if not the pre-eminent issue facing our service demand requirements.

Q. I'll return to that in a moment, can we just go to some of the numbers. Dealing with the category of mental health transfers, is it correct that there were approximately 14,000 under section 351?
A. Yes. So, that's where we apprehend someone under 351 and transfer them to a facility for them to be assessed.

Q. And that was in 2016/17, compared with, say, 2010-11 there was a 169 per cent increase.
A. Yes. So, again, that needs to be taken into account with population increase and greater data collection, but still, there was an unbelievable explosion in demand for service in that space.

Q. Then, turning to the question of e-Health referrals, which are the consent referrals in non-crisis situations, your data says that between 2014/15 on the one hand, for which you have data, and 2017/18 on the other, for which you also have data, there was 172 per cent increase?
A. Yes, in that three-year period, the data around that, I'd be fairly confident is pretty reflective and pretty right.

I think it shows a couple of things really: it shows an increased level of awareness and performance of duty by our people, but it also shows a significant increase in the demand for that duty to be performed.

Q. Can I finally ask you about the rates of police responses to events coded as "psychiatric crisis". There has been an increase between 2014/15 on the one hand and 2017/18 on the other of 87.9 per cent; is that correct?

A. That's true. And I suppose they go hand-in-glove in terms of how it's coded, is dependent on the information that's received at the time.

Q. Of course, and where there is a record of psychiatric crisis and suicide attempts or threats between those same periods, there was an increase of 32.2 per cent?
A. That is correct.

Q. Can I ask you about the effect on your capacity, as a service, of that increase in numbers?
A. Yes. Obviously, as I said before, we will always respond to those events because it is one of our core duties. And when you think about our duties as outlined under section 9 of the Victoria Police Act where it talks about helping those in need of assistance, I can think of not many other incidents where we must help those in need of assistance, so we do.

Of course, we have finite resources and our ability to perform our other duties is significantly impacted by high-end events that are discretionary, such as the events we're talking about here.

The effect on our people too is really a concern for Victoria Police. The emergence of our first responders, not just police but other first responders, but our people experiencing higher than normal rates of mental health illness is a concern. The vicarious trauma or transfer of trauma, the effect it has on our people from attending repeat, high-end, high risk incidents, is something that's a real concern for us.

Q. Did you say earlier the effect on your capacity was the number one issue for you?
A. It's right, we have significant issues around family violence; that's been discussed. Road trauma is another one, but I mean, things that are absolutely non-negotiable and we must attend to involving people with mental health experiences is increasing. Of course, it's not a siloed approach to mental health; the mental health impact is also across a whole range of issues, particularly family violence, particularly youth offending, particularly road trauma.

Particularly, and it was discussed yesterday at a forum held here by all Deputy Commissioners and Assistant

Commissioners from across Australia dealing with road policing, the increasing impact of the mental health presentations that we're seeing in the road trauma space.

Q. While we're on that subject, can I ask you briefly about the force's own mental well-being program.
A. Sure.

Q. You now have a Mental Health Strategy and Wellbeing Action Plan commencing in 2017?
A. Yes. So, in 2016 we undertook a wide-ranging review into the mental health of Victoria Police members because we'd seen a rise in people experiencing significant mental health issues. It was quite confronting, we had quite good buy-in from the survey and the data collection that we did. Out of that's come an identification that we need a strategic approach to this, so we've undertaken and developed a mental health strategy and out of that strategy's come an action plan where there are a number of key activities that we all have committed to undertake.

That's been accompanied by a recognition that it's just not serving police who are experiencing these issues, and we've recently launched - Blue Space is the name of our online portal for serving police, police veterans, but also importantly their families, because the trauma that our police families suffer as well by virtue of living with the issues that serving police experience is really significant.

It's been accompanied by a level of commitment at the top level of our organisation. You will probably recall last year the Chief Commissioner and the head of the Police Association co-jointly undertaking a large walk to raise awareness around mental health, which was I think really impactful in terms of the vision and the commitment.

We realise, as a senior police leader, this is something that I think about every day, that I deal with every day, the mental health of my people, and it's a real concern. Just as road trauma, crime rates, all the other things that I worry about from a day-to-day basis, the health and wellbeing of my people is absolutely at the top of all that we think.

Q. We have asked you about some of the assistance that you could do with, with some of the significant work and

challenges that you undertake. You've said this in your statement:

> "A significant challenge Victoria Police faces is the increasing ongoing reliance on police responses for people in crisis."

Which you've already addressed. You've said that it would be very helpful to have better support by having more direct access to clinical services. Can you say what that means?

A. I think everything we do and every response that we undertake for a variety of actions is based on a risk assessment, and formulating a plan, or turning an unplanned response into a planned response is really key for us. So, the ability to do that is very much reliant on the information that you have at your disposal.

A simple, efficient way to get that information, I think, is a key to us successfully, efficiently, and in the least impactful way on the person experiencing the mental health issues, I think that's an absolutely vital way for us to do that.

Q. When you say "a simple, efficient way", is there something you have in mind in particular in terms of getting access to clinical expertise?

A. I suppose it's an outcome or a practice that might come from a broader piece of understanding of the needs of a whole range of sectors, including police, and providing that leadership at a high level. We're dealing with a health issue here, a significant health issue. We are a key part in that solution, but it needs leadership and it needs direction.

The ability for us to, somewhere down the track once that direction is owned, decided upon and brought to life, a key part of that will be our ability to engage and to access what we need to access really quickly, taking into account people's privacy and people's rights around protection, but the longer that we delay, the less concise, relevant clinical information that we get, furthers the harm potentially that is done to that person experiencing mental health.

Q. You mentioned leadership just a moment ago: what do you see as particularly important about leadership in this

space, the context of which is the engagement with Victoria Police with a system existing in various ways across the state?
A. So, we have a system that exists that I think has been roundly recognised and it's been commented on at the highest levels of government that the system's broken. I think we can look back why that's happened but I don't think that's particularly helpful because we are where we are today.

I think everyone's worked really hard and nobly in our own particular areas to do the best we can, but there's been no high-level coordination or leadership of a lot of the services that are being provided, and not only how that service operates for that particular silo but how it works in integrating it with all the others.

So I think as an outcome, from a health-driven perspective, to provide clear, concise direction around what is trying to be achieved to help people experiencing mental health and to prevent people who might be at the risk of falling into the harm space to be done, that's really quite clear. To provide high level, joined up, coordinated and integrated approaches to what we're all doing for a common purpose, to reduce any barriers that might exist between agencies, even between intra-agency, I think, is absolutely vital.

But if we keep doing the same thing and expect a different outcome, then I don't think that's realistic. So, there needs to be a recognition of where we are right at the moment and what needs to be done in order to go forward. Certainly, Victoria Police is a key player in that, and we have structures in place at local level and at regional level to deal with these issues, but I think there's a higher piece here and I think there's a piece for health to really own, drive, coordinate and integrate the whole-of-sector approach.

MS NICHOLS: Thank you very much. Chair, do the Commissioners have questions?

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for your excellent evidence, Commissioner. I'm interested in the dollar cost of the police involvement in mental health. You have given

us a sort of start on fairly useful time data. I just want to ask you a question on notice, as it were, whether you could think about whether could you give some ballpark estimates of the costs of mental health to the Police Service.

Just to take one bit of the story, it's only one bit, you gave us some numbers on the number of 43,000 cases, and maybe there are three or four police involved in that. You've given us maybe two or three hours' time, I could think of putting a dollar cost on that one bit of the story.

I just wonder whether you could have a think about whether it is possible to give some kind of ballpark cost or not on that and other things?

A. I mean, certainly given - we could take on notice that we could provide, given the data that has been provided, what the cost that we do know, I suppose the broader piece is the cost that we don't know. Because, as I said in my evidence, the impact of mental health across the whole spectrum of policing, not just in dealing with those people who obviously present as experiencing mental health, but the impact that we do on a day-to-day basis with mental health as a causation or a driver would be really difficult to unpack, I think.

But in answer to your question, we could certainly aggregate or work out the cost of what it's costing based on the evidence that I've given, and we can take that on notice to take away and provide that back to the Commission.

COMMISSIONER FELS: Thank you.

CHAIR: Thank you. Assistant Commissioner, a few other points from me, thank you. Again, I reiterate, a very good overview of the role that the police are playing in response to mental health issues.

I think the numbers of call-outs that you've described and the police investment that there is and what you accept as part of your responsibility to assist those in need was very important.

But I did notice, particularly in the scenarios that you described for us in the back of your written

submission, some concerning issues which I'd like to ask you to talk to.

One was a case where you talked about the fact that there was a young person that you were required to assist and, because of the lack of availability of an ambulance, the young woman concerned with suicide ideation was transferred to hospital but she, from all accounts, seemed to spend a very long time in the back of a divi van. I guess that is illustrative of the concern you've already raised about the transport arrangement.

But is that a frequent occurrence, that sort of scenario?
A. I'm happy to say that it's becoming less frequent. Certainly, if we had have been in this place six or seven years ago, it would be - the concern level would have been right at the front of my evidence I think in terms of that happening. I'm happy to say that certainly there's been, with the increase in ambulance resources over recent years, that that becomes less and less, where the people are transported by police just because we're waiting for an ambulance.

There will always be need to take some people in secure transport in a police van because of their acts and it's not safe for ambulance staff to do that.

We take very seriously the responsibility of the care that we have to exhibit when people are conveyed in the back of a van, and we've done a lot of work in what the inside of the back of a divisional van looks like: with cameras and recording and being able to look and seatbelts. Over recent years our infrastructure design has improved a lot to mitigate the risk that it presents but it still is risky.

To be honest, the last thing we want to do is transport someone in the back of a divisional van if they don't need to be, however practicality says that sometimes we have to do that. But we are very conscious of, even if they are and you're waiting at hospital, there is still a level of care that we have to exhibit and make sure that that person's welfare is looked after as best we can.

Q. Thank you. The other scenario that you describe was a scenario where there were three call-outs and transfers to

hospital for the same consumer over a course of five days.
A. Yes.

Q. And on each occasion that person not being admitted, although requiring significant police and emergency department presentations. Is that too a --
A. That is a regular occurrence, and that scenario which I know of, I know the detail of that one, and that is not unusual. And, of course, we're making non-clinical decisions about what is the need, and the other thing with that scenario is that it was an accelerating scenario where each time there was more aggressive and irrational behaviour that was never going to be dealt with at the scene or by any other way than by an apprehension, a transport and an assessment.

Our people do get frustrated, probably because we are not trained clinicians, so we do get frustrated by what seems to be sometimes a revolving door around people who are apprehended, taken, assessed and then three or four days later we're back again.

But we trust the professional clinical diagnosis and treatment options that are put forward and, while it's not ideal, if we have issues we do have a process through liaison officers where we can raise those concerns with the appropriate mental health service area, unpack the reasons why: is there a treatment plan, are there other options? Because it is very time-consuming, very dangerous. That particular scenario ended up being quite dangerous and it's not a place we want to be in unless it's absolutely avoidable.

Q. We did notice them, and heard you again say in both your written statement and your evidence today that you thought police were becoming increasingly the first responder to many mental health issues, and you helpfully referenced a piece of work that had been done in the UK that we will look at further.

You have also referenced the important role the PACERs are playing, and we have heard that in the course of our hearings and consultations.

Just for me to make sure I understand it, I think you said there were 19 PACERs state-wide. When I looked just at the breadth of your responsibilities alone, I think I

counted up, I think you've got about 110 police stations alone that you're responsible for in your area.

What does that mean in terms of the availability of these PACERs to provide the type of support you're saying across the state?
A. That's one of the frustrations, I suppose, that we have a really good model that appears to work really well, but it is on a limited geographic basis for a limited time during the day. So, when you see something that works really well, naturally you default, well, that would be really good to have all the time.

There is a fair bit of flexibility and agility, particularly the clinicians who are engaged and work with our police members in the PACER construct, work tremendously hard and are really professional and engaging. And, it is something that I'm quite strong on that I think goes some way towards answering some of the issues that I've raised as being gaps.

It might not be the best practice model, but until we get a full and thorough evaluation we won't really know, but I can see it as being something that's not the answer to everything, but it is certainly an answer to a number of the problems that we see as a policing agency.

CHAIR: Thank you, Assistant Commissioner.

MS NICHOLS: May the Assistant Commissioner be excused, please?

CHAIR: Yes, thank you very much for your evidence today.

<**THE WITNESS WITHDREW**

MS BATTEN: Chair, the next witness to be called is Sally Jennings. Her evidence is the subject of a restricted publication order. I understand that you will read out the terms of the order.

CHAIR: The Royal Commission has made an order, pursuant to the Inquiries Act 2014, prohibiting the publication of any information that might identify the next witness. A copy of that order has been placed next to the door of the hearing room.

The order requires that, throughout the hearing the next witness will be referred to as the pseudonym "Sally Jennings". I'd like to remind all persons present, including the media, that any material or information which would enable the identification of this witness cannot be published.

The Commissioners have also ordered that the hearing of Ms Jennings' evidence will be limited to the people attending the hearing today. For those watching on the life stream, this portion of the hearing today will not be broadcasted. I ask that the live stream now be cut.

(Live stream cut.)

MS BATTEN: Thank you. I call Sally Jennings.

<**SALLY JENNINGS, affirmed and examined: [12.39pm]**

MS BATTEN: Q. Thank you, Sally. If you just make yourself comfortable and just make sure, please, we can hear you in the microphone.
A. Is that okay?

Q. Yes. You're quite softly spoken, so I'll just need you to speak up clearly.
A. Sure.

Q. And we'll both try and go at a slow pace. Can you please start at the beginning and tell the Commission when you first became seriously concerned about your son?
A. Sure. So, just before I start I just want to acknowledge the beautiful boy that my son is, and that he's charismatic and joyful and socially engaged and smart, and he has had the impact of mental illness like many people, so that's why I'm here.

So, when he was a young child we had some early concerns, but I think he enjoyed primary school and we sort of brushed those off a little bit. As his life became busier in high school and the workload increased and he was engaged with state level sport, he became more anxious and more distressed around his capacity to deal with all of these things.

And so, some of it might have seemed a little bit, you know, normal teenage angst, but it had gone beyond that,

and we discovered that he was self-harming. He hadn't disclosed that to us originally, but it became evident that he was doing that [redacted].

He'd also [redacted] which his brother was witness to, and so, we were attempting to deal with it at home and then it sort of reached a bit of a head and we had to attend Emergency Department with him one evening, and that was the starting point of our dealings with the health system around his mental illness.

So, he attended the Emergency Department with me, and I wasn't allowed to speak for him: you know, he was in Year 9, a 14, 15-year-old boy, not a particularly chatty sort of boy when he doesn't know people anyway, and he had to, in front of the Emergency Department, explain to the triage health worker that he was suicidal and that that's why he was presenting there. So, that was uncomfortable for him.

Then we sat down in the waiting room and waited for quite a long period of time, I can't remember the timeframe. Ended up seeing a mental health worker there and, you know, he was quite pleasant. But really, by the time we were there, and my son was really calm, he was relaxed appearing, he was polite and didn't appear to be at a heightened level of distress.

So, there was the discussion around what the capacity was in terms of the hospital attendance. It was viewed that it wasn't very helpful to admit him, so we received a couple of Valium to take home and took him home.

So, following that experience, the next day I phoned the GP. My son's always attended the same GP practice so, there's a number of GPs that work, quite a large number, and my son had requested that he see a particular GP that he felt comfortable with. So, when I phoned the GP practice and asked for this GP I was informed that, no, this GP only did mental health care plans for his clients. And, I was curious about that.

He had attended this particular GP on a number of occasions, he'd also seen a couple of other GPs on a number of occasions, and he identified this one that he'd felt comfortable with. But anyway, that wasn't an option. So,

I asked the reception staff, what was I meant to do then because we'd attended Emergency, we obviously needed some support, so she put me on hold for a little while and then came back with an appointment with a GP that he had not seen before.

We attended the GP appointment, I attended with him. She did a K10, which is a screening for anxiety and depression, and we had a referral, a mental health care plan done and a referral to a psychologist.

Q. Just before you go on, why did you attend the session with your son?
A. Well, he was a 14, 15-year-old boy, he wasn't inclined to go there and speak for himself in that regard. He's happy to answer questions, but he wouldn't have driven that himself, and I was attending to drive him there and pay for it and whatever else. He was always happy for me to come in. I always asked him, but he was happy for me to come in with him because he preferred not to - he finds it uncomfortable to speak of his own experience.

So, he started seeing this psychologist. Initially, you know, it was sort of okay and he thought there was some helpful relaxation sort of things that were coming out of it. Then we didn't really get a lot from him about that, he didn't really like to talk about it. I didn't really know what they would be talking about, you know, he doesn't speak very much around his feelings.

Q. Were you in the sessions with the psychologist?
A. No.

Q. And, why was that?
A. Well, the psychologist deemed that it was a privacy/confidentiality thing between his patient and himself, which, you know, we respected. Then, as the year progressed, it seemed that he wasn't really very well: you know, he wasn't improving, he was actually probably escalating as the end of the year and exams and whatnot sort of came about.

So my husband got in touch with the psychologist and spoke with him about some concerns and we attended one or two sessions with him. It wasn't particularly revealing, my son didn't have terribly much to say during those sessions and we didn't attend any more. That was sort of

towards the end of the year and then the following year my son only went to the psychologist about four times.

I know the mental health care plan had ran out and we didn't get another one, we used our private health insurance, and my son didn't initiate making appointments. So, I would say, "Do you want another appointment?", I'd make the appointment. He was a little bit ambivalent about it. He went another four times during that Year 10 year - Year 10, Year 11, I'm getting my years mixed up but anyway. Year 11 it must have been, Year 11 year.

The last session he went to, he was out within about 20 minutes, I was just sitting out in the car waiting for him, I'd taken him after school. I said, "Oh, that was quick", and he said, "Well, there wasn't much to talk about." He wasn't really talking to me actually at that point in time, it was really just answering things: he was quite dark, very moody, never really joyful during those times.

Q. And so, did he stop seeing the psychologist?
A. Yeah, he didn't want to go back. When we asked him what he would like to do, he said he wanted to see a psychiatrist.

Q. How did you go about finding a psychiatrist?
A. So we went to the GP again for another referral to the psychiatrist, and again, he saw a GP that he'd never seen before. The GP - again I attended with him, he wanted me to come in with him, and the GP asked my son, "How about mum leave the room and we have a man to man talk?" And he said, no, there's nothing that needs to be said that he wasn't happy for me to hear, so I stayed in the room. The GP went on to talk about how he had no reason to be anxious.

I think there was a lot of assumption that his issues were just a bit of anxiety. It seemed to always be a little bit minimalised, you know, what he was actually going through because he presented calmly. He told him he had a good life and that he had nothing to be anxious about.

He reluctantly gave us the referral to the psychiatrist but indicated that he didn't feel that that was necessary.

Q. Just before you go on to that, you mentioned in your statement that you had some difficulty identifying a psychiatrist for your son who was under 18 at that point?
A. That's right, yep. So, when we had the referral, it was a matter of who we go to. We spoke with colleagues, we work in health fields, and the recommended psychiatrists were either not available because of not being able to take on new clients, but more importantly most of them were not seeing people under 18.

So in our area there's one adolescent psychiatrist who works in a paediatric practice. And look, my son, actually, he quite likes him, you know, it wasn't a - you know, after the relationship was built it's not as if that was a problematic relationship, but there weren't options. Anyway.

Q. And you took your son to see the psychiatrist?
A. Yeah, so there was a history-taking period where my husband and I were interviewed separately, as well as my son was interviewed separately. There was a little bit of family history delved into really just about parents, grandparents, that was sort of the extent of it, and I raised some of the issues we had with my son as a young child, which he was quite sort of dismissive of, but came to the conclusion that the treatment should take into account his anxiety and also ADHD.

And, I wasn't convinced about the ADHD component, he never fit that sort of presentation, he was always really attentive at school. He would have times where he'd want to be really busy and whatnot, but he was never lacking concentration, those sorts of things.

Anyway, he was started on a medication for an amphetamine derivative medication for the ADHD, and initially the first week or so it was probably okay, and then the depressive, aggressive, really destructive behaviour started. He would just have outbursts and run off for periods of time and we felt really torn about chasing after him because we felt that would inflame things. We didn't want to call the police because he's a very - you know, he doesn't like getting in trouble, you know, he's a very well behaved person.

He started drinking quite a bit and he took a double -

so the medication was meant to be taken in the morning because it was a stimulant, and on one occasion he took - you know, he was so erratic, he was just not thinking his normal, thoughtful sort of sensible approach to life - he took a couple of, like, a double dose of the medication but at night, and so he was up all night; you know, we just couldn't get him to listen to anything, he wouldn't take any Valium to sort of settle back down.

So in the end, once we were able to get him back home and get him to calm down a bit, he was seriously depressed. I phoned the psychiatrist the next day and, when we could get in to see him later in the week, he said to stop the medication when I spoke to him on the phone, and then he saw him later in the week and felt that there was a mood component to his issues, and talked about starting him on medication to impact his mood with the idea that maybe then, once his mood was addressed, retry the medication later.

Q. If we move to late 2017, you've said that your son didn't want to go back to school but, as the medication was taking effect, he thought that he might.
A. So, he graded up into this medication, it had to be gradually increased. We had a trip away with him and then he really was feeling, over the November-December, that he just didn't want to - he did really well with a couple of VCE subjects at the end of that year, surprisingly, and then felt that he just couldn't manage it.

But then, as the medication kicked in, he started to be open to sort of going back doing maybe one or two subjects. The school was very supportive, so by the time we got to January, sort of later in January, he was agreeable. We'd met with the school, the coordinator and his home room teacher, and he was happy to go and do the three remaining subjects that would complete his VCE and he was really well supported by his home room teacher throughout that year. That was a bit of a light in the tunnel really.

Q. Was he put back on the medication at this point?
A. Yeah, so he recommenced - I think it was around February or March - he recommenced the ADHD medication and it had a much quicker negative response at this time. So, he became aggressive really quickly, he became seriously depressed really quickly. He was really

dark, he would hide in bed, he'd run off, he didn't want to be around anybody. He broke up with his girlfriend and had this dramatic response. Stole my car. He was on a learners licence, stole my car, I had to call the police. Fortunately, they were too busy to attend. And he'd managed to pull over and not drive any more. I talked him down so I could go and pick up the car.

But again, that was the catalyst to stop the medication, review things with the psychiatrist, and he commenced on some anti-anxiety medication as well instead of the - so he was on the mood and the anti-anxiety and some sleep helping medication.

Q. Just before we move to that point. When he's on the medication you talked about a situation where your whole family had to physically be on top of him.
A. That's right, so those were very aggressive times. We felt that he was really in danger of harming himself. He was taking off. He was never violent towards us, he was violent towards himself, so he'd crash himself into the garage, he'd be hitting himself, he'd start running off as if he was going to run out the gates.

And on a number of occasions my husband and I and his oldest brother sort of ended up landing on top of him, and he'd calm down with the physical pressure of us being on top, and then he'd listen to what we had to say and he'd say he wasn't safe and he wanted to go into Emergency. So, we had a couple of Emergency trips during that time.

One of them, again, the repeated speaking to triage which was uncomfortable, and he was always calm when he'd get there, so again, I think they didn't take his presentations - it didn't feel like they took his presentations seriously.

The mental health workers on one occasion were talking about, you know, "Oh, my middle daughter's anxious too, anxiety's a normal part of life." Another occasion, the last occasion which had been a really serious event following the car theft, we took him in and the worker was talking to him about cognitive behavioural therapy and this sort of thing, and I said, "Well, that would be fine possibly down the track, but at the moment he's here because he's suicidal, so that's what we need to address." And at that point he just sort of slipped into action and

became really helpful, but of course the options for him again were outlined, that it was not appropriate for him to stay in a paediatric ward. It was not optimal for him to attend as an inpatient in an adult psych ward because of his age.

Q. And, how old was your son at this point?
A. He was 17 at that point.

Q. And he was quite tall?
A. He was quite tall. He's been tall since probably Year 7, Year 8, hasn't really changed much in height. Big physically strong boy, you know, from playing a lot of sport, and he ended up being admitted to - well, not admitted, just staying the night on a trolley in Emergency, that was all they could offer him. One little 5 milligram Valium tablet that was meant to get him through the night. You know, for an 85 kilo, 180-plus centimetre young man, it's just ridiculous, he didn't sleep all night.

I was advised I'd have to pick him up at 7 am before the handover because he wasn't actually admitted to hospital. I'd have to be there before 7 to take him. So, I attended in the morning and took him home, he was fairly outraged by the whole not sleeping; anyway.

Q. Can you describe for the Commission what the impact has been on your son's life in dealing with a mental illness?
A. I think he experienced a lot of shame around his presentations, particularly with the way it didn't seem that he was being listened to or the severity that he was feeling was not being acknowledged.

He has since, in preparation for this experience for me, he's read my statement and made some comments around how shameful it made him feel attending Emergency in those ways. That he didn't find the psychologist helpful. And I think that may work for some people, but as a default setting for young people I don't know if that's a particularly helpful way to go about it.

I think, to have GPs decide whether they will or they won't do mental health care plans, and having people that he didn't even have a relationship with doing them with him, and the language they used and the assumptions they made because of his calm presentation, there wasn't even

really any discussion with him about how he actually felt, you know.

The out of hours: all of our presentations to Emergency were out of hours. GPs don't work out of hours, you know, there don't seem to be any appropriate emergency experiences for young people out of hours.

The psychiatric care: we've been keen for him to connect with some sort of ongoing psychological support, he hasn't gotten there yet. He's more open to it now, but I think the range of options for young people possibly need to be considered a little bit more individually as to what they need, what they're coming for, what would help them.

Yeah, just, you know, the way it's set up is not - he would not have attended any of those sessions without a family behind him to take him there and instigate that. You know, to be quite direct and say, "Are you planning to harm yourself?" If no-one was paying attention to him I'm confident he would have just disappeared.

MS BATTEN: Thank you very much, Ms Jennings. Chair, do the Commissioners have any questions for Ms Jennings?

CHAIR: No, thank you very much for coming and sharing your reflections with us and for obviously also engaging your son in helping with the preparation of that. Thank you very much for today.

MS BATTEN: Just before we rise, Chair, may I tender Ms Jennings statement? [WIT.0001.0025.0001]

CHAIR: Thank you.

MS BATTEN: And may Ms Jennings please be excused?

CHAIR: Yes, you are excused, thank you.

<**THE WITNESS WITHDREW**

MS BATTEN: Now, if it's convenient, may we adjourn for lunch?

CHAIR: Yes, adjourn for lunch.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

MS BATTEN: Commissioners, the next witness is Mr Simon Thomson. I call Mr Thomson.

<**SIMON ANDREW THOMSON, affirmed and examined: [2.00pm]**

MS BATTEN: Q. Thank you, Mr Thomson. If you can just make yourself comfortable and make sure we can hear you in the microphone.
A. Can you hear me okay?

Q. Yes, thank you. Have you, with the assistance of your legal team, prepared a witness statement for the Royal Commission?
A. I have.

Q. I tender that statement. [WIT.0003.0001.0001] Mr Thomson, could you start by explaining to us your current role and responsibilities, please?
A. My incumbent role is as a Regional Director with Ambulance Victoria. I am responsible for the Barwon South West region of the state, one of seven regions that operate within Ambulance Victoria. My role encompasses the management and supervision of road ambulance service delivery for both the emergency and non-emergency ambulance services, and I'm also responsible for the quality and safety of care provided by paramedics and our first responders in that region.

Q. Can you explain to us, where does Ambulance Victoria fit within the mental health system?
A. So Ambulance Victoria is a responder to patients in mental health crisis and calls to the 000 service, and we also have a series of roles that are prescribed under some of the legislation, which I'm happy to go through.

Our role in providing response to the 000 call in the way that that system works is that patients or carers may call 000. That call is received by the Emergency Services Telecommunications Authority on Ambulance Victoria's behalf and is then subjected to a non-clinical triage where they ask a series of questions about what the problem is.

Then the case is determined in terms of its level of seriousness and determined to be either an emergency or a

non-emergency case. For the lower acuity, the non-emergency cases, they are referred to a secondary triage process where paramedics and nurses have a further conversation with the caller about the problem and look for alternative solutions in terms of how we might deal with their call that day, or indeed refer it back for an emergency ambulance response.

For cases that are time-critical, where they're life-threatening, or potential harm, an ambulance will be responded. Sometimes under emergency conditions if it's life-threatening, lights and sirens, or we'll attend within an hour to see that patient and assess them and provide a plan about their care.

Q. I want to step through that a bit more slowly, and we have a slide that we can pull up to assist with that. May we have the slide up? Thank you. [WIT.0003.3000.1000] initially when there's a 000 call there's a non-clinical triage?
A. That's correct.

Q. And at that point the calls are categorised?
A. Correct.

Q. How are they categorised?
A. They are categorised into a series of case types, if you like, or conditions for what the patient may have called for, and then those conditions are matched against a clinical grid of acuity. So, we consider how we would respond to that case, so for those that are time-critical, then they will be dispatched to an ambulance response. For those cases that are not time-critical, then there's a further triaging process to assess the most appropriate response from ambulance for that call.

Q. With the calls that are non-time critical, the further triage process, dealing specifically with mental health-related calls, could you explain to us what that secondary triage process involves please?
A. So, the secondary triage process is also known as call referral. So, paramedics and nurses, and more recently mental health nurses, assess callers and assess the patients over the telephone. We use a system called Adastra which is a secondary triaging system that allows them to assess the patient; in the case of mental health patients, around risk in particular, and then look for a

solution. So, some of the solutions could include referring that patient to an area mental health service where they might already be an existing patient; to refer the person or the patient to community mental health services, or indeed refer the case back for the response of an ambulance to go and assess the patient in the community.

Q. Why has Ambulance Victoria set up that secondary triage for the mental health cases?
A. Secondary triage is set up for a whole variety of cases, not specifically for mental health cases. But in the case of mental health patients, there are many calls to the 000 service for patients experiencing mental health issues in the community: some of those are clearly crisis-related and some of those are for patients who clearly have not been able to access other services, so they've called 000. The purpose of having a mental health nurse assess them is to ascertain the best way to deal with their call that day.

What we have seen since the introduction of that mental health nurse in 2017 and that service is a considerable reduction in the amount of times that we're sending ambulances out to see those patients because we've been able to better network them back into those responsible for their care, which might be back into GP services, it might be back into area mental health services or into community mental health services, so that the reason for their call can be dealt with on that day by somebody else who's better equipped to do that.

Q. So in short it's meant less ambulances going to attend and has that ultimately freed up ambulances for other situations?
A. Yes.

Q. We might take the slide down, thank you. Could you explain the role of Ambulance Victoria under the Mental Health Act, what are your obligations under the Act?
A. So Ambulance Victoria under the Act has a series of responsibilities and paramedics are authorised persons under the Act, which provides for responsibilities and powers that allow them to assist with the management of mental health patients.

In particular, it allows for patients who are subject to orders under the Act to receive care and to be conveyed

to hospital against their will. It provides for paramedics to provide interventions and treatment which can include sedation and restraint to be able to safely transport patients to hospital. It provides provisions for searching, so it allows paramedics to conduct searches in an effort to make sure that a mental health patient isn't carrying any weapons. It also allows paramedics to enter premises where they believe that someone who is subject to an order who's required to be conveyed to hospital is; however, it would be my experience that those things very rarely happen without the police's assistance.

Q. Does Ambulance Victoria experience challenges in trying to comply with its obligations under the Mental Health Act?
A. I think that there are a series of challenges around the Mental Health Act, and in particular around conveying patients around the state. As I'm sure the Commission appreciates, there are different area mental health services. So, Ambulance Victoria is responsible to convey patients subject to orders between mental health services.

The mental health service is obviously geographically based according to where people live, so we do spend time moving patients around the state and repatriating them to the mental health service that has historically been responsible for their care over that time.

Q. So that's effectively a transport service, isn't it?
A. So effectively we're moving people around to repatriate them to a particular mental health service. Even though they may no longer live there, I think there are examples of where people move around the state, and particularly people who are homeless and patients who are homeless, end up being repatriated to mental health services that perhaps no longer provide a service in the area that they wish to live.

One of the challenges we have is that the services are about where the patient's residence is, and if they're homeless or of no fixed abode we can be moving people around. Equally challenges for custodial prisoners who are coming out of having served a prison sentence; it may be that they are a person who had previously lived in far east Gippsland or in the northern part of Victoria, discharged from a prison in the western part of Melbourne, then they need to be repatriated back to the mental health service if

they're subject to treatment orders, which is considerably imposing in terms of the amount of resources that it takes to do that.

Q. Can I ask you some questions about the proportion of time Ambulance Victoria spends assisting people with mental health presentations. The first question is, how is a person determined to be a mental health presentation?
A. So a mental health presentation or a primary mental health presenting presentation in the data is as a result of taking information from the 000 call service, information from our referral service, and information from the electronic patient records that are completed by paramedics when they see patients, and matching up the disposition in that information to ascertain that it was a mental health-related complaint.

One of the challenges we have in the dataset is that a mental health condition, a mental health illness can contribute to a physical illness and we lose that in the data. So, where someone who suffers from mental health illness perhaps presents with another medical problem, albeit that the mental health illness was possibly a factor, that won't appear in the data, so we think that it's potentially under-reported in terms of the amount of cases that we see in the community where the patient's primary problem is a mental health-related issue.

Q. Are there guidelines to ensure consistency with how things are reported, or do each of the different parts use their own outline?
A. There's a standard that's applied, so these are all drawn out of lists. Obviously the paramedics have the option, where things don't fit the category, to select something like "Other". That's one of the challenges in the dataset, where a patient might be referred to as having a condition that was "Other" when in fact it may have been a mental health-related condition.

Q. So that's how a case is determined to be a mental health presentation, and of the calls to 000, what percentage of those relate to mental illness?
A. So, of the calls to 000 - sorry, I just have to refer to my statement.

Q. No, you're fine.
A. 11 per cent of the calls to 000 were determined to be

for a mental health complaint. There were just over 60,000 calls that were determined to be a mental health-related call or a mental health-related response, and of those just under 3,000 were for the transfer of patients between mental health services.

In terms of calls further to that, there are 190,000 calls received by the secondary triage referral service, and in 2018, of those calls, 25,000 or 12 per cent were for a primary mental health-related issue.

Q. Can you explain to us what proportion of the 000 calls that relate to mental health, what proportion of those result in a transfer to hospital?
A. Of the calls that an ambulance attends, 82 per cent of those patients are conveyed to hospital; 18 per cent of the patients are not conveyed to hospital, which means that they have been referred to a mental health service, maybe an area mental health service, referred to a GP service, or indeed there wasn't a mental health-related presentation and the patient was able to refuse and stay at home.

Q. Aside from taking to hospital and referring to a service, what capacity is there for Ambulance Victoria to treat mental health situations when they respond to a call?
A. I guess in the instance where a patient needs to be taken to hospital, the paramedics are equipped and skilled to be able to assess the patient. We have a series of clinical guidelines that support that, and I guess in cases where patients are unwilling to attend, the police potentially will attend as well and then the patient is able to be managed and treated with restraint and sedation if required - hopefully not - and conveyed to the hospital.

The paramedics are also in a position to make referrals to other service providers. That does represent a series of challenges for us. Each of the area mental health services have different in-bound numbers, they have different services that are provided, and there is considerable amount of time that's required to make that referral currently, which I think drives in part why paramedics take patients to hospital, because it seems at the time to be the most expeditious approach.

Q. Can you just explain that for us: what is the time involved in making a referral, why does it take long?
A. So, for some of the area mental health services they

have a triage number that you can call. It's not uncommon for those calls to take more than an hour to be able to speak a triage practitioner and then seek a plan about that patient. We certainly experience that also through our call referral service, where they're contacting the mental health service, the area mental health service to triage a patient. So, one of the challenges I think we have is for us, ambulance services work in minutes and seconds, and the mental health service obviously work in days and weeks. So, if you like, there's a disconnection and a challenge that sits in how we respond to patients in crisis in the community.

Q. Is there no special line for Ambulance to get through to area mental health service? Or are you in with everybody else?
A. So, we join the queue along with the consumers and the other health professionals who might be calling. It does vary a little bit between services. The lack of consistency in the service has represented a challenge for paramedics. Ambulance Victoria is a state-wide service, paramedics work in different geographic locations that are covered by different area mental health services, so it can be challenging in understanding the services that are offered in each geographic catchment and indeed they all have different in-bound phone numbers to contact their triage or assessment service.

Q. In terms of referring people to other services, does that become even more challenging outside business hours?
A. Absolutely.

Q. And how so?
A. Well, I think access is a challenge generally, and I think that access is not just a challenge for the Ambulance Service, it's a challenge for the patients experiencing mental health issues and mental health crisis in the community. So, lots of services are tailored around week days, which I guess is common in organisations, most of their work is done during the day during the week.

It's a considerable challenge for Ambulance Victoria and for members of the community who experience mental health issues and crisis outside of those hours, and that results in more people being taken to Emergency Departments because there are fewer options in terms of coming up with a strategy for them on that particular occasion.

Q. Can you tell us, what's the median case time attendance where the primary issue was mental health?
A. Where paramedics attend for a mental health patient, the median time is just over 90 minutes.

Q. Can you explain to us how that's measured, how do you calculate that time?
A. The time is measured from the time that the call is placed to 000 until the time that the ambulance crew and the paramedics become available again to respond to another case.

What we know for patients experiencing mental health issues who are transported to hospital by ambulance is that there can often be extended waiting periods for them to be seen at the Emergency Departments. Emergency Departments are very busy, and for mental health patients that can often result in waiting. In many cases the paramedics and in some cases the police are also having to wait with that mental health patient until they can access an appropriate place within the Emergency Department to transfer and hand them over to the care of the doctors and nurses in the Department.

Q. Just to clarify, when you talk about the proportion of Ambulance Victoria's time is spent dealing with mental health presentations; in your view, is that a big or small proportion of Ambulance Victoria's time?
A. Well, it's a significant portion of time. If we consider that it's over 10 per cent of our work, that's a considerable period of time. We estimate it's about 90,000 hours of time. One of the challenges is that we don't have specific information to present to the Commission today, but based on the median time and the volume of cases we have, it is over 90,000 hours of resourcing time spent working with mental health patients and transporting mental health patients in the community.

Q. Can I turn to the issue of volume. You've stated:

> "The number of mental health patients being managed through referral has increased overall with more patients being risk assessed as requiring an emergency response reflecting the safety net provided by referral."

Can you elaborate on this in terms of the volume of patients?
A. So what we know, and certainly having put the mental health nurses into the referral service, we've seen a decrease in the amount of ambulance responses required to patients in crisis. In the community, however, the volume of cases that are dealt with by our referral service for mental health patients - I will just have to refer to my statement - is considerable and it's growing disproportionately compared to the growth that we see in the referral service generally.

So the referral service growth for other case types is about 9 per cent per annum, and for mental health patients it's 12 per cent per annum in terms of the numbers of calls that are being dealt with by the referral service triage.

Q. Can I ask you about the complexities of the cases that you are seeing. What are the trends in relation to the complexities of mental health incidents?
A. Sorry, I'll have to refer to my statement again.

Q. So, from paragraph 39 you talk about the complexities.
A. Sorry. We compared data between 2015 and 2018 to consider some of the changes in the types of presentations that we may have seen for patients in the community. What we have seen is a number of patients seen by paramedics with a clinical presentation of suicide or suicidal ideation increase by 52 per cent when we compared 2015 with 2018.

Likewise, patients presenting with psychosis increased by just over 21 per cent in that same, comparing those same two periods. And interestingly enough as well, the number of emergency patients with substance-related issues, which can be a considerable driver around exacerbation of mental health issues, increased by 22.6 per cent for the same comparison.

So, we would say that the complexity and the acuity of patients with mental health issues in the community, when we look at 2015 compared with 2018, seems to be increasing. So, patients are presenting with more serious and more acute problems when we compare those two periods.

We felt it was also useful to have an observation

about the work that we do with Victoria Police. So, obviously Ambulance Victoria works with Victoria Police often for patients who are presenting with mental health-related issues, and proportionately police attend 30 per cent of the time to those cases, which was static between 2015 and 2018. And whilst the volume, the number, would have increased over that time, the proportion remains stable.

Q. Are those figures for the whole of Victoria, is that what they relate to?
A. Correct.

Q. How does that compare to what you're seeing on the ground?
A. I think the data supports some of the challenges that we have around mental health patients and the acuity of mental health patients that are presenting. We know that there are challenges about accessing - particularly accessing beds for acute mental health patients and accessing care. We think that is demonstrated in the data when we see patients that are presenting with more serious problems, we're seeing more people who are at risk of suicide, we are seeing more people who are unwell with psychosis in the community, and either they are, or other members of the community or their family or carers are calling 000 in an effort to access care for them.

Q. You referred to the fact that police attend in 30 per cent of the cases with Ambulance Victoria; is that right?
A. That's correct.

Q. Is it the case that Ambulance Victoria would attend 70 per cent of crises without the police attendance?
A. That's correct.

Q. What is it that determines whether or not the police come?
A. So, the police attendance will be influenced by a variety of factors. If at the time of call there is any indication that there is violence or aggression, and we've spent a considerable amount of time and training over the last four years in particular with our paramedics around occupational violence, so looking for triggers and indicators that there may be violence at those scenes; if that was the case, then the police would be asked to

attend.

The police will also attend in some cases where the patients are subject to orders under the Mental Health Act and we require their assistance to convey them to hospital. The police sometimes also will be in attendance at those cases because they will also have been called by the family. Patients who are in crisis and families and carers who are attempting to access care will often call not only the Ambulance Service but also the police in an effort to help manage their safety.

In those cases the police and the paramedics work together to care for the patient, and in some cases the area mental health services may also be involved in that. So, where a patient has been subjected to orders and they need to be taken to an area mental health service, often the mental health service workers will be involved. The paramedics, the police and the mental health service staff will collaborate over the strategy to get that person off to the hospital in the safest way that they can.

Q. In your statement you've presented a case study which outlines the complexities faced by Ambulance Victoria. Are you able to give us a high level summary of that case study, please?
A. Yes, I will. If that's okay, I might just refer to my statement to make sure I reflect it correctly.

Q. Sure, thank you.
A. We've offered two case studies, the first one relates to a 40-year-old man who presented with suicidal ideation over a number of days in and around Metropolitan Melbourne. On the morning of the first day when he presented, he was displaying suicidal ideation and was attempting to run into traffic. He was apprehended by the police, assessed by paramedics, and he was taken to a hospital under section 351 of the Mental Health Act for an assessment.

That same day later in the afternoon the same patient presented for a second time displaying suicidal ideation and attempting to run onto the railway tracks in a southeastern metropolitan railway station. He was apprehended by police again on that occasion, assessed by paramedics and transferred by ambulance to a different hospital on that occasion.

Later that same evening Ambulance were called again to the same railway station and encountered an identical situation to the previous one with the same patient, and the patient was again apprehended by police under section 351 and conveyed to hospital.

On that same day, at almost midnight, Ambulance Victoria was called to a different railway station in the southeastern suburbs of Melbourne and encountered the patient expressing suicidal ideation and attempting to access the railway tracks once again. The patient on that occasion requested that the paramedics take him back to hospital, which they did.

Two days later, Ambulance Victoria were called to a railway station in the Central Business District where the same patient was again expressing suicidal ideation and attempting to access the railway tracks. He was apprehended again under section 351 of the Act. He was again transported to hospital. In that case it was one of the hospitals that he had been recently discharged from and was handed over to the staff at the hospital.

Later that same evening Ambulance Victoria attended that same patient again in an inner metropolitan suburb. He was again upset, expressing suicidal ideation, and on that occasion escalated and ultimately was restrained with the assistance of the police and ended up being detained and handcuffed and he was transported to hospital again under section 351 of the Mental Health Act.

In terms of summarising that case, the patient required ambulance attendance six times over a three-day period. It was a total of nine hours of involvement from Ambulance Victoria paramedics in assessing him and taking him to hospital and working with the police.

There are a number of complex issues that fall out of the case study. One of the challenges in this particular case is that this man was homeless, he was of no fixed abode. When he was taken to the first area mental health service, they were able to check his information within the mental health information system as it exists, and he was a patient that was not of their catchment, he was a patient of a catchment in Regional Victoria, and had care plans and the like, albeit that they were old.

There's challenges around the lack of coordination. In this case this patient was presented to multiple different police units, multiple different ambulance crews and multiple different hospitals.

There was considerable resourcing demand. So, this patient took a lot of resources from the Ambulance Service, from the police and from all the different hospitals who were involved in his care over what was only a three-day period of time. The challenges in that is that we don't have access to the mental health information system, so we can't look up that patient's care plan to ascertain who the area mental health service is that is responsible for his care, what the care plan is. Indeed, in these cases they've re-presented him back to the same hospital and the same health service each time, which I think from an escalation of his mental health condition would have been very useful rather than him starting from scratch again at each of these health services as he presented to them.

Currently Ambulance Victoria is not able to access that information as it's contained within the patient's mental health records because of the way that the Act is constructed. We see that that is a significant challenge in terms of coming up with good strategies and good connected strategies around care for patients and, for this gentleman, he didn't receive the care that he possibly could have received if we had access to that care plan and that strategy.

Q. Can you explain to us what the PROMPT pilot is?
A. We have a second case study which I'm happy to go into which talks about the PROMPT pilot. So, PROMPT stands for the Prehospital Response of Mental Health and Paramedic Team, it's a pilot that's been conducted in Greater Geelong. It's an initiative between Ambulance Victoria and Barwon Health. They provide the area mental health service in Greater Geelong. The PROMPT Team puts a paramedic and a mental health clinician together to respond to mental health cases received by Ambulance Victoria, are both crisis-related responses and also lower acuity responses, so they receive referrals from our call referral service and from the mental health nurses who work in the call referral service in the Greater Geelong area.

Q. Could tell us about --
A. I'll maybe go on with the case study?

Q. Yes, please. Could you just, at a high level, tell us how that panned out in this case study?
A. So, the pilot's currently running, it concludes at the end of this month. There was a particular case that we thought demonstrated how, when we do things differently, we have an opportunity for improvement.

So this is a 32-year-old man with a significant longstanding history of schizophrenia, very well-known to the mental health services at Barwon Health, and he was also being case managed through a local community-based mental health service. He presented with suicidal ideation and a call to 000 resulted in the PROMPT Team attending.

For this particular patient he had been experiencing exacerbation of his symptoms from his schizophrenia and he called 000 because he was quite agitated and was experiencing suicidal ideation.

The PROMPT Team responded. When they arrived the mental health clinician was familiar with him so it was a patient that she had been involved in the care of previously and they were able to look up his current care plan and his current, I guess, support mechanisms that he has around his care and then to assess him.

What became immediately obvious was that the problem was that he'd actually ran out of his antipsychotic medication and hadn't been taking it for the last four days. What the PROMPT Team was able to do was to liaise with a duty psychiatrist from the area mental health service, receive a prescription for him so that he could have his medication. They were able to source a supply of the medication for him, take it to him, he was able to take the medication. He was able to stay at home, it was assessed that the risk was reasonable, that he would be able to stay at home. He was cared for by his family and then they followed up with him the subsequent day and he had had a significant improvement in his condition.

When we compare that to the historical response that we would have had, we would have sent an ambulance. It's worth noting, the PROMPT Team are in an unmarked car, so it's very low visibility for the people that live around this gentleman. So, we would send an ambulance. He was expressing suicidal ideation and aggression, we would have

called the police. They would have sent multiple units. We would have then sent a second ambulance at the prospect of transporting him to hospital because he has a history of being aggressive and he's quite a strong fellow. He would ultimately have been taken into care, he would have been restrained, sedated, shackled, transported to hospital to the Barwon Health, to the University Hospital, Geelong Emergency Department, where he would have then been there for a period of time while the sedation wore off so that someone could then come and assess him for his mental health condition - all over what realistically was an issue around access to his medication.

So, the PROMPT service in that case provided a much better outcome most importantly for the patient but a much better outcome for the system. So, taking people who are experiencing thought disorders into really busy Emergency Departments is really not a very optimal way to care for them, and in this case he was able to stay at home. And increasingly became well, so there was subsequent follow-ups with him through the mental health service, and after he was taking his medication, by the end of that week he was considerably better, which I think demonstrates that when we do things differently, we can get better outcomes.

Q. We just have to go a bit slower, sorry, for the transcriber.
A. Sorry.

Q. You were referring to the area mental health service. Can you tell us about what support Ambulance Victoria needs from mental health services in order to be able to fulfil its role optimally?
A. I think access is one of the significant challenges. It's cleverly evident that mental health services are under considerable strain in terms of the demand for their services. That results in decreased access for Ambulance Victoria in terms of accessing their triage services and their clinicians to be in a position to come out and see patients. That results in patients being taken to Emergency Departments because there aren't other options for them.

So what we need from the area mental health service first of all is access. I think the other challenge that we see within the system, if indeed we describe it as a system, it's sort of a whole lot of parts that deliver

similar services not necessarily in the same way, is to have some systematic strategy and coordination of access for patients. So, we don't perhaps have patients being taken to area mental health services and to other places as a result of their geography or where they might live, that they actually are able to access the care where they need it, and that that will be more timely for Ambulance Victoria as well in terms of being able to access care for those patients.

I think the other thing we need for the mental health service is an opportunity to collaborate in the care of mental health patients. If indeed our role is about responding to crisis, it's about responding to patients who are having crisis in the community, we need to be able to collaborate with mental health services to have plans for those patients where they're known to them so that we can support a better outcome for them.

So, if the outcome is about access to an inpatient service within an area mental health service, that that's achieved in a caring and considered way and avoiding busy Emergency Departments and other services that don't deliver good experiences for those patients.

Q. Can I deal with two final topics, the first one is education. You've said in your statement:

> "AV is aware that many paramedics do not feel adequately equipped to manage and care for patients with mental health issues."

What are you referring to there; what are you aware of?

A. That goes to a study that we participated in which was a study conducted across Australia, not just in Victoria, by Beyond Blue and the Black Dog Group. There was participation from paramedics sought in the study and surveys around how confident they felt in managing mental health patients.

What the study tells us is that paramedics don't feel confident in dealing with complex mental health patients and that there's an opportunity for us to consider how we might built more capability for our paramedics or indeed how we might better respond to complex mental health patients' needs in the community to better support our

paramedics: whether that be through specialist teams or through better capability development with education or partnering with the area mental health services.

Q. Can you describe in more detail what are some of the specific gaps you see in the current education?
A. So education for paramedics. So, paramedics complete an undergraduate degree to be able to be registered as a paramedic in Australia. The training is delivered across many different jurisdictions. So, paramedics who come to work here in Victoria could have trained in New South Wales or Queensland. The content of the courses is variable around managing patients with mental health issues.

So, there's an opportunity to have some engagement, perhaps with the Paramedicine Board, about what the base standard around education for managing mental health patients are.

I think over time we have seen paramedics more involved in managing more patients with more acute problems in the community and an exacerbation of the mental health illness. We need to build more capability in our staff, particularly around risk assessments. I think for paramedics attending patients, particularly patients who express self-harm or suicidal ideation, there is an opportunity to build more capability to understand that better and have better risk assessments, and in turn be able to refer patients appropriately to services so we're not taking everybody who presents with that type of problem to an Emergency Department, which is one of the challenges that we have today.

Q. Finally, you've referred to collaboration with mental health services as being something that would improve the delivery of Ambulance Victoria's services. Are there any other changes that you want to raise now that you think would bring about lasting improvements to help people affected by a mental illness, particularly in crisis situations, from Ambulance Victoria's perspective?
A. I think I've mentioned some of them in the evidence already. I think collaboration and the sharing of information, so access to information about patients' care plans so that we can work together to come up with good solutions and good strategies for them in terms of their care. That may very well go to the information that's held within the mental health information systems as they stand.

I think there are definitely challenges, and our view is that there are challenges around the way that the system is structured in terms of area mental health services, and the need to consider a more collaborative approach collectively across the mental health services so there is indeed a system of care.

We draw comparisons to other systems of care that exist for other health-related complaints in Victoria. So, we have a system of care for patients who suffer strokes, we have a system of care for patients who suffer trauma, which is above I guess the individual services that are offered in particular geographic areas by particular health services. So, we see that there is an opportunity to have a more systematic and coordinated approach around the management of mental health patients and their access to care.

We believe that partnering with and having more open communication with the area mental health services about patients only serves to improve the outcomes for the patients and also to have options for patients who are presenting in crisis. The responsiveness of the mental health services to our requests for assistance, or the police's requests for assistance represent a significant challenge, and I think it comes to that, in an emergency service context we work in minutes and seconds: mental health services work in days, weeks and months in terms of their care for patients, so there is an obvious difference, if you like, in terms of how we deliver our services.

So, if we can connect that, if we can have a coordinated approach to it, we believe that we will have better outcomes for mental health patients in terms of their access to care.

MS BATTEN: Thank you, very much, Mr Thomson. Chair, are there any questions for Mr Thomson?

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for your excellent evidence. I'm interested in the dollar cost of mental health for Ambulance Victoria, so I was going to kind of give you a question on notice about whether you could see

if you are able to give us a ballpark estimate of the dollar cost of your services in respect of mental health. You've given us some hours, rough estimates of hours: what would that translate to, what other aspects? So, I just wondered if you could go away and think about that possibility.
A. I think we'd be happy to take the question on notice and come back to the Commission with that information. I don't have it to hand but we would be willing to take it on notice and come back with some figures.

COMMISSIONER McSHERRY: Q. Just one question from me. You mentioned sometimes the use of sedation and restraint. Could you perhaps explain what that encompasses and how often that might be used?
A. In terms of how often, I would probably have to take that on notice and come back to you with the actual numbers.

It is an end strategy always. If we think of the Act, we think of just good care. Least restrictive is always the strategy around mental health patients. However, people who are in crisis and are at risk, particularly if there's aggression, there is potential for the use of sedation. Paramedics have a couple of options in terms of the sedation that they can use. However, they are sedation that results in the patient not being in a position to contest with the transport. Paramedics can obviously provide care for those patients through that time.

In terms of restraint, every ambulance is equipped with patient restraints for the purpose of restraining mental health patients. Again, viewed with the least restrictive in nature, I don't think anyone enjoys being restrained. However, it is about the safety of the patient, it's about the safety of the paramedics, the safety of the police. What is very risky was, if during transport a patient does become - gets outs of the restraints or became aggressive in the back of the ambulance, it's a very small space and it represents considerable risk, not only to the patient, but also to the paramedics and potentially the family or the police or whoever else might be attending with him.

Q. What exactly are those restraints? Are there straps?
A. Yes, so they're straps that are attached to the ambulance stretcher. They have arm and ankle restraints,

and they're used in conjunction with the normal restraints that we use on the stretcher, which obviously are part of the standards we apply for everybody in terms of travelling in the vehicle, but they certainly do restrict the patient's ability to move or indeed to get off or out of the stretcher.

Q. Is data kept on how often that might be used?
A. Yes, it is.

MS NICHOLS: Good. It would be very useful to have that. Thank you.

CHAIR: Q. I've got a few other questions that I'd like to ask. The first one is in relation to performance criteria for Ambulance Victoria. In terms of response times we heard earlier today, for example, in Emergency Departments there's different KPIs I guess or performance standards for other forms of health care relative to mental health. Is that the case in Ambulance Victoria?
A. Yes, we have a series of metrics that are agreed with government each year around our performance. In terms of the timeliness of response: for code 1 emergencies which is a lights and sirens response, we need to attend within 85 per cent of the time, 15 minutes or less across the state; or 90 per cent of the time, 15 minutes or less in population areas of greater than 7,500 people in sort of larger communities.

Q. So that same criteria would apply whether it's someone in acute mental health crisis or someone with another form of physical illness?
A. If it was an acute mental health crisis and it was coded and determined to be a code 1, then it's exactly the same.

Q. We also heard earlier today about the occasions when it is that police might be first on scene at a critical incident and might decide an ambulance needs to come. Just to clarify the process for 000: if it's deemed to be an urgent mental health crisis, are the ambulance the first dispatched group to that emergency or is it a juggle between police and/or ambulance?
A. It will depend on the information that's received at the time of call. In Victoria the computer-aided dispatch system for all the emergency service organisations, which is operated by ESTA, is integrated. So, a person who

called for a mental health-related complaint for ambulance, where there was threats of violence or harm, that would create what we describe as a multi-agency event and we would invite the police to come with us for that event. Equally, they are able to do the same: so where it is a mental health-related complaint coded in their system it will come automatically across to the ambulance system for response.

In terms of police being present and asking for our attendance, it would depend on the information that's given at the time about the patient's presentation as to how quickly we would respond.

Q. And so, just another point in relation to that, we've often heard from consumers about the distress there is if they are transported in an emergency situation in the back of a divi van as opposed to in an ambulance. Would it be more often that someone in crisis, if both police and the ambulance are there, that if police assistance is required, they are inside the ambulance with the ambulance crew escorting the person or are they more likely to be in the back of a divi van?

A. I would say they would be most likely to be in the back of an ambulance. It's certainly our view mental health patients should be treated by clinicians and indeed be treated and supported by paramedics in that situation.

There are a handful of situations where it may be deemed that it's not safe to do that, and we certainly are aware that the police sometimes will transport patients themselves due to the amount of time they may wait for us to attend. Obviously, we have to manage all the calls that we're dealing with at any point in time, including the mental health calls. So, there are occasions where ambulances might be delayed and the police may very well be waiting for us, and equally there are times where we've called the police and we're waiting for them to come and support us with a mental health patient.

Q. There's just one last point I want to talk on. You discussed the performance criteria in metropolitan and other areas. In Rural Victoria, and this was something that's come up in our discussion so far: if you have a person who's in acute mental health crisis in a country town where there's not an inpatient unit available and the escorting of that person to the hospital that is the

nearest available inpatient care, is that just done as part of the normal emergency response of an ambulance, or how do you structure the responses to those sort of calls and transfers?
A. So, we would respond obviously to those calls, and our footprint, like the police's footprint, is across the state. I think mental health patients in Regional Victoria, particularly in Rural Victoria, represent a whole series of challenges about access to care, not only for our services but to access to care generally.

For a patient who presented and for the purposes of the police taking them into custody for a 351, they could be presented to an Emergency Department for the purpose of - or an urgent care centre for the purpose of an assessment. Indeed, if the patient was subject to orders and had to be conveyed to an area mental health service, that could be a considerable undertaking, given the area mental health services' coverage in Regional Victoria are quite significant areas.

In that case, paramedics will work with the police, they do these sorts of things often, and with the respective control centre in an effort to coordinate how we might do that, and how we might get that patient to the area mental health service where they need care, it is not without its logistical challenges, and for the patient can be challenging, particularly if we're changing the faces of the people that are caring for them, be it the paramedics and the police, through a journey. So, if it's going to take us two or three hours to get them to an area mental health service, it may be that they're handed over to subsequent teams of paramedics or police for that journey, and I think that represents a challenge around the continuity of care and for the experience for the consumer.

Q. Yes, and many times that consumer may well voluntarily want to have that transfer and admission too?
A. Indeed, and if it is voluntary, then there are some other options. We certainly can utilise our non-emergency sector. There's area mental health service transport, there's obviously Working With Families. I think the key in all of those cases is to look for the best option in terms of what works best for that patient that's safe. So, if it needs to be in our care, then that's what we will do, but equally exploring options with the area mental health service and with the patient's carers to look for ways to

get them to the mental health service safely.

CHAIR: Thank you.

MS BATTEN: No further questions for Mr Thomson. May Mr Thomson please be excused?

CHAIR: Yes, thank you very much for your evidence today, Mr Thomson.

<**THE WITNESS WITHDREW**

MS NICHOLS: The next witness is Ms Louise Glanville, I now call her to give evidence.

<**LOUISE GLANVILLE, affirmed and examined: [2.50pm]**

MS NICHOLS: Q. Ms Glanville, are you The Chief Executive Officer of Victoria Legal Aid?
A. Yes.

Q. Have you held a number of other positions both in the public and private sector, including as Deputy Chief Executive officer of the National Disability Insurance Agency?
A. Yes.

Q. And First Assistant Secretary, Access to Justice and Strategy and Delivery divisions at the Federal Attorney-General's Department?
A. Yes.

Q. Executive Director, Deputy Secretary, Legal and Equity Group at the Victorian Department of Justice?
A. Yes.

Q. And among others, Principal Legal and Social Policy Adviser to the Victorian Deputy Premier and Attorney-General within the Office of Deputy Premier and Attorney-General?
A. Yes.

Q. Alright, I won't take you to the others. Can I ask you, what services does Victoria Legal Aid provide to people with mental health issues that allows it to inform its position and understanding of the way that the mental health system works?

A. Thanks for that. Victoria Legal Aid is a statutory agency and it has, as part of its core responsibilities, the provision of legal advice, legal information and representation of people who are eligible for that representation in terms of their legal issues.

What this means is that, from our work, we glean a very significant understanding of people who experience mental health issues in not only the criminal justice system but the civil justice system as well, as well as the family law and child protection systems also, and we do this through provision of duty lawyer services in most courts in Victoria, if not all courts; through representation of defendants under the Crimes Summary Impairment Act in County and Supreme Courts. We do this by also not just having legal services but by having non-legal advocacy services such as our Independent Mental Health Advocacy and our Independent Family Advocacy and Advice Service.

We offer a telephone assistance and helpline which is available from 8 till 6 pm, and that is where anyone can actually ring and get legal information or advice.

Q. I'll take you through a few of those services, but first, was it the case that in 2017-18 Victoria Legal Aid assisted over 94,000 unique clients and, of those, 26 per cent disclosed that they had either a disability or a mental health issue?
A. Yes.

Q. Do you classify people experiencing mental health issues as priority clients?
A. Yes, we do.

Q. What do you mean by priority clients?
A. So, priority clients can include a range of different individuals and their experiences and the problems they're experiencing, but it particularly for us relates to people who are poor, because of course we have a means test and that means test is very mean. We support women and children and others as part of family violence proceedings, those experiencing mental illness, issues that relate to the legal system or in fact disability; in the context of the NDIS, we have quite a significant practice.

We also assist people in the criminal domain generally

who are defending matters before Magistrates' Courts in Victoria and indictable matters before the County and Supreme Courts as well.

Q. You have a specialist mental health legal practice?
A. We do indeed, and that encompasses not only appearances at VCAT in relation to the NDIS, but also work in relation to mental health issues, the Mental Health Tribunal, and in addition we appear in the Supreme Court, or we fund appearance in the Supreme Court for matters of law that we're wishing to test. So, for example, the recent matter in relation to the Mental Health Act and issues of capacity and how that is determined.

Q. Can I ask you a little bit about the Independent Mental Health Advocacy Service, briefly what it does and who its clients are?
A. Yes. The Mental Health Independent Advocacy Service is a really, I think, important addition to the work of Legal Aid. Often people think of Legal Aid as just providing legal services, but this is a real way in which we consider that you need to see people holistically, and so, it's non-legal advocacy that's provided.

That particular service works across all public hospitals in Victoria and really provides support and information to people who are at risk of compulsory treatment or are actually experiencing compulsory treatment.

It is very important because it puts the individual who's experiencing these issues at the very centre of what it is that is being experienced rather than being the object of services that are provided.

Q. Can I ask you to articulate what it is, in that context, to put the person at the centre?
A. Yes. Our workers, as part of that particular service, would - and I'll use a very practical example - would go to those facilities, would actually seek information on who is currently in a ward or in that situation that would benefit from seeing an independent advocate, and would sit with them and not only consider some of the areas that the Mental Health Act would require, such as how that person can be involved in their own treatment in some ways, how we can better understand that person's wishes, how we can ensure that that person is able to represent or put forward

the sorts of things that would be important to them in relation to any treatment, be that voluntary or not voluntary and, in those ways, it's a very practical and supportive orientation that puts the person experiencing the mental health issues at the very centre of what we do.

Q. Is it an affirmative outreach?
A. It's very affirmative outreach, although we don't compel, but we do seek to be very available to assist people. I think it is interesting, there has been a recent evaluation of that service. We receive funding from the Department of Health and Human Services for that, and this evaluation was particularly important in highlighting the success of that pilot which is now into its second term, and the fact that some consideration should be given, and it was one of the key recommendations, for having it as the standard practice across Victoria, so representing an opt-out option for people so that it represents state of play rather than being something which, if you happen to access it the day our people are there, then that's what happens.

Q. You have, as part of that program, consumer experts advising you?
A. We do. I think that's a particularly commendable part of the work of Legal Aid, and I say that having only recently come to Victoria Legal Aid about 10 months ago, so it's tremendous to see that Victoria Legal Aid has actually embraced this notion of, how do you better inform and design what you do, the services you provide, the legal information or legal advice you provide with reference to the user, with reference to what that person would need to make it as useful as possible to them.

So, we have an advisory panel; it not only helps us to design the sorts of services that would be most useful for people with mental illness or experiencing mental health issues, but it also assists in advising the organisation more generally about how we can be inclusive in terms of our employment practices in terms of the way in which we think about those who use our services, and in fact not objectifying them but seeing the real humanity in the people that come before us.

As part of that we also have a consultant, a mental health consultant who is a terrific woman, having met with her several times, and she not only helps to keep us

account but is very useful in suggesting best practices that might exist elsewhere that we should be thinking about in the provision of legal services and non-legal services that we offer to all Victorians.

Q. Am I right in thinking that what you would suggest is that this is a good model that other systems could observe?
A. I think the independent evaluation that was done clearly indicates that this model is working, that it is one which is empowering and assists people to take up, I think what was really intended by the Mental Health Act, which is, people participate in their treatment, in their assessment, in their recovery, and it is a model which really does assist people to understand their rights and their options and to think through how best they can actually represent those in those assessment/treatment processes.

Q. Can I ask you just to say something very briefly about Victoria Legal Aid's involvement with the specialist therapeutic courts?
A. Yes, I think Victoria, as some of the Commissioners would know, has a very proud history in relation to the sort of therapeutic jurisprudence and specialists courts. Personally, I am a great fan of these particular approaches because they not only look at perhaps the crime that has been committed, but they look at the causes of crime.

Particularly important to us at Legal Aid is the assessment and referral list at the Magistrates' Court, which is still relatively new, I think 2010 or 2011 it was introduced, and it is really important because what it does is, it looks at the sorts of wrap-around services that can assist people to get on track with their lives.

It uses judicial monitoring, which is also a similar process that is used in the Drug Court in Victoria at both Melbourne and Dandenong, and as part of that judicial monitoring it's a real sense of the person feeling valued, included, listened to - also sometimes I've seen reprimanded in some instances - but a real positive engagement which is really attempting to get that person back on track and to help them think about what's going to be important in their life to make a particular difference.

Q. Is it the fact though still that roughly one in five unique clients of Victoria Legal Aid, who you represent for

summary crime matters, disclosed a mental health issue in 2017/18?
A. Yes, that's right, and that's a fact that many of the clients that we would assist legally in summary crime would have a mental illness or mental health issues.

Q. We've asked you a question when we were seeking written evidence from you about where Victoria Legal Aid fits within the mental health system. I'd like you to, if you can, address your perspective on whether the mental health system is actually functioning as a system?
A. So, my own view is that, I don't really see it as a system as I would understand that; and, when I say that, I would mean a system that I think operates well is one in which people - there's a variety of services and support options available to them - people receive them in a timely way, there is good coordination and cooperation amongst the providers in that system, that users of the centre are very central to people's thinking in relation to that, and that in fact it's a system that doesn't focus primarily on the crisis end, or what I would call the tertiary end, but really values early intervention and prevention as very strategic and important issues in order to address and not leave people to come to the edge of that cliff and then fall off.

Q. So, these are the features that you would like to see, and we might come to those at the end. Is your evidence that you're not seeing those features in the health system from where you and Victoria Legal Aid sit?
A. That's right, and a lot of that might be because we do often get to operate at that tertiary end, so that is very challenging, but also, it is not to impugn the good work that people try and do in that system.

We think it's a system - or my personal view is that it's a system that relies very much on relationships between individuals rather than processes and coordinated endeavours through which people can move through and get the support and access to services that they need in a timely way. So, I would see it as fragmented and not coordinated in a way which can offer optimal outcomes to people experiencing mental health issues.

Q. Alright, thank you. Now let's say a little bit more about the features of a well-functioning system. You say one feature is that there needs to be clear referral

pathways and entry points. How do you see the lack of those features in the clients who Legal Aid deals with?
A. Well, I think for a lot of clients there hasn't been a clear entry point. So, where there's a possibility that someone might be able to be assisted earlier on in a journey where they've got mental health issues, that actually hasn't happened.

That might relate to a range of things, but that might be that the sorts of organisations they've come into contact with don't recognise perhaps that the person has a mental health issue: I've seen that in the justice system itself on numerous occasions. It might be that a person is really in a position where they're not able to express very clearly what it is that they need, and I think this idea of having ways in which people can be assisted by non-legal advocates in our experience, as distinct from people who are brought in at that end when there is a significant legal problem, really does escalate what the circumstances that someone might be experiencing are.

We do refer to some case studies where that early intervention approach is an appropriate entry point where someone can be assisted in a more modest way, but meaningful way, and can make a real difference to their trajectory in terms of how they experience both justice systems and mental health systems.

Q. One of the things you observe is that you often come across clients who have difficulty with the gap between the 10 sessions provided by Medicare to access a psychologist and the crisis end. Is that something that's a recurrent feature of your client base?
A. Yes, we see that a lot, and some would refer to that as the "missing middle" in a way: that people either are at that very early intervention/prevention end and there can be some localised supports for them, but that middle piece where people are really requiring something much more but they're not at that crisis end is what we would see as being a particular issue with the system.

And leaving people in this state of abyss really, where they're not being assisted with what are some very complex needs and where in fact some interventions in other systems, such as may relate to their housing circumstances or issues to do with their isolation or inclusion, are not addressed as well, and so what this means is that people

progress down a path which often invariably in our experience leads to the criminal justice system or the civil justice system in particular.

Q. Yes. Is it your view that the recovery-focused philosophy of the Mental Health Act is embodied well in the mental health system?
A. The Mental Health Act, in my view, is a good piece of legislation and it is good because it focuses on recovery, it focuses on rights and it focuses on supported decision-making, which I think we sometimes forget about in the way in which we do our work.

I think the promise of that legislation still sits there in large part, but it needs greater consideration about the implementation of the system and how the system looks, particularly with that missing middle piece in relation to being able to deliver on those objectives that the legislation has.

Q. You've made some observations about governance models, and you've suggested that the system would benefit from a governance model that brings greater independence. In this context what do you mean by independence?
A. This is a very good question. I think that our position, and certainly my evidence, is that many of the parts of the system that relate to people who are experiencing mental health issues relate directly into DHHS, and that's not unusual, you know, in government departments. But I think in this particular area we need to be able to have much more transparency in what is being done in various parts of the system.

So, the governance point is really about that transparency and I think the best example I could give of that is that Victoria Legal Aid for many years have been trying to access data that helps us understand the compulsory treatment regime, who's experiencing that, what their experiences are, what demographic groups this covers, and in fact enable us to learn how we might be able to better support and even use the data that is available in the system to design and plan for better, more effective services that can assist people.

I think with compulsory treatment it is a particular challenge, because of course compulsory treatment is exactly what it says, and so it is a very specific

intervention that exists, and that clearly I think the Act did a good thing in stepping that up to the tribunal that needs to decide whether that happens.

But when you have the missing middle piece, I suppose one fear that I would have is that people progress very quickly to that tertiary end where there are more specific regimes in place which may well not be necessary if you compared it to voluntary participation perhaps in more community settings, and I think this is where potentially that can lead us.

Q. Is it in that context that you consider that there is more room for independent oversight bodies?
A. Yes, I think so.

Q. In your evidence, you indicate that it is Victoria Legal Aid's experience that there is a relationship between limited resourcing in the mental health system and increasing use of compulsory treatment and medication. Can you elaborate on that?
A. I think it is an inevitable consequence of not having the sorts of supports and resources that people need with their mental health illness at various parts of that journey.

You know, recovery is not a thing where people, one minute they're sick and then they become well; recovery is often a lifetime experience for people, and what this means is that they need different types of supports all the way along that system. They need those supports to be able to include them, to hear their views, as I said previously, on what they think their treatment should be and how they're going to benefit from that treatment, and in that way I think it is very important that, for the tertiary end to work well, that its precursors at the prevention/early intervention space really do offer real and serious support for people when that's needed to enable only those who really need that most tertiary end treatment to receive that.

And I think, without that sort of spread and diversity and spectrum of different supports and services for people that are informed by people themselves and what they say they need, of course with the assistance of others, then too quickly people may move to the tertiary end.

Q. Does Victoria Legal Aid consider that a social model of health should be adopted?
A. Yes, and look, I think that's now - most governments accept that you can't, for example, just treat people's legal problems; you have to think of people in the context of their financial situation, the economics of their situation, their health, yes generally, whether they're employed or not, how connected they are to their community, what their relationships are with family.

I think the social determinants of health tell us that just treating perhaps a person's health issue is not necessarily going to change their experience or improve their ability to live an ordinary life, and that we have to be more holistic in this way, hence why Victoria Legal Aid has chosen to in some areas introduce a non-legal advocacy model, so housing, employment, all of those sorts of areas, inclusion, can be taken account of in terms of supporting people.

The family violence reforms are a good example of that from government's perspective. It's not just the family violence as a legal construct that I think society now understands, but is all the things which sit around that that we really need to attend to in order to make a difference in a systematic sense.

Q. Does an embracing of a social model allow a focus on strengths rather than deficits?
A. Completely, and it's why some of our non-legal advocacy services are so important because I, having had much contact with people with mental illness in a variety of the positions that I've held, I do think that the focus is often on what people can't do rather than what they can do. The assumption is to objectify people rather than see the humanity and to work with in order to build their strengths, and this is why these sorts of ideas about recovery and support and inclusion and supported decision-making, which the Mental Health Act tries to embody I think, are very, very important to a healthy mental health system.

Q. Have you observed a bidirectional relationship between health problems and legal problems?
A. Yes, I think the two can influence each other. For any of us here who have experienced legal problems, we know that not only are they costly often to deal with, but they

cause great stress to people's lives. I think the reality is that health problems for example unattended can actually serve to roll and spiral into other areas.

And, if I take some good examples, probably looking at public drunkenness and the fact that it's criminalised here in Victoria means that people who really have a social and a health issue can find themselves intersecting with the justice system reasonably quickly, and if they are homeless, if they are also poor, if they are Aboriginal or Torres Strait Islander, these are the sorts of compounding factors that can lead to people not being able to live ordinary lives and in fact to spiral to that tertiary end we've discussed.

Q. Speaking of compounding factors, what have you observed about the compounding effects of homelessness on people's ability to get access to mental health services?
A. Look, I think the situation for people who are homeless is incredibly difficult. It is hard if people don't have a fixed address, don't have a community that they relate to as many of us do if we've got a roof over our heads, are thinking every day about how they will just survive, rather than being able to focus on getting better or trying to improve the mental health issues they're experiencing.

I think homelessness, not having a roof over your head, housing, is probably one of the biggest challenges we have in large part in this space, and watching the way the therapeutic jurisprudence initiatives, problem solving courts, work in Victoria, clearly they stand for the need for having adequate housing and support - not just independent living, but supported living where people can thoroughly have an opportunity to try and right their life and to be able to be more effective in self-care as well as be safe in the environment in which they're in.

Q. Is one of the compounding factors that impedes people's ability to get access to mental health services, the cost of those services?
A. Yes, I think so. I think even people who earn a decent wage would probably find that hard, but for people who are poor - and the majority of people that we see at Legal Aid, clearly our guidelines are such that we only represent those who are the most poor - it is an obvious fact that it affects their ability to live ordinary lives.

Q. And that would particularly apply to people who find themselves in the so-called missing middle, wouldn't it?
A. Yes, because I think that sort of grouping, if we call it that, or that part of the system that needs to be strengthened, if that's not strong: if people are in that bit of the system, they can either go one way, towards sort of the prevention end, or they can go the other way, towards the crisis or tertiary end. If that middle is not strong, then we will see more people going to the crisis end because they won't have the sorts of supports they need.

Housing is a critical component of that, so is meaningful things to do everyday, whether they be paid or unpaid. So is just feeling included and connected to those around you, and also experiencing reasonable health: all of these things are vital, I think, and that middle part is where things can either go very right or very wrong depending on what the supports are that you get.

Q. In relation to things going very wrong, is there a sense in which the criminal justice system is de facto placed to deal with mental health issues?
A. You know, our experience might of course be quite biased given what we do in broad part, but I think what we do see is many people being caught up in particularly summary crime but indictable as well in the criminal justice system, who really do experience mental illness, and certainly batches of vulnerability that then, if they are homeless as well and more obvious to public authorities and to police, that can often then lead to a spiralling into the justice system.

I think that's why it's so important that the good work that Victoria Police does absolutely includes more of diversion, ways of - the multitude of powers that are available to police officers really do encompass not just moving people thoroughly into the system, but to diverting people from that system, and that's a particularly important feature that we would see.

Q. On a slightly different topic, you've made some observations about what you call the ineffective interaction between the NDIS and the housing and justice systems. Can you explain what you mean by that?
A. We've included a case study on that.

Q. Yes, would you like to address that?
A. Yes. Also in our submission which we gave to the Royal Commission last Friday, that also includes some other examples. I think the NDIS is particularly interesting for us because it does have great promise and we are a great supporter of that system and that scheme and we understand the importance of it from the perspective of people with, say, a mental illness or cognitive disability or some other sort of disability, that it is about putting them at the centre of their lives and giving them the ability to live an ordinary life. It's pretty straightforward and we get that.

It's a hard reform and it will continue to be hard for some time, but I think this is an example of someone who really spent much time in prison, much time in a custodial place when that would not have been necessary had there been proper and effective engagement and communication between the great promise of what the NDIS is and actually what happened for this person in practice.

Now, I say that as a great supporter of the scheme, and I think it's very understandable that with people with very complex needs the scheme is still evolving and working through that. But this is a good example of how people can be left in what I would call, you know, the quiet of custodial places where they're not really seen, where their circumstances continue, and where in fact, unless they're given the right supports, that becomes their way of life, rather than having available to them the sorts of supports that should have been available at a much earlier period in time.

Q. Can you say something briefly about the facts of that example that you are speaking about?
A. Yes. So, this, and I'll read from my notes if it's okay - from my evidence. Essentially John is the name we've given this person, John had an acquired brain injury as well as a schizophrenia and this had contributed to his past substance abuse, to unemployment, to housing instability, and indeed to low level offending, which is once again not an uncommon thing.

When John transitioned to the NDIS his plan was inadequate to support him, to live well in the community and, with the reduced supports that he therefore received,

John committed further offences and was taken into custody.

Due to the NDIS housing and justice systems failing to interact effectively - that is, who does what and whose role is what, and clarity around what the expectations are and some of the intergovernmental agreements, John was unable to obtain bail to live in the community. People would be aware, of course, that Victoria has very significant bail laws in place now, I think they've been described as the strongest in the country.

It look 10 months for an NDIS plan review to occur. The plan review of course is a mechanism whereby someone's package of supports is costed and designed, ideally with the person is the way it's meant to happen. Therefore, it was only once John had that, that he had a sustainable post-release package that could actually ensure that he would be safer in community in the way that he certainly deserved, and I think for the majority of times, it says there, John was in custody.

So, this is interesting to me because, clearly, we only want people to be in custody if they really should be there, and I'm happy to talk about that more thoroughly, but in this instance I think the reason was a lack of appropriate supports to enable someone to live an ordinary life in the community and, therefore, because those supports weren't there, there was a deterioration, a move towards the more tertiary end and the person before we know it is into the criminal justice system. And, once there, it is actually quite a difficult system to get out in Legal Aid's experiences.

Q. Can I ask you a couple more questions about governance and oversight. When we have asked you the question, how could systems work better together for improvement, one of the things you have said is that:

> "Regulatory structures that are measured against actual quality improvements would really assist."

Can you explain what you mean by that?

A. Well, I think quality should be determined by people who use services, that is my personal belief, and that is the best outcome measure that we could have: by seeking what is it that someone's wanting from a particular service

intervention or arrangement? What's actually achieved at the end of that?

I think the regulatory structure currently looks at having oversight impossibility for review in a variety of ways, and I think that's a good thing and I've already mentioned the example of the Mental Health Tribunal and that people can appeal those matters to VCAT and to the Supreme Court. But you don't want people to have to do that.

Q. I see.
A. So you really want there to be ways in which we can monitor and assess what's going on in terms of the outcomes for individuals from good data that's available. I think in my own experience there is a very significant connection between good regulation, the availability of good data, but also that data is available publicly where it is needed. It's an important part, I think, of the regulatory frame that this should be more possible than what we currently see with the mental health system in Victoria.

Q. Just on the question of data, you say there are several data inadequacies of which you're aware. The first is a lack of available data on complaints about the Victorian mental health system. Among others, how widespread those complaints are.
A. I think that's right, and that we particularly - as I think I previously mentioned - see this and are very interested in this in the context of compulsory treatment. The main way we learn about what's happening with compulsory treatment is when people come to us or we come across people who need our assistance, either non-legal support or legal support. It would be - I think civil societies and open government now requires much more transparency in the way in which business is done, if I can put it that way.

The reason we want that is not because there's a distrust. It is because, only when we see what is happening can we actually get better at what we do, can we all get better at what we do. I think we want to understand the demographics of that data, we have some assumptions around what those demographics might be from our own individual case experience, but to have that sort of data available in a comprehensive way that can really be used by governments and community organisations and

statutory agencies to improve what we do, I think, is the goal that we all should be aiming for.

Q. On another aspect of data availability, you say:

> "There is limited data to help design and implement a tailored, appropriate and culturally safe service for various groups within our community including Aboriginal and Torres Strait Islander people."

What sort of data do you have in mind that we might collect?

A. I just think it's both qualitative and quantitative. Certainly the most basic is the quantitative data, and I think for Aboriginal and Torres Strait Islander people, and certainly our partners, VALS, Victorian Aboriginal Legal Service and Djirra, what we understand by working with them - of course they are separate from us, quite appropriately, and receive funding directly currently from the Commonwealth Government, but it is clearly the case that Aboriginal and Torres Strait Islander people talk about the sorts of things that would be useful for them in a mental health system, as do many other people that we would talk to, the way in which services can be more culturally appropriate.

I think, it's interesting for me, I learned when I was at the NDIA, the National Disability Insurance Agency, that there was no such word in many of the Aboriginal communities that we were going into for "disability". This indicates something about the way in which we have to think about putting the user at the centre to understand best how we can respond to individuals in terms of meeting their needs.

Q. You also say this:

> "There is an inbuilt inequality in the system in the sense that people get different treatment depending upon where they live."

What's your observation about that?

A. Yes, I think this idea of postcode justice is not a new one, and so, we have sort of in a way borrowed this term, we haven't created it to understand what happens.

Victoria Legal Aid is across Victoria, so we are in all major regional locations, and so we have a good ability to see what services are available and are not available.

Certainly, in listening to some of the evidence of some other people who have come before the Commission to date, it is clear that rural and regional areas need particular responses, that those responses have to take account of distance. They have to take account, so importantly, of whether service providers are actually available in those areas; whether the market can deliver the sorts of capability and capacity that we need in those areas to really support people to live full lives.

I think not enough attention is paid to the gaps and the perhaps inefficiencies as a consequence, and that sort of idea of the tyranny of distance to understand that. In our written submission to the Commission we make reference to some of the case studies where the amount of travel people have had to do to get some basic support services, in my view, is completely prohibitive to them being able to focus on their own recovery and their own thinking about their life and how they can get off the treadmill that they're on.

So, we touch on that more thoroughly, but essentially that's what we mean by the postcode lottery. And I think that essentially if people are poor, and we know that in rural and regional areas there are a lot more poor people percentage-wise, that it makes it really, really difficult for people to get the help that they need.

Q. Can I just draw you out on two more aspects of your statement. The first is this, you say:

> "The current governance, oversight and accountability mechanisms in the mental health system are not working to ensure quality, or to embed the cultural change needed to promote a rights-based framework."

What specifically do you have in mind there about the governance and accountability systems?

A. Well, I think the way in which the system should work and the way in which governments should expect from the system, what it's doing, is by reference to the Mental

Health Act which is about recovery, which is about rights, and which is about co-ways of working supported decision-making.

So the rights are things like, do people get access to good information about what their treatment means? We've also included some case studies about people who don't even understand what it is they're being treated for, so basic information. Understanding alternatives. Very importantly for us, good services in that missing middle that are both, are voluntary, voluntarily offered, and that attend to that more intermediate need.

Governance of a system should attend to all of those things, it should look at where there are gaps, and I'm talking about that I suppose not in the formal regulatory sense, but in a way which says, what do we need to ensure that the system can actually work? I think the comments made in my witness statement are really about that question, the system isn't working optimally for people who experience mental health issues.

Q. I said I had two questions but I think that was my last one. Do the Commissioners have questions, Chair?

CHAIR: Commissioner McSherry, thank you.

COMMISSIONER McSHERRY: Q. Thanks very much, and we look forward to reading the submission from VLA as well. Just one question: we heard from a young woman the other day who had a terrible experience in a High Dependency Unit and I think she could have really used an advocate at that stage. Does the Independent Mental Health Advocacy Service go across units? Is it a capacity issue?
A. Well, it goes to all public hospitals, but it is not a comprehensive system, a comprehensive offering, which is why - I'm being a bit shameless in saying this in a way - but the evaluation says it should be rolled out across the state. It is a terrific service and that's not just because Legal Aid provides it. It does attend to what I would see as a classic gap in the system, and so, I think that's the issue there.

I think this also plays to another point which I note about not only sort of state funding but also Federal funding: often there's resources to do pilots but if something's proven to be effective, then it's not actually

rolled out across the system, and to me the beauty of pilots is that they can test, they can refine, but if something's shown from an independent evaluation to be good, to be something that is useful for people who are experiencing mental health issues, then in my view it is something that should be rolled out more broadly.

And, it's a relatively cost-effective system, I think, as well and it is empowering. It does focus on giving people information and talking through options. I think it helps people take responsibility for their own care in a way that's not punitive but is empowering, and I think that is a terrific outcome for many people.

Q. Just one other question. I note that you've mentioned from the data that is available, that representation before the Victorian Mental Health Tribunal is only 15 per cent.
A. Yes.

Q. Whereas it's 80 per cent before the New South Wales Mental Health Tribunal.
A. Yes.

Q. Do you know the rationale behind that?
A. Look, we would have some suggestions for that but I probably should take that on notice. Some of it will depend on what different Legal Aid Commissions or other bodies prioritise. Clearly we all live within budgets and we all pick areas of work that are more significant, but it might also relate to a systematic issue so I think we'll take that on notice and come back to you with perhaps our reflections on why that is the case.

CHAIR: Q. There's just one other point, Ms Glanville, I'd like to take up which is: you made a comment in your statement that you had a regional lawyer who talked about the fact that they felt they'd lost count of the number of times he'd stood before a magistrate and said that "we are having to use the blunt tool of the criminal justice system to deal with mental health issues".

We also heard earlier today from the Assistant Commissioner of Police about the fact that the police have been called upon more and more in their view to be the first responder around mental health issues. I noted in your example and earlier evidence you said increased visibility of police to people with mental health issues in

the community, whilst it might be helpful, can also contribute to that higher engagement in the criminal justice system.

Can you make any comment or further observations around that?

A. I think that's spot-on. I think, particularly because we've sort of been in a period of strong law and order, and I completely accept government's right to make those decisions and do that and make appropriate laws as government sees fit, but one of the consequences of that is, people who would not perhaps ordinarily have been caught up in these systems do become more visible. They may, because of their inability or without the supports to be able to have control of their lives in the way that they would wish, they move quickly down paths, and we have many examples of that.

Examples, too, of where people are brought before a court when perhaps there could have been alternatives to that being the outcome for that particular person if there was not more coordination. Better role definition, I think, Commissioner, of who does what and what are the sorts of possibilities that are available early on or in that middle piece when people are going to go one way or the other. And I think these are the challenges for us to really think those through in terms of the intersection between systems as well.

So, it's not only how mental health services relate to each other, and I think there's been some good evidence on that, but it's also the way systems relate to each other. And importantly, it's also about the way culturally we all view the person with mental health issues and whether in fact we can put them in a position which the Mental Health Act suggests they should be in, which is a participant in the process, not a person that something is done to.

I say that recognising that sometimes things have to be done to people, but I think our orientation should be to avoid that as much as possible and to have choice for people experiencing mental health issues in their lives which enables them more thoroughly to look for voluntary opportunity and participation in their own treatment before it becomes something which is mandated or compulsory and which they may feel is troubling for them.

CHAIR: Thank you.

MS NICHOLS: Before Mrs Glanville departs, may I tender her statement?

CHAIR: Yes, thank you. [WIT.0001.0036.0001]

MS NICHOLS: May Ms Glanville be excused, please?

CHAIR: Yes, thank you very much for your evidence today, Ms Glanville.

<**THE WITNESS WITHDREW**

MS NICHOLS: The next witness, and the final witness for today, is Ms Vrinda Edan. I call her to give evidence.

<**VRINDA EDAN, affirmed and examined:** **[3.38pm]**

MS NICHOLS: Q. Ms Edan, are you the Acting Chief Executive Officer of the Victorian Mental Health Awareness Council?
A. I am.

Q. Is that body also known as VMHAC?
A. Yes.

Q. Were you previously the Chair of VMHAC?
A. Yes, I was.

Q. Among other things, have you had consumer roles working in the mental health services area for over 20 years?
A. Yes, I have.

Q. Are you also a qualified nurse with a Masters Degree in Nursing?
A. Yes.

Q. Can I ask you a number of questions about the consumer and carer workforce in the mental health services area. Can we first define how this concept should be understood. Are there two principal roles in the lived experience work force: firstly, the consultant workforce and the peer support workforce?
A. Yes, that would be correct.

Q. Are each of them to be understood as comprising carers and consumers in the sense that you have carer and consumer consultants separately and carer and consumer peer support workers?
A. Yes.

Q. Are those roles in Victoria all formally recognised and do they include paid positions in Victoria?
A. Yes, they're all formally recognised under the mental health services award, the EBA, yes.

Q. Can I ask you about the history of the development of these roles. Has the role of consumer consultant existed since 1996?
A. Yes, that's correct.

Q. Was there a seminal event in 1996 that led to the development of the that role?
A. Yes. Prior to 1996 there was a project undertaken at the Royal Park Hospital called the Understanding and Involvement, or more informally known as the U and I project, and that was a participatory action research program that looked at consumer evaluation of the service. One of the recommendations that came out of that was the employment of consumers in services, that led to a quality project that employed consumers in all area mental health services in 1996.

Q. That was the first recommendation of its kind of any significance as far as you're aware?
A. As far as I'm aware, yes.

Q. After that recommendation, did it become the case that, in all area mental health services a consumer consultant and a carer consultant is required to be employed?
A. So, after that recommendation in 1996 it was consumer consultants; carer consultants were first employed in 2002 and funded by the department in 2009.

Q. I see. Is it still the case that in each area mental health service, one of each of those consultants must be employed?
A. In adult services, one of each. In child and adolescent units a carer consultant, and in aged services a carer consultant. But consumer consultants are only funded in adult services.

Q. Going back to 1996, was the funding of consumer consultants at the rate of two to three days a week?
A. Roughly, yes, that's how much it was, yes.

Q. To your knowledge, has it remained at that rate since that time?
A. Yes, it has.

Q. The funding for those roles is part of the block funding for area mental health services; is that right?
A. Yes, that's my understanding.

Q. One point you make in your statement is that over time the significance of the role and the demands placed on the person performing that role have grown considerably?
A. Yes, that's right, both the complexity - the amount of work and the complexity of the work has increased.

Q. If we focus on consumer consultants, what kind of work do they do within area mental health services?
A. Most often they are involved in quality improvement type projects, that was where the positions first sat in services, was under quality improvement. But it's expanded much beyond that to management, to influencing management decision-making of the way that services actually run, including education of services, input into complaints processes, community awareness-type projects, so very, very broad across most areas of what an area mental health service delivers. The consumer consultant would be required to give some sort of input.

Q. Focusing now on carer consultants, has there been an evolution from a focus on them performing peer support work alone, moving into a more advocacy-focused role?
A. Yes, that's correct, so they started peer support but moved into advocacy.

Q. You make the point in your statement that:

> "Peer support work is increasingly recognised as a discipline in its own right."

Can you say something about the importance of it being recognised as a discipline?
A. Peer support work takes quite a different approach to

working with someone who is in mental and emotional distress. It sits in a space of mutuality and supporting someone's human rights. That's a very different space than most workers within a mental health service, and that makes it unique and it means that it needs to sit apart from those other professions.

Q. You also make the point that there is very strong evidence that peer support reduces re-hospitalisation rates, reduces inpatient stays and lowers the overall cost of services.

Now, I've rolled up three things together, and we don't have time to discuss individual studies, but you've given a reference in your statement to a collected set of studies, it was published by Mental Health America; is that right?
A. That's right, yes.

Q. What are some of the significant findings that you're aware of just in headline form?
A. Just in headline form, a number of the peer support projects and services that are included in that study include information that re-admission rates are reduced by up to 40 per cent; that days between hospitals are increased from about 120 days on average to over 270 days; that there's reduction in the cost of community health services by up to $2,500 per person per year, and in one study there was a saving to hospitalisation costs of over half a million dollars because of the reduction in rates and the extension between hospital admissions.

Q. Are those benefits seen across a range of different services, meaning types of clinical services?
A. Yes. They are across the entirety of the United States. The study shows, across all of the states where certified peer support workers work, they show very similar results.

Q. The studies that you refer to are American studies, but is it your opinion that they're likely to apply and, in the absence of data being available in Australia, that it's useful to look to those studies?
A. Absolutely. In Australia we don't have very many peer delivered services of this nature, and so, we have to look to overseas.

Q. Can I ask you about your evidence to the effect that there was quite a significant workforce in the community managed mental health support sector which has now diminished with the advent of the NDIS?
A. Yeah, so one of the areas that we saw peer support work blossom was in the community-managed mental health sector, and up until the advent of the NDIS there were - we're not exactly sure how many, but there were many, many peer support workers. And at VMHAC at our support days, the majority for workers, the majority of workers would be from that sector.

With NDIS and the genericisation, if you like, of that workforce; that is, that now everybody is just a support worker, peer support workers have been taken out of dedicated peer support roles into generic support roles, and in that way have been not able to use their skills and expertise as a peer support worker and are actually leaving the sector in considerable numbers because of that.

Q. One initiative that you do say showed some promise was the expanding Post Discharge Support Initiative. Before I ask you about its limitations, can I ask you to say what it is?
A. So, the expanding Post Discharge Support Initiative is an initiative funded by the department to put peer support workers into area mental health services to support people in the post discharge phase. The principal idea is that, if people get more support in that 28 days post discharge, they're less likely to be re-admitted, so the support is concentrated in that time.
Q. Acknowledging that goal, one of the things you say in your evidence is that it had some implementation issues which you attribute to failing to obtain any input from consumers in the design of the program.
A. Yes.

Q. Were you asked to contribute to a guideline subsequently prepared by the Department of Health and Human Services to assist prudent and supportive peer workers to perform that role?
A. Yes, that's right. Once the consumer workforce became aware of it, we were able to do some work.

Q. Is that initiative the only funded peer support service in Victoria?
A. Yes.

Q. You say it's run on a small budget?
A. Very small and very localised, yes.

Q. You've mentioned that newer roles are emerging for peer workers, consumer policy advisers in governance. What are those roles?
A. So, it's probably - now I'm thinking about it, it's probably not right to say they're newer roles. Victoria was the first jurisdiction to put in place a consumer in a government position, a declared consumer position as a senior policy adviser, and that role was around influencing the department to undertake and improve the way that services were managed by the department from that consumer perspective.

Q. Can I ask you, what is a declared consumer position?
A. So, a declared consumer position is where only a consumer can be in it.

Q. Can you explain a little more about, when that role existed, what it involved?
A. So, it involved a lot of advice within the department. So, it had a very high level role within the Department of Health, but it also at the time enabled a process to be developed which was called the consumer - so there was a consumer and a carer partnership dialogue, and it actually created a space where consumer workers, and for the carer dialogue carer workers, got to speak directly with the department, and that was the first opportunity that consumer workers had really had in an ongoing and systematic way to speak to the department.

Q. Was it the direct relationship that was quite important about that role?
A. Absolutely, yes.

Q. And so, it wasn't mediated through a service?
A. No, it wasn't mediated, and the person in the role at that time had direct experience as a consumer worker in services, so knew the system very well.

Q. Is it the case that Victoria no longer has that role but other states do?
A. Yes, so the position two to three years ago became a non-declared position, so it moved from being a necessary requirement of the position to a desired requirement of the

position. So, the people occupying those positions now have not worked as declared consumers in the past.

Q. Is it right that you say it is preferable that it be a declared position?
A. Yes, absolutely.

Q. You've made some observations about the need for training the peer support workforce, including that that seems to be done in a more fulsome way in Western Australia. What do you say about the need for training to be provided to the peer support workforce?
A. So, like any workforce, we require training and support. At the moment the training that's delivered for peer support workers and other consumer workers is quite ad hoc.

With the advent of the Centre For Mental Health Learning, there is starting to be some coordination of that, but services themselves still make a decision about what sort of training someone will have. We don't have an accredited system at the moment for training; that's quite controversial. We require - it is our belief and what we supported with the advent of the Post Discharge Service is that peer support workers needed to be trained in intentional peer support, a particular model of delivering peer support.

We would also suggest that consumers require training in what's called emotional CPR, which is about responding to people in distress, but also consumer workers have put forward a desire for training around, you know, thinking strategically, working strategically within a department, how to influence people in high places, in power, those sorts of skills are also required.

Q. You've made some observations that overseas studies have established the effectiveness of stand-alone peer-delivered services.
A. Yes.

Q. You've given a few examples in your statement but one of them is one you have personally visited, and that's the Piri Pono - I hope I have pronounced that correctly - in Auckland.
A. Yes.

Q. Can you say something about what you observed, and firstly what the service is and why you say it is an effective service?
A. So Piri Pono is a five bed alternative to an inpatient unit. So, when people present in the triage service needing - requiring an admission, they get given the option to, if that bed is available in Piri Pono, they get given the option to go to Piri Pono rather than the inpatient unit.

One of the things that struck me about the service was the level of respect. So, all of the staff are peers, including now the clinical staff, so all of the nurses have a lived experience, and when I visited one of them had been through Piri Pono as a patient.

But one of the really significant things for me was the way in which the risk assessment was done for the service, and that is, on admission the manager of the service undertook the risk assessment with the consumer being admitted, and that risk assessment was only shared with other staff on the consent of the consumer. What that means is that everybody is treated the same, nobody gets viewed through the lens of someone else's decision that you're high risk or medium risk. We know that risk assessments actually do more harm than good in terms of building relationships with people, and that really shone through in this service to me.

Q. Do you know how long it's been operating for?
A. Well, I visited it three years ago and it had been in operation then for about three years.

Q. Okay, thank you. Can I ask you about the evidence you give in your statement about the accounts you have heard or VMHAC has heard from consumers speaking about the state and Federal divide in terms of access to services causing quite some difficulty?
A. Yes, and I think again it's increasing since the advent of NDIS.

Q. Yes.
A. But we hear a lot about, where services say, you know, we're a Federal service or we're a state service and so we don't do that bit of work. There's a lot of confusion amongst consumers about what is Federally funded and what is state funded. So, lots of people don't understand, for

instance, that the Medicare rebate is a Federal responsibility and not a state responsibility, so trying to draw those bits together becomes very difficult for people.

It's particularly - the previous testimony that spoke about the broken middle or the missing middle - that is something that we would absolutely identify.

Q. Have you also observed that people with borderline personality disorder have particular trouble accessing services?
A. Yes. We do hear a lot from consumers with a diagnosis of borderline personality disorder and it's a diagnosis that, once you have it, it becomes very difficult to access services; it's considered people with this diagnosis are often considered by services to be very difficult to work with, very challenging to work with, and so we get a lot of need for advocacy for people with this diagnosis.

Q. Can I just ask you about one of your recommendations for improving the system, and you say:

> "I believe services would be improved if governance requirements of any publicly funded mental health service required equal governance by consumers."

Can you say why you think a governance role by consumers in that sense is important?
A. Yes. So, it is both governance and operational, to be clear.

Q. Yes.
A. But I think that there are a couple of really good examples of where consumers are involved in quite high level operational management, where there's been significant improvement in the service when that occurs.

I do believe that if - and again, not at this level, but some examples close to it of: if a consumer was employed at the same level as the Clinical Director, the Operational Manager, then the level of oversight from the consumer's experiences would be drastically improved and many more decisions would be made - many more of the decisions made would be influenced by that view.

If I can give a bit of an example from my own

experience of working?

Q. Sure.
A. I worked in a service where I was in a senior management position, Director of Consumer and Carer Relations, where I had the same level of authority across the service as the manager for the adult services, the manager for CAMHS, the Financial Manager, the Director of Nursing, and this meant that I was able to, with the consumers of the service feeding through the workforce that I managed, influence things like the design of the new building, the new unit; quite significantly reduced the number of seclusion rooms that were built in that facility; we ensured that the seclusion rooms had ensuites; we were able to make decisions about the design that had a strong influence on safety for consumers.

We, as a team, were also able to influence some of the community mental health service design and the way that the services functioned, and that wouldn't have been possible if I didn't have that level of authority.

Q. Yes, and that reflects the principles of co-production; is that right?
A. Yes, that's right.

MS NICHOLS: Thank you very much for your evidence, Ms Edan. Do the Commissioners have any questions, Chair?

CHAIR: Dr Cockram.

COMMISSIONER COCKRAM: Q. Ms Edan, we heard from you about the importance of the peer support workforce and the development of the model in Victoria. You mentioned that it wasn't implemented well and guidelines needed to be written retrospectively. What didn't they get right the first time they tried to do it?
A. Which do I pick? There was a number of things that they got really wrong. One was that the first iteration of it - and this has moved a bit - but the first iteration of it was to use peer support - the idea was to use peer support workers to ensure that people got to appointments and picked up their medication and did that sort of thing, and that's completely against the principles of peer support; it's a psychiatric support officer-type role, not really one of peer support and not using that expertise.

The further issue that they got wrong is, they hadn't envisaged the training that was required for workers, they hadn't put any support processes in place for consumers being employed into a clinical service; often a clinical service that they have had personal experience with - this is actually how it rolled out - without acknowledging the trauma that those workers had experienced in that service and addressing it in some way.

So what we've found and been reported to us is some really quite disturbing discriminatory practices that are occurring towards those workers, and that's being followed in a study at the moment, so there's a research study that's actually looking at the experience of those workers in the service.

The other problem has been that all of the services, bar one, employed clinicians to oversee the peer support workers. The one that did employ a peer, that peer also had a clinical background, so there was a dual background there, and again, this meant that the peer support workers didn't have the guidance around the specialty knowledge and tasks that they needed to do with the consumers.

COMMISSIONER COCKRAM: Okay, thank you.

MS NICHOLS: May I tender Ms Edan's statement?

CHAIR: Yes, thank you.

Q. There's one other point I would like to follow up. I was very pleased to hear that example of the facility you visited in New Zealand. We've heard very positive feedback through the course of this Royal Commission already of the role and important function by peer supporters, consumers with lived experience.

I'm wondering how, from those experiences, what you think is important in providing support for those with lived experience who are undertaking these very challenging roles sometimes, very emotionally charged difficult roles, what do you think is going to be important, if we build this workforce, to make sure those lived experience workers are supported in terms of their working environment?
A. So, training, and training that's delivered by consumers. Consumer perspective supervision. There's a new framework that was released last year that talks about

consumer perspective supervision and how to provide that and what the principles around that are. So, every consumer worker should be given the opportunity to have independent consumer perspective supervision.

And, career structure. So, one of the things at the moment is that there's no career structure for consumer workers. So, you come into a role and that's it basically. We need to be thinking about this as a discipline, we need to be developing senior roles with appropriate remuneration and developing them into leaders and managers of those services.

CHAIR: Thank you. Thank you very much.

MS NICHOLS: May Ms Edan be excused?

<**THE WITNESS WITHDREW**

CHAIR: Yes, thank you very much for your evidence today.

MS NICHOLS: That concludes the evidence today, Commissioners.

THE CHAIR: Thank you.

AT 4.05PM THE COMMISSION WAS ADJOURNED TO FRIDAY, 12 JULY 2019 AT 10.00AM

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