Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF MARK ORR AM

I, Mark Orr, Chief Executive Officer, of 5 Figtree Drive, Sydney Olympic Park, New South Wales, say as follows:

Background

1 I am the Chief Executive Officer (CEO) of Flourish Australia (**Flourish**). I have been in this role since January 2018. Prior to this role, I held the position of Chief Information Officer at Flourish from July 2012 to December 2017.

2 I am also a:

(a) Board Director of the Mental Health Coordinating Council (**MHCC**), the peak body for community mental health organisations in New South Wales; and

(b) Board Director and Vice President of the Australian Federation of AIDS Organisations (**AFAO**), the peak national organisation for Australia's community HIV response.

3 I have previously held the following roles:

(a) From October 2006 to November 2015, I was the President of ACON Health Limited, a New South Wales based health promotion organisation specialising in HIV prevention care and support, LGBT community health, and social inclusion. Between 2006 and 2015, I also held various roles on the Board of ACON, including as President (Board Chair) and Board Secretary.

(b) Between 2010 and 2012, I was a Divisional Manager and then Acting Chief Operations Officer of Psychiatric Rehabilitation Australia (**PRA**). PRA provided accommodation support, support employment, social activities and rehabilitation support for people with complex mental health issues in NSW. PRA ultimately amalgamated with the Richmond Fellowship of NSW in 2012 to become RichmondPRA, and then Flourish.

(c) Between 2008 and 2010 I was a part-time Member of the Social Security Appeals Tribunal.

(d) Between 1999 and 2001, I was Assistant Director, Estate Management and then between 2001 and 2007, I was the Deputy Protective Commissioner and Director, Client Services, in the Office of the Protective Commissioner within the NSW

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

Attorney-General's Department. In these roles I assisted the Protective Commissioner, under delegated authority, to manage the financial affairs and estates of persons with decision making disabilities who were not able to manage their own affairs.

(e) Between 1994 and 1999, I was the Regional Manager, Sydney Metropolitan Region in the Office of the Public Guardian, within the NSW Attorney General's Department. In this role, I acted under delegated authority of the Public Guardian of NSW to manage the substitute decision making and advocacy in relation to people with a "decision-making disability" under the Public Guardian's guardianship. This was for personal and health care decisions, and medical and dental consents within the region.

4 I have a Graduate Diploma in Special Education from the University of Canberra, a Master of E-Health (Health Informatics) from the University of Tasmania, and a Bachelor of Science (Honours) and Master of Health Services Management from the University of Newcastle.

5 I also hold a Graduate Certificate in Applied Finance (FINSIA) and Investment and a Graduate Diploma in Applied Corporate Governance (Chartered Secretaries Australia). I am a Graduate Member of the Australian Institute of Company Directors and a Fellow of the Governance Institute of Australia.

6 I am currently undertaking a Doctorate in Public Health at the University of New South Wales. I have a specific interest in service redesign, innovation and evaluation, and the use of technology to deliver information and supports to people with lived experience of a mental health issue, their families and their carers.

7 I am an Australian Health Practitioner Regulation Agency Registered Psychologist.

8 In 2019, I was appointed a Member of the Order of Australia in the General Division, for significant service to community health.

9 Attached to this statement and marked 'MO-1' is a copy of my CV.

10 I confirm that I am giving evidence on behalf of Flourish and that I am authorised to do so.

Lived experience in governance and decision making

About Flourish Australia

11 Between 2012 and 2016 Flourish was known as RichmondPRA. It is a community managed, not-for-profit organisation, established in 1955. Formed by the amalgamation in 2012 of the Richmond Fellowship of NSW and PRA:

(a) The Richmond Fellowship of NSW was in existence since the late 1960s, providing community-based support for people with lived experience as they transitioned from long-term hospital stays to community living.

(b) PRA, as stated above, was established in 1955 and has grown its services to now provide accommodation support, support employment, social activities and rehabilitation support for people with complex mental health issues in NSW.

12 Flourish operates 71 local offices in Queensland, New South Wales, ACT and a mobile service in Victoria not tied to an office. Flourish provides practical supports for people with lived experience of a mental health issue (as well as their families and carers) to support them to live in the community. It provides information about and support for mental health issues, accessing the National Disability Insurance Scheme, helping people find meaningful employment or stable housing, making new friends or developing new skills and interests, and connecting people with the right people or support services. It also provides support to families and carers of people with lived experience of a mental health issue. Flourish Australia is the lead agency in four headspace Centres and operates a specialist program for people for mothers with a mental health issue and their children.

13 As a general rule, Flourish supports adults with complex mental health issues. Many of these people have had contact with public mental health services and their pathway to Flourish is through referral from community mental health teams. More recently people have come to Flourish to participate in the National Disability Insurance Scheme due to a psychosocial disability arising from their complex mental health issue. Of course, headspace Centres provide supports to young people aged 12 to 25, generally experiencing depression or anxiety.

14 Flourish employs both ‘mental health workers’ and ‘peer workers’ in direct service delivery. Each group of workers does similar things, but peer workers in our frontline services use their lived experience intentionally to support someone else with a lived experience. They are expected to be open that they have a lived experience and are expected to use that lived experience in professional ways to inspire hope. At the same time, we do have mental health workers who have lived experience, but we don’t expect them to disclose they have a lived experience. They can do so if they like, but there is no obligation for them to.

15 Flourish aims to provide services that respond to what a person’s individual support requirements are. We call this providing person-led services, not person-centred services. This emphasises that the person is the decision maker about their own lives, and Flourish are here to support them to do that. When people access Flourish’s services, usually either a mental health worker and a peer worker will work with them to explore what their recovery journey will look like – what outcome(s) do they want to achieve; what changes do they want to make; what are the things they are looking from Flourish to help

them? If Flourish is not the organisation that can help the person, then we will work with the person to identify who may be able to help and support the person to connect with that organisation.

16 Therefore, a large part of what Flourish does is helping people understand and explore what they want, and to help them dream bigger than maybe what they think is possible; but it's also helping them navigate what, in my view, is a complex service system.

17 Flourish's service delivery is outcomes-focussed, recovery-oriented and trauma-informed. Recovery-oriented support is about helping people to create and live a meaningful and contributing life in a community of their choice, whilst acknowledging that personal recovery is different for everyone. Aside from having a large peer workforce (which I describe further below), I believe that one of the reasons people recognise and trust Flourish is because of our commitment to recovery-oriented support.

Flourish's workforce

18 Flourish has a traditional management structure in that it has a Board of Directors and an executive management team, as well as regional (cluster) managers and local managers. It employs about 900 people. Approximately 56% of staff members at Flourish have a lived experience of a mental health issue – including people on its board, on its senior executive and management teams, and within its service delivery staff. Flourish has great staff, experienced and qualified in what they do, but they also have a great set of values, who value lived experience themselves. Many have been in the situations we're supporting people in. Flourish values lived experience across the organisation, and we practically demonstrate it in what we do – it's not just something that we promote on a website.

19 In addition to having a high number of people across the organisation with lived experience of a mental health issue, Flourish:

(a) has a 'community advisory council', comprised of people who access its services and who come together twice a year to provide Flourish with advice about service delivery, service evaluation, and research, how it talks about Flourish publicly, and what may or may not be working in its local offices; and

(b) has one of Australia's largest mental health peer workforces, with over 260 peer workers.

20 Flourish tries to instil in people a view that everybody can work and do their job. It believes that everyone wants to do a good job at work, and it's Flourish's job to support people to do so by enabling them to work flexibly in order to draw the best from of them. For example, some of Flourish's staff want to work part-time, or want to work casually; others

may have times when they are not as resourceful as they usually are, and so Flourish provides additional flexibility during those times.

21 For each of its staff members, Flourish offers a 'personal situation plan'. These plans provide for this additional flexibility recognising that everyone's lives can become complex at times. We have conversations with people to plan ahead in case something happens in relation to physical health, caring responsibilities or mental health, and we document those conversations and the agreed responses through these individual plans. In that way we can then activate those plans in a time of need, without the staff member having to worry, or guessing what they need us to do. I believe that creating an environment that allows for individual needs, adjustments and flexibility is the secret to creating a successful, engaged and committed workforce.

The success of Flourish's peer workforce

22 I have heard some people say that because Flourish has a high lived experience workforce, that we must have a higher level of sick leave. That's not our experience, and I think that is so because we work so flexibly, and we try to work with people to ensure that their employment arrangements work for them.

23 As to running a successful peer workforce, in my view it is about:

(a) people believing in what they do and being passionate about supporting people to live their best life and have a contributing life. With over half of our staff having experienced some of the challenges that are facing the people we support, in my view our staff understand that experience. They are keen to give back and to help make the experience for other people different, and better. I have heard people say that they come and work for Flourish because they want to be part of what we do, and want to be part of our commitment to peer workforce, because it gives them a sense that there can be a different and better future for people with lived experience; and

(b) engaging with staff about what a good service looks like. We ask our staff how we can create an organisation and a service that delivers great trauma-informed recovery-oriented services to people. In that way, we are respecting and valuing the expertise of people with a lived experience, but also not forgetting those who don't have lived experience, but are passionate about what we do. This engagement takes place all across our organisation - from our Board to our local service delivery staff.

Providing people with lived experience with a meaningful voice in decision-making

24 Flourish actively engages with people with a lived experience to hear their voice and to use it in decision-making, particularly through its community advisory council. As referred

to above, this is a council that meets twice a year and provides feedback about Flourish's services. We are deeply committed to engaging with people who access our services in each site, and hearing from them about issues that affect them and how we might improve our services.

25 In addition, following the amalgamation (referred to at paragraph 11 above) between 2012 and 2014, Flourish developed with staff and people who access its services a Recovery Action Framework. The Framework provides a public commitment to embedding recovery-oriented practice throughout the organisation. As part of implementing that Framework, we undertook a 'roadshow' across our sites and engaged with staff and people who accessed our services, talking about what it meant for an organisation to be truly recovery-oriented; what sort of behaviours we needed to demonstrate to people to show that we were committed to that goal. And that had a profound impact on our staff and on the people who access our services. Everybody now knows what recovery-orientation at Flourish means, and that we are accountable to each other in ensuring that our behaviour meets the expectations that we have set for each other in the organisation. We give each other permission to talk to each other if our language, performance or behaviour falls below those expectations. And that has had a positive effect on people. It's not just about structures; it's about setting expectations for each other, and everyone holding each other to account, including holding me as the CEO to account.

Workforce

Capabilities and skills needed by workforces to enable collaborative and consumer-focused practice

26 In my view, one of the most important features necessary to ensure a workforce that enables collaborative and consumer-focussed practice is ensuring a recruitment process there is a match of the values of Flourish with the values of the person we are recruiting. Flourish's values are trust, respect, hope, including, integrity, diversity, and partnership. Those values are important to us, and we are focussed on finding and nurturing people who also hold those values.

27 In addition to looking for someone with shared values:

(a) We look for people who have the right approach in valuing lived experience of a mental health issue. For example, are people coming to do something to somebody as part of service delivery, or are they there to walk the journey with them and help them to explore what the opportunities and options are for them?

(b) We seek people who understand what mental health recovery is, and in particular understand that mental health recovery is a personal journey for each and every person. It is not about what an organisation does for somebody; it's about a

person's journey and choices – and that we are there as an organisation to support them and help them work out what their options are, and support them to make their own choices.

(c) We seek people who understand that we deliver trauma-informed support. Many people with whom we work have lives that are complicated and complex, and they have often experienced trauma. Whatever we do, we are conscious not to add to that trauma, but rather seek to engage with people in ways that they find supportive and encouraging.

(d) We require people to have the capability to work in partnership – not just with people with lived experience, but with their colleagues and partner organisations, so that we provide integrated care and support both within and outside the organisation. We see ourselves as part of a broader mental health and social support eco-system which often includes a person's family and carers, as well as other support networks.

28 Finally, in my view people also need to have the capacity to deliver culturally responsive and safe services; whether it's to people from Aboriginal and Torres Strait Islander communities, to people with disabilities, to people from the LGBTQIA+ community, or to people from culturally and linguistically diverse communities. We need people to understand that it's not one size fits all, and that we need to be led by people in order to be able to respond effectively to the complexity and the diversity of their lives and their social networks.

The retention of a peer workforce

29 Before discussing strategies around the retention of lived experience and peer workers, I note that Flourish has workers with lived experience across all levels of its organisation. There are people in our head office who have lived experience as well as people providing services at each of our sites who have lived experience. Some of these people are peer workers. These jobs are an integral part of our organisation – they are not 'additional' to what we need.

30 In terms of retention of staff, in my view it is important that people have clearly defined jobs with position descriptions which are clear as to what is expected of them. For our peer workers who are working in service delivery, it is important that our peer workers are integrated so that they are part of the local team – they are not an 'add on'. This makes people feel valued and their experience respected.

31 Another key strategy around retention is having the right training and development. I believe it's necessary to have dedicated training, particularly when we have such a large peer workforce. Flourish endeavours to provide the following three training opportunities for peer workers:

(a) we run training about how workers should use their lived experience intentionally. The training was developed by Flourish and runs over the course of a day. It provides peer workers with opportunity to reflect on how they can use their own lived experience; to identify opportunities to share that experience; to understand the important of boundaries when they are sharing their experience; and to explore with others the practical experience of doing so with people they work with.

(b) we periodically run intentional peer support training which is an approach developed by Shery Mead in the USA.[1] It helps peer workers focus on the importance of relationships, of communication, of mutual accountability, of growing together; and to develop associated skills which helps people experience hope and be open to possibilities for their future.

(c) we support our staff to undertake the Certificate IV in Mental Health Peer Work, a twelve-month training course for workers who have lived experience of mental health issues and who work in services such as ours as peer workers.

32 In my view, the above training opportunities provide people who want to be peer workers with the confidence and ability required, and develop the capabilities and skills they need to deliver safe, quality, recovery-oriented, trauma-informed peer work supports. However, Flourish continues to look at ways in which it can train and develop staff – for example, we are currently looking at what additional supports our peer workers might need, how we can train our managers about managing a peer workforce, and developing specialist peer worker supervisor training.

Crisis and emergency department responses

33 A readily accessible, comprehensive continuum of services to support people with lived experience in times of crisis is required. This includes everything from information services through to in hospital clinical supports. More intensive support in a hospital setting may be appropriate for some people at times, but with an increase in supports provided in the community and working together with the person and their clinical and personal support networks, we can often work successfully with many people in the community. Flourish aims to increase supports as early as possible and to increase supports in ways in which an admission into hospital can be avoided or limited in duration.

34 That "early intervention" is sought to be achieved by working with people to help them plan ahead by developing personal safety plans for themselves. In our experience, people who are some way along their recovery journey will have some experience with what works for them, and what doesn't. Flourish works with the person (and usually their

[1] https://www.intentionalpeersupport.org.

clinician(s)) to identify and document what works for them so that everyone is clear about what to do when the person becomes distressed or unwell. That way it is an integrated approach that the person feels more in control of.

35 Flourish does have some 24 hour support services that can provide afterhours telephone support and discuss with people their plan and talk about what they have already identified they should do, and what others should do to support them.

36 We recognise that these plans may not always prevent a need for crisis response, and therefore Flourish does have some experience supporting people in times of crisis. It may be that for some people at a particular time, the appropriate response is to head to the emergency department and possibly admission to hospital. People often recognise that they need somewhere that's safe and supportive, and they can't necessarily stay where they are or stay at home, and they need some alternatives. For some people, there is nothing available other than the emergency department and so that is where they head.

Alternatives to crisis responses

37 In Flourish's experience, if there are other alternatives that are appropriate, then people will often choose those alternatives, because they don't want to be admitted to hospital. People have told us that going to the emergency department in a crisis situation is traumatising. And for me this makes sense – imagine a person who is distressed, and is walking into a place that is bright, busy, noisy, with things happening everywhere. It's not, in my view, an environment that people are keen to go to. At the same time, if there are no other alternatives, then people have no choice. In part, it's the same with admissions into mental health units. People have told us they it is not the place they want to be; what other option do they have?

38 Flourish tries to provide alternatives by planning well ahead in advance as to what would work for each person – it may be that they can't be at home, but they need to be somewhere else.

39 For example, Flourish has a peer-operated service in Hervey Bay which provides an alternative option for people than going to the emergency department and being admitted into hospital, if they do not require it. I discuss the Hervey Bay program further below.

40 Flourish also operates a program in Orange and in Western Sydney, New South Wales called the Resolve Program, which has been in operation since October 2017. As part of the Program, Flourish partners with the NSW Government to provide supports to people who have been hospitalised for an extended period of time. Resolve is staffed by peer workers. It includes access to 24/7 short term respite residential support, outreach for in-home supports and opportunities for social connection with others during the week. It also provides access to a 24/7 warm line which provides non-crisis supports on the phone

when people feel distressed or just need to talk. The program's aim is to reduce the likelihood of readmission for people with a mental health issue, and operates as a two year program. It is free for eligible people.

41 The respite house offered as part of the Resolve Program is comfortable and quiet, and is a place where people can feel safe and supported by peer workers. They don't need to worry about food or any other things; they can focus on getting on top of what's going on. That may include accessing clinical support at times.

The Hervey Bay program

42 As mentioned before, the people with lived experience I talk to generally say that they don't want to go to the emergency department in a crisis, and that if there is another alternative, that would be better. That alternative may be, for example, a site that is adjacent or close to the emergency department.

43 As mentioned above, one alternative that Flourish offers is its peer-operated service in Hervey Bay, Queensland. The program has been operating since approximately 2011 and is funded by the Queensland Government. It was initially funded as part of a pilot program with a small number of centres established, of which there are now only two which remain operational.

44 The centre at Hervey Bay is fully staffed by peer workers. It has a good relationship with the local hospital and the local mental health team, meaning people are often referred to us by those places. We are part of the local service network.

45 There are three main parts to the model at Hervey Bay:

(a) There is a resource centre, which is a space for people to attend group activities and one-on-one peer support when needed. This includes providing people with the opportunity to learn new skills, to learn about living with a mental health issue, to make new friends and to reduce isolation. What we often see is that the resource centre acts as a capacity building process for people. They attend, start to make new friends, want to continue being part of the program, and then they also then start facilitating groups themselves. It also helps people to build more natural supports such as friendships outside of the centre.

(b) There is a 'warm line', which is a limited hours telephone support line for consumers. It is not a crisis line; it's a line which operates, usually after hours, so when people feel emotionally vulnerable or distressed they can call and talk with a peer worker. People can also schedule a call in advance when they know ahead of time that something might happen later in the week and they are going to need additional support.

(c) There is a respite house, which offers a short stay residence for people with complex mental health issues who may need to have a break away from their usual living arrangements. The respite house contains four bedrooms and can support three people at any one time, with 24/7 peer worker support.

46 We used our experience at the Hervey Bay centre to develop the Resolve Program model, which is discussed at paragraph 40 above. Similar to the Hervey Bay centre, we also have, as part of the Resolve Program, a respite house, group activity stays, a warm line which staffed 24/7, and outreach support. As mentioned above, we provide these supports to people who have been in hospital in the last 12 months between 40 and 270 days in a mental health unit to help support them stay out of hospital.

47 Flourish has had success out of its Resolve Program. Flourish collected data every three months to evaluate the program, and that evaluation is contained in a report by Social Ventures Australia, our partner organisation, issued March 2019 called 'Resolve Social Benefit Bond'.[2] The evaluation found that:

(a) during the first year of delivery, 167 people were referred to the Resolve Program, and of those, 165 people engaged in the Program;

(b) 80% of participants have participated actively in the program for more than 80% of the time they have been enrolled;

(c) there was a 35% reduction in hospital admissions, and a 20% reduction in presentations to the emergency department.

48 In my view, these types of services in the community, where people can choose what services they want to use and when they want to use them – whether it's the warm line or the respite centre – is a good alternative for people who have spent a lot of time in hospital; or who want an alternative to presenting at an emergency department unless absolutely necessary.

Role of telephone helplines and digital technology

49 Before I was CEO of Flourish, I acted as their Chief Information Officer, and worked for about 5-6 years on digital technology. I am also, as part of my doctorate, doing research in technology and peer work.

50 In my view, the role of telephone helplines and digital technology is an important avenue for exploration for the mental health system. The research is clear in that people with serious mental illness can use and do use technology, and they use it a lot, even in terms of finding information and support for their mental health issues. For example, people with

[2] https://www.socialventures.com.au/assets/Resolve_SBB_Annual_Investor_Report_2019_web.pdf.

a diagnosis of schizophrenia have been shown to use the internet to be an important source of information (Villani and Kovess-Masfety, 2017).[3]

51 Whilst I agree that mobile mental health apps and digital technology is a big part of a future mental health system, particularly where young people increasingly use technology, the question is whether people with serious or complex mental health issues have access to, and can use the technology to access these supports. For example, Aschbrenner et al (2018)[4] investigated access to online and mobile technology by people with a serious mental illness within non-clinical peer support agencies in the USA. Across 195 people with a serious mental illness in 10 agencies they found that 81% of respondents owned a mobile phone, 72% used text messaging, 58% used a smart phone and 72% used social media, 82% used the internet and 63% connected to the internet at the agency. In Australia, looking at a group of people with serious mental illness connected to an inner-city mental health service, Thomas et al (2017)[5] found that 86% of respondents owned a mobile phone, but only 51% had access to the internet services (a data plan) attached to their phone, and only 45% had access to the internet at home.

52 There is also a consideration as to what role technology plays in conjunction with face to face support, which often cannot be totally replaced. Therefore, in my view there needs to be some fundamental questions answered about how technology can be co-developed with people with complex mental health issues, and used effectively and respectfully in ways in which people feel they are being listened to.

53 One of the examples that I have seen in which technology has been used well is the use of online forums by SANE Australia; one for family members and carers, and one for people with lived experience. This is a great example of natural peer support in action in a digital space. A moderator is used to approve posts and monitor the information on the forums, but in my view it's a great way of facilitating connections between people that are sometimes long distances away who share their experience and information to support each other. I think it's an exciting addition to the service network.

54 Another one in its early stages of development is digital peer support, and specifically using technology to deliver peer support from paid peer workers. The challenge however,

---

[3] Villani, M. & Kovess-Mafesty, V. (2017). How do people experiencing schizophrenia spectrum disorders or other psychotic disorders use the internet to get information on their mental health? Literature review and recommendations. *JMIR Mental Health*, 4: e1. DOI: 10.2196/mental.5946.

[4] Aschbrenner, K.A, Naslund, J.A., Grinley, T., Bienvenida, J.C.M., Bartels, S.J. & Brunette, M. (2018). A survey of online and mobile technology use at peer support agencies. *Psychiatric Quarterly*. DOI: 10.1007/s11126-017-9561-4.

[5] Thomas, N., Foley, F., Lindblom, K. & Lee, S. (2017). Are people with mental illness ready for online interventions? Access and use of the internet in Australian mental health service users. *Australian Psychiatry*, 25, 257-261. DOI: 10.1177/1039856217689913.

is that this requires access to the required hardware (e.g., a smartphone, computer), a data plan and access to the internet (see also my comments about access at 51). All of these things cost money and require a degree of skill. My caution is that it can't be just accepted that people with complex mental health issues have this access to technology or skills; we might need to focus on how we facilitate those things if this approach is to be deliver on its exciting promise.

55 I am particularly interested in how we can use videoconferencing technology to deliver supports and specifically peer support. At its most basic level it would be using something like Skype or Zoom (though using a product that is more secure and protects people's privacy and the confidentiality of the interaction). My doctoral research is looking at access to technology, as well as the features and training required to transform a traditional in person experience of peer support to a digital space. Initial feedback from people with complex mental health issues and peer workers from focus groups that have been run is positive. Both groups are very interested and supportive, and see the promise.

56 If we can use technology in the right way then in my view it will provide significant improvements to the delivery of mental health services, particularly for people who live remotely or cannot easily connect with supports for whatever reason.

57 Further, in my view, any approach using technology must be co-developed with people with lived experience, by asking them how to create the best possible experience for somebody; an experience that delivers the supports they need not what someone else thinks they do.

The role of mental health telephone triage services

58 In my view, mental health triage telephone services are an important part of a continuum of services that should be offered to people. These sorts of services can be useful in situations where a person becomes vulnerable, distressed or worried, and there may not be a service that is physically open. People in the community (and their families and carers) are not always connected to support services and are often seeking advice about where to get the support they need to feel safe, to address their presenting issues, or to obtain support for their family member. Whilst I think there is a role for mental health triage telephone services to play, for the people Flourish supports it will seldom replace good planning ahead, and thoughtful access to other options that people may have.

The role of crisis outreach teams and police

59 My experience with people with mental health issues is that their interactions with police are not always positive, particularly when people have in their past been taken to hospital against their will. From Flourish's perspective, by supporting people to plan ahead and make decisions about what should happen at different points, we seek to avoid people

having to interact with crisis outreach teams and the police. The plan can assist with identifying answer to questions like: *Do they need to talk to their psychiatrist or general practitioner? Do they need to change their medication now? Do they need more peer support?* And where Flourish can assist, we increase the level of supports, perhaps from contacting a person once a day, to contacting them two or three times a day. It's again about early intervention and the early ramp up of supports, then early engagement with clinicians to try and avert people getting to the point where they have no other option but to involve the police or require more assertive intervention.

60 I understand the PACER (Police, Ambulance and Clinical Early Response) model, a joint crisis response from police, ambulance and mental health clinicians, was used to respond to people experiencing a crisis, and I think this is a good example of trying to have more involvement of mental health specialists at a critical time. The model is about recognising that we shouldn't expect police to manage what may be a mental health crisis alone; they can assist with ensuring safety but the mental health specialists can provide the required expertise and advice on how best to support the person in mental health "crisis". I would suggest there may also be an opportunity to explore an enhancement of that model to provide a role for specialist peer workers who may be able to connect with somebody in a highly distressed or agitated state, hopefully making the experience in that moment and presentation to an emergency department less traumatic for the person.

61 In summary, I think that the Commission's deliberations should seek to draw more on the expertise of people with lived experience to co-create an eco-system that respects, supports and keeps people safe. To me it's about co-producing, co-developing, and co-evaluating services so that people with lived experience are involved in all stages of the mental health system's development, delivery and evaluation. We need to draw more on people's live experience expertise and respect and value it alongside the professional expertise of others. We have to do this together.

sign here ►

print name Mark Orr

date 6 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT MO-1

This is the attachment marked 'MO-1' referred to in the witness statement of Mark Orr dated 06/05/2020.

Attachment MO-1

Mark Orr AM GAICD FGIA FCIS

Resumè

An innovative senior executive and psychologist with over 25 years of experience in complex health, human services and mental health fields. Specialises in the application of best practice corporate governance, strategic planning and execution, collaborative management and stakeholder relations.

Employment History

- CEO and Company Secretary, Flourish Australia [2018 - current]
- Chief Information Officer, Flourish Australia [2012 - 2017]
- Divisional Manager, Rehabilitation, Psychiatric Rehabilitation Australia [2010 - 2012]
- Part-time Member, Social Security Appeals Tribunal [2008 - 2010]
- Interim CEO, AIDS Trust of Australia [2007 - 2008]
- Deputy Protective Commissioner and Director, Client Services, Office of the Protective Commissioner, Attorney General's Department NSW [2001- 2007]
- Assistant Director, Northern NSW, Office of the Protective Commissioner, Attorney General's Department NSW [1999 - 2001]
- Regional Manager, Sydney Metropolitan, Office of the Public Guardian, Attorney General's Department NSW [1994 - 1999]

Pro Bono Board Directorships

- Mental Health Coordinating Council of NSW Limited [2018 - current]
- Ostara Australia Limited [2018]

Volunteer Community Board Directorships and Committee Memberships

- National Vice President, Australia Federation of AIDS Organisations Limited [2017 - current]
- President, ACON Health Limited and AIDS Council of NSW Incorporated [2008 - 2015]
- Board Member AIDS Council of NSW Incorporated [2006 - 2008]
- Member, Finance Advisory Group, People with Disabilities Australia [2009 - 2013]
- Director and Co-Chair, New Mardi Gras Limited (now renamed as Sydney Gay and Lesbian Mardi Gras Limited) [2003 - 2005]

Awards

- Appointed a Member in the General Division of the Order of Australia for significant service to community health through a range of initiatives. Australia Day Honours List 2019

Qualifications

- Master of e-Health (Health Informatics) (Tasmania)
- Master of Health Services Management (Newcastle)
- Bachelor of Science (Honours) (Newcastle)
- Bachelor of Science (Newcastle)
- Graduate Diploma in Applied Corporate Governance (Chartered Secretaries Australia)
- Graduate Diploma in Special Education (Canberra)
- Graduate Certificate in Applied Finance and Investments (FINSIA)

- Registered Psychologist
- Chartered Company Secretary

Current Studies

- Doctor of Public Health (UNSW). Area: Technology and mental health peer support.

Professional Memberships

- Graduate Member, Australian Institute of Company Directors (GAICD)
- Fellow, Governance Institute of Australia (FGIA)
- Fellow, The Chartered Governance Institute (FCIS)