

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

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

5
6 The second witness is Ms Tracey Morgan who is the
7 Community Mental Health Services Manager at the Casey Area
8 Mental Health Service and she will talk about the Enhanced
9 Crisis Assessment Team and its work at the Casey Hospital.

10
11 Next we have Assistant Commissioner Glenn Weir from
12 Victoria Police, who will discuss Victoria Police's
13 engagement with people presenting with mental health
14 problems and the mental health system.

15
16 Next we have Ms Sally Jennings, who is a community
17 witness and carer for her teenage son, and she'll be giving
18 evidence under that pseudonym.

19
20 We have Mr Simon Thomson, who is the Regional Director
21 for Barwon South West Region Ambulance Victoria, and he
22 will discuss the management of 000 mental health
23 presentations.

24
25 We have Ms Louise Glanville, who is The Chief
26 Executive Officer of Legal Aid, whose clients of course are
27 among the most disadvantaged in the Victorian community,
28 and a high proportion of them present with mental health
29 conditions.

30
31 Finally, Ms Vrinda Edan is the Acting Chief Executive
32 of the Victorian Mental Illness Awareness Council. She
33 will be speaking about the role of consumers and carers in
34 the mental health workforce.

35
36 Commissioners, I now call Dr Ainslie Senz to give
37 evidence

38
39 **<AINSLIE LYNEA SENZ, affirmed and examined: [10.03am]**

40
41 MS NICHOLS: Q. Dr Senz, just make yourself comfortable.
42 If you need to stand at any stage because you are
43 uncomfortable, please just do that and we'll manage.

44
45 Are you the Director of the Department of Emergency
46 Medicine at the Footscray Hospital?
47 A. Yes.

1
2 Q. Are you an emergency physician and in the course of
3 that work you deal directly with patients?
4 A. Yes.
5
6 Q. Do you have quite some experience in working with
7 alcohol and drug abuse?
8 A. I do, within my role as an emergency doctor and I have
9 previously held a role of alcohol and other drugs portfolio
10 within the Emergency Department.
11
12 Q. Thank you. With the assistance of the Royal
13 Commission, have you prepared a statement which answers the
14 questions we have asked of you?
15 A. I have.
16
17 Q. I tender the statement. [WIT.0002.0016.0001] Can I
18 ask you about the Footscray Emergency Department. About
19 how many patients present there annually?
20 A. So it's a 40,000 per year Emergency Department, which
21 is kind of a medium-sized Emergency Department, meaning
22 about 115-120 patients a day.
23
24 Q. About what percentage of patients present with mental
25 health problems or apparent mental health problems?
26 A. The data would suggest about 5 per cent of the
27 population, or 5 per cent of the presentations. I will
28 clarify that to say that the data searches are really a
29 little bit tricky. They do depend on particular search
30 terms being able to be defined. Some of the search terms
31 might be "suicide", "self-harm", "intentional",
32 "section 351" might come up as a search term.
33
34 But if someone presents with a laceration and it's
35 actually not defined anywhere in any of the search terms
36 that that was intentional, then they may be lost to the
37 data search, so 5 per cent is what we can gather at the
38 moment.
39
40 Q. Speaking generally, what kinds of mental health
41 conditions do you see in patients who present to the
42 Emergency Department?
43 A. So, we see a range of mental health problems and a
44 range of severity as well. So, there are acute
45 exacerbations of chronic problems. So, the chronic
46 problems might be schizophrenia, bipolar, depression, and
47 the exacerbation triggered, usually by alcohol and drug

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

3
4 We see self-harm and suicide attempts that range from
5 very, very superficial lacerations with intent to harm,
6 right through to quite significant overdoses and injuries.
7 We can see just baseline chronic conditions, so people who
8 are not in an acute exacerbation but are requiring help
9 with anxiety, depression, schizophrenia and personality
10 disorders within that group as well.

11
12 We see alcohol and drug use triggering acute mental
13 health issues in people who don't have chronic mental
14 health conditions, and we see a range of other things on a
15 sort of less frequent basis.

16
17 Q. What have you observed about the trends in the types
18 of presentations?

19 A. So, Emergency Department presentations are increasing
20 in general and I would say that mental health presentations
21 are increasing as well and the data would suggest that.
22 The severity of presentations is not increasing, so in fact
23 the rate of admissions for people presenting with mental
24 health problems is reducing. It's probably
25 multi-factorial, but the severity of presentations would be
26 part of that, and the presentations related to alcohol and
27 drug abuse, or use or intoxication, are increasing.

28
29 Q. Can I ask you how mental health services are provided
30 at the Footscray Emergency Department?

31 A. So, Western Health, which Footscray is part of, does
32 not own its own mental health service. So, Footscray is
33 serviced by Werribee-Mercy Mental Health Service.

34
35 Q. Can I just get you to say what is Western Health
36 before you go on?

37 A. Sorry. So, Western Health is a multi-campus health
38 service: so Footscray Hospital, Sunshine Hospital and
39 Williamstown Hospital, as well as a few other day - so
40 Sunbury Hospital and a few other centres. Sunshine
41 Hospital is the largest of them now, especially because
42 it's got a new Joan Kirner, and Footscray Hospital is the
43 smaller of the two emergency centres.

44
45 Q. So --

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

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

3
4 Q. How does the servicing occur in a practical sense?

5 A. Not very well, to be honest. So, what happens from an
6 Emergency Department point of view, is that we have staff
7 within the Emergency Department who are employed by
8 Werribee-Mercy, they are our Emergency Mental Health staff,
9 and that part works very well.

10
11 But then, because the next step is actually provided
12 by a completely different service, the lines of
13 communication and the accountability are quite problematic.

14
15 Q. Can I just take you back. So, you have staff and what
16 kind of roles do those staff fulfil?

17 A. So, they're called our Emergency Mental Health staff
18 or EMH staff. They range in qualifications and they're
19 usually mental health nurses or allied health staff such as
20 psychologists, and what they do is they provide mental
21 health assessments within the Emergency Department. On a
22 shift basis we have one of those per shift 24 hours a day,
23 so that's three per day.

24
25 Q. That arrangement works well, you say?

26 A. Yes, that actually does, they're part of the Emergency
27 Department team.

28
29 Q. Does that mean you are able to give relevant
30 directions when you need to about who needs to see which
31 patient?

32 A. So, that's not as easy, and I suppose this is one of
33 the reasons why owning our own health service might be a
34 little bit better, and it's nothing to do with the staff
35 themselves, I might say, it's just about the systems that
36 go around it.

37
38 So, I'll provide the example of the medical and
39 surgical teams which Western Health does own; that dialogue
40 is very easy, there are very clear systems around that,
41 including policies and procedures which they have to
42 follow; and so, we all know where we stand and we all know
43 what our responsibilities are.

44
45 When you're dealing with a service that's not provided
46 by you, that responsibility and the lines of accountability
47 are not there, so we sometimes don't have the same

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

3
4 Q. You started with the mental health staff and you were
5 about to move up to the next level.

6 A. Yes, so the mental health staff are managed by an EMH
7 manager. So, that role is again employed by Werribee-Mercy
8 and, up until recently, was completely off-site. We do
9 have now the capability to have them have some office
10 space, not five days a week, but temporarily at Footscray.
11 Also that role has been vacant quite a lot and has just
12 been re-appointed to, literally just recently.

13
14 Then above that they obviously have their own off-site
15 managers within the mental health service. One of the
16 things that Western Health did do to create a little bit
17 more of a relationship between the two health services, was
18 to make a liaison role; it's called the Service Development
19 and Operations Manager, and that was a Western Health role
20 that was responsible for liaising and opening the dialogue
21 between the two different health services and trying to
22 break down some of the barriers and also trying to help
23 with some of the accountability piece or the governance
24 piece within there.

25
26 That role has been quite important, and has been there
27 for about two years. However, it has had periods of
28 vacancy and is currently vacant.

29
30 Q. Thank you. Can you say briefly how is the Emergency
31 Department at Footscray funded?

32 A. So, EDs in general are funded on projections of
33 activity based on previous numbers and also projected
34 numbers, so we get sort of a lump sum of money to do what
35 we do. It doesn't actually take into account any kind of
36 complexity of care.

37
38 There are obviously projections about complexity of
39 care but it doesn't really - unlike other parts of the
40 hospital which will be managed on the type of patient that
41 they eventually get and the complexity of the surgery,
42 et cetera, we don't have anything like that in ED.

43
44 Q. Can I change topics now and ask you to go back to the
45 presentation of patients to the Emergency Department. How
46 are mental health patients presenting at triage?

47 A. So there are two different components to triage for

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

8
9 Then there's a mental health triage that goes
10 alongside that which puts people into, like, a risk
11 category in terms of their harm to their self or their harm
12 to other people, and then along with that gives some advice
13 on what level of supervision they might need. So, a
14 level 1 would be that they're very high risk to themselves
15 or a risk to other people and they need a high level of
16 supervision, right down to no risk and no supervision
17 required.

18
19 Q. Which patients will the mental health staff see?

20 A. So, generally speaking the high acuity, so the higher
21 end of the triage, as in the 1s and 2s. Just to explain
22 that a little bit more, we really don't have a service that
23 can provide a lot of assistance to the really low acuity
24 patients.

25
26 So, if you really need an admission and you're
27 obviously very unwell, then that's not an issue. But the
28 people who are presenting for help or assistance but don't
29 have - I'll give some examples - don't have active suicidal
30 ideation and don't have active acute mental health issues,
31 it's very limited what we do for those patients.

32
33 Q. Once you've got through triage, if you are a low
34 acuity patient and you're assessed as not being a risk to
35 yourself or to others, what happens next after triage?

36 A. You'll be seen by a doctor, a nurse as well as a
37 doctor, but if you're a low acuity patient without risk,
38 then you won't be seen by the Emergency Mental Health
39 staff.

40
41 Q. Once a person's been seen by a doctor, are they then
42 discharged into the community?

43 A. Yes, if there's no other reason for them to stay.

44
45 Q. Is there any availability of information that can be
46 given to patients about seeking out help once they go back
47 into the community?

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

4
5 Q. Is that essentially how you provide that support, by
6 giving information to people?

7 A. That's right.

8
9 Q. What about patients who are perhaps more unwell but
10 they don't need to be admitted to a bed?

11 A. So, they'll be seen medically as well by nurses and
12 doctors to assess the medical state, and the people who are
13 more unwell will be seen by Emergency Mental Health. The
14 Emergency Mental Health staff will then determine whether
15 an admission is required or not, and then if in the
16 scenario you're suggesting they're not required, then
17 they'll arrange some kind of community follow-up for them.

18
19 Q. Can I ask you about the process for admitting people
20 to a bed: who can make that decision and how does it occur?

21 A. So, the Emergency Mental Health staff make that
22 decision, and this is a unique area within my workplace.
23 So, for every other type of patient I am empowered to make
24 the decision about admission as a senior doctor in the
25 Emergency Department. The way that it works: if I think
26 someone needs an admission under a medical team and they
27 don't think so, they need to come and see the patient
28 themselves and then manage the care and either agree with
29 me or disagree with me and manage the ongoing care of that
30 patient, and that's very clearly written in Western Health
31 policy and is very common amongst Emergency Department
32 practice.

33
34 Within psychiatry I do not have that power. I can
35 only refer to the Emergency Mental Health staff and then
36 they will do the assessment and then they will make the
37 decision about whether the patient needs an admission or
38 not.

39
40 Q. What's the reason for that difference between mental
41 health and general health?

42 A. I think for us one of the biggest reasons is that we
43 don't own the mental health service.

44
45 Q. What do you say about the availability of beds, even
46 though it's not within your control, what have you
47 experienced in terms of the availability?

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

10
11 So, if I just give you some examples: 70 per cent of
12 the patients requiring an inpatient bed under mental health
13 will stay more than eight hours and 20 per cent will stay
14 more than 12 hours, whereas for all the other groups of
15 patients it's actually half that number.

16
17 The other part about this is that there's a 24-hour
18 rule, so essentially no patient is allowed to spend more
19 than 23 hours and 59 minutes in an Emergency Department.
20 That's very clearly set and it is not breached at any
21 point for any patient other than mental health patients.
22 And so, what that does is it means that mental health
23 patients can breach that 24-hour mark, and unfortunately
24 it's not very pleasant to say but they can breach a 48-hour
25 mark and a 72-hour mark as well.

26
27 Every month we have around two or three patients
28 breaching a 24-hour mark; sometimes it's zero a month. The
29 worst month that we've had in the last few years that I've
30 been Director is 14 in a month.

31
32 The longest length of stay we've had in the Emergency
33 Department for a mental health patient is five days.

34
35 Q. What happens when you don't have a bed available and a
36 person is waiting for 24 hours or more? What happens to
37 the patient?

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

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

3
4 Q. Can you give an example by reference to a general
5 health condition?

6 A. So, if someone has pneumonia, then I will be giving
7 them the oxygen and the antibiotics and the IV fluids if
8 they require whilst they wait for a bed in the ward, and
9 their team, the general physicians, will come and see them,
10 they will admit them, which is essentially a process on
11 paper, and then they will come and review that patient
12 whilst they're still in the Emergency Department. So, they
13 see that they are actually - they own that patient.

14
15 If there's something that goes wrong, so just say that
16 patient with pneumonia deteriorates and needs some higher
17 level care, then I will manage that in conjunction with the
18 team, the general physicians, who will come down from the
19 ward to do that. That is the not the case in psychiatry.

20
21 So essentially a patient waiting in the Emergency
22 Department for a mental health bed will get medications
23 charted by me in the Emergency Department. They will get
24 reviews by the Emergency Mental Health staff, but they
25 won't get any psychiatry care, and they definitely don't
26 get anything therapeutic, so there's nothing that they get
27 in terms of an intervention for counselling or therapy,
28 there's just medications.

29
30 They also don't get meals, they don't necessarily get
31 showers - this is something that we from the Emergency
32 Department are trying to work on, but if you can imagine
33 we're geared towards fast turnover of patients, most
34 patients don't need meals or showers, and we're not very
35 well geared to patients who are staying there for a really
36 long time, so things like meals and showers can actually be
37 overlooked for this group of patients unless they're
38 actually asking us.

39
40 Q. And so, are there really two parts to the problem, one
41 is that there's no capacity for them to go where they
42 should be going, and that the Emergency Department being an
43 Emergency Department is not equipped to manage people on a
44 longer-term basis?

45 A. And a third component which is that the psychiatry
46 team is not involved in their care during their stay. So,
47 I gave the example of the pneumonia patient deteriorating

1 before. If a patient with mental health problems
2 deteriorates the usual course for that or the usual
3 scenario would be a behavioural crisis in which they get
4 quite agitated and need management of that, and that will
5 all be up to the Emergency Department to manage as well.
6

7 Now, we're very well trained in de-escalation and
8 behavioural crisis management, so the skill set is there,
9 it's just that I don't manage anyone else's deterioration
10 without the other team involved, but I do manage the
11 deterioration of a mental health patient without the
12 involvement of psychiatry.
13

14 Q. Just returning to the question of wait times. The
15 National Emergency Access Target, or NEAT, is eight hours;
16 is that right?

17 A. It's four hours for the general population.
18

19 Q. Sorry, four hours. And is it different for mental
20 health?

21 A. It's set at eight for the mental health population.
22

23 Q. Is it set at eight officially according to that
24 target?

25 A. It's a bit complicated but that's the one that we run
26 on.
27

28 Q. Can you explain that?

29 A. The four-hour one is pretty much for every other part,
30 but the eight-hour one is giving it a little bit of
31 flexibility for the mental health system.
32

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

35 A. Yes.
36

37 Q. You referred to 24-hour breaches before: does a breach
38 occur when a patient has been in the Emergency Department
39 for 24 hours?

40 A. Yes, for 24 hours or more, yeah.
41

42 Q. And that applies whether or not they're a mental
43 health patient?

44 A. That's right.
45

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

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

9

10 Q. Can I just draw you out on that little bit, about not
11 being as rigorous where there is a breach of the 24-hour
12 rule in relation to a mental health patient: what do you
13 mean by not as rigorous?

14 A. It's probably best said that we tolerate the 24-hour
15 breach in the mental health patient because we know that
16 the system is much more difficult and also because, at
17 Western Health in particular, we know that we have little
18 control over the system of getting the beds. So, for the
19 non-mental health patient it's very much in our control to
20 make that bed happen, and so, therefore if it doesn't
21 happen the accountability is with us and there is a very,
22 very detailed investigation that goes into what happened.

23

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

30

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

42

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

1 stay area, especially after they have to wait for 24 or
2 more hours, and the other thing is that we realised that
3 hiding the problem wasn't actually solving the problem.
4

5 Q. So, who are 24-hour breaches reported to?

6 A. So, me and sometimes --
7

8 Q. Beyond you?

9 A. Yes, so then upwards through the hospital to the CEO.
10 The CEO or the Executive Director of Operations will then
11 have to answer to the Department of Health.
12

13 Q. On the basis of your knowledge, when you say the
14 24-hour or more breaches in respect of mental health
15 patients aren't rigorously investigated: firstly, do you
16 mean at a hospital CEO level?

17 A. I'm sorry, I can't really comment on that. I just
18 know that I don't have to do the investigation that I would
19 for another patient.
20

21 Q. I see.

22 A. I imagine, but I don't know, that the CEO still has to
23 have a dialogue with the Department of Health about it,
24 there's an understanding that these will happen.
25

26 Q. So your knowledge only goes so far as your
27 involvement?

28 A. That's right.
29

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

34 A. That's right.
35

36 Q. Thank you. Can I ask you about what occurs with
37 patients who are brought to the Emergency Department under
38 section 351 of the Mental Health Act?

39 A. These patients are brought in - essentially they're
40 brought in against their will to have a psychiatric or a
41 mental health assessment within an Emergency Department;
42 they're usually brought in by police with ambulance
43 assistance as well. So, these patients can - not really
44 want to be in the Emergency Department and may be quite
45 angry at the fact that they are there, hence why the police
46 are involved.
47

1 Q. What management issues arise for you in the Emergency
2 Department?

3 A. These type of patients are managed very similarly to
4 someone who is coming in with quite an urgent medical
5 condition, so they need very quick attention from medical
6 nursing and Emergency Mental Health staff. They are quite
7 resource-intensive usually, and they also involve our
8 security staff. We obviously need to get the police back
9 out to the community, and so, our security staff will take
10 over some of that role.

11
12 What happens with some of these patients - so there's
13 a few different groups within this: the first group would
14 be people who are easily de-escalated, and by that I mean
15 they become calm and they realise that they're in the
16 Emergency Department for a reason, they're agreeable to
17 having a mental health assessment.

18
19 Obviously you have the other spectrum where people are
20 not agreeable to be there, and that can either be because
21 they intentionally don't want to be there, or it can be
22 because they're actually quite unwell and they're not
23 thinking well enough to actually make a decision about
24 whether they should be there or not. In those situations
25 people can be incredibly agitated and violent and require
26 behavioural management and usually chemical restraint. So,
27 by that I mean we give people medications to help
28 facilitate them to be calm, and unfortunately in some
29 situations we also have to physically and mechanically
30 restrain people, and I do mean by that that we have to
31 strap them down to the bed.

32
33 Q. What are the challenges that your staff face in
34 dealing with that sort of situation?

35 A. So they're very challenging I think for any staff
36 member, no matter how experienced you get with dealing with
37 behavioural crises, they're quite confronting. There's
38 always the risk of violence and injury to staff. There's
39 also quite a lot of disruption to the remaining - the other
40 patients and other relatives within the Emergency
41 Department and it's quite distressing for them.

42
43 It's not easy to hide what's going on from the rest of
44 the department, and at Footscray in particular we don't
45 have a behavioural assessment room yet, it's being built,
46 but it's not there so most of this happens in front of
47 everybody else, and that can be very distressing.

1
2 Violence is a big risk within there scenarios, or
3 injury is a big risk within these scenarios, and we do have
4 staff being injured. I'm happy to report that our staff
5 injury rate is actually quite low and we've got some other
6 structures in place to help with that, but these particular
7 crises can end in injury.
8

9 Q. The bringing on line of the behavioural assessment
10 unit, do you think that will provide real assistance in
11 that respect?

12 A. It provides it - so, you're talking about the
13 behavioural assessment room?
14

15 Q. Sorry, room, I beg your pardon.

16 A. Yeah, no, that's fine. Yeah, so it provides a
17 different space. So, the idea of the behavioural
18 assessment room is to provide a space in a place that's
19 more conducive to the patient's dignity and the distress
20 levels of the other patients and relatives. So, you're
21 usually a little bit out of the way, closer to the
22 emergency and the ambulance entrance of the Emergency
23 Department and a bit more soundproofed.
24

25 Q. Can I ask you a bit more about the physical makeup of
26 the Emergency Department. You say in your statement that
27 the environment of the Emergency Department is not suited
28 well to mental health patients. Can you elaborate on that?

29 A. So, Footscray Emergency Department itself is very old,
30 it's very small and cramped and low ceilings, and it sounds
31 really silly to make that point, but it is actually really
32 impressively small. And it's also very busy and it's a
33 24-hour business, and so, the lights are on all the time
34 and there's lots of noise and there's lots of stimulation,
35 so none of those things are very good for patients who are
36 acutely unwell with mental health issues and they're also
37 not good for other patients who are not as well but still
38 needing to be there.
39

40 Q. You've made the point in your statement that Western
41 Health is in the process of implementing a crisis hub at
42 Sunshine Hospital. What's your view about the utility of
43 those hubs and how compatibly they sit with the practice of
44 emergency medicine?

45 A. So, I think one of the things about all of the
46 different types of strategies that people use is, everyone
47 wants to make the Emergency Department better for every

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

5
6 And so, I would prefer to manage the number of
7 patients who are coming to me and the need for the
8 Emergency Department, but also then manage getting them out
9 of the Emergency Department to actually the destination
10 they need to go to, rather than create an environment that
11 is better for people to stay longer in an Emergency
12 Department. So, I'd prefer the process and the system to
13 be fixed rather than to make the environment better to stay
14 longer, if you understand.

15
16 So, from the crisis hub point of view, I think there's
17 some elements of that that are really, really useful, but
18 the problems that I have with it are that they, again, make
19 the Emergency Department seem like the centre of care for
20 all of the community, whereas I don't actually think that
21 that's what we're there for, and it feeds into that idea of
22 a one-stop shop, and that's the concern that I have, is
23 that, the other part of this from my Emergency Director
24 point of view is that I could do this for all different
25 patient groups.

26
27 So, the same concept happens for the elderly
28 population, that I should make an Emergency Department
29 that's beautiful for the elderly population to be there for
30 longer than anyone should ever be in an Emergency
31 Department, so how about I just fix the scenario of moving
32 the patient through to their actual appropriate destination
33 and we could make that environment appropriate for the
34 elderly population rather than the Emergency Department.

35
36 Q. Can I ask you about discharge planning: what's
37 involved in discharge planning insofar as that occurs with
38 mental health patients?

39 A. So, as a doctor I'm not involved in much of the
40 discharge planning, the Emergency Mental Health staff are
41 involved in the discharge planning. I imagine that it's
42 community follow-up, some of that will be general, as in go
43 back to a psychologist, here's the way you can do that;
44 some of that will be coordinated through the community
45 strategies such as having a caseworker.

46 Q. So, you don't do it yourself?

47 A. I don't personally arrange the follow-up.

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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

1 Department should get some kind of value-add, and that's
2 not necessarily what the patient thinks that they were
3 coming for, so it's not necessarily a diagnosis, but it can
4 be reassurance, it can be education, it can be a diagnosis,
5 it can be symptom management.
6

7 For mental health patients, especially in the low
8 acuity, I provide nothing. I might provide a card for a
9 phone number, but that's about all.
10

11 Q. We've already addressed, I think, the needs of
12 patients requiring admissions. Can I ask you your views
13 about how demand on the Emergency Department, at least in
14 your area, is changing?

15 A. So, we're growing; I think every Emergency Department
16 is growing. The rate of growth at the moment for Footscray
17 Emergency Department is about 5 per cent, and that's been
18 consistent. Sometimes it goes a little bit higher than
19 that but it's consistently about 5 per cent over the last
20 few years. That's higher than the population growth rate,
21 and I think that's probably reflected around a lot of
22 Emergency Departments, that the growth of Emergency
23 Department presentations outstrips the population growth.
24

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

28 A. Yes.
29

30 Q. The college, our Emergency Department College does
31 research on alcohol in itself and says at least 10 per cent
32 of presentations to Emergency Departments are
33 alcohol-related, that's not including other drugs at all,
34 and the trend is, yes, that they are increasing.
35

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

40 A. Yes.
41

42 Q. You've mentioned the need for additional capacity
43 which we've already discussed. In terms of the changes
44 outside of Footscray Emergency Department, what do you
45 think are the important changes that need to be made?

46 A. So, I do think there needs to be a lot more
47 community-based resources. I actually think that it's

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

9
10 I did mention in my statement that I think one of the
11 things the Royal Commission could do was - is very powerful
12 around the awareness of mental health and the way that
13 employers and insurers could actually manage mental health
14 risk. I made the point that mental health exclusions at
15 insurance levels is actually not based on any type of risk
16 assessment or severity level, unlike any other kind of
17 illness, and I think that that's a form of discrimination.
18 And, although that does not impact on Footscray Emergency
19 Department at all, I actually think it's a very powerful
20 thing that the community could benefit from.

21
22 MS NICHOLS: Thank you, Dr Senz. Chair, do the
23 Commissioners have any questions?

24
25 CHAIR: Yes, please, Professor McSherry.

26
27 COMMISSIONER MCSHERRY: Q. Thanks very much for your
28 comprehensive statement. Just a couple of questions.
29 Would you have any data about how often patients would be
30 transferred and treated on a compulsory basis?

31 A. I'm sorry, I don't. It's not an uncommon request that
32 patients are brought to the Emergency Department because
33 they're on a compulsory treatment order; that would be one
34 of the main reasons that someone would be referred to the
35 Emergency Department by the community teams, but I'm sorry,
36 I don't have that data on me.

37
38 Q. Okay. You've described some circumstances that might
39 lead to the use of physical or chemical restraint. Can you
40 perhaps explain what chemical restraint means in this
41 context?

42 A. So we do use it as a bit of a broad term and it can
43 be, at the lower end of it, using oral sedation, so tablet
44 forms of sedation such as Valium, or there's another one
45 that's commonly used which is called Olanzapine. To take
46 an oral medication a patient has to be fairly compliant and
47 cooperative with that, and so that's the lower end of

1 things and we generally use that after de-escalation, or
2 talking with the patient is what we mean by that,
3 addressing their concerns, and then we'd offer something
4 like Valium to say, look, you're probably going to be
5 waiting a little while, do you think that this would help
6 you to manage your symptoms and your anxieties whilst
7 you're here? So that's the lower end of the spectrum.
8

9 In the behavioural crisis that we were talking about
10 before involving a lot of security guards and the idea of
11 mechanical restraint, we're usually giving an injection of
12 a sedative.
13

14 Q. And, what happens then?

15 A. So then the patient is asleep. So, there's a few
16 different combinations to what happens then. So, what
17 happens then is the psychiatrist has to be informed that
18 that has happened. There are a whole lot of compliance
19 things that we need to do as Emergency Department staff:
20 so, regular observations, regular checks of the restraints
21 to make sure that they're not causing injuries.
22

23 The patients are actually managed in resus, which is a
24 one-on-one nursing area so that we can identify if there's
25 any problems. Because the other side of things is the
26 sedation part, so the drugs are very powerful and we need
27 to continue to monitor them like an unconscious patient
28 essentially.
29

30 And then what happens is that we wait for the
31 medication to wear off; during that time we may have
32 released the restraints and, when they wake up, we do a
33 further assessment. Some patients wake up and that's
34 really all they needed, was a really good sleep and sort of
35 removing all of that anxiety and the really high crisis
36 state and the time under the medication has actually helped
37 that occur. Other people wake up and they're still very
38 unwell and, depending on what goes on, people unfortunately
39 could require further sedation.
40

41 Q. How often would that occur, that extreme circumstance?

42 A. So, we're doing much better at this now. When I say
43 "much better at this", we have a system in Footscray
44 Emergency Department where we actually identify behaviours
45 of concern proactively, so we're trying to reduce the
46 number of times that patients get to a crisis point.
47

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

7
8 Not every crisis point or code grey requires someone
9 to be retrained or to be given injections of medication, so
10 that might occur two or three times a week. It does
11 depend, we get peaks and flows.

12
13 Q. Just to clarify, so two or three times a week a
14 patient might be sedated to unconscious levels?

15 A. Yes. It might be more than that on some occasions, it
16 might be less. The other part of that is that some
17 patients require it repeatedly.

18
19 COMMISSIONER McSHERRY: Thank you.

20
21 CHAIR: Q. Thank you. Dr Senz, thank you very much for
22 the overview, I think you've given us a very good
23 illustration of how an ED department works and the
24 challenges in managing it. I'd like to clarify: you do
25 say:

26
27 "'Ice' is a particular problem with mental
28 health as its harmful effects are more
29 immediate and it has a significant
30 relationship with psychosis."

31
32 You have referenced that a few times. Can you
33 describe for us what in fact occurs in relation to that and
34 if there are any particular management challenges you face
35 that are --

36 A. With psychosis or with ice?

37
38 Q. Both.

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

45
46 Some patients with psychosis are paranoid, and if
47 their paranoia is very real for them and they think that

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

3
4 There's obviously variations on a theme within that,
5 but ice can trigger a psychosis, and again, that could be a
6 spectrum but it tends to be very acute. Most of the
7 pharmacological psychoses are very real and very acute and
8 patients are incredibly scared or angry.

9
10 Q. Thank you. We have heard from a number of witnesses
11 already before the Royal Commission about their experiences
12 of going to Emergency Departments, and I think that fear
13 that you've talked about is very often what they will
14 describe.

15
16 They have also talked about though the impact of the
17 waiting times in an Emergency Department, and hence, eight
18 hours might seem a very, very long time for someone in
19 acute mental health crisis, let alone the other extremes
20 you've talked about, and so, we do hear from time to time
21 people have talked to us about the fact they just can't
22 wait in that environment, they find the loss of dignity,
23 the noise that you've described very eloquently, the lack
24 of privacy overwhelming and they leave and don't seek the
25 assistance that they've come to get. Would that be your
26 experiences in terms of the impact of those wait times?

27 A. Absolutely. I think all patients do a good job
28 waiting, the level of time that they have to wait. And
29 obviously, if we could make it a shorter wait, we would.
30 But I think for mental health patients in particular it's
31 very challenging to wait that long, and, like you've just
32 explained, the stimulating environment is not conducive to
33 them waiting, and also, if they're very acutely unwell,
34 they're actually not as well understanding what's going on.

35
36 So I think it is very challenging, and I'll say, even
37 once they get in and if we're waiting for a bed, one of the
38 biggest reasons for a behavioural crisis or an escalation
39 of behaviour is just waiting.

40
41 Q. And that might mean a response with security guards as
42 a result?

43 A. Absolutely, yeah, and it's just awful. It's
44 especially awful because we can't do anything about it. We
45 feel powerless as well, but it's a trend that patients do
46 get to - and most patients I'm going to say, most patients
47 would get frustrated, but the behavioural crisis is a

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

3
4 CHAIR: Thank you very much.

5
6 MS NICHOLS: May Dr Senz be excused?

7
8 CHAIR: Yes, thank you very much for your evidence today,
9 Dr Senz.

10
11 <THE WITNESS WITHDREW

12
13 MS BATTEN: Commissioners, the next witness is Ms Tracey
14 Morgan. I call Ms Morgan.

15
16 <TRACEY LEE MORGAN, affirmed and examined: [10.42am]

17
18 MS BATTEN: Q. Thank you, Ms Morgan. Have you, with the
19 assistance of Monash Health's legal advisors, made a
20 witness statement to this Royal Commission?
21 A. Yes, I have.

22
23 Q. I tender that statement. [WIT.0002.0013.0001] You are
24 the Community Mental Health Services Manager of the Casey
25 Area Mental Health Service; that's right?
26 A. That's correct.

27
28 Q. Could you please outline what that role involves?
29 A. So, Casey Area Mental Health Service is part of the
30 Monash Health Service. We have a number of sites and
31 area-based services, Casey being one. My current role
32 involves oversight of the CAT teams, the Continuing Care
33 Teams, our PARCs units and our psychiatric triage service,
34 and I've previously as well been involved both in a
35 manager's position and in this position, and as a clinician
36 in working in our Emergency Department services.

37
38 Q. Previously you were involved in overseeing the
39 Emergency Department, could you just elaborate for us what
40 that role involved?
41 A. Yes, so I was the manager of the ECAT services, so the
42 mental health clinicians that were based in the Emergency
43 Department providing assessment and treatment for clients
44 that presented.

45
46 Q. What is the ECAT service?
47 A. So, ECAT is the Enhanced CAT TEAM. So essentially CAT

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

5
6 Q. You've said they're clinicians: can you just clarify
7 what roles people occupy in that team?

8 A. Yep, so we have a mixture; the majority are usually
9 mental health nurses or psychiatric nurses. We do have
10 social workers, we do have OTs, we do also on occasions
11 have psychologists, so it's usually a mixture.

12
13 Q. Referrals are made to the ECAT Team by Emergency
14 Department staff; is that right?

15 A. That's correct, so someone may present to the triage
16 window, describe having a mental health issue and then that
17 referral can come directly to the ECAT clinicians, or it
18 may be that people have presented for something different
19 altogether, but in the course of investigating that,
20 medical staff in the Emergency Department have discovered
21 that there's a mental health component and as a consequence
22 they have made a referral to the team.

23
24 Q. People may also come to the ECAT Team through the
25 psychological triage service, which is a phone service?

26 A. That's correct, yeah.

27
28 Q. People can ring that service and be referred to the ED
29 and come to you that way?

30 A. That's correct, so that's our 24-hour contact service,
31 so it may be that people have called that phone number,
32 there's been a concern about their level of risk, so that
33 they don't feel that people can wait to be seen in the
34 community and they may be directed to present to the ED and
35 present to that triage window, but will be contacted to be
36 advised that they're coming and what information's been
37 discussed so far.

38
39 Q. Can you clarify for us, what's the criteria to be
40 referred to the ECAT Team? What do you have to satisfy to
41 come to your team?

42 A. Look, we are I think probably more flexible than some
43 other services. So, for us - I know we were hearing
44 before, that very acute sort of end of the service. We
45 would tend to see anybody in our Emergency Department that
46 presents with a mental health issue. So, we don't wait for
47 a criteria that's about risk or suicidality or the acuity.

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

5
6 Q. You've stated:

7
8 "Most of our patients present in crisis.
9 Some who feel they are in crisis do not
10 satisfy the objective criteria for access
11 to crisis support services."
12

13 Can you first just clarify, what crisis support
14 services are you referring to there?

15 A. So in that circumstance I'm talking about either
16 potentially admissions, or CAT Team follow-up as a specific
17 community treatment team. We have clients that will
18 present that we may refer to other services as well outside
19 of that particular crisis space. So, it might be - we
20 don't tend to refer very much to our Continuing Care Teams
21 directly from the Emergency Department, but we might use
22 programs like The Way Back who provide sort of three months
23 support in the community but it's more psychosocial in
24 nature. We might use other non-government organisations,
25 we might send people back to GPs for referrals to
26 psychologists or private psychiatrists, so we look at a
27 number of options in terms of what's available in the
28 community.
29

30 Q. You've referred to the objective criteria for those
31 services: are criteria for those higher than getting to the
32 ECAT Team?

33 A. Yep. Sorry, can I just check: so, you're asking about
34 the criteria of how people would be referred to the CAT
35 Team, what that would look like?
36

37 Q. Yes.

38 A. In doing the assessment people would be presenting
39 either as at risk but able to work with us in terms of
40 being kept safe in the community and having support, or
41 they may be very psychotic or very unwell but their risk is
42 otherwise manageable, so they're not acutely suicidal
43 per se but still very unwell and able to engage with us in
44 treatment.
45

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

1
2 "There is a growing need for mental health
3 services and waiting times are increasing."
4

5 Could you outline for us what the growing need is?

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

23
24 Q. When you say "the waiting times are increasing",
25 waiting times for what do you mean?

26 A. Across the board really, so the waiting times in the
27 Emergency Department when people present there just to see
28 people are increasing. For Casey Hospital the average over
29 the last 12 months would be five hours, but that's the
30 average, some people may wait an hour, some people may wait
31 eight or nine. It's a 20-bed department and it's very
32 small. Casey over the last four months has averaged about
33 360 mental health presentations a month, so it's a lot of
34 people to sort of move through what's a fairly small
35 Emergency Department.

36
37 But also, as community services are put in place, so
38 any of those non-government organisations for example,
39 there will be an influx of referrals as they start and then
40 things will get to the point where there are waiting lists
41 and it's difficult to access those services.

42
43 There are also a number of community-based services
44 that exist, but they're tendered, so they're only there for
45 short periods of time, and after a couple of years they may
46 change names or location and it's very difficult to track
47 that, so if you're in the community trying to find support

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

3
4 Q. In the Emergency Department you've said that clients
5 can wait - the average is five hours, is that what you
6 said?

7 A. Yes, and that's just for the initial assessment, to
8 see a mental health clinician, that's the average, but it
9 can be much longer than that.

10
11 Q. In your statement you said:

12
13 "When I was first working with ECAT over
14 10 years ago I saw more patients with
15 depression and psychosis but now we see
16 patients with a wider range of mental
17 health issues."

18
19 Can you elaborate for us what are the wider range of
20 mental health issues that you're seeing?

21 A. Yes, so I think we're seeing a lot more clients who
22 are, as I say, in that psychosocial crisis and have mental
23 health impacts as a result of that. We're seeing a lot of
24 clients whose behaviour and mental health has been impacted
25 with substance use. It's not that those clients weren't
26 there before but I think the increase in the use of
27 stimulants has meant that we get a lot more presentations,
28 I think, with quite agitated and behaviourally disturbed
29 clients who then have mental health impacts as a result of
30 that substance use.

31
32 We still do see clients obviously who are either
33 psychotic or having more traditional presentations like
34 bipolar disorders and more chemically driven depression,
35 but I think we have a greater number of people whose mental
36 health has been impacted by what's going on within their
37 lives, as well as a behaviourally/biologically presented
38 illness.

39
40 Q. Are you able to comment on what proportion of patients
41 who come to the Emergency Department are involuntary
42 patients?

43 A. I couldn't tell you off the top of my head the number.
44 I know that we work very hard to try and keep as many
45 people as voluntary as possible, but there certainly is a
46 component of people who are brought there against their
47 will either by the police under the section 351 that we

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

5
6 Q. Staying in the Emergency Department, when someone's
7 come to the Emergency Department and they've been triaged,
8 where are they physically waiting then?

9 A. So it sort of depends on how they've presented and
10 where they present. If they've presented themselves to the
11 window, unless they're triaged as being at high risk,
12 they'll most likely be waiting in the waiting room. For
13 those clients who may present with police or ambulance, the
14 ED staff will do a triage of their presentation, and again,
15 depending on their risk, they may go directly through to a
16 cubicle or it may be that they go to the waiting room to
17 wait as well.

18
19 Q. You said in your statement that the ED environment is
20 not helpful for patients who present in crisis or who are
21 exhibiting mental illness. Can you elaborate on why it's
22 not helpful?

23 A. I think very much, as we were hearing before,
24 Emergency Departments are very busy places, they're fully
25 lit 24 hours a day. You know, they might turn some lights
26 off at night, but it's never not lit up there. They're
27 noisy, they've got a lot going on.

28
29 Some of the noises that you hear and the voices that
30 you hear across the Emergency Department are not only loud
31 but very distressing. You'll have families in there who
32 are in the process of being given the news that their
33 family member's not going to survive; you've got people
34 coming in with trauma incidents and that's noisy and quite
35 chaotic; you've also got people coming in behaviourally
36 disturbed either because they're substance intoxicated or
37 because of other things that are going on for them at the
38 time, or because of pain, and so all of those noises are
39 sort of constant and 24 hours.

40
41 And when you've come in in crisis and you don't know
42 quite what's going to happen, and you're scared and
43 overwhelmed and you're in this environment where you're not
44 necessarily going to get any sleep, your support people or
45 your family may or may not be there, and people aren't in a
46 position to spend a lot of time with you to provide any
47 reassurance. I mean, we will provide what we can in terms

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

7
8 Q. When someone sees the ECAT team, where is the
9 assessment conducted?

10 A. It's usually in a cubicle. Cubicles in Casey
11 Hospital, some have physical walls, there are some specific
12 rooms that are there, but the majority of cubicles are sort
13 of paper curtains and things that you can draw around to
14 get at least a little bit of privacy. Casey, unlike some
15 of the other departments, doesn't have a specific interview
16 area that we can use to see people, so we're reliant on a
17 cubicle being available.

18
19 Q. Can I turn to the issue of treatment. You've stated
20 that ECAT does not turn anyone away.

21
22 What does that mean? Does that mean everyone who is
23 referred to ECAT gets assessed?

24 A. (Witness nods).

25
26 Q. Do they also receive treatment?

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

40
41 Q. I'd like to go through each of the options but just at
42 the outset can you clarify what they are: one option is
43 admission?

44 A. Yes.

45
46 Q. One option is linking to community services?

47 A. Yep, so that would be more primarily our acute CAT

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

5

6 Q. I will ask you some questions about that. But in
7 terms of the options, is the only other option discharging
8 people?

9 A. By and large they're the sort of acute options. We do
10 have Continuing Care Teams, but when people have presented
11 in crisis that's not normally the sort of treatment that's
12 best suited. It may be that you get followed up by our CAT
13 Team initially and then we look at those longer-term sort
14 of referrals at that point.

15

16 Q. Can we turn first to the option of admission. What
17 proportion of people who present to ED with mental health
18 issues get admitted?

19 A. Look, I think it is sort of between about a third and
20 50 per cent, and then we get skewed a little bit because
21 some of those people coming to the Emergency Department are
22 coming specifically for a bed because our community
23 services aren't able to provide them with that support in
24 the community any more, but that would be the number from
25 the Emergency Department that goes through to wait for a
26 bed.

27

28 Q. You've stated:

29

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

35

36 Can you explain to us, why is that the assessment
37 criteria for whether someone gets a bed?

38 A. Admission to hospital at the moment, so our inpatient
39 unit stay, is around about nine days. The inpatient unit
40 does a great job and they provide containment and support.

41

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

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

6
7 But if we can't keep you safe at home or if you've got
8 to a point with your family and your loved ones, because
9 it's taken quite some time for them to be able to get to a
10 point of getting treatment and support, they are just not
11 in a position to be able to continue to offer that support
12 and we can't keep you safe, then we would again look at
13 hospital and that option.

14
15 Q. When the person is admitted on that risk criteria, is
16 the underlying condition treated or is the crisis just
17 managed?

18 A. So look, they will be started on treatment for the
19 condition itself, but that treatment won't reach a point
20 where we'll see whether it's going to resolve the symptoms
21 or not. For most medications and treatments that we start,
22 and it's really that medication treatment that we're
23 looking at initially, it will take a couple of weeks before
24 I even start to see whether it's having much impact on your
25 symptoms. Mostly I'll know if it's giving you
26 side-effects, that if it seems like the right kind of
27 choice, it will take quite some time from there to see
28 resolution of symptoms.

29
30 So people aren't going home from hospital, you know,
31 with a full recovery of their illness, but medication will
32 be started.

33
34 In terms of the more psychological kind of treatments,
35 again you might speak to somebody during your inpatient
36 stay but that's longer-term work that will happen in the
37 community.

38
39 Q. I'd like to turn to the issue of suicide. You have
40 stated:

41
42 "Admission is necessary where there is a
43 risk of suicide or a high risk of self-harm
44 or harm to others."

45
46 Does Monash Health have experience of people who
47 present to the ED who are suicidal who are not admitted?

1 A. Yes, we do.

2

3 Q. Why aren't all people who present as suicidal
4 admitted?

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

23

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

31

32 Q. If a person is suicidal but is not admitted, what
33 treatment or support is provided in that scenario?

34 A. So some are referred to our acute community team, so
35 they may go to a CAT Team for follow-up. For some where
36 the suicidality may be about that more chronic kind of
37 picture but not an acute experience of it, it would be
38 looking at what the best sort of treatment is for that.

39

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

46

47 Q. Does Monash Health have experience of people who

1 present to the ED, who are suicidal, who are not admitted,
2 and then who die by suicide?

3 A. Yes, we do.

4
5 Q. Have you been involved in reviews of those situations?

6 A. Yes.

7
8 Q. Have there been systematic changes as a result of
9 those reviews?

10 A. Yep, yep.

11
12 Q. Could you outline for us some examples of the types of
13 systematic changes?

14 A. Yep, so we've done a variety of different things, I
15 guess, over the years. One of the more recent ones is
16 quite extensive review about how we do risk assessment and
17 how we capture sort of what I was talking about before,
18 that difference between that very acute picture of
19 suicidality and then a picture of chronic suicidality that
20 may have become more acute, so we've done quite a bit of
21 work in terms of working with our staff and our
22 documentation around trying to be able to predict those
23 sorts of factors better than what we had.

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

32
33 So, if you're sick enough to stay there and wait for a
34 bed we should be checking how you're doing. We've got our
35 medical support for - our ECAT teams going in and starting
36 treatment, rather than waiting to start treatment when they
37 get to the ward. We're getting those staff involved
38 earlier in trying to get those things rather than waiting
39 for people to get to the next stage in their treatment.

40
41 Q. And so, there's been a change to the assessment
42 process, that's been implemented?

43 A. Yes.

44
45 Q. Since that change, has anyone presented to the ED
46 suicidal, not been admitted and then died by suicide?

47 A. Yes.

1
2 Q. In your experience, is that situation unique to
3 Monash's ED?

4 A. I don't believe so, no.
5

6 Q. We were talking about the options when someone
7 presents to the Emergency Department and we were talking
8 about admission. Can we now turn to the issue of when
9 someone is not admitted: what happens in that scenario?

10 A. Yep, so where someone is not admitted they will often
11 go onto our CAT teams for community support, so that's a
12 community-based team, usually geographically located. They
13 will go out and either see people at home or have people
14 come into a clinic to see them. That's sort of the primary
15 team that we offer.
16

17 We also have the APM service, our psychological
18 service, that we can make a referral to, or alternately we
19 can look at what other services are available in that local
20 area that people may be able to access: it may be a program
21 that we're currently involved with called The Way Back
22 where a non-clinical person provides three months worth of
23 support in a catch up with people and also helping them to
24 work through some of the psychosocial challenges that are
25 contributing to their mental health distress.
26

27 It may be other non-government organisations who are
28 able to provide sort of follow-up and support for periods
29 of time.
30

31 Q. One of the options you just referred to is the Agile
32 Psychological Medicine. The Commission has heard evidence
33 that the number of people who could benefit from that
34 service hugely outnumbers the actual referrals they
35 receive; are you aware of that?

36 A. Certainly at the beginning, yes, I was, and I'm aware
37 of the evidence, yes, earlier.
38

39 Q. Can you explain for us what is the barrier, why aren't
40 the referrals making it to the Agile Clinic?

41 A. I can sort of talk to the Casey experience of it
42 probably more than anything else. I know that certainly
43 initially it was a bit of a challenge for people to think
44 about things in that different way, and triage is probably
45 the other area I'm aware of in terms of how they can refer
46 directly into this clinic.
47

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

8
9 Q. You also refer to the fact that you manage a PARC?

10 A. Yes.

11
12 Q. You've said in your statement:

13
14 "PARC performance is not tied to KPIs of
15 any kind but occupancy need is directly
16 linked to hospital demands."

17
18 Can you please explain what you mean by that?

19 A. So I think PARC is - I know there's been a previous
20 witness during the week as well - PARC is a residential
21 recovery service that's available for people to use for a
22 sort of two to four week period depending on the nature of
23 their presentation and their recovery goals.

24
25 What we are finding is that, because of the pressure
26 on beds at that end of the service, we're finding that the
27 kinds of clients that we're having come, is what we call a
28 step-down. So, there's always been the option of people to
29 come from hospital to a PARC to continue to have support,
30 working to integrate back into their home life or going
31 back to work and those sorts of things, that's always been
32 available.

33
34 What we're finding I think more is that people are
35 coming to PARC as well because we needed some place for
36 them to go to be able to create acute beds for people who
37 are coming from Emergency Departments or who need that more
38 sort of contained environment, and that means that some of
39 the clients that we've got are not as engaged in the
40 recovery progress and the referral is more about having
41 some place for them to go to reintegrate to going back
42 home. So it sort of compromises the program to a degree.
43 But people need some place to be, they need that support.
44 There are still things that we can help them with and work
45 on but it just means that things are not exactly the same
46 and the stay is shorter than what it may have been, you
47 know, if I compared it to a couple of years ago.

1
2 Q. Can I turn to the issue of homelessness. In relation
3 to patients who are homeless you've stated:
4

5 "If the patient does not need treatment or
6 admission, we keep them in the ED until
7 accommodation somewhere is found or they
8 are able to be linked to a crisis
9 accommodation service."
10

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

14 A. Yeah, it's unfortunately a growing number. Our
15 information so far suggests I would think probably around
16 about a third are experiencing homelessness, but we
17 consider that quite a broad category, so it's not just
18 people who don't have a home full stop although there are a
19 number of people in that circumstance.
20

21 What we're finding is more and more clients who either
22 financially are not able to afford the housing options that
23 are available, they may have been displaced from home
24 either again because of mortgage stress, relationship
25 breakups, domestic violence. They're not able to return
26 there but they can't afford accommodation to go anywhere
27 else.
28

29 There's also people who, because of the nature of
30 their illness they're just not in a position where they
31 have the skill to sort of manage being in what is some
32 fairly unpleasant accommodation services that are out
33 there. I was hearing the other day of a client who had
34 been sent to an accommodation through an accommodation
35 service to some place that didn't actually even have a door
36 on the room that they could close.
37

38 So the nature of the accommodation services that are
39 available if you either don't have access to any kind of
40 Centrelink or any kind of financial support, or you're not
41 able to return to a home for other reasons, whether it be
42 an AVO or a relationship breakup, your options are very,
43 very limited.
44

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

1 accommodation services - you know, suitable accommodation.
2 People will be put up in hotels for a couple of days which
3 is not sustainable.
4

5 What we find is that, while people are struggling with
6 those sorts of issues, it's incredibly difficult to make a
7 plan about how to engage with a psychologist or a
8 counsellor or anyone around your psychological needs when
9 you're trying to figure out where you're going to sleep
10 safely tonight. And, by the time people get to us, they've
11 often worked their way through couch-surfing and staying
12 with friends and families, and that's no longer a viable
13 option for some of these people either and makes it really
14 difficult for them.
15

16 Q. You've said in your statement that you have staff on
17 the phones in the ED trying to find a place for people in
18 the community. What staff do that role, who's performing
19 that role?

20 A. Primarily it's trying to contact crisis emergency
21 services, and that's ECAT primarily. We've had discussions
22 with our social work services in the Emergency Department
23 but they don't have any better options either, so
24 essentially if we were to ask them for support, they would
25 be providing the emergency accommodation service phone
26 numbers.
27

28 Q. You've also referred to the ED being a stressful place
29 and the pressure on staff. Can you elaborate on the
30 pressures that are experienced by staff in the Emergency
31 Department?

32 A. Yep. So, look, from an ECAT perspective, there isn't
33 ever not really people with a mental health issue in the
34 Emergency Department. I know when I look through, I get a
35 text every morning that tells me how many people are in the
36 Emergency Department, and every morning you start your day
37 with six or seven people in the department that have been
38 there from the night before, some are there waiting for
39 beds, some are there waiting for reviews, some are there
40 waiting for us to try and help with accommodation or
41 linkage to other services because they're being discharged.
42

43 That's sort of where you start, and so, you start
44 working your way through those clients, but in the meantime
45 you've got other clients continuing to come into the
46 department.
47

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

15
16 You've got a department and staff that are also kind
17 of saying, what are you doing? Why are people still here?
18 Where are they going? It's not an easy place to work.

19
20 Q. Finally, Ms Morgan, what changes to the system do you
21 think would help ECAT better meet its objectives?

22 A. Look, I think there is a big gap in terms of people
23 being able to access services before they get to the
24 Emergency Department. I mean, things have been added: we
25 have things like our PACER units which is where clinicians
26 go out with police to try and see people, where things have
27 got to a point where 000 has been called because of
28 emotional distress or the situation in terms of
29 containment, but a clinician who can go out and assess
30 situations there and make direct links to our CAT teams and
31 admission beds as well to try and support people not having
32 to come to the Emergency Department for that assessment.

33
34 But I think, you know, I speak to a number of families
35 and a number of clients who talk about being - you know,
36 knowing that things aren't going well, but not being able
37 to access help, there's a huge gap in terms of being able
38 to identify services who can provide help before it gets to
39 that crisis point.

40
41 And, whilst it was a service that we used to be able
42 to offer in our community teams, the demand at that crisis
43 end now means that we don't get as involved with people in
44 those earlier stages where you could avoid people getting
45 to crisis point.

46
47 And, in terms of the non-government organisations,

1 because they're tendered, because they move, because they
2 change; I know they're there and I have trouble finding
3 them and figuring out who it is and who doesn't have
4 waiting lists. If you don't know the system and you're
5 going to look, it's really, really hard to find people.
6

7 Then, you can look at GP and private psychologists and
8 private psychiatrists, but that's not necessarily
9 financially sustainable. There are not many that actually
10 do bulk bill. So, even though there is government support
11 for accessing those services, it's not necessarily enough
12 sessions or long enough to address the kind of issues that
13 people are trying to deal with, and they don't have the
14 capacity to financially sustain those gap payments and
15 trying to access the treatments and services that would
16 help them to develop better coping strategies or help
17 people to understand their illness better and how to manage
18 it, you know.
19

20 That middle part of the system has kind of disappeared
21 and families understandably are very distressed, that they
22 know that their family member is going unwell, the family
23 member might not think they are, but they know that they
24 are and they don't have capacity to get help for them in
25 the way that they think would be useful.
26

27 MS BATTEN: Thank you very much, Ms Morgan. Chair, are
28 there any questions for Ms Morgan?
29

30 CHAIR: No, thank you very much, Ms Morgan, for your
31 overview this morning.
32

33 MS BATTEN: May Ms Morgan be excused?
34

35 CHAIR: Yes, please.
36

37 **<THE WITNESS WITHDREW**
38

39 MS BATTEN: Thank you. Chair, is now a convenient time for
40 a morning break?
41

42 CHAIR: Yes, thank you very much.
43

44 **SHORT ADJOURNMENT**
45

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

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<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.

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

4 A. That is true.

5

6 Q. Will those situations include times where mental
7 health issues are explicitly called out when police are
8 contacted but also times when it is not?

9 A. Yes, so there's generally three ways that we come into
10 contact with people, and that is either those people who we
11 come in contact through the criminal justice system; there
12 are those that we come across by virtue of calls for
13 assistance, that can be from members of the public, family
14 members, or people in the medical sector; or those that we
15 just come across in everyday policing, including random
16 connections in the street, through traffic intercepts,
17 through attending people who might be victims of crime,
18 road policing intercepts, or attending accidents. There is
19 a broad range of ways we come into contact with people
20 experiencing mental health.

21

22 Q. Do mental health clinicians sometimes ask you to do
23 welfare checks?

24 A. Often. That is a duty that we perform many times
25 every day and to varying degrees of severity, and varying
26 outcomes and varying ways that we would respond dependent
27 on what we know or find out during that contact.

28

29 Q. You've said in your statement that police are not
30 mental health clinicians but are nevertheless expected to
31 make decisions about an appropriate response in those
32 circumstances you've just described, including whether or
33 not to engage other services?

34 A. Yes. In my experience of 38 years, whilst we're not
35 mental health clinicians, you quickly become experienced in
36 recognising attributes of mental health for those people
37 experiencing mental health. Our experience level and our
38 structure around supervision, risk assessment, seeking
39 information prior to engaging someone, in particular when
40 we're called for a planned response to, in particular from
41 a mental health clinician or from the health sector varies,
42 but we try and obtain as much information as we can, and we
43 make assessments based on the facts as they present and
44 take a course of action as those circumstances dictate.

45

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

1 provide guidance to police about how to interact with
2 mental health clinicians?

3 A. There is. The Mental Health Act provides us with
4 legislative powers to do certain things in response to
5 certain incidents. The practice guide, the protocol, has
6 been developed to inform what the legislation allows us to
7 do in a more prescriptive and assisting manner and it's
8 used daily and it's of great assistance.

9
10 Q. Is one way that the Police Act is a conduit between
11 people in the community and the mental health system, by
12 making a referral under the Victorian Police e-Referral
13 system?

14 A. It is. So, there's two streams here, and one enables
15 us to - I suppose we have three options: one is to do
16 nothing if the circumstances dictate that there's no
17 requirement; (2) is to make a referral for a non-crisis
18 issue through the Victoria Police Electronic Referral
19 System, and I'll explain that a bit further in a moment.
20 The third option, of course, if the circumstances present,
21 is for us to enact our powers under the legislation and
22 take that person to a place for assessment or further
23 treatment.

24
25 Q. We'll go back to that in a moment, but can we return
26 to the e-Referral system?

27 A. Sure.

28
29 Q. Sure. So, we have a system, an Electronic Referral
30 System, that is utilised for 26 different circumstances,
31 excluding family violence which has its own particular
32 referral system. For mental health referrals, people
33 experiencing mental health, we gather data, fill in a form,
34 and that is transmitted to Monash Health which has the
35 contract and responsibility with us to receive, triage and
36 action those referrals.

37
38 We have a "no wrong, door approach." By that I mean,
39 the referral may be for someone who has a drug and alcohol
40 issue, as the non-clinically trained police would attend
41 and think that might be the issue, and that might be
42 referred off, but then it might turn out that there's
43 actually a mental health issue, so there's a re-referral.

44
45 And Monash Health certainly work the other way: if
46 they receive a referral for someone who's experiencing
47 mental health and through their contact realise that, well,

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

6
7 Q. So, this as consent-based system for non-urgent
8 situations?

9 A. Yeah, correct, and that can be problematic, is that it
10 has to be consent-based. However, with respect to people's
11 privacy and their human rights we make that call that we
12 don't refer people if they don't consent.

13
14 Q. So essentially, the police officer involved, with the
15 consent of the person, will take their details?

16 A. Yeah.

17
18 Q. And enter them into the portal and then Monash Health
19 will contact the person?

20 A. That is, in essence, what happens.

21
22 Q. Is another more direct way in which the police are
23 involved in connecting people with the mental health system
24 the one you mentioned before, which is where they are
25 called to apprehend someone under section 351 of the Mental
26 Health Act?

27 A. Yes, so that particular provision in the Act, it gives
28 us the legislative power to apprehend people and to take
29 them for assessment. However, that power is not used
30 lightly and it is often the end point of a considerable
31 period of engagement, discussion, intelligence and
32 information gathering from as many areas as we can before
33 we take that decision to apprehend someone, which can be
34 quite traumatic for the person, for their family, for
35 observers, for the police, and to then take them by either
36 police transport, which is not ideal, our preferable method
37 is that they are transported by ambulance if possible.

38
39 Of course, some people experiencing mental health are
40 extremely violent and are extremely, by nature of their
41 illness, irrational and are not able to be talked into
42 going to an ambulance. We would never put ambulance at
43 risk and we have quite good discussions and we have a
44 really good relationship with Ambulance Victoria around
45 what happens.

46
47 In the past there have been significant issues with

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

5
6 Q. Is the objective of doing so, in order to get them
7 more quickly to an Emergency Department?

8 A. Yes, but it's also - it's often done for a couple of
9 reasons. One is that sitting and waiting with a person
10 experiencing mental health issues can sometimes be fine and
11 you'll build up great rapport and assist the family. Other
12 times it heightens their stress, and so we do that.

13
14 There's a practicality too to our service demand
15 requirements. Whilst the police are there dealing with
16 that person, they're not doing all their other duties. It
17 shouldn't be our core duty to be a transport for people
18 experiencing mental health, but practically we realise that
19 sometimes that will always happen, just like we shouldn't
20 be the agency of first resort rather than last resort, we
21 seem to have become the agency of first resort over
22 the years.

23
24 Q. Just following that journey, if you are dealing with a
25 response to a section 351 situation - and we'll go back to
26 the criteria for that in a moment - one option you have is
27 to seek the attendance of the Mental Health Police Response
28 Unit, otherwise known as PACER, to conduct an in-field
29 assessment, and the other alternative is to arrange a
30 transfer to the Emergency Department. Are those the two
31 pathways?

32 A. Those would be and then the sub-pathway to the
33 transport is either us or ambulance, yeah. But the
34 attendance of a clinician through the PACER program is
35 absolutely beneficial, which I'll expand on in due course.

36
37 Q. Yes, we'll get to the PACER in due course. When you
38 get to the Emergency Department, what, if you can say, is
39 the experience of the police in terms of wait times?

40 A. It varies and it has improved, I'd like to say
41 significantly but I can't say that. We work really well
42 with hospitals and Emergency Departments who do their best
43 in a really difficult situation to give priority to police
44 who have presented at their facility with someone needing
45 assessment who's been detained under section 351 of the
46 Act.

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

7
8 One of the barriers is that, the legislation dictates
9 that when we apprehend someone under section 351, we cannot
10 discharge our duty that we've enacted under that
11 section until a person is seen and assessed by a medical
12 practitioner or a qualified mental health practitioner, and
13 appropriate handover and transfer of relevant information
14 has occurred.

15
16 Reading that in isolation you think, oh, that sounds
17 simple enough, but it is a timely, impactful process. I
18 sort of outline sometimes there are multiple police there
19 with multiple patients. We cannot transfer between the
20 police. Once you enact that power, then you must stay
21 there until that is discharged.

22
23 A lot of EDs, of course, are not designed to have
24 police and people needing assessment sitting there with
25 other patients. Some do have areas where they go. You
26 know, they all have security that we can't discharge that
27 responsibly to but do assist, but it's impactful and it
28 doesn't de-stigmatise the experience that mental health
29 patients have because, if the police are there with them,
30 everyone's looking: everyone's looking and I'm not sure
31 what impact that has on other patients, what impact it has
32 on that person themselves. We don't want to be there doing
33 that.

34
35 We realise there is always going to be a role in
36 dealing with people experiencing mental health for the
37 police, we realise that. However, I'm not sure that, as
38 things have changed over time, that there's been a broader
39 more strategic piece of thinking done about what all the
40 impacts are.

41
42 Q. Just collecting the thoughts there for a minute, what
43 are the particular gaps in the system that you see that
44 mean police are performing that role when you really would
45 prefer not to be?

46 A. So, the significant gap I think is that people often
47 go from low-level - "low-level?" - that go from

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

3
4 So, the first time often that police will have any
5 involvement, is when it's reached crisis level. So, the
6 missing middle as it's been described is a significant
7 issue, in my view.

8
9 People who have the ability to engage with
10 practitioners and clinicians and avoid taking that step to
11 crisis generally function and live really well, and we
12 don't know what we don't know because we don't have a lot
13 to do with people who aren't at crisis. So, that is a
14 significant gap, I think.

15
16 The other gap is where we are engaged with people
17 through a whole variety of means: be it a call for welfare
18 assistance or we come into someone who's in crisis at the
19 top end, right back to where people are experiencing issues
20 with family members and, you know, we're the default
21 agency, and we're a 24/7 agency, we have a leadership role
22 in community, I think that's really important, so people
23 come to us. So we will make the referral through the
24 referral system, but sometimes it needs more than that.

25
26 But the ability for us to have one single point of
27 entry into the system that allows us to find out what that
28 person's particular issues, history, needs are, is not
29 there.

30
31 The PACER program that you mentioned before is a
32 classic example of something that works sometimes, in some
33 places at some level, but again it's piecemeal.

34
35 Q. Can I just take you back to what you said a moment
36 ago. You mentioned one single entry point into the system:
37 did you have something in particular in mind when you said
38 that?

39 A. So, depending where the incident occurs, where the
40 police are, where the person experiencing mental health
41 that you're dealing with is, it means a completely
42 different system or process depending on where you are.

43
44 Q. You mean, where you are geographically?

45 A. Yes, so there's no consistent integrated model across
46 Victoria. All the mental health areas work incredibly hard
47 and are incredibly professional and compassionate people in

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

3
4 The ability for us to have one point of entry into the
5 system, to then be appropriately referred to the
6 appropriate area for the appropriate clinician to give you
7 the appropriate advice that helps you risk assess or
8 provide assistance to those needing it is vital, in my
9 view. It is far too complex and inefficient at the moment.

10
11 Q. By one point of entry, do you mean a consistent way of
12 entering the system?

13 A. Yeah.

14
15 Q. Or one portal or both?

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

23
24 Q. And so, would it be fair to say that, as a police
25 force you are trying to meet people's needs and work in
26 with a system that's quite fragmented?

27 A. It is, and we often make it work, but we don't always
28 get it right. You know, there's examples where we haven't
29 got it right. And there's systematic fails or process
30 failures and there's human failures, and we make human
31 failures like everyone.

32
33 But if we had an efficient, consistent, integrated,
34 one service entry across the state that all police,
35 ambulance, clinicians understood and were able to access it
36 would be highly efficient, lessen the stress on consumers
37 of those services; de-stigmatise mental health, because
38 you're not standing around for ages; or you're unsure who
39 to ring, so the person's heightened stress is exacerbated
40 because the police or the other service providers are
41 trying to figure out what's the best possible solution
42 here. If we had a well understood, coordinated system,
43 that would lessen that impact I think.

44
45 Q. Thank you. Can I ask you about the PACERs, which are
46 the Police, Ambulance and Clinical Early Response program.
47 Can you say in short form what that program involves and

1 how it works?

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

8

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

15

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

20

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

25

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

30

31 Q. What would you like to see happen?

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

37

38 Q. Alright, have you been given a date for its
39 commencement?

40 A. No.

41

42 Q. And I take it, you'd like a date for its commencement?

43 A. I'd be very much liking a date, and I'm sure that will
44 happen, we'll now engage and get that to progress, because
45 we see the benefit of PACER; there are numerous examples
46 where it has proved to be extremely efficient, but they are
47 all different models, they all work slightly different, so

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

9
10 I think the need to potentially expand it to a 24/7,
11 365 model --

12
13 Q. Yes, and you mentioned that it's in 19 regions?

14 A. Yes.

15
16 Q. Out of how many?

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

25
26 Q. I see, but your operating premise is that PACER is
27 effective and needed, and you would like it to be enhanced
28 and expanded?

29 A. Well, potentially without getting ahead of any
30 evaluation.

31
32 Q. Subject to that review, yes.

33 A. We would need to see the evidence that falls out of
34 the evaluation, but I would be really surprised if that
35 wasn't an outcome.

36
37 Q. Can I ask you about the Enhanced Critical Response
38 Program. Can you say firstly what is that program?

39 A. So, that's a program that has been developed between
40 NorthWestern Health and our Critical Incident Response Team
41 to deal with high-end critical incidents involving persons
42 experiencing mental health.

43
44 It's a service that actually provides exactly what I
45 just described: a one-stop shop where our trained
46 negotiators who form part of that team can have instant
47 access to a clinician, who can then provide detail of the

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

5
6 It's been really successful, it's been going since
7 2014. It's seen as a really effective tool. In fact
8 last year it was awarded the Minister of Health's award for
9 excellence in helping people with mental health, so it's
10 seen by our key tactical operators, the Critical Incident
11 Response teams and the Special Operations Group who deal
12 with people who are barricaded or high risk or armed with
13 significant weapons, that's seen as a really good model and
14 we look forward to that continuing for a long time.

15
16 Q. Is it available wherever the Critical Incident
17 Response team works across Victoria?

18 A. Yes, it's aligned to that group rather than a
19 geographic area, because it is one clinician - you know,
20 they wouldn't have the capacity to deal with enquiries from
21 all over that don't reach that threshold for the
22 intervention by the Critical Incident Response people.

23
24 Q. Can I ask you now some questions about the amount of
25 time spent by Victoria Police in responding to situations
26 involving mental health issues, people with mental health
27 issues. In your statement you have said that there is
28 certain data that is captured, you don't capture everything
29 but you capture certain data.

30
31 Can we start with this: in 2017-18 police officers
32 were dispatched to approximately 43,000 events coded as
33 "psychiatric crisis and suicide attempt or threat", which
34 averaged across the year means Victoria Police responded to
35 a mental health callout of this nature approximately every
36 12 minutes during 2017-18.

37 A. Yes.

38
39 Q. Can I ask you about the trends in relation to these
40 numbers. Sorry, you go ahead.

41 A. It's increasing. I just got a note of caution I
42 suppose, our data capture and our data integrity around
43 these issues is getting a lot better, but to compare
44 year-to-year-to-year going back would be a little
45 dangerous, I think.

46
47 But we are certainly seeing an ongoing and consistent

1 increase in the number of those types of events that we are
2 being dispatched through and we record that through our
3 computer aided dispatch and through our Comms Centre.
4

5 Obviously Victoria's population is growing, so there
6 needs to be that recognition, that it is in line with
7 population growth, but even taking that into account and
8 even taking into account we have more rigorous governance,
9 supervision and oversight of our data collection now, so
10 that's going to increase as well. Even taking those two
11 things into account, the number of incidents that we're
12 attending is increasing incredibly and it is one of the, if
13 not the pre-eminent issue facing our service demand
14 requirements.
15

16 Q. I'll return to that in a moment, can we just go to
17 some of the numbers. Dealing with the category of mental
18 health transfers, is it correct that there were
19 approximately 14,000 under section 351?

20 A. Yes. So, that's where we apprehend someone under 351
21 and transfer them to a facility for them to be assessed.
22

23 Q. And that was in 2016/17, compared with, say, 2010-11
24 there was a 169 per cent increase.

25 A. Yes. So, again, that needs to be taken into account
26 with population increase and greater data collection, but
27 still, there was an unbelievable explosion in demand for
28 service in that space.
29

30 Q. Then, turning to the question of e-Health referrals,
31 which are the consent referrals in non-crisis situations,
32 your data says that between 2014/15 on the one hand, for
33 which you have data, and 2017/18 on the other, for which
34 you also have data, there was 172 per cent increase?

35 A. Yes, in that three-year period, the data around that,
36 I'd be fairly confident is pretty reflective and pretty
37 right.
38

39 I think it shows a couple of things really: it shows
40 an increased level of awareness and performance of duty by
41 our people, but it also shows a significant increase in the
42 demand for that duty to be performed.
43

44 Q. Can I finally ask you about the rates of police
45 responses to events coded as "psychiatric crisis". There
46 has been an increase between 2014/15 on the one hand and
47 2017/18 on the other of 87.9 per cent; is that correct?

1 A. That's true. And I suppose they go hand-in-glove in
2 terms of how it's coded, is dependent on the information
3 that's received at the time.
4

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

8 A. That is correct.
9

10 Q. Can I ask you about the effect on your capacity, as a
11 service, of that increase in numbers?

12 A. Yes. Obviously, as I said before, we will always
13 respond to those events because it is one of our core
14 duties. And when you think about our duties as outlined
15 under section 9 of the Victoria Police Act where it talks
16 about helping those in need of assistance, I can think of
17 not many other incidents where we must help those in need
18 of assistance, so we do.
19

20 Of course, we have finite resources and our ability to
21 perform our other duties is significantly impacted by
22 high-end events that are discretionary, such as the events
23 we're talking about here.
24

25 The effect on our people too is really a concern for
26 Victoria Police. The emergence of our first responders,
27 not just police but other first responders, but our people
28 experiencing higher than normal rates of mental health
29 illness is a concern. The vicarious trauma or transfer of
30 trauma, the effect it has on our people from attending
31 repeat, high-end, high risk incidents, is something that's
32 a real concern for us.
33

34 Q. Did you say earlier the effect on your capacity was
35 the number one issue for you?

36 A. It's right, we have significant issues around family
37 violence; that's been discussed. Road trauma is another
38 one, but I mean, things that are absolutely non-negotiable
39 and we must attend to involving people with mental health
40 experiences is increasing. Of course, it's not a siloed
41 approach to mental health; the mental health impact is also
42 across a whole range of issues, particularly family
43 violence, particularly youth offending, particularly road
44 trauma.
45

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

1 Commissioners from across Australia dealing with road
2 policing, the increasing impact of the mental health
3 presentations that we're seeing in the road trauma space.
4

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

7 A. Sure.
8

9 Q. You now have a Mental Health Strategy and Wellbeing
10 Action Plan commencing in 2017?

11 A. Yes. So, in 2016 we undertook a wide-ranging review
12 into the mental health of Victoria Police members because
13 we'd seen a rise in people experiencing significant mental
14 health issues. It was quite confronting, we had quite good
15 buy-in from the survey and the data collection that we did.
16 Out of that's come an identification that we need a
17 strategic approach to this, so we've undertaken and
18 developed a mental health strategy and out of that
19 strategy's come an action plan where there are a number of
20 key activities that we all have committed to undertake.
21

22 That's been accompanied by a recognition that it's
23 just not serving police who are experiencing these issues,
24 and we've recently launched - Blue Space is the name of our
25 online portal for serving police, police veterans, but also
26 importantly their families, because the trauma that our
27 police families suffer as well by virtue of living with the
28 issues that serving police experience is really
29 significant.
30

31 It's been accompanied by a level of commitment at the
32 top level of our organisation. You will probably recall
33 last year the Chief Commissioner and the head of the Police
34 Association co-jointly undertaking a large walk to raise
35 awareness around mental health, which was I think really
36 impactful in terms of the vision and the commitment.
37

38 We realise, as a senior police leader, this is
39 something that I think about every day, that I deal with
40 every day, the mental health of my people, and it's a real
41 concern. Just as road trauma, crime rates, all the other
42 things that I worry about from a day-to-day basis, the
43 health and wellbeing of my people is absolutely at the top
44 of all that we think.
45

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

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

3
4 "A significant challenge Victoria Police
5 faces is the increasing ongoing reliance on
6 police responses for people in crisis."

7
8 Which you've already addressed. You've said that it
9 would be very helpful to have better support by having more
10 direct access to clinical services. Can you say what that
11 means?

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

18
19 A simple, efficient way to get that information, I
20 think, is a key to us successfully, efficiently, and in the
21 least impactful way on the person experiencing the mental
22 health issues, I think that's an absolutely vital way for
23 us to do that.

24
25 Q. When you say "a simple, efficient way", is there
26 something you have in mind in particular in terms of
27 getting access to clinical expertise?

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

35
36 The ability for us to, somewhere down the track once
37 that direction is owned, decided upon and brought to life,
38 a key part of that will be our ability to engage and to
39 access what we need to access really quickly, taking into
40 account people's privacy and people's rights around
41 protection, but the longer that we delay, the less concise,
42 relevant clinical information that we get, furthers the
43 harm potentially that is done to that person experiencing
44 mental health.

45
46 Q. You mentioned leadership just a moment ago: what do
47 you see as particularly important about leadership in this

1 space, the context of which is the engagement with Victoria
2 Police with a system existing in various ways across the
3 state?

4 A. So, we have a system that exists that I think has been
5 roundly recognised and it's been commented on at the
6 highest levels of government that the system's broken. I
7 think we can look back why that's happened but I don't
8 think that's particularly helpful because we are where we
9 are today.

10
11 I think everyone's worked really hard and nobly in our
12 own particular areas to do the best we can, but there's
13 been no high-level coordination or leadership of a lot of
14 the services that are being provided, and not only how that
15 service operates for that particular silo but how it works
16 in integrating it with all the others.

17
18 So I think as an outcome, from a health-driven
19 perspective, to provide clear, concise direction around
20 what is trying to be achieved to help people experiencing
21 mental health and to prevent people who might be at the
22 risk of falling into the harm space to be done, that's
23 really quite clear. To provide high level, joined up,
24 coordinated and integrated approaches to what we're all
25 doing for a common purpose, to reduce any barriers that
26 might exist between agencies, even between intra-agency, I
27 think, is absolutely vital.

28
29 But if we keep doing the same thing and expect a
30 different outcome, then I don't think that's realistic.
31 So, there needs to be a recognition of where we are right
32 at the moment and what needs to be done in order to go
33 forward. Certainly, Victoria Police is a key player in
34 that, and we have structures in place at local level and at
35 regional level to deal with these issues, but I think
36 there's a higher piece here and I think there's a piece for
37 health to really own, drive, coordinate and integrate the
38 whole-of-sector approach.

39
40 MS NICHOLS: Thank you very much. Chair, do the
41 Commissioners have questions?

42
43 CHAIR: Professor Fels.

44
45 COMMISSIONER FELLS: Q. Thank you for your excellent
46 evidence, Commissioner. I'm interested in the dollar cost
47 of the police involvement in mental health. You have given

1 us a sort of start on fairly useful time data. I just want
2 to ask you a question on notice, as it were, whether you
3 could think about whether could you give some ballpark
4 estimates of the costs of mental health to the Police
5 Service.
6

7 Just to take one bit of the story, it's only one bit,
8 you gave us some numbers on the number of 43,000 cases, and
9 maybe there are three or four police involved in that.
10 You've given us maybe two or three hours' time, I could
11 think of putting a dollar cost on that one bit of the
12 story.
13

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

17 A. I mean, certainly given - we could take on notice that
18 we could provide, given the data that has been provided,
19 what the cost that we do know, I suppose the broader piece
20 is the cost that we don't know. Because, as I said in my
21 evidence, the impact of mental health across the whole
22 spectrum of policing, not just in dealing with those people
23 who obviously present as experiencing mental health, but
24 the impact that we do on a day-to-day basis with mental
25 health as a causation or a driver would be really difficult
26 to unpack, I think.
27

28 But in answer to your question, we could certainly
29 aggregate or work out the cost of what it's costing based
30 on the evidence that I've given, and we can take that on
31 notice to take away and provide that back to the
32 Commission.
33

34 COMMISSIONER FELLS: Thank you.
35

36 CHAIR: Thank you. Assistant Commissioner, a few other
37 points from me, thank you. Again, I reiterate, a very good
38 overview of the role that the police are playing in
39 response to mental health issues.
40

41 I think the numbers of call-outs that you've described
42 and the police investment that there is and what you accept
43 as part of your responsibility to assist those in need was
44 very important.
45

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

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

3
4 One was a case where you talked about the fact that
5 there was a young person that you were required to assist
6 and, because of the lack of availability of an ambulance,
7 the young woman concerned with suicide ideation was
8 transferred to hospital but she, from all accounts, seemed
9 to spend a very long time in the back of a divi van. I
10 guess that is illustrative of the concern you've already
11 raised about the transport arrangement.

12
13 But is that a frequent occurrence, that sort of
14 scenario?

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

24
25 There will always be need to take some people in
26 secure transport in a police van because of their acts and
27 it's not safe for ambulance staff to do that.

28
29 We take very seriously the responsibility of the care
30 that we have to exhibit when people are conveyed in the
31 back of a van, and we've done a lot of work in what the
32 inside of the back of a divisional van looks like: with
33 cameras and recording and being able to look and seatbelts.
34 Over recent years our infrastructure design has improved a
35 lot to mitigate the risk that it presents but it still is
36 risky.

37
38 To be honest, the last thing we want to do is
39 transport someone in the back of a divisional van if they
40 don't need to be, however practicality says that sometimes
41 we have to do that. But we are very conscious of, even if
42 they are and you're waiting at hospital, there is still a
43 level of care that we have to exhibit and make sure that
44 that person's welfare is looked after as best we can.

45
46 Q. Thank you. The other scenario that you describe was a
47 scenario where there were three call-outs and transfers to

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

3
4 Q. And on each occasion that person not being admitted,
5 although requiring significant police and emergency
6 department presentations. Is that too a --

7 A. That is a regular occurrence, and that scenario which
8 I know of, I know the detail of that one, and that is not
9 unusual. And, of course, we're making non-clinical
10 decisions about what is the need, and the other thing with
11 that scenario is that it was an accelerating scenario where
12 each time there was more aggressive and irrational
13 behaviour that was never going to be dealt with at the
14 scene or by any other way than by an apprehension, a
15 transport and an assessment.

16
17 Our people do get frustrated, probably because we are
18 not trained clinicians, so we do get frustrated by what
19 seems to be sometimes a revolving door around people who
20 are apprehended, taken, assessed and then three or four
21 days later we're back again.

22
23 But we trust the professional clinical diagnosis and
24 treatment options that are put forward and, while it's not
25 ideal, if we have issues we do have a process through
26 liaison officers where we can raise those concerns with the
27 appropriate mental health service area, unpack the reasons
28 why: is there a treatment plan, are there other options?
29 Because it is very time-consuming, very dangerous. That
30 particular scenario ended up being quite dangerous and it's
31 not a place we want to be in unless it's absolutely
32 avoidable.

33
34 Q. We did notice them, and heard you again say in both
35 your written statement and your evidence today that you
36 thought police were becoming increasingly the first
37 responder to many mental health issues, and you helpfully
38 referenced a piece of work that had been done in the UK
39 that we will look at further.

40
41 You have also referenced the important role the PACERs
42 are playing, and we have heard that in the course of our
43 hearings and consultations.

44
45 Just for me to make sure I understand it, I think you
46 said there were 19 PACERs state-wide. When I looked just
47 at the breadth of your responsibilities alone, I think I

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

3
4 What does that mean in terms of the availability of
5 these PACERs to provide the type of support you're saying
6 across the state?

7 A. That's one of the frustrations, I suppose, that we
8 have a really good model that appears to work really well,
9 but it is on a limited geographic basis for a limited time
10 during the day. So, when you see something that works
11 really well, naturally you default, well, that would be
12 really good to have all the time.

13
14 There is a fair bit of flexibility and agility,
15 particularly the clinicians who are engaged and work with
16 our police members in the PACER construct, work
17 tremendously hard and are really professional and engaging.
18 And, it is something that I'm quite strong on that I think
19 goes some way towards answering some of the issues that
20 I've raised as being gaps.

21
22 It might not be the best practice model, but until we
23 get a full and thorough evaluation we won't really know,
24 but I can see it as being something that's not the answer
25 to everything, but it is certainly an answer to a number of
26 the problems that we see as a policing agency.

27
28 CHAIR: Thank you, Assistant Commissioner.

29
30 MS NICHOLS: May the Assistant Commissioner be excused,
31 please?

32
33 CHAIR: Yes, thank you very much for your evidence today.

34
35 **<THE WITNESS WITHDREW**

36
37 MS BATTEN: Chair, the next witness to be called is Sally
38 Jennings. Her evidence is the subject of a restricted
39 publication order. I understand that you will read out the
40 terms of the order.

41
42 CHAIR: The Royal Commission has made an order, pursuant
43 to the Inquiries Act 2014, prohibiting the publication of
44 any information that might identify the next witness. A
45 copy of that order has been placed next to the door of the
46 hearing room.

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

7
8 The Commissioners have also ordered that the hearing
9 of Ms Jennings' evidence will be limited to the people
10 attending the hearing today. For those watching on the
11 life stream, this portion of the hearing today will not be
12 broadcasted. I ask that the live stream now be cut.

13
14 (Live stream cut.)

15
16 MS BATTEN: Thank you. I call Sally Jennings.

17
18 **<SALLY JENNINGS, affirmed and examined: [12.39pm]**

19
20 MS BATTEN: Q. Thank you, Sally. If you just make
21 yourself comfortable and just make sure, please, we can
22 hear you in the microphone.

23 A. Is that okay?

24
25 Q. Yes. You're quite softly spoken, so I'll just need
26 you to speak up clearly.

27 A. Sure.

28
29 Q. And we'll both try and go at a slow pace. Can you
30 please start at the beginning and tell the Commission when
31 you first became seriously concerned about your son?

32 A. Sure. So, just before I start I just want to
33 acknowledge the beautiful boy that my son is, and that he's
34 charismatic and joyful and socially engaged and smart, and
35 he has had the impact of mental illness like many people,
36 so that's why I'm here.

37
38 So, when he was a young child we had some early
39 concerns, but I think he enjoyed primary school and we sort
40 of brushed those off a little bit. As his life became
41 busier in high school and the workload increased and he was
42 engaged with state level sport, he became more anxious and
43 more distressed around his capacity to deal with all of
44 these things.

45
46 And so, some of it might have seemed a little bit, you
47 know, normal teenage angst, but it had gone beyond that,

1 and we discovered that he was self-harming. He hadn't
2 disclosed that to us originally, but it became evident that
3 he was doing that [REDACTED].
4

5 He'd also [REDACTED]
6 [REDACTED] which his brother was witness to, and
7 so, we were attempting to deal with it at home and then it
8 sort of reached a bit of a head and we had to attend
9 Emergency Department with him one evening, and that was the
10 starting point of our dealings with the health system
11 around his mental illness.
12

13 So, he attended the Emergency Department with me, and
14 I wasn't allowed to speak for him: you know, he was in
15 Year 9, a 14, 15-year-old boy, not a particularly chatty
16 sort of boy when he doesn't know people anyway, and he had
17 to, in front of the Emergency Department, explain to the
18 triage health worker that he was suicidal and that that's
19 why he was presenting there. So, that was uncomfortable
20 for him.
21

22 Then we sat down in the waiting room and waited for
23 quite a long period of time, I can't remember the
24 timeframe. Ended up seeing a mental health worker there
25 and, you know, he was quite pleasant. But really, by the
26 time we were there, and my son was really calm, he was
27 relaxed appearing, he was polite and didn't appear to be at
28 a heightened level of distress.
29

30 So, there was the discussion around what the capacity
31 was in terms of the hospital attendance. It was viewed
32 that it wasn't very helpful to admit him, so we received a
33 couple of Valium to take home and took him home.
34

35 So, following that experience, the next day I phoned
36 the GP. My son's always attended the same GP practice so,
37 there's a number of GPs that work, quite a large number,
38 and my son had requested that he see a particular GP that
39 he felt comfortable with. So, when I phoned the GP
40 practice and asked for this GP I was informed that, no,
41 this GP only did mental health care plans for his clients.
42 And, I was curious about that.
43

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

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

6
7 We attended the GP appointment, I attended with him.
8 She did a K10, which is a screening for anxiety and
9 depression, and we had a referral, a mental health care
10 plan done and a referral to a psychologist.

11
12 Q. Just before you go on, why did you attend the session
13 with your son?

14 A. Well, he was a 14, 15-year-old boy, he wasn't inclined
15 to go there and speak for himself in that regard. He's
16 happy to answer questions, but he wouldn't have driven that
17 himself, and I was attending to drive him there and pay for
18 it and whatever else. He was always happy for me to come
19 in. I always asked him, but he was happy for me to come in
20 with him because he preferred not to - he finds it
21 uncomfortable to speak of his own experience.

22
23 So, he started seeing this psychologist. Initially,
24 you know, it was sort of okay and he thought there was some
25 helpful relaxation sort of things that were coming out of
26 it. Then we didn't really get a lot from him about that,
27 he didn't really like to talk about it. I didn't really
28 know what they would be talking about, you know, he doesn't
29 speak very much around his feelings.

30
31 Q. Were you in the sessions with the psychologist?

32 A. No.

33
34 Q. And, why was that?

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

42
43 So my husband got in touch with the psychologist and
44 spoke with him about some concerns and we attended one or
45 two sessions with him. It wasn't particularly revealing,
46 my son didn't have terribly much to say during those
47 sessions and we didn't attend any more. That was sort of

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

3
4 I know the mental health care plan had ran out and we
5 didn't get another one, we used our private health
6 insurance, and my son didn't initiate making appointments.
7 So, I would say, "Do you want another appointment?", I'd
8 make the appointment. He was a little bit ambivalent about
9 it. He went another four times during that Year 10 year -
10 Year 10, Year 11, I'm getting my years mixed up but anyway.
11 Year 11 it must have been, Year 11 year.

12
13 The last session he went to, he was out within about
14 20 minutes, I was just sitting out in the car waiting for
15 him, I'd taken him after school. I said, "Oh, that was
16 quick", and he said, "Well, there wasn't much to talk
17 about." He wasn't really talking to me actually at that
18 point in time, it was really just answering things: he was
19 quite dark, very moody, never really joyful during those
20 times.

21
22 Q. And so, did he stop seeing the psychologist?

23 A. Yeah, he didn't want to go back. When we asked him
24 what he would like to do, he said he wanted to see a
25 psychiatrist.

26
27 Q. How did you go about finding a psychiatrist?

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

37
38 I think there was a lot of assumption that his issues
39 were just a bit of anxiety. It seemed to always be a
40 little bit minimalised, you know, what he was actually
41 going through because he presented calmly. He told him he
42 had a good life and that he had nothing to be anxious
43 about.

44
45 He reluctantly gave us the referral to the
46 psychiatrist but indicated that he didn't feel that that
47 was necessary.

1
2 Q. Just before you go on to that, you mentioned in your
3 statement that you had some difficulty identifying a
4 psychiatrist for your son who was under 18 at that point?

5 A. That's right, yep. So, when we had the referral, it
6 was a matter of who we go to. We spoke with colleagues, we
7 work in health fields, and the recommended psychiatrists
8 were either not available because of not being able to take
9 on new clients, but more importantly most of them were not
10 seeing people under 18.

11
12 So in our area there's one adolescent psychiatrist who
13 works in a paediatric practice. And look, my son,
14 actually, he quite likes him, you know, it wasn't a - you
15 know, after the relationship was built it's not as if that
16 was a problematic relationship, but there weren't options.
17 Anyway.

18
19 Q. And you took your son to see the psychiatrist?

20 A. Yeah, so there was a history-taking period where my
21 husband and I were interviewed separately, as well as my
22 son was interviewed separately. There was a little bit of
23 family history delved into really just about parents,
24 grandparents, that was sort of the extent of it, and I
25 raised some of the issues we had with my son as a young
26 child, which he was quite sort of dismissive of, but came
27 to the conclusion that the treatment should take into
28 account his anxiety and also ADHD.

29
30 And, I wasn't convinced about the ADHD component, he
31 never fit that sort of presentation, he was always really
32 attentive at school. He would have times where he'd want
33 to be really busy and whatnot, but he was never lacking
34 concentration, those sorts of things.

35
36 Anyway, he was started on a medication for an
37 amphetamine derivative medication for the ADHD, and
38 initially the first week or so it was probably okay, and
39 then the depressive, aggressive, really destructive
40 behaviour started. He would just have outbursts and run
41 off for periods of time and we felt really torn about
42 chasing after him because we felt that would inflame
43 things. We didn't want to call the police because he's a
44 very - you know, he doesn't like getting in trouble, you
45 know, he's a very well behaved person.

46
47 He started drinking quite a bit and he took a double -

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

9
10 So in the end, once we were able to get him back home
11 and get him to calm down a bit, he was seriously depressed.
12 I phoned the psychiatrist the next day and, when we could
13 get in to see him later in the week, he said to stop the
14 medication when I spoke to him on the phone, and then he
15 saw him later in the week and felt that there was a mood
16 component to his issues, and talked about starting him on
17 medication to impact his mood with the idea that maybe
18 then, once his mood was addressed, retry the medication
19 later.

20
21 Q. If we move to late 2017, you've said that your son
22 didn't want to go back to school but, as the medication was
23 taking effect, he thought that he might.

24 A. So, he graded up into this medication, it had to be
25 gradually increased. We had a trip away with him and then
26 he really was feeling, over the November-December, that he
27 just didn't want to - he did really well with a couple of
28 VCE subjects at the end of that year, surprisingly, and
29 then felt that he just couldn't manage it.

30
31 But then, as the medication kicked in, he started to
32 be open to sort of going back doing maybe one or two
33 subjects. The school was very supportive, so by the time
34 we got to January, sort of later in January, he was
35 agreeable. We'd met with the school, the coordinator and
36 his home room teacher, and he was happy to go and do the
37 three remaining subjects that would complete his VCE and he
38 was really well supported by his home room teacher
39 throughout that year. That was a bit of a light in the
40 tunnel really.

41
42 Q. Was he put back on the medication at this point?

43 A. Yeah, so he recommenced - I think it was
44 around February or March - he recommenced the ADHD
45 medication and it had a much quicker negative response at
46 this time. So, he became aggressive really quickly, he
47 became seriously depressed really quickly. He was really

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

8
9 But again, that was the catalyst to stop the
10 medication, review things with the psychiatrist, and he
11 commenced on some anti-anxiety medication as well instead
12 of the - so he was on the mood and the anti-anxiety and
13 some sleep helping medication.

14
15 Q. Just before we move to that point. When he's on the
16 medication you talked about a situation where your whole
17 family had to physically be on top of him.

18 A. That's right, so those were very aggressive times. We
19 felt that he was really in danger of harming himself. He
20 was taking off. He was never violent towards us, he was
21 violent towards himself, so he'd crash himself into the
22 garage, he'd be hitting himself, he'd start running off as
23 if he was going to run out the gates.

24
25 And on a number of occasions my husband and I and his
26 oldest brother sort of ended up landing on top of him, and
27 he'd calm down with the physical pressure of us being on
28 top, and then he'd listen to what we had to say and he'd
29 say he wasn't safe and he wanted to go into Emergency. So,
30 we had a couple of Emergency trips during that time.

31
32 One of them, again, the repeated speaking to triage
33 which was uncomfortable, and he was always calm when he'd
34 get there, so again, I think they didn't take his
35 presentations - it didn't feel like they took his
36 presentations seriously.

37
38 The mental health workers on one occasion were talking
39 about, you know, "Oh, my middle daughter's anxious too,
40 anxiety's a normal part of life." Another occasion, the
41 last occasion which had been a really serious event
42 following the car theft, we took him in and the worker was
43 talking to him about cognitive behavioural therapy and this
44 sort of thing, and I said, "Well, that would be fine
45 possibly down the track, but at the moment he's here
46 because he's suicidal, so that's what we need to address."
47 And at that point he just sort of slipped into action and

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

6
7 Q. And, how old was your son at this point?

8 A. He was 17 at that point.

9
10 Q. And he was quite tall?

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

20
21 I was advised I'd have to pick him up at 7 am before
22 the handover because he wasn't actually admitted to
23 hospital. I'd have to be there before 7 to take him. So,
24 I attended in the morning and took him home, he was fairly
25 outraged by the whole not sleeping; anyway.

26
27 Q. Can you describe for the Commission what the impact
28 has been on your son's life in dealing with a mental
29 illness?

30 A. I think he experienced a lot of shame around his
31 presentations, particularly with the way it didn't seem
32 that he was being listened to or the severity that he was
33 feeling was not being acknowledged.

34
35 He has since, in preparation for this experience for
36 me, he's read my statement and made some comments around
37 how shameful it made him feel attending Emergency in those
38 ways. That he didn't find the psychologist helpful. And I
39 think that may work for some people, but as a default
40 setting for young people I don't know if that's a
41 particularly helpful way to go about it.

42
43 I think, to have GPs decide whether they will or they
44 won't do mental health care plans, and having people that
45 he didn't even have a relationship with doing them with
46 him, and the language they used and the assumptions they
47 made because of his calm presentation, there wasn't even

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

3

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

8

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

15

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

22

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

25

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

30

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

33

34 CHAIR: Thank you.

35

36 MS BATTEN: And may Ms Jennings please be excused?

37

38 CHAIR: Yes, you are excused, thank you.

39

40 **<THE WITNESS WITHDREW**

41

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

44

45 CHAIR: Yes, adjourn for lunch.

46

47 **LUNCHEON ADJOURNMENT**

1
2 UPON RESUMING AFTER LUNCH:

3
4 MS BATTEN: Commissioners, the next witness is Mr Simon
5 Thomson. I call Mr Thomson.

6
7 <SIMON ANDREW THOMSON, affirmed and examined: [2.00pm]
8

9 MS BATTEN: Q. Thank you, Mr Thomson. If you can just
10 make yourself comfortable and make sure we can hear you in
11 the microphone.

12 A. Can you hear me okay?

13
14 Q. Yes, thank you. Have you, with the assistance of your
15 legal team, prepared a witness statement for the Royal
16 Commission?

17 A. I have.

18
19 Q. I tender that statement. [WIT.0003.0001.0001]

20 Mr Thomson, could you start by explaining to us your
21 current role and responsibilities, please?

22 A. My incumbent role is as a Regional Director with
23 Ambulance Victoria. I am responsible for the Barwon South
24 West region of the state, one of seven regions that operate
25 within Ambulance Victoria. My role encompasses the
26 management and supervision of road ambulance service
27 delivery for both the emergency and non-emergency ambulance
28 services, and I'm also responsible for the quality and
29 safety of care provided by paramedics and our first
30 responders in that region.

31
32 Q. Can you explain to us, where does Ambulance Victoria
33 fit within the mental health system?

34 A. So Ambulance Victoria is a responder to patients in
35 mental health crisis and calls to the 000 service, and we
36 also have a series of roles that are prescribed under some
37 of the legislation, which I'm happy to go through.

38
39 Our role in providing response to the 000 call in the
40 way that that system works is that patients or carers may
41 call 000. That call is received by the Emergency Services
42 Telecommunications Authority on Ambulance Victoria's behalf
43 and is then subjected to a non-clinical triage where they
44 ask a series of questions about what the problem is.

45
46 Then the case is determined in terms of its level of
47 seriousness and determined to be either an emergency or a

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

8
9 For cases that are time-critical, where they're
10 life-threatening, or potential harm, an ambulance will be
11 responded. Sometimes under emergency conditions if it's
12 life-threatening, lights and sirens, or we'll attend within
13 an hour to see that patient and assess them and provide a
14 plan about their care.

15
16 Q. I want to step through that a bit more slowly, and we
17 have a slide that we can pull up to assist with that. May
18 we have the slide up? Thank you. [WIT.0003.3000.1000]
19 initially when there's a 000 call there's a non-clinical
20 triage?

21 A. That's correct.

22
23 Q. And at that point the calls are categorised?

24 A. Correct.

25
26 Q. How are they categorised?

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

36
37 Q. With the calls that are non-time critical, the further
38 triage process, dealing specifically with mental
39 health-related calls, could you explain to us what that
40 secondary triage process involves please?

41 A. So, the secondary triage process is also known as call
42 referral. So, paramedics and nurses, and more recently
43 mental health nurses, assess callers and assess the
44 patients over the telephone. We use a system called
45 Adastra which is a secondary triaging system that allows
46 them to assess the patient; in the case of mental health
47 patients, around risk in particular, and then look for a

1 solution. So, some of the solutions could include
2 referring that patient to an area mental health service
3 where they might already be an existing patient; to refer
4 the person or the patient to community mental health
5 services, or indeed refer the case back for the response of
6 an ambulance to go and assess the patient in the community.
7

8 Q. Why has Ambulance Victoria set up that secondary
9 triage for the mental health cases?

10 A. Secondary triage is set up for a whole variety of
11 cases, not specifically for mental health cases. But in
12 the case of mental health patients, there are many calls to
13 the 000 service for patients experiencing mental health
14 issues in the community: some of those are clearly
15 crisis-related and some of those are for patients who
16 clearly have not been able to access other services, so
17 they've called 000. The purpose of having a mental health
18 nurse assess them is to ascertain the best way to deal with
19 their call that day.
20

21 What we have seen since the introduction of that
22 mental health nurse in 2017 and that service is a
23 considerable reduction in the amount of times that we're
24 sending ambulances out to see those patients because we've
25 been able to better network them back into those
26 responsible for their care, which might be back into GP
27 services, it might be back into area mental health services
28 or into community mental health services, so that the
29 reason for their call can be dealt with on that day by
30 somebody else who's better equipped to do that.
31

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

35 A. Yes.
36

37 Q. We might take the slide down, thank you. Could you
38 explain the role of Ambulance Victoria under the Mental
39 Health Act, what are your obligations under the Act?

40 A. So Ambulance Victoria under the Act has a series of
41 responsibilities and paramedics are authorised persons
42 under the Act, which provides for responsibilities and
43 powers that allow them to assist with the management of
44 mental health patients.
45

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

1 to hospital against their will. It provides for paramedics
2 to provide interventions and treatment which can include
3 sedation and restraint to be able to safely transport
4 patients to hospital. It provides provisions for
5 searching, so it allows paramedics to conduct searches in
6 an effort to make sure that a mental health patient isn't
7 carrying any weapons. It also allows paramedics to enter
8 premises where they believe that someone who is subject to
9 an order who's required to be conveyed to hospital is;
10 however, it would be my experience that those things very
11 rarely happen without the police's assistance.
12

13 Q. Does Ambulance Victoria experience challenges in
14 trying to comply with its obligations under the Mental
15 Health Act?

16 A. I think that there are a series of challenges around
17 the Mental Health Act, and in particular around conveying
18 patients around the state. As I'm sure the Commission
19 appreciates, there are different area mental health
20 services. So, Ambulance Victoria is responsible to convey
21 patients subject to orders between mental health services.
22

23 The mental health service is obviously geographically
24 based according to where people live, so we do spend time
25 moving patients around the state and repatriating them to
26 the mental health service that has historically been
27 responsible for their care over that time.
28

29 Q. So that's effectively a transport service, isn't it?

30 A. So effectively we're moving people around to
31 repatriate them to a particular mental health service.
32 Even though they may no longer live there, I think there
33 are examples of where people move around the state, and
34 particularly people who are homeless and patients who are
35 homeless, end up being repatriated to mental health
36 services that perhaps no longer provide a service in the
37 area that they wish to live.
38

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

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

4
5 Q. Can I ask you some questions about the proportion of
6 time Ambulance Victoria spends assisting people with mental
7 health presentations. The first question is, how is a
8 person determined to be a mental health presentation?

9 A. So a mental health presentation or a primary mental
10 health presenting presentation in the data is as a result
11 of taking information from the 000 call service,
12 information from our referral service, and information from
13 the electronic patient records that are completed by
14 paramedics when they see patients, and matching up the
15 disposition in that information to ascertain that it was a
16 mental health-related complaint.

17
18 One of the challenges we have in the dataset is that a
19 mental health condition, a mental health illness can
20 contribute to a physical illness and we lose that in the
21 data. So, where someone who suffers from mental health
22 illness perhaps presents with another medical problem,
23 albeit that the mental health illness was possibly a
24 factor, that won't appear in the data, so we think that
25 it's potentially under-reported in terms of the amount of
26 cases that we see in the community where the patient's
27 primary problem is a mental health-related issue.

28
29 Q. Are there guidelines to ensure consistency with how
30 things are reported, or do each of the different parts use
31 their own outline?

32 A. There's a standard that's applied, so these are all
33 drawn out of lists. Obviously the paramedics have the
34 option, where things don't fit the category, to select
35 something like "Other". That's one of the challenges in
36 the dataset, where a patient might be referred to as having
37 a condition that was "Other" when in fact it may have been
38 a mental health-related condition.

39
40 Q. So that's how a case is determined to be a mental
41 health presentation, and of the calls to 000, what
42 percentage of those relate to mental illness?

43 A. So, of the calls to 000 - sorry, I just have to refer
44 to my statement.

45
46 Q. No, you're fine.

47 A. 11 per cent of the calls to 000 were determined to be

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

6
7 In terms of calls further to that, there are 190,000
8 calls received by the secondary triage referral service,
9 and in 2018, of those calls, 25,000 or 12 per cent were for
10 a primary mental health-related issue.

11
12 Q. Can you explain to us what proportion of the 000 calls
13 that relate to mental health, what proportion of those
14 result in a transfer to hospital?

15 A. Of the calls that an ambulance attends, 82 per cent of
16 those patients are conveyed to hospital; 18 per cent of the
17 patients are not conveyed to hospital, which means that
18 they have been referred to a mental health service, maybe
19 an area mental health service, referred to a GP service, or
20 indeed there wasn't a mental health-related presentation
21 and the patient was able to refuse and stay at home.

22
23 Q. Aside from taking to hospital and referring to a
24 service, what capacity is there for Ambulance Victoria to
25 treat mental health situations when they respond to a call?

26 A. I guess in the instance where a patient needs to be
27 taken to hospital, the paramedics are equipped and skilled
28 to be able to assess the patient. We have a series of
29 clinical guidelines that support that, and I guess in cases
30 where patients are unwilling to attend, the police
31 potentially will attend as well and then the patient is
32 able to be managed and treated with restraint and sedation
33 if required - hopefully not - and conveyed to the hospital.

34
35 The paramedics are also in a position to make
36 referrals to other service providers. That does represent
37 a series of challenges for us. Each of the area mental
38 health services have different in-bound numbers, they have
39 different services that are provided, and there is
40 considerable amount of time that's required to make that
41 referral currently, which I think drives in part why
42 paramedics take patients to hospital, because it seems at
43 the time to be the most expeditious approach.

44
45 Q. Can you just explain that for us: what is the time
46 involved in making a referral, why does it take long?

47 A. So, for some of the area mental health services they

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

13
14 Q. Is there no special line for Ambulance to get through
15 to area mental health service? Or are you in with
16 everybody else?

17 A. So, we join the queue along with the consumers and the
18 other health professionals who might be calling. It does
19 vary a little bit between services. The lack of
20 consistency in the service has represented a challenge for
21 paramedics. Ambulance Victoria is a state-wide service,
22 paramedics work in different geographic locations that are
23 covered by different area mental health services, so it can
24 be challenging in understanding the services that are
25 offered in each geographic catchment and indeed they all
26 have different in-bound phone numbers to contact their
27 triage or assessment service.

28
29 Q. In terms of referring people to other services, does
30 that become even more challenging outside business hours?

31 A. Absolutely.

32
33 Q. And how so?

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

41
42 It's a considerable challenge for Ambulance Victoria
43 and for members of the community who experience mental
44 health issues and crisis outside of those hours, and that
45 results in more people being taken to Emergency Departments
46 because there are fewer options in terms of coming up with
47 a strategy for them on that particular occasion.

1
2 Q. Can you tell us, what's the median case time
3 attendance where the primary issue was mental health?

4 A. Where paramedics attend for a mental health patient,
5 the median time is just over 90 minutes.
6

7 Q. Can you explain to us how that's measured, how do you
8 calculate that time?

9 A. The time is measured from the time that the call is
10 placed to 000 until the time that the ambulance crew and
11 the paramedics become available again to respond to another
12 case.
13

14 What we know for patients experiencing mental health
15 issues who are transported to hospital by ambulance is that
16 there can often be extended waiting periods for them to be
17 seen at the Emergency Departments. Emergency Departments
18 are very busy, and for mental health patients that can
19 often result in waiting. In many cases the paramedics and
20 in some cases the police are also having to wait with that
21 mental health patient until they can access an appropriate
22 place within the Emergency Department to transfer and hand
23 them over to the care of the doctors and nurses in the
24 Department.
25

26 Q. Just to clarify, when you talk about the proportion of
27 Ambulance Victoria's time is spent dealing with mental
28 health presentations; in your view, is that a big or small
29 proportion of Ambulance Victoria's time?

30 A. Well, it's a significant portion of time. If we
31 consider that it's over 10 per cent of our work, that's a
32 considerable period of time. We estimate it's about
33 90,000 hours of time. One of the challenges is that we
34 don't have specific information to present to the
35 Commission today, but based on the median time and the
36 volume of cases we have, it is over 90,000 hours of
37 resourcing time spent working with mental health patients
38 and transporting mental health patients in the community.
39

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

41
42 "The number of mental health patients being
43 managed through referral has increased
44 overall with more patients being risk
45 assessed as requiring an emergency response
46 reflecting the safety net provided by
47 referral."

1
2 Can you elaborate on this in terms of the volume of
3 patients?

4 A. So what we know, and certainly having put the mental
5 health nurses into the referral service, we've seen a
6 decrease in the amount of ambulance responses required to
7 patients in crisis. In the community, however, the
8 volume of cases that are dealt with by our referral service
9 for mental health patients - I will just have to refer to
10 my statement - is considerable and it's growing
11 disproportionately compared to the growth that we see in
12 the referral service generally.

13
14 So the referral service growth for other case types is
15 about 9 per cent per annum, and for mental health patients
16 it's 12 per cent per annum in terms of the numbers of calls
17 that are being dealt with by the referral service triage.

18
19 Q. Can I ask you about the complexities of the cases that
20 you are seeing. What are the trends in relation to the
21 complexities of mental health incidents?

22 A. Sorry, I'll have to refer to my statement again.

23
24 Q. So, from paragraph 39 you talk about the complexities.

25 A. Sorry. We compared data between 2015 and 2018 to
26 consider some of the changes in the types of presentations
27 that we may have seen for patients in the community. What
28 we have seen is a number of patients seen by paramedics
29 with a clinical presentation of suicide or suicidal
30 ideation increase by 52 per cent when we compared 2015 with
31 2018.

32
33 Likewise, patients presenting with psychosis increased
34 by just over 21 per cent in that same, comparing those same
35 two periods. And interestingly enough as well, the number
36 of emergency patients with substance-related issues, which
37 can be a considerable driver around exacerbation of mental
38 health issues, increased by 22.6 per cent for the same
39 comparison.

40
41 So, we would say that the complexity and the acuity of
42 patients with mental health issues in the community, when
43 we look at 2015 compared with 2018, seems to be increasing.
44 So, patients are presenting with more serious and more
45 acute problems when we compare those two periods.

46
47 We felt it was also useful to have an observation

1 about the work that we do with Victoria Police. So,
2 obviously Ambulance Victoria works with Victoria Police
3 often for patients who are presenting with mental
4 health-related issues, and proportionately police attend
5 30 per cent of the time to those cases, which was static
6 between 2015 and 2018. And whilst the volume, the number,
7 would have increased over that time, the proportion remains
8 stable.

9
10 Q. Are those figures for the whole of Victoria, is that
11 what they relate to?

12 A. Correct.

13
14 Q. How does that compare to what you're seeing on the
15 ground?

16 A. I think the data supports some of the challenges that
17 we have around mental health patients and the acuity of
18 mental health patients that are presenting. We know that
19 there are challenges about accessing - particularly
20 accessing beds for acute mental health patients and
21 accessing care. We think that is demonstrated in the data
22 when we see patients that are presenting with more serious
23 problems, we're seeing more people who are at risk of
24 suicide, we are seeing more people who are unwell with
25 psychosis in the community, and either they are, or other
26 members of the community or their family or carers are
27 calling 000 in an effort to access care for them.

28
29 Q. You referred to the fact that police attend in
30 30 per cent of the cases with Ambulance Victoria; is that
31 right?

32 A. That's correct.

33
34 Q. Is it the case that Ambulance Victoria would attend
35 70 per cent of crises without the police attendance?

36 A. That's correct.

37
38 Q. What is it that determines whether or not the police
39 come?

40 A. So, the police attendance will be influenced by a
41 variety of factors. If at the time of call there is any
42 indication that there is violence or aggression, and we've
43 spent a considerable amount of time and training over the
44 last four years in particular with our paramedics around
45 occupational violence, so looking for triggers and
46 indicators that there may be violence at those scenes; if
47 that was the case, then the police would be asked to

1 attend.

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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.

1 Later that same evening Ambulance were called again to
2 the same railway station and encountered an identical
3 situation to the previous one with the same patient, and
4 the patient was again apprehended by police under
5 section 351 and conveyed to hospital.
6

7 On that same day, at almost midnight, Ambulance
8 Victoria was called to a different railway station in the
9 southeastern suburbs of Melbourne and encountered the
10 patient expressing suicidal ideation and attempting to
11 access the railway tracks once again. The patient on that
12 occasion requested that the paramedics take him back to
13 hospital, which they did.
14

15 Two days later, Ambulance Victoria were called to a
16 railway station in the Central Business District where the
17 same patient was again expressing suicidal ideation and
18 attempting to access the railway tracks. He was
19 apprehended again under section 351 of the Act. He was
20 again transported to hospital. In that case it was one of
21 the hospitals that he had been recently discharged from and
22 was handed over to the staff at the hospital.
23

24 Later that same evening Ambulance Victoria attended
25 that same patient again in an inner metropolitan suburb.
26 He was again upset, expressing suicidal ideation, and on
27 that occasion escalated and ultimately was restrained with
28 the assistance of the police and ended up being detained
29 and handcuffed and he was transported to hospital again
30 under section 351 of the Mental Health Act.
31

32 In terms of summarising that case, the patient
33 required ambulance attendance six times over a three-day
34 period. It was a total of nine hours of involvement from
35 Ambulance Victoria paramedics in assessing him and taking
36 him to hospital and working with the police.
37

38 There are a number of complex issues that fall out of
39 the case study. One of the challenges in this particular
40 case is that this man was homeless, he was of no fixed
41 abode. When he was taken to the first area mental health
42 service, they were able to check his information within the
43 mental health information system as it exists, and he was a
44 patient that was not of their catchment, he was a patient
45 of a catchment in Regional Victoria, and had care plans and
46 the like, albeit that they were old.
47

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

5
6 There was considerable resourcing demand. So, this
7 patient took a lot of resources from the Ambulance Service,
8 from the police and from all the different hospitals who
9 were involved in his care over what was only a three-day
10 period of time. The challenges in that is that we don't
11 have access to the mental health information system, so we
12 can't look up that patient's care plan to ascertain who the
13 area mental health service is that is responsible for his
14 care, what the care plan is. Indeed, in these cases
15 they've re-presented him back to the same hospital and the
16 same health service each time, which I think from an
17 escalation of his mental health condition would have been
18 very useful rather than him starting from scratch again at
19 each of these health services as he presented to them.

20
21 Currently Ambulance Victoria is not able to access
22 that information as it's contained within the patient's
23 mental health records because of the way that the Act is
24 constructed. We see that that is a significant challenge
25 in terms of coming up with good strategies and good
26 connected strategies around care for patients and, for this
27 gentleman, he didn't receive the care that he possibly
28 could have received if we had access to that care plan and
29 that strategy.

30
31 Q. Can you explain to us what the PROMPT pilot is?

32 A. We have a second case study which I'm happy to go into
33 which talks about the PROMPT pilot. So, PROMPT stands for
34 the Prehospital Response of Mental Health and Paramedic
35 Team, it's a pilot that's been conducted in Greater
36 Geelong. It's an initiative between Ambulance Victoria and
37 Barwon Health. They provide the area mental health service
38 in Greater Geelong. The PROMPT Team puts a paramedic and a
39 mental health clinician together to respond to mental
40 health cases received by Ambulance Victoria, are both
41 crisis-related responses and also lower acuity responses,
42 so they receive referrals from our call referral service
43 and from the mental health nurses who work in the call
44 referral service in the Greater Geelong area.

45
46 Q. Could tell us about --

47 A. I'll maybe go on with the case study?

1
2 Q. Yes, please. Could you just, at a high level, tell us
3 how that panned out in this case study?

4 A. So, the pilot's currently running, it concludes at the
5 end of this month. There was a particular case that we
6 thought demonstrated how, when we do things differently, we
7 have an opportunity for improvement.
8

9 So this is a 32-year-old man with a significant
10 longstanding history of schizophrenia, very well-known to
11 the mental health services at Barwon Health, and he was
12 also being case managed through a local community-based
13 mental health service. He presented with suicidal ideation
14 and a call to 000 resulted in the PROMPT Team attending.
15

16 For this particular patient he had been experiencing
17 exacerbation of his symptoms from his schizophrenia and he
18 called 000 because he was quite agitated and was
19 experiencing suicidal ideation.
20

21 The PROMPT Team responded. When they arrived the
22 mental health clinician was familiar with him so it was a
23 patient that she had been involved in the care of
24 previously and they were able to look up his current care
25 plan and his current, I guess, support mechanisms that he
26 has around his care and then to assess him.
27

28 What became immediately obvious was that the problem
29 was that he'd actually ran out of his antipsychotic
30 medication and hadn't been taking it for the last four
31 days. What the PROMPT Team was able to do was to liaise
32 with a duty psychiatrist from the area mental health
33 service, receive a prescription for him so that he could
34 have his medication. They were able to source a supply of
35 the medication for him, take it to him, he was able to take
36 the medication. He was able to stay at home, it was
37 assessed that the risk was reasonable, that he would be
38 able to stay at home. He was cared for by his family and
39 then they followed up with him the subsequent day and he
40 had had a significant improvement in his condition.
41

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

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

13
14 So, the PROMPT service in that case provided a much
15 better outcome most importantly for the patient but a much
16 better outcome for the system. So, taking people who are
17 experiencing thought disorders into really busy Emergency
18 Departments is really not a very optimal way to care for
19 them, and in this case he was able to stay at home. And
20 increasingly became well, so there was subsequent
21 follow-ups with him through the mental health service, and
22 after he was taking his medication, by the end of that week
23 he was considerably better, which I think demonstrates that
24 when we do things differently, we can get better outcomes.

25
26 Q. We just have to go a bit slower, sorry, for the
27 transcriber.

28 A. Sorry.

29
30 Q. You were referring to the area mental health service.
31 Can you tell us about what support Ambulance Victoria needs
32 from mental health services in order to be able to fulfil
33 its role optimally?

34 A. I think access is one of the significant challenges.
35 It's cleverly evident that mental health services are under
36 considerable strain in terms of the demand for their
37 services. That results in decreased access for Ambulance
38 Victoria in terms of accessing their triage services and
39 their clinicians to be in a position to come out and see
40 patients. That results in patients being taken to
41 Emergency Departments because there aren't other options
42 for them.

43
44 So what we need from the area mental health service
45 first of all is access. I think the other challenge that
46 we see within the system, if indeed we describe it as a
47 system, it's sort of a whole lot of parts that deliver

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

10
11 I think the other thing we need for the mental health
12 service is an opportunity to collaborate in the care of
13 mental health patients. If indeed our role is about
14 responding to crisis, it's about responding to patients who
15 are having crisis in the community, we need to be able to
16 collaborate with mental health services to have plans for
17 those patients where they're known to them so that we can
18 support a better outcome for them.

19
20 So, if the outcome is about access to an inpatient
21 service within an area mental health service, that that's
22 achieved in a caring and considered way and avoiding busy
23 Emergency Departments and other services that don't deliver
24 good experiences for those patients.

25
26 Q. Can I deal with two final topics, the first one is
27 education. You've said in your statement:

28
29 "AV is aware that many paramedics do not
30 feel adequately equipped to manage and care
31 for patients with mental health issues."

32
33 What are you referring to there; what are you aware
34 of?

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

41
42 What the study tells us is that paramedics don't feel
43 confident in dealing with complex mental health patients
44 and that there's an opportunity for us to consider how we
45 might built more capability for our paramedics or indeed
46 how we might better respond to complex mental health
47 patients' needs in the community to better support our

1 paramedics: whether that be through specialist teams or
2 through better capability development with education or
3 partnering with the area mental health services.
4

5 Q. Can you describe in more detail what are some of the
6 specific gaps you see in the current education?

7 A. So education for paramedics. So, paramedics complete
8 an undergraduate degree to be able to be registered as a
9 paramedic in Australia. The training is delivered across
10 many different jurisdictions. So, paramedics who come to
11 work here in Victoria could have trained in New South Wales
12 or Queensland. The content of the courses is variable
13 around managing patients with mental health issues.
14

15 So, there's an opportunity to have some engagement,
16 perhaps with the Paramedicine Board, about what the base
17 standard around education for managing mental health
18 patients are.
19

20 I think over time we have seen paramedics more
21 involved in managing more patients with more acute problems
22 in the community and an exacerbation of the mental health
23 illness. We need to build more capability in our staff,
24 particularly around risk assessments. I think for
25 paramedics attending patients, particularly patients who
26 express self-harm or suicidal ideation, there is an
27 opportunity to build more capability to understand that
28 better and have better risk assessments, and in turn be
29 able to refer patients appropriately to services so we're
30 not taking everybody who presents with that type of problem
31 to an Emergency Department, which is one of the challenges
32 that we have today.
33

34 Q. Finally, you've referred to collaboration with mental
35 health services as being something that would improve the
36 delivery of Ambulance Victoria's services. Are there any
37 other changes that you want to raise now that you think
38 would bring about lasting improvements to help people
39 affected by a mental illness, particularly in crisis
40 situations, from Ambulance Victoria's perspective?

41 A. I think I've mentioned some of them in the evidence
42 already. I think collaboration and the sharing of
43 information, so access to information about patients' care
44 plans so that we can work together to come up with good
45 solutions and good strategies for them in terms of their
46 care. That may very well go to the information that's held
47 within the mental health information systems as they stand.

1
2
3 I think there are definitely challenges, and our view
4 is that there are challenges around the way that the system
5 is structured in terms of area mental health services, and
6 the need to consider a more collaborative approach
7 collectively across the mental health services so there is
8 indeed a system of care.

9
10 We draw comparisons to other systems of care that
11 exist for other health-related complaints in Victoria. So,
12 we have a system of care for patients who suffer strokes,
13 we have a system of care for patients who suffer trauma,
14 which is above I guess the individual services that are
15 offered in particular geographic areas by particular health
16 services. So, we see that there is an opportunity to have
17 a more systematic and coordinated approach around the
18 management of mental health patients and their access to
19 care.

20
21 We believe that partnering with and having more open
22 communication with the area mental health services about
23 patients only serves to improve the outcomes for the
24 patients and also to have options for patients who are
25 presenting in crisis. The responsiveness of the mental
26 health services to our requests for assistance, or the
27 police's requests for assistance represent a significant
28 challenge, and I think it comes to that, in an emergency
29 service context we work in minutes and seconds: mental
30 health services work in days, weeks and months in terms of
31 their care for patients, so there is an obvious difference,
32 if you like, in terms of how we deliver our services.

33
34 So, if we can connect that, if we can have a
35 coordinated approach to it, we believe that we will have
36 better outcomes for mental health patients in terms of
37 their access to care.

38
39 MS BATTEN: Thank you, very much, Mr Thomson. Chair, are
40 there any questions for Mr Thomson?

41
42 CHAIR: Professor Fels.

43
44 COMMISSIONER FELLS: Q. Thank you for your excellent
45 evidence. I'm interested in the dollar cost of mental
46 health for Ambulance Victoria, so I was going to kind of
47 give you a question on notice about whether you could see

1 if you are able to give us a ballpark estimate of the
2 dollar cost of your services in respect of mental health.
3 You've given us some hours, rough estimates of hours: what
4 would that translate to, what other aspects? So, I just
5 wondered if you could go away and think about that
6 possibility.

7 A. I think we'd be happy to take the question on notice
8 and come back to the Commission with that information. I
9 don't have it to hand but we would be willing to take it on
10 notice and come back with some figures.

11
12 COMMISSIONER McSHERRY: Q. Just one question from me.
13 You mentioned sometimes the use of sedation and restraint.
14 Could you perhaps explain what that encompasses and how
15 often that might be used?

16 A. In terms of how often, I would probably have to take
17 that on notice and come back to you with the actual
18 numbers.

19
20 It is an end strategy always. If we think of the Act,
21 we think of just good care. Least restrictive is always
22 the strategy around mental health patients. However,
23 people who are in crisis and are at risk, particularly if
24 there's aggression, there is potential for the use of
25 sedation. Paramedics have a couple of options in terms of
26 the sedation that they can use. However, they are sedation
27 that results in the patient not being in a position to
28 contest with the transport. Paramedics can obviously
29 provide care for those patients through that time.

30
31 In terms of restraint, every ambulance is equipped
32 with patient restraints for the purpose of restraining
33 mental health patients. Again, viewed with the least
34 restrictive in nature, I don't think anyone enjoys being
35 restrained. However, it is about the safety of the
36 patient, it's about the safety of the paramedics, the
37 safety of the police. What is very risky was, if during
38 transport a patient does become - gets out of the
39 restraints or became aggressive in the back of the
40 ambulance, it's a very small space and it represents
41 considerable risk, not only to the patient, but also to the
42 paramedics and potentially the family or the police or
43 whoever else might be attending with him.

44
45 Q. What exactly are those restraints? Are there straps?

46 A. Yes, so they're straps that are attached to the
47 ambulance stretcher. They have arm and ankle restraints,

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

7

8 Q. Is data kept on how often that might be used?

9 A. Yes, it is.

10

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

13

14 CHAIR: Q. I've got a few other questions that I'd like
15 to ask. The first one is in relation to performance
16 criteria for Ambulance Victoria. In terms of response
17 times we heard earlier today, for example, in Emergency
18 Departments there's different KPIs I guess or performance
19 standards for other forms of health care relative to mental
20 health. Is that the case in Ambulance Victoria?

21 A. Yes, we have a series of metrics that are agreed with
22 government each year around our performance. In terms of
23 the timeliness of response: for code 1 emergencies which is
24 a lights and sirens response, we need to attend within
25 85 per cent of the time, 15 minutes or less across the
26 state; or 90 per cent of the time, 15 minutes or less in
27 population areas of greater than 7,500 people in sort of
28 larger communities.

29

30 Q. So that same criteria would apply whether it's someone
31 in acute mental health crisis or someone with another form
32 of physical illness?

33 A. If it was an acute mental health crisis and it was
34 coded and determined to be a code 1, then it's exactly the
35 same.

36

37 Q. We also heard earlier today about the occasions when
38 it is that police might be first on scene at a critical
39 incident and might decide an ambulance needs to come. Just
40 to clarify the process for 000: if it's deemed to be an
41 urgent mental health crisis, are the ambulance the first
42 dispatched group to that emergency or is it a juggle
43 between police and/or ambulance?

44 A. It will depend on the information that's received at
45 the time of call. In Victoria the computer-aided dispatch
46 system for all the emergency service organisations, which
47 is operated by ESTA, is integrated. So, a person who

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

9
10 In terms of police being present and asking for our
11 attendance, it would depend on the information that's given
12 at the time about the patient's presentation as to how
13 quickly we would respond.

14
15 Q. And so, just another point in relation to that, we've
16 often heard from consumers about the distress there is if
17 they are transported in an emergency situation in the back
18 of a divi van as opposed to in an ambulance. Would it be
19 more often that someone in crisis, if both police and the
20 ambulance are there, that if police assistance is required,
21 they are inside the ambulance with the ambulance crew
22 escorting the person or are they more likely to be in the
23 back of a divi van?

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

28
29 There are a handful of situations where it may be
30 deemed that it's not safe to do that, and we certainly are
31 aware that the police sometimes will transport patients
32 themselves due to the amount of time they may wait for us
33 to attend. Obviously, we have to manage all the calls that
34 we're dealing with at any point in time, including the
35 mental health calls. So, there are occasions where
36 ambulances might be delayed and the police may very well be
37 waiting for us, and equally there are times where we've
38 called the police and we're waiting for them to come and
39 support us with a mental health patient.

40
41 Q. There's just one last point I want to talk on. You
42 discussed the performance criteria in metropolitan and
43 other areas. In Rural Victoria, and this was something
44 that's come up in our discussion so far: if you have a
45 person who's in acute mental health crisis in a country
46 town where there's not an inpatient unit available and the
47 escorting of that person to the hospital that is the

1 nearest available inpatient care, is that just done as part
2 of the normal emergency response of an ambulance, or how do
3 you structure the responses to those sort of calls and
4 transfers?

5 A. So, we would respond obviously to those calls, and our
6 footprint, like the police's footprint, is across the
7 state. I think mental health patients in Regional
8 Victoria, particularly in Rural Victoria, represent a whole
9 series of challenges about access to care, not only for our
10 services but to access to care generally.

11
12 For a patient who presented and for the purposes of
13 the police taking them into custody for a 351, they could
14 be presented to an Emergency Department for the purpose of
15 - or an urgent care centre for the purpose of an
16 assessment. Indeed, if the patient was subject to orders
17 and had to be conveyed to an area mental health service,
18 that could be a considerable undertaking, given the area
19 mental health services' coverage in Regional Victoria are
20 quite significant areas.

21
22 In that case, paramedics will work with the police,
23 they do these sorts of things often, and with the
24 respective control centre in an effort to coordinate how we
25 might do that, and how we might get that patient to the
26 area mental health service where they need care, it is not
27 without its logistical challenges, and for the patient can
28 be challenging, particularly if we're changing the faces of
29 the people that are caring for them, be it the paramedics
30 and the police, through a journey. So, if it's going to
31 take us two or three hours to get them to an area mental
32 health service, it may be that they're handed over to
33 subsequent teams of paramedics or police for that journey,
34 and I think that represents a challenge around the
35 continuity of care and for the experience for the consumer.

36
37 Q. Yes, and many times that consumer may well voluntarily
38 want to have that transfer and admission too?

39 A. Indeed, and if it is voluntary, then there are some
40 other options. We certainly can utilise our non-emergency
41 sector. There's area mental health service transport,
42 there's obviously Working With Families. I think the key
43 in all of those cases is to look for the best option in
44 terms of what works best for that patient that's safe. So,
45 if it needs to be in our care, then that's what we will do,
46 but equally exploring options with the area mental health
47 service and with the patient's carers to look for ways to

1 get them to the mental health service safely.

2

3 CHAIR: Thank you.

4

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

7

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

10

11 <THE WITNESS WITHDREW

12

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

15

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

17

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

20

21 A. Yes.

22

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

27

28 A. Yes.

29

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

33

34 A. Yes.

35

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

38

39 A. Yes.

40

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

45

46 A. Yes.

47

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

1 A. Thanks for that. Victoria Legal Aid is a statutory
2 agency and it has, as part of its core responsibilities,
3 the provision of legal advice, legal information and
4 representation of people who are eligible for that
5 representation in terms of their legal issues.
6

7 What this means is that, from our work, we glean a
8 very significant understanding of people who experience
9 mental health issues in not only the criminal justice
10 system but the civil justice system as well, as well as the
11 family law and child protection systems also, and we do
12 this through provision of duty lawyer services in most
13 courts in Victoria, if not all courts; through
14 representation of defendants under the Crimes Summary
15 Impairment Act in County and Supreme Courts. We do this by
16 also not just having legal services but by having non-legal
17 advocacy services such as our Independent Mental Health
18 Advocacy and our Independent Family Advocacy and Advice
19 Service.
20

21 We offer a telephone assistance and helpline which is
22 available from 8 till 6 pm, and that is where anyone can
23 actually ring and get legal information or advice.
24

25 Q. I'll take you through a few of those services, but
26 first, was it the case that in 2017-18 Victoria Legal Aid
27 assisted over 94,000 unique clients and, of those,
28 26 per cent disclosed that they had either a disability or
29 a mental health issue?

30 A. Yes.
31

32 Q. Do you classify people experiencing mental health
33 issues as priority clients?

34 A. Yes, we do.
35

36 Q. What do you mean by priority clients?

37 A. So, priority clients can include a range of different
38 individuals and their experiences and the problems they're
39 experiencing, but it particularly for us relates to people
40 who are poor, because of course we have a means test and
41 that means test is very mean. We support women and
42 children and others as part of family violence proceedings,
43 those experiencing mental illness, issues that relate to
44 the legal system or in fact disability; in the context of
45 the NDIS, we have quite a significant practice.
46

47 We also assist people in the criminal domain generally

1 who are defending matters before Magistrates' Courts in
2 Victoria and indictable matters before the County and
3 Supreme Courts as well.
4

5 Q. You have a specialist mental health legal practice?

6 A. We do indeed, and that encompasses not only
7 appearances at VCAT in relation to the NDIS, but also work
8 in relation to mental health issues, the Mental Health
9 Tribunal, and in addition we appear in the Supreme Court,
10 or we fund appearance in the Supreme Court for matters of
11 law that we're wishing to test. So, for example, the
12 recent matter in relation to the Mental Health Act and
13 issues of capacity and how that is determined.
14

15 Q. Can I ask you a little bit about the Independent
16 Mental Health Advocacy Service, briefly what it does and
17 who its clients are?

18 A. Yes. The Mental Health Independent Advocacy Service
19 is a really, I think, important addition to the work of
20 Legal Aid. Often people think of Legal Aid as just
21 providing legal services, but this is a real way in which
22 we consider that you need to see people holistically, and
23 so, it's non-legal advocacy that's provided.
24

25 That particular service works across all public
26 hospitals in Victoria and really provides support and
27 information to people who are at risk of compulsory
28 treatment or are actually experiencing compulsory
29 treatment.
30

31 It is very important because it puts the individual
32 who's experiencing these issues at the very centre of what
33 it is that is being experienced rather than being the
34 object of services that are provided.
35

36 Q. Can I ask you to articulate what it is, in that
37 context, to put the person at the centre?

38 A. Yes. Our workers, as part of that particular service,
39 would - and I'll use a very practical example - would go to
40 those facilities, would actually seek information on who is
41 currently in a ward or in that situation that would benefit
42 from seeing an independent advocate, and would sit with
43 them and not only consider some of the areas that the
44 Mental Health Act would require, such as how that person
45 can be involved in their own treatment in some ways, how we
46 can better understand that person's wishes, how we can
47 ensure that that person is able to represent or put forward

1 the sorts of things that would be important to them in
2 relation to any treatment, be that voluntary or not
3 voluntary and, in those ways, it's a very practical and
4 supportive orientation that puts the person experiencing
5 the mental health issues at the very centre of what we do.
6

7 Q. Is it an affirmative outreach?

8 A. It's very affirmative outreach, although we don't
9 compel, but we do seek to be very available to assist
10 people. I think it is interesting, there has been a recent
11 evaluation of that service. We receive funding from the
12 Department of Health and Human Services for that, and this
13 evaluation was particularly important in highlighting the
14 success of that pilot which is now into its second term,
15 and the fact that some consideration should be given, and
16 it was one of the key recommendations, for having it as the
17 standard practice across Victoria, so representing an
18 opt-out option for people so that it represents state of
19 play rather than being something which, if you happen to
20 access it the day our people are there, then that's what
21 happens.
22

23 Q. You have, as part of that program, consumer experts
24 advising you?

25 A. We do. I think that's a particularly commendable part
26 of the work of Legal Aid, and I say that having only
27 recently come to Victoria Legal Aid about 10 months ago, so
28 it's tremendous to see that Victoria Legal Aid has actually
29 embraced this notion of, how do you better inform and
30 design what you do, the services you provide, the legal
31 information or legal advice you provide with reference to
32 the user, with reference to what that person would need to
33 make it as useful as possible to them.
34

35 So, we have an advisory panel; it not only helps us to
36 design the sorts of services that would be most useful for
37 people with mental illness or experiencing mental health
38 issues, but it also assists in advising the organisation
39 more generally about how we can be inclusive in terms of
40 our employment practices in terms of the way in which we
41 think about those who use our services, and in fact not
42 objectifying them but seeing the real humanity in the
43 people that come before us.
44

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

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

5
6 Q. Am I right in thinking that what you would suggest is
7 that this is a good model that other systems could observe?

8 A. I think the independent evaluation that was done
9 clearly indicates that this model is working, that it is
10 one which is empowering and assists people to take up, I
11 think what was really intended by the Mental Health Act,
12 which is, people participate in their treatment, in their
13 assessment, in their recovery, and it is a model which
14 really does assist people to understand their rights and
15 their options and to think through how best they can
16 actually represent those in those assessment/treatment
17 processes.

18
19 Q. Can I ask you just to say something very briefly about
20 Victoria Legal Aid's involvement with the specialist
21 therapeutic courts?

22 A. Yes, I think Victoria, as some of the Commissioners
23 would know, has a very proud history in relation to the
24 sort of therapeutic jurisprudence and specialists courts.
25 Personally, I am a great fan of these particular approaches
26 because they not only look at perhaps the crime that has
27 been committed, but they look at the causes of crime.

28
29 Particularly important to us at Legal Aid is the
30 assessment and referral list at the Magistrates' Court,
31 which is still relatively new, I think 2010 or 2011 it was
32 introduced, and it is really important because what it does
33 is, it looks at the sorts of wrap-around services that can
34 assist people to get on track with their lives.

35
36 It uses judicial monitoring, which is also a similar
37 process that is used in the Drug Court in Victoria at both
38 Melbourne and Dandenong, and as part of that judicial
39 monitoring it's a real sense of the person feeling valued,
40 included, listened to - also sometimes I've seen
41 reprimanded in some instances - but a real positive
42 engagement which is really attempting to get that person
43 back on track and to help them think about what's going to
44 be important in their life to make a particular difference.

45
46 Q. Is it the fact though still that roughly one in five
47 unique clients of Victoria Legal Aid, who you represent for

1 summary crime matters, disclosed a mental health issue in
2 2017/18?

3 A. Yes, that's right, and that's a fact that many of the
4 clients that we would assist legally in summary crime would
5 have a mental illness or mental health issues.
6

7 Q. We've asked you a question when we were seeking
8 written evidence from you about where Victoria Legal Aid
9 fits within the mental health system. I'd like you to, if
10 you can, address your perspective on whether the mental
11 health system is actually functioning as a system?

12 A. So, my own view is that, I don't really see it as a
13 system as I would understand that; and, when I say that, I
14 would mean a system that I think operates well is one in
15 which people - there's a variety of services and support
16 options available to them - people receive them in a timely
17 way, there is good coordination and cooperation amongst the
18 providers in that system, that users of the centre are very
19 central to people's thinking in relation to that, and that
20 in fact it's a system that doesn't focus primarily on the
21 crisis end, or what I would call the tertiary end, but
22 really values early intervention and prevention as very
23 strategic and important issues in order to address and not
24 leave people to come to the edge of that cliff and then
25 fall off.
26

27 Q. So, these are the features that you would like to see,
28 and we might come to those at the end. Is your evidence
29 that you're not seeing those features in the health system
30 from where you and Victoria Legal Aid sit?

31 A. That's right, and a lot of that might be because we do
32 often get to operate at that tertiary end, so that is very
33 challenging, but also, it is not to impugn the good work
34 that people try and do in that system.
35

36 We think it's a system - or my personal view is that
37 it's a system that relies very much on relationships
38 between individuals rather than processes and coordinated
39 endeavours through which people can move through and get
40 the support and access to services that they need in a
41 timely way. So, I would see it as fragmented and not
42 coordinated in a way which can offer optimal outcomes to
43 people experiencing mental health issues.
44

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

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

8
9 That might relate to a range of things, but that might
10 be that the sorts of organisations they've come into
11 contact with don't recognise perhaps that the person has a
12 mental health issue: I've seen that in the justice system
13 itself on numerous occasions. It might be that a person is
14 really in a position where they're not able to express very
15 clearly what it is that they need, and I think this idea of
16 having ways in which people can be assisted by non-legal
17 advocates in our experience, as distinct from people who
18 are brought in at that end when there is a significant
19 legal problem, really does escalate what the circumstances
20 that someone might be experiencing are.

21
22 We do refer to some case studies where that early
23 intervention approach is an appropriate entry point where
24 someone can be assisted in a more modest way, but
25 meaningful way, and can make a real difference to their
26 trajectory in terms of how they experience both justice
27 systems and mental health systems.

28
29 Q. One of the things you observe is that you often come
30 across clients who have difficulty with the gap between the
31 10 sessions provided by Medicare to access a psychologist
32 and the crisis end. Is that something that's a recurrent
33 feature of your client base?

34 A. Yes, we see that a lot, and some would refer to that
35 as the "missing middle" in a way: that people either are at
36 that very early intervention/prevention end and there can
37 be some localised supports for them, but that middle piece
38 where people are really requiring something much more but
39 they're not at that crisis end is what we would see as
40 being a particular issue with the system.

41
42 And leaving people in this state of abyss really,
43 where they're not being assisted with what are some very
44 complex needs and where in fact some interventions in other
45 systems, such as may relate to their housing circumstances
46 or issues to do with their isolation or inclusion, are not
47 addressed as well, and so what this means is that people

1 progress down a path which often invariably in our
2 experience leads to the criminal justice system or the
3 civil justice system in particular.
4

5 Q. Yes. Is it your view that the recovery-focused
6 philosophy of the Mental Health Act is embodied well in the
7 mental health system?

8 A. The Mental Health Act, in my view, is a good piece of
9 legislation and it is good because it focuses on recovery,
10 it focuses on rights and it focuses on supported
11 decision-making, which I think we sometimes forget about in
12 the way in which we do our work.
13

14 I think the promise of that legislation still sits
15 there in large part, but it needs greater consideration
16 about the implementation of the system and how the system
17 looks, particularly with that missing middle piece in
18 relation to being able to deliver on those objectives that
19 the legislation has.
20

21 Q. You've made some observations about governance models,
22 and you've suggested that the system would benefit from a
23 governance model that brings greater independence. In this
24 context what do you mean by independence?

25 A. This is a very good question. I think that our
26 position, and certainly my evidence, is that many of the
27 parts of the system that relate to people who are
28 experiencing mental health issues relate directly into
29 DHHS, and that's not unusual, you know, in government
30 departments. But I think in this particular area we need
31 to be able to have much more transparency in what is being
32 done in various parts of the system.
33

34 So, the governance point is really about that
35 transparency and I think the best example I could give of
36 that is that Victoria Legal Aid for many years have been
37 trying to access data that helps us understand the
38 compulsory treatment regime, who's experiencing that, what
39 their experiences are, what demographic groups this covers,
40 and in fact enable us to learn how we might be able to
41 better support and even use the data that is available in
42 the system to design and plan for better, more effective
43 services that can assist people.
44

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

1 intervention that exists, and that clearly I think the Act
2 did a good thing in stepping that up to the tribunal that
3 needs to decide whether that happens.
4

5 But when you have the missing middle piece, I suppose
6 one fear that I would have is that people progress very
7 quickly to that tertiary end where there are more specific
8 regimes in place which may well not be necessary if you
9 compared it to voluntary participation perhaps in more
10 community settings, and I think this is where potentially
11 that can lead us.
12

13 Q. Is it in that context that you consider that there is
14 more room for independent oversight bodies?

15 A. Yes, I think so.
16

17 Q. In your evidence, you indicate that it is Victoria
18 Legal Aid's experience that there is a relationship between
19 limited resourcing in the mental health system and
20 increasing use of compulsory treatment and medication. Can
21 you elaborate on that?

22 A. I think it is an inevitable consequence of not having
23 the sorts of supports and resources that people need with
24 their mental health illness at various parts of that
25 journey.
26

27 You know, recovery is not a thing where people, one
28 minute they're sick and then they become well; recovery is
29 often a lifetime experience for people, and what this means
30 is that they need different types of supports all the way
31 along that system. They need those supports to be able to
32 include them, to hear their views, as I said previously, on
33 what they think their treatment should be and how they're
34 going to benefit from that treatment, and in that way I
35 think it is very important that, for the tertiary end to
36 work well, that its precursors at the prevention/early
37 intervention space really do offer real and serious support
38 for people when that's needed to enable only those who
39 really need that most tertiary end treatment to receive
40 that.
41

42 And I think, without that sort of spread and diversity
43 and spectrum of different supports and services for people
44 that are informed by people themselves and what they say
45 they need, of course with the assistance of others, then
46 too quickly people may move to the tertiary end.
47

1 Q. Does Victoria Legal Aid consider that a social model
2 of health should be adopted?

3 A. Yes, and look, I think that's now - most governments
4 accept that you can't, for example, just treat people's
5 legal problems; you have to think of people in the context
6 of their financial situation, the economics of their
7 situation, their health, yes generally, whether they're
8 employed or not, how connected they are to their community,
9 what their relationships are with family.

10
11 I think the social determinants of health tell us that
12 just treating perhaps a person's health issue is not
13 necessarily going to change their experience or improve
14 their ability to live an ordinary life, and that we have to
15 be more holistic in this way, hence why Victoria Legal Aid
16 has chosen to in some areas introduce a non-legal advocacy
17 model, so housing, employment, all of those sorts of areas,
18 inclusion, can be taken account of in terms of supporting
19 people.

20
21 The family violence reforms are a good example of that
22 from government's perspective. It's not just the family
23 violence as a legal construct that I think society now
24 understands, but is all the things which sit around that
25 that we really need to attend to in order to make a
26 difference in a systematic sense.

27
28 Q. Does an embracing of a social model allow a focus on
29 strengths rather than deficits?

30 A. Completely, and it's why some of our non-legal
31 advocacy services are so important because I, having had
32 much contact with people with mental illness in a variety
33 of the positions that I've held, I do think that the focus
34 is often on what people can't do rather than what they can
35 do. The assumption is to objectify people rather than see
36 the humanity and to work with in order to build their
37 strengths, and this is why these sorts of ideas about
38 recovery and support and inclusion and supported
39 decision-making, which the Mental Health Act tries to
40 embody I think, are very, very important to a healthy
41 mental health system.

42
43 Q. Have you observed a bidirectional relationship between
44 health problems and legal problems?

45 A. Yes, I think the two can influence each other. For
46 any of us here who have experienced legal problems, we know
47 that not only are they costly often to deal with, but they

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

4
5 And, if I take some good examples, probably looking at
6 public drunkenness and the fact that it's criminalised here
7 in Victoria means that people who really have a social and
8 a health issue can find themselves intersecting with the
9 justice system reasonably quickly, and if they are
10 homeless, if they are also poor, if they are Aboriginal or
11 Torres Strait Islander, these are the sorts of compounding
12 factors that can lead to people not being able to live
13 ordinary lives and in fact to spiral to that tertiary end
14 we've discussed.

15
16 Q. Speaking of compounding factors, what have you
17 observed about the compounding effects of homelessness on
18 people's ability to get access to mental health services?

19 A. Look, I think the situation for people who are
20 homeless is incredibly difficult. It is hard if people
21 don't have a fixed address, don't have a community that
22 they relate to as many of us do if we've got a roof over
23 our heads, are thinking every day about how they will just
24 survive, rather than being able to focus on getting better
25 or trying to improve the mental health issues they're
26 experiencing.

27
28 I think homelessness, not having a roof over your
29 head, housing, is probably one of the biggest challenges we
30 have in large part in this space, and watching the way the
31 therapeutic jurisprudence initiatives, problem solving
32 courts, work in Victoria, clearly they stand for the need
33 for having adequate housing and support - not just
34 independent living, but supported living where people can
35 thoroughly have an opportunity to try and right their life
36 and to be able to be more effective in self-care as well as
37 be safe in the environment in which they're in.

38
39 Q. Is one of the compounding factors that impedes
40 people's ability to get access to mental health services,
41 the cost of those services?

42 A. Yes, I think so. I think even people who earn a
43 decent wage would probably find that hard, but for people
44 who are poor - and the majority of people that we see at
45 Legal Aid, clearly our guidelines are such that we only
46 represent those who are the most poor - it is an obvious
47 fact that it affects their ability to live ordinary lives.

1
2 Q. And that would particularly apply to people who find
3 themselves in the so-called missing middle, wouldn't it?

4 A. Yes, because I think that sort of grouping, if we call
5 it that, or that part of the system that needs to be
6 strengthened, if that's not strong: if people are in that
7 bit of the system, they can either go one way, towards sort
8 of the prevention end, or they can go the other way,
9 towards the crisis or tertiary end. If that middle is not
10 strong, then we will see more people going to the crisis
11 end because they won't have the sorts of supports they
12 need.

13
14 Housing is a critical component of that, so is
15 meaningful things to do everyday, whether they be paid or
16 unpaid. So is just feeling included and connected to those
17 around you, and also experiencing reasonable health: all of
18 these things are vital, I think, and that middle part is
19 where things can either go very right or very wrong
20 depending on what the supports are that you get.

21
22 Q. In relation to things going very wrong, is there a
23 sense in which the criminal justice system is de facto
24 placed to deal with mental health issues?

25 A. You know, our experience might of course be quite
26 biased given what we do in broad part, but I think what we
27 do see is many people being caught up in particularly
28 summary crime but indictable as well in the criminal
29 justice system, who really do experience mental illness,
30 and certainly batches of vulnerability that then, if they
31 are homeless as well and more obvious to public authorities
32 and to police, that can often then lead to a spiralling
33 into the justice system.

34
35 I think that's why it's so important that the good
36 work that Victoria Police does absolutely includes more of
37 diversion, ways of - the multitude of powers that are
38 available to police officers really do encompass not just
39 moving people thoroughly into the system, but to diverting
40 people from that system, and that's a particularly
41 important feature that we would see.

42
43 Q. On a slightly different topic, you've made some
44 observations about what you call the ineffective
45 interaction between the NDIS and the housing and justice
46 systems. Can you explain what you mean by that?

47 A. We've included a case study on that.

1
2 Q. Yes, would you like to address that?

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

14
15 It's a hard reform and it will continue to be hard for
16 some time, but I think this is an example of someone who
17 really spent much time in prison, much time in a custodial
18 place when that would not have been necessary had there
19 been proper and effective engagement and communication
20 between the great promise of what the NDIS is and actually
21 what happened for this person in practice.

22
23 Now, I say that as a great supporter of the scheme,
24 and I think it's very understandable that with people with
25 very complex needs the scheme is still evolving and working
26 through that. But this is a good example of how people can
27 be left in what I would call, you know, the quiet of
28 custodial places where they're not really seen, where their
29 circumstances continue, and where in fact, unless they're
30 given the right supports, that becomes their way of life,
31 rather than having available to them the sorts of supports
32 that should have been available at a much earlier period in
33 time.

34
35 Q. Can you say something briefly about the facts of that
36 example that you are speaking about?

37 A. Yes. So, this, and I'll read from my notes if it's
38 okay - from my evidence. Essentially John is the name
39 we've given this person, John had an acquired brain injury
40 as well as a schizophrenia and this had contributed to his
41 past substance abuse, to unemployment, to housing
42 instability, and indeed to low level offending, which is
43 once again not an uncommon thing.

44
45 When John transitioned to the NDIS his plan was
46 inadequate to support him, to live well in the community
47 and, with the reduced supports that he therefore received,

1 John committed further offences and was taken into custody.

2
3 Due to the NDIS housing and justice systems failing to
4 interact effectively - that is, who does what and whose
5 role is what, and clarity around what the expectations are
6 and some of the intergovernmental agreements, John was
7 unable to obtain bail to live in the community. People
8 would be aware, of course, that Victoria has very
9 significant bail laws in place now, I think they've been
10 described as the strongest in the country.

11
12 It took 10 months for an NDIS plan review to occur.
13 The plan review of course is a mechanism whereby someone's
14 package of supports is costed and designed, ideally with
15 the person in the way it's meant to happen. Therefore, it
16 was only once John had that, that he had a sustainable
17 post-release package that could actually ensure that he
18 would be safer in community in the way that he certainly
19 deserved, and I think for the majority of times, it says
20 there, John was in custody.

21
22 So, this is interesting to me because, clearly, we
23 only want people to be in custody if they really should be
24 there, and I'm happy to talk about that more thoroughly,
25 but in this instance I think the reason was a lack of
26 appropriate supports to enable someone to live an ordinary
27 life in the community and, therefore, because those
28 supports weren't there, there was a deterioration, a move
29 towards the more tertiary end and the person before we know
30 it is into the criminal justice system. And, once there,
31 it is actually quite a difficult system to get out in Legal
32 Aid's experiences.

33
34 Q. Can I ask you a couple more questions about governance
35 and oversight. When we have asked you the question, how
36 could systems work better together for improvement, one of
37 the things you have said is that:

38
39 "Regulatory structures that are measured
40 against actual quality improvements would
41 really assist."

42
43 Can you explain what you mean by that?

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

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

3
4 I think the regulatory structure currently looks at
5 having oversight impossibility for review in a variety of
6 ways, and I think that's a good thing and I've already
7 mentioned the example of the Mental Health Tribunal and
8 that people can appeal those matters to VCAT and to the
9 Supreme Court. But you don't want people to have to do
10 that.

11
12 Q. I see.

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

22
23 Q. Just on the question of data, you say there are
24 several data inadequacies of which you're aware. The first
25 is a lack of available data on complaints about the
26 Victorian mental health system. Among others, how
27 widespread those complaints are.

28 A. I think that's right, and that we particularly - as I
29 think I previously mentioned - see this and are very
30 interested in this in the context of compulsory treatment.
31 The main way we learn about what's happening with
32 compulsory treatment is when people come to us or we come
33 across people who need our assistance, either non-legal
34 support or legal support. It would be - I think civil
35 societies and open government now requires much more
36 transparency in the way in which business is done, if I can
37 put it that way.

38
39 The reason we want that is not because there's a
40 distrust. It is because, only when we see what is
41 happening can we actually get better at what we do, can we
42 all get better at what we do. I think we want to
43 understand the demographics of that data, we have some
44 assumptions around what those demographics might be from
45 our own individual case experience, but to have that sort
46 of data available in a comprehensive way that can really be
47 used by governments and community organisations and

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

3
4 Q. On another aspect of data availability, you say:

5
6 "There is limited data to help design and
7 implement a tailored, appropriate and
8 culturally safe service for various groups
9 within our community including Aboriginal
10 and Torres Strait Islander people."

11
12 What sort of data do you have in mind that we might
13 collect?

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

27
28 I think, it's interesting for me, I learned when I was
29 at the NDIA, the National Disability Insurance Agency, that
30 there was no such word in many of the Aboriginal
31 communities that we were going into for "disability". This
32 indicates something about the way in which we have to think
33 about putting the user at the centre to understand best how
34 we can respond to individuals in terms of meeting their
35 needs.

36
37 Q. You also say this:

38
39 "There is an inbuilt inequality in the
40 system in the sense that people get
41 different treatment depending upon where
42 they live."

43
44 What's your observation about that?

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

1 Victoria Legal Aid is across Victoria, so we are in all
2 major regional locations, and so we have a good ability to
3 see what services are available and are not available.
4

5 Certainly, in listening to some of the evidence of
6 some other people who have come before the Commission to
7 date, it is clear that rural and regional areas need
8 particular responses, that those responses have to take
9 account of distance. They have to take account, so
10 importantly, of whether service providers are actually
11 available in those areas; whether the market can deliver
12 the sorts of capability and capacity that we need in those
13 areas to really support people to live full lives.
14

15 I think not enough attention is paid to the gaps and
16 the perhaps inefficiencies as a consequence, and that sort
17 of idea of the tyranny of distance to understand that. In
18 our written submission to the Commission we make reference
19 to some of the case studies where the amount of travel
20 people have had to do to get some basic support services,
21 in my view, is completely prohibitive to them being able to
22 focus on their own recovery and their own thinking about
23 their life and how they can get off the treadmill that
24 they're on.
25

26 So, we touch on that more thoroughly, but essentially
27 that's what we mean by the postcode lottery. And I think
28 that essentially if people are poor, and we know that in
29 rural and regional areas there are a lot more poor people
30 percentage-wise, that it makes it really, really difficult
31 for people to get the help that they need.
32

33 Q. Can I just draw you out on two more aspects of your
34 statement. The first is this, you say:
35

36 "The current governance, oversight and
37 accountability mechanisms in the mental
38 health system are not working to ensure
39 quality, or to embed the cultural change
40 needed to promote a rights-based
41 framework."
42

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

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

1 Health Act which is about recovery, which is about rights,
2 and which is about co-ways of working supported
3 decision-making.
4

5 So the rights are things like, do people get access to
6 good information about what their treatment means? We've
7 also included some case studies about people who don't even
8 understand what it is they're being treated for, so basic
9 information. Understanding alternatives. Very importantly
10 for us, good services in that missing middle that are both,
11 are voluntary, voluntarily offered, and that attend to that
12 more intermediate need.
13

14 Governance of a system should attend to all of those
15 things, it should look at where there are gaps, and I'm
16 talking about that I suppose not in the formal regulatory
17 sense, but in a way which says, what do we need to ensure
18 that the system can actually work? I think the comments
19 made in my witness statement are really about that
20 question, the system isn't working optimally for people who
21 experience mental health issues.
22

23 Q. I said I had two questions but I think that was my
24 last one. Do the Commissioners have questions, Chair?
25

26 CHAIR: Commissioner McSherry, thank you.
27

28 COMMISSIONER McSHERRY: Q. Thanks very much, and we look
29 forward to reading the submission from VLA as well. Just
30 one question: we heard from a young woman the other day who
31 had a terrible experience in a High Dependency Unit and I
32 think she could have really used an advocate at that stage.
33 Does the Independent Mental Health Advocacy Service go
34 across units? Is it a capacity issue?

35 A. Well, it goes to all public hospitals, but it is not a
36 comprehensive system, a comprehensive offering, which is
37 why - I'm being a bit shameless in saying this in a way -
38 but the evaluation says it should be rolled out across the
39 state. It is a terrific service and that's not just
40 because Legal Aid provides it. It does attend to what I
41 would see as a classic gap in the system, and so, I think
42 that's the issue there.
43

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

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

7
8 And, it's a relatively cost-effective system, I think,
9 as well and it is empowering. It does focus on giving
10 people information and talking through options. I think it
11 helps people take responsibility for their own care in a
12 way that's not punitive but is empowering, and I think that
13 is a terrific outcome for many people.

14
15 Q. Just one other question. I note that you've mentioned
16 from the data that is available, that representation before
17 the Victorian Mental Health Tribunal is only 15 per cent.

18 A. Yes.

19
20 Q. Whereas it's 80 per cent before the New South Wales
21 Mental Health Tribunal.

22 A. Yes.

23
24 Q. Do you know the rationale behind that?

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

33
34 CHAIR: Q. There's just one other point, Ms Glanville,
35 I'd like to take up which is: you made a comment in your
36 statement that you had a regional lawyer who talked about
37 the fact that they felt they'd lost count of the number of
38 times he'd stood before a magistrate and said that "we are
39 having to use the blunt tool of the criminal justice system
40 to deal with mental health issues".

41
42 We also heard earlier today from the Assistant
43 Commissioner of Police about the fact that the police have
44 been called upon more and more in their view to be the
45 first responder around mental health issues. I noted in
46 your example and earlier evidence you said increased
47 visibility of police to people with mental health issues in

1 the community, whilst it might be helpful, can also
2 contribute to that higher engagement in the criminal
3 justice system.
4

5 Can you make any comment or further observations
6 around that?

7 A. I think that's spot-on. I think, particularly because
8 we've sort of been in a period of strong law and order, and
9 I completely accept government's right to make those
10 decisions and do that and make appropriate laws as
11 government sees fit, but one of the consequences of that
12 is, people who would not perhaps ordinarily have been
13 caught up in these systems do become more visible. They
14 may, because of their inability or without the supports to
15 be able to have control of their lives in the way that they
16 would wish, they move quickly down paths, and we have many
17 examples of that.
18

19 Examples, too, of where people are brought before a
20 court when perhaps there could have been alternatives to
21 that being the outcome for that particular person if there
22 was not more coordination. Better role definition, I
23 think, Commissioner, of who does what and what are the
24 sorts of possibilities that are available early on or in
25 that middle piece when people are going to go one way or
26 the other. And I think these are the challenges for us to
27 really think those through in terms of the intersection
28 between systems as well.
29

30 So, it's not only how mental health services relate to
31 each other, and I think there's been some good evidence on
32 that, but it's also the way systems relate to each other.
33 And importantly, it's also about the way culturally we all
34 view the person with mental health issues and whether in
35 fact we can put them in a position which the Mental Health
36 Act suggests they should be in, which is a participant in
37 the process, not a person that something is done to.
38

39 I say that recognising that sometimes things have to
40 be done to people, but I think our orientation should be to
41 avoid that as much as possible and to have choice for
42 people experiencing mental health issues in their lives
43 which enables them more thoroughly to look for voluntary
44 opportunity and participation in their own treatment before
45 it becomes something which is mandated or compulsory and
46 which they may feel is troubling for them.
47

1 CHAIR: Thank you.

2

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

5

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

7

8 MS NICHOLS: May Ms Glanville be excused, please?

9

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

12

13 <THE WITNESS WITHDREW

14

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

17

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

19

20 MS NICHOLS: Q. Ms Edan, are you the Acting Chief
21 Executive Officer of the Victorian Mental Health Awareness
22 Council?

23 A. I am.

24

25 Q. Is that body also known as VMHAC?

26 A. Yes.

27

28 Q. Were you previously the Chair of VMHAC?

29 A. Yes, I was.

30

31 Q. Among other things, have you had consumer roles
32 working in the mental health services area for over
33 20 years?

34 A. Yes, I have.

35

36 Q. Are you also a qualified nurse with a Masters Degree
37 in Nursing?

38 A. Yes.

39

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

46 A. Yes, that would be correct.

47

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

5 A. Yes.

6

7 Q. Are those roles in Victoria all formally recognised
8 and do they include paid positions in Victoria?

9 A. Yes, they're all formally recognised under the mental
10 health services award, the EBA, yes.

11

12 Q. Can I ask you about the history of the development of
13 these roles. Has the role of consumer consultant existed
14 since 1996?

15 A. Yes, that's correct.

16

17 Q. Was there a seminal event in 1996 that led to the
18 development of the that role?

19 A. Yes. Prior to 1996 there was a project undertaken at
20 the Royal Park Hospital called the Understanding and
21 Involvement, or more informally known as the U and I
22 project, and that was a participatory action research
23 program that looked at consumer evaluation of the service.
24 One of the recommendations that came out of that was the
25 employment of consumers in services, that led to a quality
26 project that employed consumers in all area mental health
27 services in 1996.

28

29 Q. That was the first recommendation of its kind of any
30 significance as far as you're aware?

31 A. As far as I'm aware, yes.

32

33 Q. After that recommendation, did it become the case
34 that, in all area mental health services a consumer
35 consultant and a carer consultant is required to be
36 employed?

37 A. So, after that recommendation in 1996 it was consumer
38 consultants; carer consultants were first employed in 2002
39 and funded by the department in 2009.

40

41 Q. I see. Is it still the case that in each area mental
42 health service, one of each of those consultants must be
43 employed?

44 A. In adult services, one of each. In child and
45 adolescent units a carer consultant, and in aged services a
46 carer consultant. But consumer consultants are only funded
47 in adult services.

1
2 Q. Going back to 1996, was the funding of consumer
3 consultants at the rate of two to three days a week?
4 A. Roughly, yes, that's how much it was, yes.
5
6 Q. To your knowledge, has it remained at that rate since
7 that time?
8 A. Yes, it has.
9
10 Q. The funding for those roles is part of the block
11 funding for area mental health services; is that right?
12 A. Yes, that's my understanding.
13
14 Q. One point you make in your statement is that over time
15 the significance of the role and the demands placed on the
16 person performing that role have grown considerably?
17 A. Yes, that's right, both the complexity - the amount of
18 work and the complexity of the work has increased.
19
20 Q. If we focus on consumer consultants, what kind of work
21 do they do within area mental health services?
22 A. Most often they are involved in quality improvement
23 type projects, that was where the positions first sat in
24 services, was under quality improvement. But it's expanded
25 much beyond that to management, to influencing management
26 decision-making of the way that services actually run,
27 including education of services, input into complaints
28 processes, community awareness-type projects, so very, very
29 broad across most areas of what an area mental health
30 service delivers. The consumer consultant would be
31 required to give some sort of input.
32
33 Q. Focusing now on carer consultants, has there been an
34 evolution from a focus on them performing peer support work
35 alone, moving into a more advocacy-focused role?
36 A. Yes, that's correct, so they started peer support but
37 moved into advocacy.
38
39 Q. You make the point in your statement that:
40
41 "Peer support work is increasingly
42 recognised as a discipline in its own
43 right."
44
45 Can you say something about the importance of it being
46 recognised as a discipline?
47 A. Peer support work takes quite a different approach to

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

7
8 Q. You also make the point that there is very strong
9 evidence that peer support reduces re-hospitalisation
10 rates, reduces inpatient stays and lowers the overall cost
11 of services.

12
13 Now, I've rolled up three things together, and we
14 don't have time to discuss individual studies, but you've
15 given a reference in your statement to a collected set of
16 studies, it was published by Mental Health America; is that
17 right?

18 A. That's right, yes.

19
20 Q. What are some of the significant findings that you're
21 aware of just in headline form?

22 A. Just in headline form, a number of the peer support
23 projects and services that are included in that study
24 include information that re-admission rates are reduced by
25 up to 40 per cent; that days between hospitals are
26 increased from about 120 days on average to over 270 days;
27 that there's reduction in the cost of community health
28 services by up to \$2,500 per person per year, and in one
29 study there was a saving to hospitalisation costs of over
30 half a million dollars because of the reduction in rates
31 and the extension between hospital admissions.

32
33 Q. Are those benefits seen across a range of different
34 services, meaning types of clinical services?

35 A. Yes. They are across the entirety of the
36 United States. The study shows, across all of the states
37 where certified peer support workers work, they show very
38 similar results.

39
40 Q. The studies that you refer to are American studies,
41 but is it your opinion that they're likely to apply and, in
42 the absence of data being available in Australia, that it's
43 useful to look to those studies?

44 A. Absolutely. In Australia we don't have very many peer
45 delivered services of this nature, and so, we have to look
46 to overseas.

1 Q. Can I ask you about your evidence to the effect that
2 there was quite a significant workforce in the community
3 managed mental health support sector which has now
4 diminished with the advent of the NDIS?

5 A. Yeah, so one of the areas that we saw peer support
6 work blossom was in the community-managed mental health
7 sector, and up until the advent of the NDIS there were -
8 we're not exactly sure how many, but there were many, many
9 peer support workers. And at VMHAC at our support days,
10 the majority for workers, the majority of workers would be
11 from that sector.
12

13 With NDIS and the genericisation, if you like, of that
14 workforce; that is, that now everybody is just a support
15 worker, peer support workers have been taken out of
16 dedicated peer support roles into generic support roles,
17 and in that way have been not able to use their skills and
18 expertise as a peer support worker and are actually leaving
19 the sector in considerable numbers because of that.
20

21 Q. One initiative that you do say showed some promise was
22 the expanding Post Discharge Support Initiative. Before I
23 ask you about its limitations, can I ask you to say what it
24 is?

25 A. So, the expanding Post Discharge Support Initiative is
26 an initiative funded by the department to put peer support
27 workers into area mental health services to support people
28 in the post discharge phase. The principal idea is that,
29 if people get more support in that 28 days post discharge,
30 they're less likely to be re-admitted, so the support is
31 concentrated in that time.

32 Q. Acknowledging that goal, one of the things you say in
33 your evidence is that it had some implementation issues
34 which you attribute to failing to obtain any input from
35 consumers in the design of the program.

36 A. Yes.
37

38 Q. Were you asked to contribute to a guideline
39 subsequently prepared by the Department of Health and Human
40 Services to assist prudent and supportive peer workers to
41 perform that role?

42 A. Yes, that's right. Once the consumer workforce became
43 aware of it, we were able to do some work.
44

45 Q. Is that initiative the only funded peer support
46 service in Victoria?

47 A. Yes.

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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

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

3
4 Q. Is it right that you say it is preferable that it be a
5 declared position?

6 A. Yes, absolutely.

7
8 Q. You've made some observations about the need for
9 training the peer support workforce, including that that
10 seems to be done in a more fulsome way in Western
11 Australia. What do you say about the need for training to
12 be provided to the peer support workforce?

13 A. So, like any workforce, we require training and
14 support. At the moment the training that's delivered for
15 peer support workers and other consumer workers is quite
16 ad hoc.

17
18 With the advent of the Centre For Mental Health
19 Learning, there is starting to be some coordination of
20 that, but services themselves still make a decision about
21 what sort of training someone will have. We don't have an
22 accredited system at the moment for training; that's quite
23 controversial. We require - it is our belief and what we
24 supported with the advent of the Post Discharge Service is
25 that peer support workers needed to be trained in
26 intentional peer support, a particular model of delivering
27 peer support.

28
29 We would also suggest that consumers require training
30 in what's called emotional CPR, which is about responding
31 to people in distress, but also consumer workers have put
32 forward a desire for training around, you know, thinking
33 strategically, working strategically within a department,
34 how to influence people in high places, in power, those
35 sorts of skills are also required.

36
37 Q. You've made some observations that overseas studies
38 have established the effectiveness of stand-alone
39 peer-delivered services.

40 A. Yes.

41
42 Q. You've given a few examples in your statement but one
43 of them is one you have personally visited, and that's the
44 Piri Pono - I hope I have pronounced that correctly - in
45 Auckland.

46 A. Yes.

1 Q. Can you say something about what you observed, and
2 firstly what the service is and why you say it is an
3 effective service?

4 A. So Piri Pono is a five bed alternative to an inpatient
5 unit. So, when people present in the triage service
6 needing - requiring an admission, they get given the option
7 to, if that bed is available in Piri Pono, they get given
8 the option to go to Piri Pono rather than the inpatient
9 unit.

10
11 One of the things that struck me about the service was
12 the level of respect. So, all of the staff are peers,
13 including now the clinical staff, so all of the nurses have
14 a lived experience, and when I visited one of them had been
15 through Piri Pono as a patient.

16
17 But one of the really significant things for me was
18 the way in which the risk assessment was done for the
19 service, and that is, on admission the manager of the
20 service undertook the risk assessment with the consumer
21 being admitted, and that risk assessment was only shared
22 with other staff on the consent of the consumer. What that
23 means is that everybody is treated the same, nobody gets
24 viewed through the lens of someone else's decision that
25 you're high risk or medium risk. We know that risk
26 assessments actually do more harm than good in terms of
27 building relationships with people, and that really shone
28 through in this service to me.

29
30 Q. Do you know how long it's been operating for?

31 A. Well, I visited it three years ago and it had been in
32 operation then for about three years.

33
34 Q. Okay, thank you. Can I ask you about the evidence you
35 give in your statement about the accounts you have heard or
36 VMHAC has heard from consumers speaking about the state and
37 Federal divide in terms of access to services causing quite
38 some difficulty?

39 A. Yes, and I think again it's increasing since the
40 advent of NDIS.

41
42 Q. Yes.

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

1 instance, that the Medicare rebate is a Federal
2 responsibility and not a state responsibility, so trying to
3 draw those bits together becomes very difficult for people.
4

5 It's particularly - the previous testimony that spoke
6 about the broken middle or the missing middle - that is
7 something that we would absolutely identify.
8

9 Q. Have you also observed that people with borderline
10 personality disorder have particular trouble accessing
11 services?

12 A. Yes. We do hear a lot from consumers with a diagnosis
13 of borderline personality disorder and it's a diagnosis
14 that, once you have it, it becomes very difficult to access
15 services; it's considered people with this diagnosis are
16 often considered by services to be very difficult to work
17 with, very challenging to work with, and so we get a lot of
18 need for advocacy for people with this diagnosis.
19

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

22
23 "I believe services would be improved if
24 governance requirements of any publicly
25 funded mental health service required equal
26 governance by consumers."
27

28 Can you say why you think a governance role by
29 consumers in that sense is important?

30 A. Yes. So, it is both governance and operational, to be
31 clear.
32

33 Q. Yes.

34 A. But I think that there are a couple of really good
35 examples of where consumers are involved in quite high
36 level operational management, where there's been
37 significant improvement in the service when that occurs.
38

39 I do believe that if - and again, not at this level,
40 but some examples close to it of: if a consumer was
41 employed at the same level as the Clinical Director, the
42 Operational Manager, then the level of oversight from the
43 consumer's experiences would be drastically improved and
44 many more decisions would be made - many more of the
45 decisions made would be influenced by that view.
46

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

1 experience of working?

2
3 Q. Sure.

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

17
18 We, as a team, were also able to influence some of the
19 community mental health service design and the way that the
20 services functioned, and that wouldn't have been possible
21 if I didn't have that level of authority.

22
23 Q. Yes, and that reflects the principles of
24 co-production; is that right?

25 A. Yes, that's right.

26
27 MS NICHOLS: Thank you very much for your evidence,
28 Ms Edan. Do the Commissioners have any questions, Chair?

29
30 CHAIR: Dr Cockram.

31
32 COMMISSIONER COCKRAM: Q. Ms Edan, we heard from you
33 about the importance of the peer support workforce and the
34 development of the model in Victoria. You mentioned that
35 it wasn't implemented well and guidelines needed to be
36 written retrospectively. What didn't they get right the
37 first time they tried to do it?

38 A. Which do I pick? There was a number of things that
39 they got really wrong. One was that the first iteration of
40 it - and this has moved a bit - but the first iteration of
41 it was to use peer support - the idea was to use peer
42 support workers to ensure that people got to appointments
43 and picked up their medication and did that sort of thing,
44 and that's completely against the principles of peer
45 support; it's a psychiatric support officer-type role, not
46 really one of peer support and not using that expertise.

47

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

9
10 So what we've found and been reported to us is some
11 really quite disturbing discriminatory practices that are
12 occurring towards those workers, and that's being followed
13 in a study at the moment, so there's a research study
14 that's actually looking at the experience of those workers
15 in the service.

16
17 The other problem has been that all of the services,
18 bar one, employed clinicians to oversee the peer support
19 workers. The one that did employ a peer, that peer also
20 had a clinical background, so there was a dual background
21 there, and again, this meant that the peer support workers
22 didn't have the guidance around the specialty knowledge and
23 tasks that they needed to do with the consumers.

24
25 COMMISSIONER COCKRAM: Okay, thank you.

26
27 MS NICHOLS: May I tender Ms Edan's statement?

28
29 CHAIR: Yes, thank you.

30
31 Q. There's one other point I would like to follow up. I
32 was very pleased to hear that example of the facility you
33 visited in New Zealand. We've heard very positive feedback
34 through the course of this Royal Commission already of the
35 role and important function by peer supporters, consumers
36 with lived experience.

37
38 I'm wondering how, from those experiences, what you
39 think is important in providing support for those with
40 lived experience who are undertaking these very challenging
41 roles sometimes, very emotionally charged difficult roles,
42 what do you think is going to be important, if we build
43 this workforce, to make sure those lived experience workers
44 are supported in terms of their working environment?

45 A. So, training, and training that's delivered by
46 consumers. Consumer perspective supervision. There's a
47 new framework that was released last year that talks about

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

5
6 And, career structure. So, one of the things at the
7 moment is that there's no career structure for consumer
8 workers. So, you come into a role and that's it basically.
9 We need to be thinking about this as a discipline, we need
10 to be developing senior roles with appropriate remuneration
11 and developing them into leaders and managers of those
12 services.

13
14 CHAIR: Thank you. Thank you very much.

15
16 MS NICHOLS: May Ms Edan be excused?

17
18 <THE WITNESS WITHDREW

19
20 CHAIR: Yes, thank you very much for your evidence today.

21
22 MS NICHOLS: That concludes the evidence today,
23 Commissioners.

24
25 THE CHAIR: Thank you.

26
27 **AT 4.05PM THE COMMISSION WAS ADJOURNED TO**
28 **FRIDAY, 12 JULY 2019 AT 10.00AM**
29

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