ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Wednesday, 10 July 2019 at 10.00am

(Day 7)

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

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

MS NICHOLS: Commissioners, we have five witnesses today. The first is Associate Professor Dean Stevenson. He's the Clinical Services Director at the Mercy Mental Health Services and it services Melbourne's South West Metropolitan catchment.

We have Professor Malcolm Hopwood next who is a private psychiatrist practising at the Albert Road Clinic.

Then Ms Liz Crowther who is the CEO of Wellways; that's the large organisation that operates up the southeastern coast of Australia. It provides a range of psychosocial support services and, among the things it does, is to operate six PARCs.

Peter Ruzyla is the next witness, he's the CEO of EACH. That organisation provides housing and psychosocial support services. He will be speaking about the psychosocial support aspect of EACH's work.

Finally, Ingrid Amann works at the North Fitzroy PARC.

Beg your pardon, I made an error. There is another witness who we'll be hearing from, Georgia Harraway-Jones, who is a community witness.

I call Associate Professor Dean Stevenson.

<**DEAN ASHLEY STEVENSON, sworn and examined: [10.03am]**

MS NICHOLS: Q. Mr Stevenson, are you okay there with the light shining in your eyes?
A. It's very dazzling. I'll be okay, thank you.

Q. You don't want to pivot towards one way or the other?
A. I might do that, it helps a little.

Q. Great. Are you the Clinical Services Director at Mercy Mental Health?
A. That's correct, I am.

Q. Have you been a specialist psychiatrist since 1994?
A. That's correct.

Q. We have your CV so I won't ask you questions about it but thank you for providing it. Is Mercy Mental Health a tertiary provider of adult mental health services in

Melbourne's South West Metropolitan catchment?
A. That's correct. Mercy Mental Health provides services to the cities of Hobsons Bay, Maribyrnong and Wyndham.

Q. Thank you. Is it correct that it provides treatment to consumers with severe mental health issues who require acute inpatient treatment or continuing care?
A. That's correct. The focus of treatment provided by Mercy Mental Health is to consumers with severe mental illness, and that is both acute and community-based care.

Q. Can I just ask you briefly to confirm the services that Mercy Mental Health provides. Does it provide an acute inpatient bed service which has 54 physical beds at the Clare Moore Building?
A. That's correct.

Q. And an additional 16 beds at the Ursula Frayne Centre?
A. That's correct, which is based at Footscray Hospital.

Q. Is there a community care unit with 20 beds in Werribee?
A. Yes.

Q. And a Prevention and Recovery Care Unit, or a PARC, which has 10 beds located in Deer Park?
A. In Deer Park, correct.

Q. And that's outside of your catchment area?
A. Our PARC serve is located outside our catchment area and co-located with PARC service from Mid West Area Mental Health Service.

Q. Do you have two community mental health teams?
A. We do.

Q. Where are they based?
A. We have one based in Footscray at Saltwater Clinic, and then we have another based in Hoppers Crossing.

Q. Do you have a Mother and Baby Unit which operates six beds on the Werribee Mercy Hospital site?
A. We do. We have a well developed perinatal psychiatric service which includes inpatient beds at Werribee: six mothers and six babies. We also have an outpatient Mother Baby Service which is located at our Hoppers Crossing clinic, and we also have a consultation liaison perinatal

psychiatric service based at Mercy Hospital For Women.

Q. Thank you. Do you have a Secure Extended Care Unit, or a SECU, which has access to five beds at the Sunshine Hospital?
A. We don't have a SECU, but we have access to five beds at the regional SECU which is based at Sunshine Hospital and is managed by Mid West Area Mental Health Service.
Q. So, if you need to place patients there, that's where you place them?
A. That's where we place them, correct.

Q. In relation to your community-based acute services, do you operate a CATT?
A. We do operate a separate CATT Team and our CATT Team is based at our Hoppers Crossing clinic site.

Q. And a Post-Admission Support Team?
A. We do have a Post-Support Admissions Team which work out of the inpatient unit at Werribee Mercy Hospital, the Clare Moore Building.

Q. Can you tell the Commissioners what that team does?
A. This team provides support to consumers who have had an acute inpatient admission and are discharged back into the community, but will not be receiving case management services from the mental health service. So, it's a service designed to support consumers as they transition from inpatient care to re-engagement with their primary caregivers, their general practitioners or possibly private psychiatrists.

Q. For how long does that support last?
A. It can last for up to three months. My apologies, I'm confusing that with HOPE, it's up to a month.

Q. Up to a month?
A. Up to a month, that's correct.

Q. Do you provide emergency mental health services assessment services in the emergency departments of both the Werribee Mercy Hospital and the Footscray Hospital?
A. Yes, we provide those services which are 24-hour services to both the emergency departments in our catchment area.

Q. How do those services work, how are they engaged by

the emergency departments of those hospitals?
A. The clinicians, which are known as ECATT, Enhanced Crisis and Assessment Treatment Clinicians, are based in the emergency department and they see consumers with mental illness on referral from the emergency department staff.

Q. Do you provide consultation, liaison, psychiatric services to the Footscray Hospital and the Werribee Mercy Hospital?
A. We do. This is a recently new development within our service at the Werribee site, but we have for a good number of years provided consultation liaison service to Footscray Hospital.

Q. What's involved in the provision of consultation liaison services?
A. That involves providing psychiatric consultation to patients who are admitted either to medical surgical wards and may develop psychiatric complication while they are inpatients, so the purpose is to provide psychiatric assessment and advice to the medical or surgical teams who would be managing those patients.

Q. Can I ask you about the PARC, just returning to that subject. Does that function both as a step-up and a step-down facility?
A. It is designed to work as a step-up and step-down facility. We tend to use our PARC, although we do use it as a step-up, we tend to use it as a step-down facility because of the demand for inpatient beds. We use it particularly for consumers who require longer inpatient support or care. Once the acuity of their current episode has settled, they'll be discharged and stepped down, I suppose would be the term, to PARC where they may stay for up to another four weeks.

Q. Are you indicating that, because of the demand on inpatient beds, the PARC service is really not available to be used as a step-up facility?
A. It is not as available as it should be. We do - there is always a waiting list for step-up patients, and unfortunately we have to give priority to the step-down patients in order to create vacancies within the inpatient units to promote flow from the emergency departments. So, although there are some step-ups, it tends to be predominantly step-down.

Q. Thank you. Just on that question of demand, we've asked you, in broad, is supply keeping up with demand and you've said, no, it is not, can I just take you through some elements of that.
A. Yes.

Q. You've commented in your statement on the pressure on acute bed-based care and you've said you have high occupancy rates.
A. Yes.

Q. What are your occupancy rates and why are they problematic?
A. Our occupancy rates are running at around 97 per cent at the moment, which is an improvement. We've recently - well, not recently, but over the last two years, been fortunate enough to open a number of more inpatient beds which has dropped the occupancy rate from 100 per cent down to 97 per cent.

Across Metropolitan Melbourne through, there are - occupancy rates are always around high 90s to 100 per cents.

Q. What are the kinds of problems that are created when you have occupancy rates at that level?
A. It's well-known that in order to ensure that the system is well functioning and that there's sufficient space available for consumers requiring inpatient beds, occupancy rates should be around 80-85 per cent, and clearly Metropolitan Melbourne occupancy rates are way off, are way higher than that mark.

Q. For about how long have you been operating at an occupancy rate around the high 90s?
A. For as long as I can remember. I've been working in the service for many years, 17 years, and particularly out in the Western Suburbs occupancy rate has always been a very high 90s to 100.

Q. Do you know whether in the Western Suburbs you have higher occupancy rates than elsewhere?
A. I don't believe we have higher occupancy rates, no, I think occupancy rates across Metropolitan Melbourne are consistently high.

Q. You've also commented on the fact that consumers face

long waits in the emergency departments waiting for psychiatric beds. In the context of mental health what do you mean by "long waits"?
A. Long waits could be anything from eight hours to 24 hours. There have been occasions where people have stayed much longer than that, 48, 56 hours, when services are being bed-blocked and we've been unable to access inpatient beds anywhere across the state.

Q. Of the patients who wait 24 hours or longer in the emergency department, what proportion of those are mental health patients?
A. Oh, well, if I use the emergency departments in the Mercy Mental Health catchment area --

Q. Yes.
A. -- probably 99 per cent of those patients are mental health consumers.

Q. How does the 24-hour period correlate with the eight-hour benchmark set by the department? Are they measuring two different things?
A. Well, they're measuring length of stay in the emergency department, but unfortunately because of the very high demand and the low bed capacity across Metropolitan Melbourne, our focus in terms of managing demand is on the 24-hour breaches rather than eight-hour breaches.

Q. Is that specifically for mental health patients or more generally?
A. No, those are benchmarked emergency departments need targets, so those aren't necessarily specific for mental health, that's across the whole health spectrum.

Q. You've commented on the fact that your CATTs at times carry high caseload which limits their availability. What's the effect of high caseloads on the CATTs?
A. It limits their ability to provide timely assessments and impacts on their ability to provide home treatment, which is a core part of their role. Our comfortable numbers are in the vicinity of 20-25 consumers at a time who are being treated, but it's when demand is very high those numbers get up to around 40 which, as you can imagine, across a catchment area the size of Mercy Mental Health's catchment area, it does limit their availability to, for example, conduct an assessment somewhere in Footscray and then travel all the way across to Wyndham

Vale where the next assessment might be or home treatment might be.

So, we try and provide, for example, supervision of medication if necessary with twice daily visits. When the numbers on the CATT board are low we are able to do that. When the numbers start getting higher than 25, then becomes very difficult to provide twice daily visits.

Q. Does it mean in effect that you see the same number of consumers but they have less contact?
A. They would, by virtue of the demand that the CATT team are dealing with, you know, having to manage their workload, they would have less contact with the CATT clinicians, yes.

Q. Can I ask you about the community-based services that are caseload managed. In what respect are they not keeping up with demand?
A. The case managed clients? So, yes. My experience with the Mercy Mental Health over the last - probably it's been something that's been happening for the last 10 years ago is, because the demand is always visible in the acute services, that there's been a slow shift of resources within mental health services from the community to acute services which has left community services in a very difficult position of not having sufficient staff to provide or meet the case management needs of the people that we treat in our catchment area.

Q. What are the practical consequences of that for patient management?
A. Well, there may be unacceptably long wait times before a person is allocated to a case manager. We try not to have any wait lists for case management patients. However, the caseloads of the clinicians then become high, the number of clinical contacts that the case manager is able to have with the person diminishes, and the whole model of community care breaks down, I guess, to be frank.

People relapse in the community, there's not sufficient early relapse prevention in the community, which then feeds into a high demand at the acute end of services, with people relapsing and then having to move back into an inpatient admission, so it becomes a vicious cycle.

Q. I'll ask you more about that cycle shortly. Do you

say you've seen that cycle over at least the last 10 years ago?
A. Within our services, yes.

Q. Would it go beyond --
A. I can't speak to other services but we've certainly experienced that in the Western Suburbs, yes.

Q. Does it extend back beyond 10 years ago?
A. I think it's probably been the last 10 years ago which it's been most prominent.

Q. You've also spoken about invisible demand as being an important gap; can you say what you mean by "invisible demand"?
A. The invisible demand is the consumer's living with very severe mental illness who we don't know about. We know that we should be providing services to about - 3 per cent of the population would suffer with a very severe mental illness. We're probably reaching less than half of that, so there is this whole group of people out there in the community which aren't getting the services and the treatments that they require to manage and to assist them manage their severe mental illness.

Q. You mentioned consumers with chronic and unremitting symptoms who require long-term inpatient care. What are the difficulties in meeting demand there?
A. The only facilities - often this group of people require longer inpatient admissions in order to support their recovery. Acute Inpatient Units have to have a high turnover in order to meet demand coming in. The only facility that we have for longer term is the SECU, of which we have five beds plus an extra bed on rotation available to us, so that is a very limited resource which means that there's usually fairly lengthy waiting lists for people to get in to access those beds.

Q. What happens to patients when they're waiting to get into that facility?
A. If it's safe for them to be treated in the community, they may be treated in the community, but inevitably these consumers spend long periods of time in Acute Inpatient Units.

Q. You've also mentioned that the treatment of consumers with comorbid alcohol and other drug disorders is often

fragmented across the mental health system. Can you say something about the nature of that fragmentation?
A. That's correct. That is one of the many services which we experience as fragmented across the Western Suburbs. We are certainly seeing a high concurrence of major mental illness and substance use disorders, and the substance use disorders are addressed by services outside of mental health programs, mental health treatment programs, which then just add to the complexity in ensuring that consumers are able to access those services. It impacts on the transition of consumers from a mental health service to a drug and alcohol service, so it's not an effective model. We would much prefer to see drug and alcohol services embedded within mental health services.

Q. What provision do you have for secondary consultation to support general practitioners?
A. Unfortunately, we have very, very little capacity. We, in the past, had a well developed Primary Mental Health Team which in our service is known as the Consultation and Partnerships Team. That consisted of a registrar, a half-time consultant and psychologist and clinicians, and this team was able to provide secondary consult to general practitioners in their consulting rooms in the region.

That team was slowly dismantled. Our service went through two rounds of integration of community teams and our primary mental health function was slowly lost. It was slowly integrated into the community teams, and then we were just unable to maintain that capacity, so that again is a big gap in services to practitioners.

Q. Can you explain what was happening when you went through two rounds of integration. What did you mean by "integration" in that context and why did it happen?
A. Mental health services, I believe 15 years ago, had well-developed community models; there were specialised teams within the community. So, you had specialised clinicians providing specialised tasks to consumers with a mental illness.

As the funding became tighter and demand grew, we were no longer able to meet the demand with these specialised teams, and these teams were then slowly integrated to multi-functional teams. So, we slowly over time lost the capacity of specialised care and we moved towards a more generic case management model, where everybody did the same

work.

Q. Can you talk about what is a generic case managed model as opposed to one which is specialised?
A. If I use the example of the HOPS, Homeless Outreach Services. 15 years ago we had a well developed Homeless Outreach Team who were specialised in engaging people with homelessness. In order to do that they had specialised skills. That over the years has slowly degraded, and we still have HOPS clinicians, but HOPS clinicians are now buried within the general clinical teams, and their caseloads are not just homeless consumers, they are also providing - although they provide a bit of a specialist role, they are still expected to provide generic case management as well.

That would be similar - for example, if we take clinical psychology in public mental health services - and again, I'm having to speak to our service - in the past we had clinical psychologists who provided evidence-based therapies to consumers and case managed consumers. Those roles were slowly eroded and clinical psychologists became generic case managers, so they provided case management support, but the ability to provide evidence-based psychotherapies to our consumer group has slowly disappeared.

Q. When you say those roles became eroded, what was involved in that process? Was it a process of recruiting for more general positions with a generic range of skills or something different?
A. We still tend to recruit - we don't recruit as many clinical psychologists as what we did, simply because clinical psychologists are trained in therapies and want to do therapies, so it's a little more difficult to attract them to the public mental health service. Sorry, can you just repeat that?

Q. I was asking you about the erosion of those teams, about the process by which that happens and what it actually means.
A. Yes, as I say, our service went through two phases of what we call integrations of services and in that process you lost the multidisciplinary specificity, I suppose, of clinicians: so, your occupational therapists became generic case managers and your social workers became generic case managers, and so everybody then fulfilled a similar kind of

role and you lost the multidisciplinary input into clinical teams which I believe is very, very important in mental health services.

Q. So, is there an erosion of the skill base?
A. Well, I think over time there is erosion of the skill base, yes. I think what's added to the erosion too is, certainly noticed over the last six or seven years that mental health services have become very focused on a medical model. By that I mean a focus on treating symptoms and treating acuity and using medication to do that.

I think in that process as well, your psychosocial supports and your psychosocial tools then become lost with the focus on, well, what tablet are we going to give you now to see whether that will help you or not. I think that's been a very unfortunate path that - and I would imagine this has happened in many other areas of mental health services - again, I'm speaking from my experience and certainly it's been evident in my service.

I can maybe add as well, is that, another thing that we've noticed is that your case managers - if I'm thinking back again 15 years - the case managers seemed much more confident in managing consumers with complex mental health disorders. Whereas now we notice, it may well be a function of the medical model, but we do notice within the clinic settings that clinicians are - case managers are very dependent on some kind of medical input: they struggle to make decisions without some guiding and that's not what the model's about and that's not what the model should be about. I think that's a very good example of what I believe is a slow disintegration of the skill set.

Q. Just for some clarification, when you talk about an emphasis on a medical model, are you talking about a reliance on medication?
A. Yes, I am.

Q. If we can perhaps look at the issue from a different perspective. If you were to have a properly funded, well functioning community-based clinical mental health service, what features would it have that you don't see now?
A. Well, there's a number of things. I think the first thing you would want to see is that there is quick access to services, that there's not a long waiting period, that the services are there that you can provide, and you should

be able to provide a spectrum of services. So, there shouldn't be just a focus on severe low prevalence disorders, like chronic schizophrenia for example.

There should also be a whole suite of services other than medications which can be offered to people.

Q. Can you give some examples?
A. Psychotherapies, group work. Area mental health services provide treatment to consumers with borderline personality disorder. There are, in my view again, great deficits in the treatment that area mental health services do provide to this group. There's a lot of evidence-based work on successful ways of managing people with borderline personality disorder, an example is dialectical behavioural therapy groups. Fortunately we're in the process now where we're starting to develop that within our service but there's many services that don't have that available. So, consumers have to rely on treatment as usual, which is case management and a doctor, which usually means pills.

Q. Would such a service have an integration between clinical and non-clinical services?
A. Oh, yes. Yes.

Q. So your psychosocial support services would have a strong connection?
A. Would also be involved absolutely, there needs to be a greater collaboration with non-clinical and clinical services within area mental services as well.

Q. In going back to the present reality: in your community-based health service, do you still have the capacity for mobile support teams?
A. Unfortunately not. We lost that capacity in the very first integration, which I think took place in 2010, 2011. We integrated the assertive outreach role of our mobile support team into our community clinics, into our normal community roles; and, with time, that assertive outreach component of services has also dwindled and doesn't exist any more.

Q. What do you see as the importance of assertive outreach in the community context?
A. Predominantly to provide support to consumers with complex mental illnesses and complex psychosocial settings. There is much more regular contact with a person, there's a

stronger role in relapse prevention, early identification of relapse symptoms, managing of those symptoms within the community which then might avert an inpatient admission, might prevent a consumer from having the trauma of being in a high dependency unit or in seclusion on an inpatient unit.

Q. Thank you. We've asked you about what your view is about the drivers of unmet need, and among other things you've said that:

> "There's chronic underinvestment and underfunding of mental health services."

Can I ask you, firstly, about the difference between underinvestment and underfunding?
A. I think when I'm talking about underinvestment, I'm talking about the structural buildings and wards. And underinvestment I think I'm talking - the other component, I'm talking about money that services are given to run.

I believe our service is a good example of what a little more investment can do. We've struggled for many, many, many years with shortage of inpatient beds and major access problems to inpatient beds. We were very fortunate enough to receive funding four years ago to build a new inpatient unit. We now have a state of the art 54 bed inpatient unit - it's been a struggle to staff that, but that's another issue.

Q. We will come to that.
A. But if one looks at our performance and our waiting times in emergency departments, by having more beds there's been a dramatic improvement in that wait. So, I think that's a very good example of infrastructure investment having positive outcomes.

Q. Do you think that that's relieved some pressure on the community-based services as well?
A. Well, at this point in time, no, I think it's actually put more pressure on the community services because there is a high number of consumers who are being admitted and being discharged from inpatient units than before, which means that the demand for community services is higher. And, unfortunately, the focus at that point in time was on building the building, it wasn't on providing funding to increase community resources.

Q. So, does that suggest that, if resources are increased, they need to be increased in tandem in community-based services and acute bed-based services?
A. Absolutely. There's no doubt in my mind about that and that's something that we've seen in our service, and have always in our plannings and our discussions with the leadership team have always been very concerned about.

Q. When you say you've been concerned about that, what features do you see that concern you?
A. Simply that we don't have the community infrastructure to supply, to meet the demand and, in trying to meet the demand, people in the community are not getting the services that they should be getting.

Q. Can I return to your evidence about underfunding. Do you have a sense of the scale or can you convey a sense of the scale of the underfunding, say, over the last decade?
A. I wouldn't have a dollar figure.

Q. No.
A. But it would be very - it would be greatly substantial. It would involve, I think, investments in more teams, more proactive outreach teams. If I had to make an estimate, I think we'd probably have to see at least a doubling of funding to community teams to adequately provide services to those who need them the most.

Q. You talk about chronic underinvestment and underfunding. I think I know why, but why is the word "chronic" an appropriate desk descriptor?
A. Well, I've been in this position for probably 15 years now, and every year there's been: how are we going to manage the budget this year? What services are we going to reduce? How are we going to manage that?

Last year, it was a wonderful year for Mercy Mental Health because it's the first time that we've seen funding flowing into area mental health services, and you're really starting to see differences, so that's another example of, when you do see reasonable amounts of funding flowing into services, what positive effects you see.

So, probably from - I came into the job as Clinical Director in 2005, and probably all the way up to 2017, it was always, how are we going to manage with this amount of

money, what services are we going to reduce, how are we going to balance the books?

Whereas, last financial year there was funding that was coming in and suddenly it was, what services can we now develop to meet the needs of the community, which is a very exciting place to be in and contrasts very starkly to the previous 15 years.

Q. Do you know why there was a difference last year?
A. I think there's a realisation at a government level that mental health services are in a very, very bad shape and that the system is broken and it needs to be fixed.

Q. We've asked you specifically about the contributors to the lack of appropriate resourcing, and you've said that in your opinion:

"There's limited population-based planning in the growth corridors."

In your observation, what's happened to population growth in the growth corridors?
A. Well, there's been an explosion of the population, particularly down the corridors, the Western corridor and up North Western area and out in the far East as well. One just needs to have a look at the performance of area mental health services in those particular areas to see how they're struggling with demand. So, that can only have arisen from an underestimation of the amount of growth that was occurring in those corridors.

Q. Is there any observable correlation between population growth and the type of capital investment and funding that's been allowed for, leaving to one side last year?
A. I'm still not sure that the funding is related to population growth, so I still have concerns that that may not be taking place.

Q. What are the indications to you that there is a lack of population-based planning?
A. Well, I think if you look at an area mental health service like ours as well, if you have a look at the growth in the different sectors of the population as well: we provide services to an adult population only, but being a young area there's been a massive growth in demand for child, adolescent and youth services which I don't think

has been considered. There's also massive growth in people 65 years and over.

If you do some projecting, and we use the National Mental Health Service's Planning Framework to do that, in 10 years ago' time there's going to be an almost 80 per cent - 10-13 years' time, there's going to be an almost 80 per cent increase in the population in that region in the 65-plus age group. There's going to be around about a 50 per cent increase in the 0-15 year age group. Those figures are very concerning when the area mental health service in that area only provides services to 16-65.

Q. And there's no planning on the horizon that you're aware of that is going to allow for that population growth to be catered for?
A. That's the concern. If the planning doesn't happen now - it takes you five years to build an inpatient unit - if that planning doesn't happen now, I think we're going to be sitting in a very difficult situation trying to provide adequate services to those particular groups of the population.

Q. When you're trying to understand need in your area, have you come across any frameworks and tools that give you a good understanding of what's needed?
A. We've been using the National Mental Health Services Planning Framework, which is a tool that was developed by the University of Queensland, myself and the program director were trained in the use of the tool. We think it's a very unique tool that has a look at - that takes population data as well as data from consensus groups and provides it to model services on. So, we've used that tool extensively in our service planning and I think it's a wonderful tool which should be used extensively by services/by government.

Q. You raised workforce issues before, can I ask you about workforce shortages in your area?
A. Workforce is a constant headache and has been a headache for as long as I've worked at Mercy. We've struggled for both senior and junior medical staff.

Over the last few years we've been fortunate enough to stabilise our senior medical workforce, but we continue to struggle with junior workforce.

A good example is, at the moment I have seven vacancies of junior staff in the service, struggling to fill them. We still over the years haven't been able to open the full 54 beds at the new inpatient units, there's still four beds that we haven't been able to open simply because we don't have the medical staff to provide services to the unit.

I'm going to talk to medical staffing, but there's a similar shortage with nursing staff as well. We have noticed that we're also dependent on international medical workforce, so many of our junior doctors are international medical graduates. They tend not to remain within services for a while, and so, we have a high turnover of staff.

Because of the nature of our workforce as well, registration takes an extraordinary length of time, so it can take anywhere from three months to seven, eighth months to get a doctor on board to work. That doctor may then stay for four months or six months and then move on to another position, so there's a very high turnover of staff.

Q. Can I ask you a little bit more about the issue of fragmentation. You've said there are limitations in the catchment design.
A. Yes.

Q. And in particular, that the mental health providers, or you don't provide for the whole-of-age.
A. That's correct.

Q. Mercy has made a submission that there should be one mental health service provider in the catchment and each service provider should service all cohorts. Do you want to elaborate on that?
A. Yes. This is probably one of my big frustrations in my work, is that Mercy provides only services to 60-65, and we then have to deal with three other - well, four, I suppose, four other service providers.

So, we have to deal with the Royal Children's Hospital who provide services to the 0-15, to the child and adolescent population. We also have to deal with Orygen: Orygen provides services to the young adults from 16-25. And then we also have to deal with the aged psychiatric services which are provided by NorthWestern Mental Health.

One of the challenges that we face is that the emergency departments in both - both emergency departments where we provide services to have presentations of everybody across the age range, and then we are then having to try and access inpatient services from services which aren't under our management, and that provides various kind of frustrations.

From a consumer point of view, it is also very complex. People have got given a triage number and phone the triage and then are told by triage, well, you're 17 years of age, you probably should be speaking to Orygen and here's their number; or you're over 65 and this is who you need to talk to. So, we like to believe that we have a single point of entry for services in the Western Suburbs, but in fact it's fragmented across these different services.

Of course, you could add, in terms of fragmentation as well, you could add drug and alcohol services into that complex pattern as well.

Q. I was just about to ask you about that. You said there's been some reform in partner sectors that hasn't really been aligned --
A. Hasn't really aligned with mental health services, no.

Q. Can you elaborate on that in the context of alcohol and other drug services?
A. Yes, well, it's still services which are provided outside of mental health services. We now have a drug and alcohol worker in the emergency department at Werribee Mercy Hospital, but that's one clinician, so it hasn't really had much impact on the demand.

Q. You have described this fragmentation as:

"A lack of systematic whole-of-life approach."

Can you say what a systematic whole-of-life approach should look like in the delivery of mental health services?
A. I think if we use the example of a consumer with a major psychiatric illness, like schizophrenia for example. If we follow the path of that person, they become unwell in their late adolescence, they live in the Werribee catchment

area. Then their initial treatment is provided by Orygen, so for 18 months to two years their care is provided by Orygen. Once their time is up at the two-year period, they are then transferred into an adult service, so their experience then might be different. They then will stay with the adult service, but then once they're over 65 they will move to another service again. I think, in order to have seamless continuity of care within the service, one provider should provide the whole spectrum of treatment to a person.

Q. We've asked you about whether, in your observation, clinical mental health services are crisis-driven and your answer was?
A. No doubt.

Q. One of the factors that you have identified as evidencing crisis-driven service, among the others you've already mentioned, is:

> "... insufficient leadership within the mental health program to enable area mental health services to strategically design and shift functioning to a more proactive future-focused service delivery."

Can you say what you mean by a lack of leadership in that context?
A. What I'm implying there, is that, services which are crisis-driven become very inward-looking. The focus is on managing the demand from hour-to-hour to day-to-day, which doesn't give leaders within the programs the ability to step back and to have a look at how things might be done a little differently.

Also, the funding that comes into mental health services from the department is always tagged to some or other function. So, there's, this money comes and it's to provide X services. There's never any money that comes into services to provide a leadership structure which could help assist services move from a crisis-driven, inward looking service to a more broadly outward looking service. I think that's what I'm implying by that.

So, the division between strategic and operational within a service like ours is greatly challenging because the operational pull is very, very strong, so one doesn't

have the scope and the time to spend strategising on how to improve. And I don't believe that the funding model from the department supports any kind of development in moving towards a more strategic management structure within a mental health service.

Q. On the question of funding, one of the things that you have said enables your service to function as well as it does despite the challenges, is that the funding earmarked for mental health is ring-fenced by Mercy Hospitals Victoria Limited. Can you say why it is that ring-fencing of mental health funding is so important?
A. That's correct. We're very fortunate in having a board who is strongly supportive of mental health services and the development of mental health services. The board is committed to, all funding that comes to mental health stays with mental health. I understand that that's not always the case with other services, but the case with Mercy, everything that is provided by the department for mental health services comes to mental health services. I think that's a very positive feature of Mercy Health.

Q. You've said that the board is very committed to that. Is that essentially what secures the ring-fencing, that the board has an understanding of and is committed to it?
A. Yes, I believe so. Yeah, I think the commitment needs to be at a board level and we certainly have that within Mercy.

Q. On funding, we've asked you, what are the most significant challenges facing the mental health system and you've said:

> "There's a lack of transparency and much variation between catchments regarding base level mental health service provision and subspecialty care."

My question to you is, when it comes to resourcing, are all catchments treated equally?
A. No, and I suppose that's one of my concerns about service provision across the state. I strongly believe that, if you live in Wyndham, or you live in Footscray or you live in Toorak, you should be able to access the same level and the same quality of services, and that's not the case across Metropolitan Melbourne. Services are, I believe, funded differently, nobody's really aware of

what other services are getting, so there's certainly a lack of transparency about what the department is providing to services in terms of funding to that particular area.

Q. In terms of lack of transparency, what information would be useful to have that you don't have?
A. I think, again, talking at a broader departmental level, I think in terms of planning new service models, we are often informed that receiving a letter to say, you are receiving X amount of money to provide this type of service. We would like the freedom to say, well, we need the money, thank you very much, but we don't need the money to provide that service, we need the money to provide this service. I think there's a lack of transparency in terms of planning those kinds of services.

We don't understand - I certainly don't understand - where the decisions are made about what kind of services area mental health services are going to be asked to provide.

Q. Do you think it would be helpful to understand, between the services, how they're each funded each year?
A. I think it would be very helpful, yes.

Q. Why is that?
A. Well, I think it creates some equity across services. You know, one understands what their problems might be and I think it just creates a much more open system.

Q. Does the current funding model, which is block funding, contribute to inequality between catchments in your view?
A. Well, the block funding is based on bed numbers and community contact hours, so it may well. We would much prefer to see more an activity-focused funding. So, if you are treating consumers of a higher complexity on an inpatient unit that you would get, that your work would be recognised, rather than getting a flat bed day rate for that person.

Q. Can I perhaps put the question differently. Would activity-based funding assist the resourcing of different catchment areas to be more equitable, do you think?
A. Well, I think there will be the recognition of the different levels of complexity that services might be managing, which the model at the moment doesn't. I think,

with that kind of funding model, you'd be recognised for the actual work that you're doing; where at the moment there's no recognition, and that accounts for all services.

Q. Do you see scope for outcomes-based funding?
A. I think outcomes-based funding has a place, yes, because again it goes to the amount of work and the effectiveness of your work.

Q. One of the things we asked you was about the critical elements of a well-functioning mental health system, and among other things you said:

> "It is important that the recognition that mental health is not only a health issue and requires strategic alignment with other sectors outside of health such as housing and employment."

Do you have views about how strategic alignment with other sectors can be effected?
A. How it can be effected? Well, it would be a regional approach to including - a regional and a government approach - involving those particular service providers within your area.

I think one of the challenges with moving mental health services forward, is that, the focus should not be on health alone. Mental health is much more complex than that and we need to consider - you know, homelessness is very high, so we need to consider housing services. Employment is a major issue with the automation and the changes in the job market: our consumers are struggling to find work, so having some links with employment services, I think, are very important in providing more of a holistic approach to the care that services provide to consumers.

Q. Dr Stevenson, is there anything important you wanted to say that I haven't asked you about?
A. Not at this stage, I think we've covered everything.

MS NICHOLS: Do the Commissioners have any questions?

CHAIR: Q. I have one, please. I just was interested in the fact that you referenced the fragmentation particularly around drug and alcohol and mental health services, and you also talked about some of the changes you'd seen over

the years and one of the factors you identified was the prevalence of substance abuse and in particular the prevalence of ice.
A. Yes.

Q. You went on then to argue that, in fact, you thought the model wasn't effective currently with the separation, and that you would rather see drug and alcohol services embedded in mental health services.
A. Yes.

Q. Can you just give us a sense of what you think would be gained by doing that and, if you are, what might be the arguments against it?
A. I think, as I mentioned in my argument there, there is a high percentage of our consumers who are being admitted with drug and alcohol use disorders as well as major mental health disorders. At the moment there's a very piecemeal approach to the management. There is a drug and alcohol worker on the inpatient unit, but they're employed by another service, so they provide an in-reach service.

The challenge, I believe, is with the discharge and the ongoing treatment in the community, because that's where it becomes more fragmented. If the person is being case managed, they will then move onto a mental health community clinic; whereas they may have a drug and alcohol worker through one of the other services, so there already you have a division of service and, if there's not close liaison between care providers, it becomes complicated and it increases the risk of gaps in care.

So I think, if those treatments are unified and are under one management, I think that the gaps in care and the communication is a much simpler process, much more streamlined process.

CHAIR: Thank you very much.

MS NICHOLS: Dr Stevenson, I omitted to ask you at the outset, did you prepare a statement in response to a request by the Royal Commission?
A. I did prepare a statement, yes.

Q. Does that statement set out your opinions and your answers to the questions we've provided?
A. It does.

MS NICHOLS: I tender that statement, thank you. [WIT.0002.0008.0001] May Dr Stevenson be excused please?

CHAIR: Thank you very much for your evidence, Dr Stevenson.

<**THE WITNESS WITHDREW**

MS BATTEN: Commissioners, the next witness is Professor Malcolm Hopwood. I call Professor Hopwood.

<**MALCOLM JOHN HOPWOOD, affirmed and examined: [11.01am]**

MS BATTEN: Q. Thank you, Professor Hopwood. If you could just sit so that we can hear you in the microphone and just make yourself comfortable, thank you.

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

Q. I tender that statement. [WIT.0001.0010.0001] Professor Hopwood, would you please briefly describe your current role and your responsibilities?
A. I am the Ramsay Healthcare Professor of Psychiatry at the University of Melbourne, based at the Albert Road Clinic here in Melbourne, a private psychiatric hospital and there I lead a clinical unit that looks after patients, as well as run an outpatient private psychiatric practice.

Q. I'd first like to ask you some questions about the private sector. So, what is the private sector?
A. So, the private sector in mental health, I'll be predominantly talking about the specialist private mental health sector as opposed to primary care. That would include private psychiatric hospitals and private psychiatrists, some of whom will work as a tenant within a hospital, others who will have a practice in a separate building. Those private psychiatric hospitals often provide services like outreach home-based care, home nursing care, or day programs for patients as well.

Q. You've talked to us about what the private sector is made up of. How do Victorians access the private sector?
A. Predominantly access is via primary care with a GP

referral to a psychiatrist. We do also sometimes have people who access our service via the public mental health services, where they can be referred by doctors from the public mental health system as well.

Q. What are some of the barriers to accessing the private sector?
A. I think the outpatient private psychiatrist consulting, one of the most significant gaps for many people is the out-of-pocket expense that that involves. Of course for some people who are acutely unwell, the simple process of obtaining a referral in a crisis can be difficult, and there are usually waiting times for appointments, with most consultant psychiatrists having waiting times that run into several weeks which may not be appropriate for all clinical situations.

Q. I will return to the issue of cost, but first I'd like to ask you about the Albert Road Clinic. Could you tell us what the Albert Road Clinic is, please?
A. Yes, so the Albert Road Clinic is a 120 bed private psychiatric facility, run and operated by Ramsay Healthcare. It has a series of units: general adult psychiatry, addictions, adolescent mental health, old age mental health, and the professorial psychiatry unit I run, as well as that, it has a set of consulting suites within the premises that psychiatrists will rent and we run day programs and outreach services from that site.

Q. You mentioned you have addiction services. Do you have the capacity to treat people for addiction within the Albert Road Clinic?
A. Yes, it's a very pleasing and, in my view, a very appropriate model to have them under the same roof, where patients can be detoxified and receive specific treatments for their addictions and their comorbid mental health problems, we know about the frequency of overlap, can be treated under the same roof.

Q. You've mentioned people with addictions, who in general receives services from the Albert Road Clinic?
A. For addictions?

Q. No, more generally?
A. The commonest diagnosis we see would be mood and anxiety disorders, comorbidities with addictions, personality disorders would be very common. In the old age

group obviously we're more likely to see disorders like dementia evolving.

About 15 per cent of our admissions are for patients with psychotic disorders like schizophrenia, but clearly that balance with mood disorders would be largely the reverse of what's seen in the public mental health system.

Q. Why do you think that is?
A. I think that's a very interesting question. I think that there is an active discriminatory process against patients with mood disorders in the public mental health system where they find it difficult to access that system. We have many patients with severe mood disorders within our facility who really struggle to access care.

Q. Can you elaborate on what you mean by active discrimination?
A. I think the public mental health system has become very skilled at dealing with psychotic disorders like schizophrenia and some types of severe personality disorder, perhaps arguably borderline personality disorder.

But patients with, for example, severe depression, with suicidality, often experience great difficulty accessing public mental health services, and that's important because they constitute the single largest group of Victorians who ultimately commit suicide.

Q. Can I come back to the Albert Road Clinic and who receives the clinic's services; what are the criteria to get in to receive the services, in terms of, you mentioned a GP referral, what are the things that you need to satisfy to get in?
A. It's an entirely voluntary admission process, you're unable to be admitted as an involuntary patient. For admission to the hospital, generally that requires private health insurance that covers inpatient psychiatric care.

The out-of-pocket bed day cost would be approximately $800 to $900 which over a two to three week stay clearly would be financially intolerable for many people, so private insurance is central to the inpatient care.

The voluntary status, as I described, in terms of level of behavioural disturbance, the hospital will have some limits on physical aggression towards others, or other

disinhibited behaviour, for example sexually disinhibited behaviour, but otherwise retains fairly broad admission criteria, which I think is very important.

Q. You mentioned two to three weeks in an inpatient admission; what does that reflect? Is that an average length of stay?
A. So, the average length of stay in my professorial psychiatry unit is 20 days.

Q. Did you say $800 to $900 a day?
A. A day, if you would pay fully out-of-pocket.

Q. So that's for the inpatient admission. What about seeing a private psychiatrist for a one-hour session, what is the cost of that?
A. Private psychiatrists set their own fees and that's entirely up to them. I gave in my statement an estimate that the commonest fee for an initial consultation would be somewhere around the $130 to $200 mark, and subsequent appointments may have a similar or smaller fee. Psychiatrists also have the right to choose to reduce that fee in the setting of financial difficulties, and as I mentioned in my statement, a substantial minority are bulk billed. From my recent work as Chair of the Medicare Review Committee For Psychiatry for the Commonwealth Department of Health, I can say that estimate is about one in three who see a consultant psychiatrist are bulk billed.

Q. In terms of the fees that the psychiatrists charge, has that fee grown?
A. Yes, my sense, and obviously it can only be a sense because people set their own fees and don't always discuss them, is that the gap has grown over the last decade. I think that probably is largely a result of the failure of the Medicare rates to match inflation during that time and been specifically frozen for a period of that time.

Q. So the cost is roughly up to $200, that's the gap cost?
A. That's the out-of-pocket gap cost.

Q. And then, can you give us an average of how - and I understand this is a broad question because it will depend on the condition that a person has - but how frequently may someone need to see a private psychiatrist?
A. It would be typical obviously in the more acute phases

of illness to see them more frequently, weekly for example, and then as things are stabilised it would be more likely to be several weeks and then during a stable period, months. So, an average would probably be measured in a few weeks, that's the roughest estimate I can provide.

Q. Basically, is it the case that you need private health insurance to access treatment at the Albert Road Clinic?
A. To access inpatient treatment. Obviously, a very small proportion of people could pay that sort of money out-of-pocket. To access outpatient consulting by one of the psychiatrists there, insurance doesn't make any difference to that cost.

To access the day program and the average nursing services, they are also funded by insurance.

Q. So why does it make a difference to the cost? You've still got the out-of-pocket gap, the insurance won't cover that; is that right?
A. Yeah, so private insurance does not cover a consultation with a specialist medical practitioner like a psychiatrist.

Q. So a person needs to have the capacity to pay for that?
A. Correct.

Q. You mentioned briefly the kind of clinical problems that you see. Would you just describe again for us, who is the makeup of the people that come into your service?
A. I think the commonest diagnosis we'd see is bipolar disorder, both manic and depressed phases; major depression. Generally the people who are admitted will have moderate to severe major depression with common symptoms like suicidality. Many of those patients will also have problems with anxiety disorders, like generalised anxiety disorder, panic disorder, obsessive compulsive disorder.

As I mentioned before we see a proportion of patients who have psychosis. Amongst the patients with those disorders, there's also a high rate of people who have comorbid abnormal personalities, or personality disorder, and that will include many people who have histories of abuse, childhood trauma or violence in their lives.

Q. You gave an estimate that you thought 80 per cent of the people in the professorial unit had suicidal ideation?
A. Yes, so at the time of the admission rates of suicidal ideation and suicidality are very high; it's an estimate made by myself rather than an established figure, of at least 80 per cent.

Q. That's a broad cohort of illnesses that you treat, how do you handle those problems, what sort of treatment do you offer?
A. Many of the treatments we'd offer are broadly similar to those in the public mental health system. They would involve a combination of pharmacotherapies, psychotherapies, both group and individual. We may use treatments where appropriate like TMS, transcranial magnetic stimulation, or ECT, electroconvulsive therapy.

A very important part of the treatment is the treatment outside of hospital and the subsequent follow-up arrangement, and quite typically that would involve attendance in a day program where group therapy and individual therapy are practised, as well as attendance at a psychiatrist, sometimes also a psychologist for individual therapy as well.

Q. Can you tell us what the Health of the Nation Outcome Scale is, please?
A. Yes, it's a measure of health-related disability that's utilised in the mandated Mental Health Outcome Measurement Suite across public and private inpatient mental health services in Australia.

Q. Sorry, what does it measure?
A. It measures health-related disability.

Q. You have stated:

"It may be valuable to know that the average level of disability of those people as measured with the Health of the Nation Outcome Scale is exactly the same as those admitted to the acute units publicly."

When you say "those people", you're referring to people in the professorial psychiatric unit?
A. That's correct.

Q. That's the people you're referring to. So what does it mean that the average level of disability is the same in that unit and in the acute units publicly?
A. So the study we conducted involved looking at the admission HoNOS scores for people admitted to the professorial psychiatry unit I lead. Really to compare then to the national average of people admitted to public acute adult units - most of the patients in my unit are adult.

There is a perception, I think, in some quarters that patients admitted to private services are not as unwell. My perception would be, in fact, they are very unwell, perhaps just in some different ways. We indeed found that the average score we obtained on admission to our unit was essentially identical to that in acute adult public units across Australia. That data's available on the Commonwealth website.

Q. In terms of demand, are there enough private psychiatrists to service the demand?
A. No, as best demonstrated by the waiting list for most private psychiatrists. So, most private psychiatrists have a waiting list measured in many weeks, even though clearly clinically that's often not desirable to help deal with acute mental health problems.

In fact, if we talked to general practitioners, they will frequently comment on how difficult it is to access a private psychiatrist, so it clearly appears there is not enough to meet need.

Q. Do you have experience with consumers whose needs are too complex for the primary care system but who are not sick enough to obtain access to the specialist mental health services?
A. Yes, I think we probably do. Within private psychiatric broadly we would see I think a range of disability beyond that that's currently seen in public mental health. So we see some very unwell people, but particularly in outpatient practice perhaps some of those who are slightly less disabled and would form a significant proportion of that group up to the 3 per cent that's frequently mentioned in the planning framework is what we'd like to cover. But I clearly can describe from their experience that, despite being within that 3 per cent, they would still experience great difficulty accessing public

services.

Q. Do you see them at your service?
A. Yes, we do.

Q. You have mentioned this earlier but you have stated in your statement:

> "In my view it is a mistake to think that those higher prevalence conditions are always less severe."

The higher prevalence conditions that you were referring to are the depression conditions. Why is it a mistake to think that they're always less severe?
A. I think there's often been a concern in our system response that, if we respond to the needs of everyone with depression, which affects after all one in five people in the community at some point in their lifetime, that our services will be overwhelmed.

I think we can quite reliably state that somewhere around 5 per cent of people with depression have severe depression and therefore probably require a specialist response, as opposed to a purely primary care response.

However, my perception, and I acknowledge it is my perception, is that depression is frequently defined as being less significant and therefore there is less of a public mental health response to it.

Q. Are you separating forms of depression there then? The category that's 5 per cent, is that a major depression or how do you categorise that?
A. No, that would be severe major depression. I recognise the terminology is often debated and a little confusing. Major depression is a term that's used to describe what most people in the community would say is depression. Within major depression there's severe, moderate and mild, and severe would be about 5 per cent of that category.

Q. And so, is it the 5 per cent in the severe category that's not being properly serviced; is that what you're saying?
A. Yes.

Q. Can I ask you about the comparisons between the public system and the private system. First of all, in what circumstances would you send patients to the public system? So, when are you no longer able to treat patients?
A. It predominantly relates to their capacity to make decisions around their treatment. So, we would provide treatment to everyone, as long as they're able to abide by some simple regulations about behaviour within the hospital. If, however, their illness deteriorated to the point that they were no longer able to make informed decisions about their care, then issues related to the Mental Health Act may well become relevant. That would be the circumstance in which we would transfer to public mental health care.

Q. How often does that happen?
A. From Albert Road approximately once a month or every two months.

Q. What do you do with the people who have got behavioural problems?
A. Well, it's really best, where possible, to discuss and deal with those before a person comes into hospital. So, part of our screening procedure for a potential referral for admission would be to ask about difficult issues, perhaps arrange for an assessment before a person comes in, and try and work out a management plan where we can find a way around that.

It would be, thankfully, rare that we would actually say no, and I think that's as it should be.

Q. Can you talk to us about the key differences between the private mental health system and the public mental health system?
A. I think in terms of the patient experience of entering the system, I think the environments at a simple level tend to be nicer environments, and I think that is an important part of care, that the facilities are nicer and I don't think that should be underestimated in how that influences people's experiences of care.

Q. Why is that important and why should that not be understated?
A. Well, if you receive care in a building that is well maintained and attractive, it is likely to be a much better experience than if you receive care in a building that is

not well maintained and unattractive or even not fit for purpose.

I think one of the key elements of the experience from receiving private mental health care is about ongoing relationships; that's particularly the ongoing relationship with the private psychiatrist. So, for many patients experiencing public mental health care one of their concerns is that staff, including medical staff, may turn over, particularly trainee psychiatrists turn over every six months, whereas in private they're more likely to have an ongoing relationship with a doctor of their choice.

We're fortunate at Albert Road that we also have quite a lot of stability of staff; it's seen as, I think, a reasonably desirable place, for example for nursing staff to work. So, people also have an affiliation with the place that I think can be really important as well.

Q. One of the other factors you mentioned in your statement is access, and you've referred to the issue of private health insurance, but you've also made mention of the need for a GP referral and the fact that for someone who is acutely unwell, that's no small task to get that. Could you elaborate on that, please?
A. Well, it requires the organisation to get to a general practitioner and get a referral arranged, assuming the general practitioner is happy to do so. As I say, that might seem like a straightforward task but, when you're acutely unwell it's not necessarily easy. If you lack the motivation to have a shower in the morning because of severe depression, getting to a GP can be difficult.

So, it's not easy for everyone. I would emphasise, I don't think it's these days much of a barrier at the GP level. If someone requests a referral, in my experience most general practitioners are very willing to do so.

Q. Could you talk to the Commission about what the current interaction is between the public and private mental health system. What exists at the moment?
A. Well, I've mentioned the potential for transfer to public mental health for inpatient care if necessitated by involuntary status. There is also a flow the other way, a relatively small flow of patients, say, referred from the emergency department, who in the emergency department it's discovered they have private insurance, so their mental

health admission could appropriately be done privately.

I think that there is also an interchange, as patients stabilise in public community mental health, they may be referred to a private psychiatrist for ongoing care.

I would make a general comment that I feel those interactions are still relatively small in scale and there is the potential, I think, for significantly greater utilisation of the resources that lie in the private psychiatric sector.

Q. Just before I ask you to expand on that, when you say if someone's got private health insurance and they can do a private admission, does that mean that they would still be admitted into the public hospital or they'd be physically transferred to your facility?
A. No, I was referring to being physically transferred to our facility; obviously, only relevant if it's a voluntary admission.

Q. You said there's broader scope for more integration and collaboration between the private sector and the public sector. Do you have any ideas on how that could be done?
A. Yes, I think it's important to acknowledge, we have a resource of 700 private psychiatric beds approximately in Victoria; that's a very large resource. It does have quite high occupancy rates currently, but we've seen some arrangements, most recently with Victorian drug and alcohol services where, to ease some waiting list difficulties, they've contracted with private providers like Albert Road to admit a number of people for detoxification.

We've had some attempts some years ago in Victoria to look at similar public/private arrangements for psychiatric admission, but to the best of my knowledge none currently exist.

I think there's also potential to look at better arrangements around those emergency situations. Private psychiatric hospitals are generally not perhaps as well geared as they could be for emergency admissions, particularly after-hour emergency admissions, and I wonder with some planning there might be an opportunity to utilise that resource better.

Finally, I think it's worth acknowledging that, in

terms of consultant psychiatry resource, even though it's heavily utilised, there is a lot of resource in the private sector at a time when, I'm sure you've heard, psychiatrist resource in the public sector is strained and often difficult. I have often thought there might be the opportunity for more arrangements to facilitate an interchange between private psychiatric outpatient practice and public mental health care. For private psychiatrists, that would need to involve I think confidence that the arrangements would be a truly shared care arrangement with ease of transfer between private and public services.

Q. You referred to the occupancy rates in private facilities. Are you able to give an indication of what those occupancy rates are, at least for the Albert Road Clinic potentially more broadly?
A. Probably only for the Albert Road. The occupancy rate at Albert Road is approximately 90 per cent; it fluctuates but approximately 90 per cent, but that implies there is relatively some capacity there that could be utilised.

Q. In terms of accessing psychiatrists, you referred in your statement to the issue of retaining and recruiting psychiatrists for rural areas. Could you talk to the Commission about some of the issues that there are with attracting and retaining psychiatrists in rural areas?
A. I think there are a set of issues that are common to attracting and retaining psychiatrists in rural areas, private or public, and then some specific to either.

Some of those issues are common to other medical specialities who suffer some of the same problems. They are around professional isolation, difficulties accessing continuing professional development, lack of peer interaction opportunities, perhaps often feeling like the only specialist in that area in the facility or in the area. And, depending on the size of the area, some concerns about the nature of psychiatric practice and operating as perhaps a sole practitioner in a small community where the chances of meeting people that you are currently engaging in treatment are somewhat higher than perhaps if you're operating in a large metropolitan area.

I think there are also issues that are perhaps a little more specific to public psychiatrists in rural areas, where we know that currently in Victoria a considerable proportion of that workforce is

overseas-trained. They are often seeking to obtain their Australian and New Zealand Fellowship, but that can be very difficult to get the requisite education, and the rural mental health services vary in how supportive they are of that pursuit. I think that's a very challenging situation for someone who's been an established practitioner in their own country.

It's not surprising that that results in often a relatively high turnover of specialists in public rural mental health services in Victoria, which tends to accelerate the problem in a sense rather than establishing a good core.

Q. Are you aware of initiatives to try and recruit and retain psychiatrists to rural areas?
A. I think there have been some initiatives, so the development of a position linked to the office of the Chief Psychiatrist that focuses on training for overseas-trained specialists in rural areas, and I think that's a good and positive initiative.

I think that further initiatives are at the behest of that specific service. So, there was some tremendous initiatives under development in some areas of Victoria I can think of that gave people both specific psychiatric education and access to visiting academics and others who do teaching, as well as cultural training.

I've often thought it's very challenging that we bring people from overseas and perhaps send them to areas in Victoria - I can say this coming from the country - that culturally might be the most difficult for them to immediately settle into.

Q. You have identified in your statement that funding is a significant challenge facing the mental health system. Where do you think the funding should be invested?
A. I would begin by saying, I think across the board there is a lift in funding needed, including in inpatient services, and there I would like it to particularly support the development of a range of inpatient services.

In some areas, a decreasing number, if the only resource available to adults for example is an acute, rather closed ward, that can be a very intimidating environment for people, perhaps particularly for their

first time in hospital, and so, a range of step-up and step-down environments should definitely be supported.

I think our community-based care has declined in the last decade in both its sub-specialisation and its capacity relative to population growth in particular. I think one element of that that I mentioned specifically in my evidence relates to capacity to provide home-based care to individuals.

It is important to remember that one of the key design elements of de-institutionalisation was the capacity to provide home-based care based on research looking at intensive outreach treatment, and in the early days of de-institutionalisation that was a significant component of our community-based care for people with mental health problems. That has declined as a proportion significantly, particularly over the last decade, in my view, and I think that's very unfortunate. I think that's a wonderful way to be able to treat many people.

Q. Why do you say it's wonderful; what's the benefit of that type of care?
A. I think for some people, and some families, the opportunity to have care at home is something they value greatly. Many people feel much safer receiving care in home, they feel they've got the support of their family close by, and they feel I think a greater sense of control over the situation, which I think is very important for all of us at the end of the day. So, it needed to be judged carefully who it was appropriate for and monitored closely how it was going, but it was something that many people clearly liked and appreciated greatly.

Q. Did it have a positive impact on their treatment and their outcomes?
A. Well, the research that supported de-institutionalisation demonstrated that for many people assertive community-based care in their own home or residence decreased subsequent admission and improved outcomes, so that was a key plank of the de-institutionalisation movement.

Q. Was that research from the 90s?
A. Yes, it is somewhat old now, but it is worth noting it's repeated in many countries, and many of the original research was in fact Australian, including work by John

Holt in Sydney.

Q. Are you aware if there's more current research?
A. It's probably not my main area of current research interest, so --

Q. You don't have to answer that. You talked about the environment in which care is provided, and you referred to the need for different forms of environments to treat different types of conditions. You also referred to various international models, in particular the Copenhagen Mood Disorder Clinic. Could you tell us what the Copenhagen Mood Disorder Clinic is and how it provides treatment?
A. So, that model was designed in response to some similar problems, where it was perceived that within the public mental health system, which is very strong in Denmark, skills and expertise around mood disorders and their management had declined within the system.

So, it's a multidisciplinary clinic, staffed by psychiatrists, psychologists, social workers and nurses, that patients are referred to specifically with severe mood disorders, it is targeted at the severe mood disorder group. Referral is encouraged early in the course of illness. It provides a strong secondary consultation service, as well as ongoing periods of care for a relatively small number of people. Clearly, there needs to be some definition about what percentage of people with mood disorders at clinics such as that you could treat in an ongoing way.

Those treatments offered there would include pharmacotherapy, psychotherapy, much as I outlined are offered at Albert Road Clinic. It operates on a regionalised basis and there's significant evidence that's demonstrated it's improved outcomes for patients with mood disorders compared to treatment as unusual in a neighbouring region of Denmark and done so in a cost-effective manner.

Q. And so, is it your view that the whole model could be considered for the Victorian framework or are there parts of it that you would recommend?
A. Look, I think clearly any introduction of such a model would need to involve a negotiation about how does that fit within the current Victorian sphere, including within the

current regionalisation of services in Victoria.

I would see, if it came to Victoria, another important role that - although less well written - the Copenhagen clinic has is around education for mental health services around the management of mood disorders. If you establish a specialist group, why not also utilise them to upskill all of the workforce?

Q. Professor Hopwood, is there anything that we haven't covered in my questions to you that you would like to raise with the Commission?
A. No, not particularly, thank you.

MS BATTEN: Chair, they are the questions, do the Commissioners have any questions?

COMMISSIONER McSHERRY: Q. Thanks very much for your statement. Just a couple of quick questions really. We've been hearing a lot about the public system, particularly for women: fears of sexual safety, violations and so on. You've mentioned in your statement you don't use seclusion, you don't use physical restraints. Are there separate places for women within the Albert Road Clinic?
A. Not formally, no. Perhaps to describe a little bit about the unit I run. First of all, everyone has a single room and their own bathroom. All rooms are lockable.

Q. That was going to be the next question.
A. We do have, and it's an interesting concept, we do have a high dependency area. Now, it's an interesting notion, people voluntarily agreeing to be in a closed area, but people do so. That enables us to manage sometimes situations that would create risk and fear.

I mentioned that many of the patients we have within our service, and indeed I'm sure in public mental health services too, have a history of violence and sexual abuse, either as a child or as an adult or, sadly, both; so it's also about a culture within the staff of awareness of risk and awareness of sensitivity of particular people to that risk and managing that carefully. I think those elements of culture are just as important as the literal structural arrangement of the ward.

Q. The other question, just following up, you said it's usually on average once a month a patient might have to be

transferred to the compulsory system. You mentioned that sometimes that might occur because of a lack of capacity to make an informed decision. I just wanted to query that, because that's not a criterion in the Mental Health Act. Is it more because of a risk to health or safety that the person actually becomes transferred?
A. Usually fundamentally, without risk, it wouldn't occur. Where it occurs, the clinical issue is usually about a person's illness is such that they are no longer able to make good decisions about how their illness and that risk should be managed.

I would add, just as a statement to that: it is interesting that most patients who experience care in the private system do wish to continue to do so and they and their families are often very keen that they remain with us, which often creates a tension that we need to manage very carefully.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Q. Professor, I'd like to ask two more follow-up issues. One was that, when you described the services that you provide at Albert Road Clinic, you mentioned that you have day programs. Could you please explain to us what they are and what your consumer feedback is about their relevance to their care and treatment?
A. So day programs, which are things people can either attend before admission, after admission or independent of admission, are therapeutic programs where the person would attend usually once a week, approximately four to six hours they would be attending at the hospital. They would be predominantly psychotherapeutically-based, so people would attend a number of groups during that time, and they would usually also have an individual session as part of that time.

We run a range of programs targeting the common issues that we confront clinically: a dialectical behaviour therapy program to assist people with borderline personality disorder, addictions program, an adolescent program, old age program, managing mood. We also have recently instituted, I think very importantly, a physical wellbeing program, noting the very important data about physical ill-health in people with serious mental illness.

We also run a series of anxiety disorder programs

specific to the relative anxiety disorders that have a cognitive behavioural basis. For most people attending the day program, effectively everyone, they'll also be attending a psychiatrist who is likely to be attending to the biological management, if I can put it that way.

Q. Typically, does that mean, whilst the people are participating in the day program, they're also simultaneously also maybe seeing their psychiatrist at various times?
A. Yes, yes. We try generally to organise it on the same day to assist people: sometimes that works, sometimes it doesn't.

Q. Is the participation rate in those day programs high?
A. Yes, it is. The participation is dependent on referral from a psychiatrist. Perhaps the most relevant parameter is, what is the persistence rate? Do people stay for the duration of program? And those rates are high, generally over 75 per cent would complete a full treatment program, and their satisfaction is good. It is quite obviously never going to be perfect but is generally very good.

I think that reflects the challenges perhaps accessing organised therapeutic programs like that on a broader community basis: they're not widely available.

CHAIR: Thank you.

MS BATTEN: Thank you. May Professor Hopwood please be excused?

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

<**THE WITNESS WITHDREW**

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

CHAIR: Yes, thank you, we're adjourned.

SHORT ADJOURNMENT

MS COGHLAN: The next witness to be called is Georgia Harraway-Jones, and I call her now.

<**GEORGIA KATE HARRAWAY-JONES, affirmed and examined:**

[12.00pm]

MS COGHLAN: Q. Thank you, Georgia, I'll ask you to sit closer to the microphone so that we can hear you clearly. You provided a statement with the assistance of the lawyers for the Commission?
A. Yes.

Q. I tender that statement. [WIT.0001.0014.0001] You're currently 20 years of age?
A. Yes.

Q. Just over two years ago, you began to suffer from a debilitating eating disorder?
A. Yeah, that's right.

Q. You were living at that time in regional Victoria?
A. Yes, in Ballarat.

Q. Can I just ask you then about really your early teenage years around 13 and 14 and what was going on really with your thought patterns at that time?
A. Yeah. At the age of 13 or 14 I started to develop, like, depressive and eating disorder thoughts. I wasn't necessarily acting out on behaviours or whatnot, but I definitely had the thoughts. I did try and seek help, but I was told that there was nothing wrong and I was fine and --

Q. What was the avenue that you sought help from at that time?
A. Through the counsellors at the school I was at.

Q. And nothing was forthcoming?
A. No, nothing was forthcoming. After that I was kind of too scared to reach out for anything for quite a number of years, I didn't believe that I was sick or that this was abnormal.

Q. By the time you turned 18 and you finished high school, what was happening with your friendships?
A. Yeah, as everyone knows, once you finish high school it's a time of huge change, people are moving off and starting the next chapter of their lives. A lot of my friends moved up to Melbourne to study, I started working

full-time at a local high school doing education support.

Q. You've just been talking about working at the local high school, and this time in your life after you finished school yourself. So, what then changed for you in terms of your behaviours?
A. I guess thoughts started getting stronger and stronger and then I guess I had this immense feeling of isolation and whatnot and I guess the eating disorder behaviour became a maladaptive coping mechanism for those thoughts that I was having at the time, yeah.

Q. Was that feeling of isolation because of the friends moving away?
A. All sorts of things. At the time, you know, like, depressive thoughts were getting quite strong as well as the anxiety, and so I utilised my eating disorder behaviours as a way to manage and cope with, you know, what was going on, yeah.

Q. Can I take you to March 2017, what had developed by that time?
A. I started using a lot of behaviours and I lost a bit of weight, and like particularly family and those that were close to me were starting to notice that things weren't right.

Q. You ended up seeing a GP in July 2017. What drove you to do that at that time?
A. I honestly didn't think that I was sick, but my mum was on my back a lot, really wanting me to go get help and whatnot. So, I went to the doctors to assuage her worries, you know, I was convinced I would walk out and there would be nothing wrong, but I walked out of that doctor's appointment with a diagnosis of depression, anxiety and an eating disorder, along with a referral to a psychologist.

Q. And so, you're 18 years old at that time?
A. Yep.

Q. Can I ask you then, from then, really about the difficulty you had in accessing services to start with that. You've talked about the referral that you got from your GP for a psychologist. What happened with that?
A. Well, initially I was referred to one psychologist who had a wait time of over 12 weeks. So, I went back to another doctor to get a different referral, because I

didn't really want to wait, I can't remember, it was a couple of months, and it was recommended to me by their clinic to find someone else. So, I found someone else and I went to them, but again I had about a wait time of about 8-10 weeks. I was referred mid-July and I didn't see them till late September.

Q. You were able to get 10 sessions?
A. Yes, that's right.

Q. You were later on referred to a dietician as well?
A. Yes.

Q. What were the wait times like there?
A. With the dietician it was even worse. So, I was referred to a dietician through the public hospital so I wouldn't have to pay. I was referred in September, I think, of 2017, early on in September, and I didn't see someone until around 13 December or something like that, so roughly mid-December, so quite a long wait.

Initially I was referred to someone through [redacted], and again, I had to wait for them for quite a while, but on my first appointment I was told they can't do anything for me, so I waited practically two months for nothing, which was quite difficult.

Q. You also had to wait for an appointment with a psychiatrist?
A. Yes. So again, I was referred September 2017 and I didn't see them till early January 2018.

Q. Can you just describe what it was like for you during those wait periods?
A. It was really isolating, and I guess I was stuck in this limbo between where I was too sick for places such as Headspace, they weren't equipped to deal with my mental illness, but I wasn't sick enough for the hospital and I was stuck in this period between supports. In that time I feel that my eating disorder really tightened its grip around my throat. I lost a lot of weight to the point where I was threatened with involuntary admission. Yeah, it's very isolating when you're - like, it's really difficult when you're waiting - or having all those waiting times and having that difficulty accessing help, and also, like, I guess with eating disorders it's hard to actually want that treatment too, so it kind of has to come from

within, you know, to wait out those wait times and keep yourself as well as you possibly can during those times, but that's difficult, really difficult.

Q. And so, in July-August 2018, you ended up in a private clinic?
A. Yeah, that's right. So, probably in, like, May-June I had a bit of a relapse of my eating disorder, like heading into then, and then May/June it's when it got more severe. So, at that time my psychiatrist wanted me to go into hospital, an inpatient admission. We looked into the public health system. I would have had to have waited about three months to get into a bed at one of the public hospitals here in Melbourne.

At that time I was quite suicidal, I had a plan and all that, and like, I really wasn't eating and I don't think I would have made those three months if I had have waited; I honestly don't think I'd be here, so I'm very thankful for my mum and dad and their private health insurance, because I was able to go into the Geelong clinic where I stayed as a 40-day inpatient.

Q. You talked earlier about the fact that you were living in Ballarat at the time.
A. Yeah.

Q. So what was available to you in terms of public hospital was only in Melbourne?
A. Yeah, so there's nothing in regional Victoria, nothing in Ballarat anyway to do with eating disorders, nothing very specific, and that's one of the difficulties I faced, you know: there needs to be more specific support, but no-one apart from my dietician or my treatment team had a lot of experience of dealing with people with disordered eating problems.

If I was referred to the hospital back in Ballarat it would have just been into a general mental health wing of the local public hospital, so not necessarily targeted towards dealing with someone with an eating disorder.

Q. You found that the private clinic you attended had a good understanding of eating disorders?
A. Yeah, so they had an eating disorder wing as part of the Geelong clinic, and the staff there were so understanding of me having an eating disorder. I found it

- you know, I felt understood and I know they really helped me unpack why I used certain behaviours, and helped me explore different avenues for coping when, you know, the alternative for me would have been using the behaviours. Yeah, I felt really understood and was well supported there.

Q. What about feeling isolated given that it's in Geelong rather than your hometown?
A. Yeah, and that was one of the difficult things. For the whole 40 days I think I had people come up and visit twice, maybe three times. I was away from all my friends, all my family, everyone in my treatment team. Yeah, so it was quite isolating being away from everyone when you're kind of going through a really difficult time, yeah.

Q. And so, how were things at the end of that 40 day inpatient stay once you returned home?
A. I found it really disjointed. Going from care that was, I don't, I guess continuous and whatnot, it made it difficult going back to Ballarat and I was having to make appointments to see a psychiatrist, psychologist, dietician, and everyone else; and then there was waiting times for those people again too, so I was having to wait a couple of weeks before I could actually get in to see the people I was seeing prior to the admission.

Q. Can you talk about the impact that your eating disorder had on your life and the life of others?
A. Yeah, it really devastated my life, I guess. Yeah, I felt isolated. Like, as I've mentioned in my witness statement, when I lost weight, when I was sick with my eating disorder, I didn't lose just weight, I lost friendships, I lost employment. I had to drop out of my university course because the stress was too much, and it was hard managing that with a severe eating disorder.

Yeah, I lost independence. I genuinely - yeah, I was struggling. And like, it impacted my family too, seeing the stress it had on my younger brother really broke my heart, and there'd be times where I'd be talking about it in front of him to mum and dad and he'd just leave the room all of a sudden, and I know how much it upset him and hurt him, and at the time he was still in high school when I was working and he'd have people from the school I was working at asking questions about me and what's wrong, and all this, so it was really difficult for him.

But also for my mum and dad too. Like, my mum was my primary carer at home: the amount of stress it took on her, she was having to take time off work because she wasn't sleeping, she was too anxious about me and whatnot, which is why I think there definitely needs to be some kind of outreach to carers, because they suffer too when there's someone suffering with an eating disorder.

Even my dad found it quite difficult to even know what to do with me, and so that impacted our relationship too, it became quite distant.

Q. There was also a financial impact for your family?
A. Definitely, yes. So, thankfully my parents have private health insurance, otherwise I wouldn't have been able to go into that clinic, but out-of-pocket expenses, medications, can add up when you're on a few. Doctors' appointments, I'm lucky enough that I'm bulk billed, but my psychiatrist in Ballarat isn't bulk billing and I was having to pay, I think it was $150 per session and when I was at my sickest I was having to see them practically weekly.

When I ran out of Medicare funded sessions for my psychologist we went to Chronic Health Conditions, so I was able to get five but at a cheaper rate, but still having to pay a bit of out-of-pocket there, it just adds up. Even now that I'm living out of home it's quite difficult.

I've been referred to a psychiatrist here in Melbourne who has experience with eating disorders, and yeah, he's quite expensive, and I've also got to include the travel times and the time I've had to take off work to go see him and all that, it definitely adds up. It's quite stressful.

Q. Can I ask you about some specific changes that you see could be made, and you've touched on one in the evidence that you've already given, really about access in regional areas and the experience you've had?
A. Definitely. Access needs to be improved. There's not a lot in regional and rural areas, and I was talking to one of my close friends who's recently moved to East Gippsland area. She's moved over six months ago but in that time she's been trying to contact psychologists within a 30-minute radius of where she is. No-one is available, they all say they can't take care of her or they're fully

booked and they'll have to wait another six months before they're taking on new patients.

And like for myself having to travel down to Melbourne or to Geelong to receive specific support, it's not practical, especially as I'm working full-time at the moment, I'm having to take time off work. I think of the travel times for me from Ballarat, it's only about an hour and a half from where I live, but think of the people that live out in Beaufort and further out, the travel times, it definitely blocks access, which I think is quite unfortunate, yeah.

Q. What about a more holistic approach to services, you would consider that to be helpful?
A. Definitely. At the moment our mental health system's quite crisis-based. So, as I was saying earlier on, there was that period of time where I wasn't sick enough for the hospitals and stuff back in Ballarat. So I think treatment to mental health should be more encompassing of the person's life, so not just targeting mental health, targeting physical health and social wellbeing and all that kind of stuff, but it also should be something that's targeted even through, like, the curriculum.

I personally think that young people need to have the skills and the capability to recognise signs of mental illness within themselves and others and have the skills to reach out for support when they need it, so that being part of our national curriculum could be of benefit I guess, and building resilience and actually assisting young people to actually receive help earlier. Because I think, the earlier you receive help the earlier and the easier it is going to be to recover.

I think that counsellors should be in all schools. As someone working in a primary school, I'm an education support officer with a wellbeing role, I find I'm often acting as a counsellor for students in this school. We don't have a school counsellor and I'm not qualified to do that, but what I'm faced with, you know, not helping someone or doing it, I'll do it, but again, that's not my role. I think young kids need to have that support where they're going to be ably assisted from someone.

Headspace services, I think the Headspace services are really great, however I think that there needs to be

something for those younger than 12, because mental health issues don't just start when you turn 12 or when you're older. I think Headspace is great in terms of targeting mental health for people aged 12-25 but there's a whole gap there. Again, working in a primary school, I'm not sure if referral pathways - I think services such as Headspace would be great for younger people.

I also think potentially grouping Headspace services to deal with people who are more acute, I guess. Because yeah, in my own experience that whole however many weeks, 10 weeks or so without support, I really struggled and I probably could have done with support during that time, yeah.

MS COGHLAN: Thank you, Georgia. Chair, are there any questions from the Commissioners?

CHAIR: Q. I just want to go to, one of the points you made, thank you very much, in your submission, Georgia, where you talk about there needing to be more specific eating disorder supports, and when you talked about the availability, had you thought about the role of telemedicine and whether that would be appropriate in something like an eating disorder, whether someone like you might have found that helpful?
A. Sorry, what was that?

Q. So telemedicine, so either Skype or some other way of engaging online?
A. During my illness I did contact Butterfly Foundation and Eating Disorders Victoria, both of which are brilliant organisations and do a lot to help people like myself, but I think seeing someone also in the flesh and actually being able to, you know - yeah, it feels different online or over the phone than what it is to sit face-to-face with someone and I think you feel more supported, it's more personal.

CHAIR: Thank you very much.

MS COGHLAN: May Georgia be excused please?

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

<**THE WITNESS WITHDREW**

MS BATTEN: Thank you, Commissioners. The next witness is Ms Elizabeth Crowther. I call Ms Crowther.

<**ELIZABETH CROWTHER, affirmed and examined: [12.19pm]**

MS BATTEN: Q. Thank you, Ms Crowther. Have you, with the assistance of the Royal Commission's legal team, prepared a witness statement for the Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0027.0001] Could you please start by describing for us your current role and responsibilities?
A. Sure. My role is Chief Executive of Wellways Australia.

Q. What do you have to do in that role?
A. Look after the health and the wellbeing of the organisation, the people who we serve, and our staff and the communities in which we work. We serve 12,000 people a year and we have nearly 2,000 staff with whom to do that.

Q. Could you give us a little bit more detail about what Wellways is and what kinds of services you provide, please?
A. We work with people principally 16 years and over, with the exception in North Queensland where we work with young children in out-of-home care. We work with people, our primary work is with people who have severe and enduring mental health issues, and we work with people who have intellectual disabilities and physical illnesses.

Our services are mainly in the community, in the home. We offer some services in collaboration with hospitals such as prevention and recovery units and some other youth residential services, but mainly our services are in people's homes where we aim to create connections for people so that they can live independently, where we can help people attain and gain hope, where we can help people attain an identity other than an illness identity, and where we assist people establish meaning and empowerment in their lives. So, they're the principles underlying all of our services, whether they're in the home or whether they're in a residential setting.

Q. You clarified in your statement that you're not a case management service, that's not your role.
A. No.

Q. Your role is more to empower people for them to do it themselves; is that right?
A. Yeah, we sort of think about our role as doing everything that we can to make sure people live a life that's satisfying in the community, and that we try to work with people to manage the risks that will pull them out of living in the community.

Q. One of the programs that you've described in your statement is the Doorway Program; could you describe in detail what that program is, please?
A. Sure. It's a housing program. We began looking at this about 10 years ago. Like today, and probably today is even worse, people were waiting between seven and 10 years to get a house.

So, we went to the literature and did the grand, "What's happening around the world?", and we found a program in New York called Housing First and we worked to bring that program to Australia. Basically, it's using the rental market to provide housing to people so that they can actually get into housing in a timely manner.

Our average at the moment is it takes people, once registering with the program, about 90 days to get from original request to being located in a home. We work with designated health services such as St Vincent's and Alfred and other hospitals to do this.

The person who's coming into the program is at risk of homelessness or is frankly homeless, couch-surfing or something like that. That person agrees to pay 30 per cent of their pension, they agree to pay the Commonwealth rental assistance, and we put in a small grant for white goods and for bedding and such things.

What works with it in those four principles that I talked about in the beginning is, it gives people choice. People can decide where they want to live, they are not linked in to being given a house, so they actually choose where they want to live.

The program lasts for about 12-18 months. The grant runs out at about the 12-month point and there's an opportunity then to be testing whether or not people can continue to pay their rental or whether or not they need

some other modifications.

It builds relationships with real estate agents. When we first began this program we thought, oh my God, real estate agents, are they really going to be up for this? And, to our absolute delight, and our belief, they were, and real estate agents in fact contact us when they have a vacancy in the area in which we work and say, "We've got a place coming up, would you like to offer somebody up?" So we do all of the work up with somebody to do that, and basically it gives people ownership of it.

In the St V's area the rentals, as you would imagine, are very, very high and the subsidy is about $100 a week. In Gippsland much less, and so, some of the strategies that we've been developing in the city areas is that people are given the choice of bringing somebody else into that home with them. Sometimes it's a family member, sometimes they go on to flatmates.com or one of those other places and they interview somebody to come in. So, it meets their agenda of somebody being in control of their environment.

Our outcomes are great. We have very, very little damage to properties and, as I said, real estate agents are very supportive of the program and there are great outcomes for the people who use it.

Q. Thank you. You mentioned briefly who receives Wellways services. Could you just elaborate on that and who are your priority target groups?
A. Well, our base, the group that we grew up with, were people who had severe and enduring mental illnesses. Today, as a consequence of NDIS, we learnt that we're very, very effective in working with people who have an intellectual disability and multiple needs.

In our Doorway Program at least 50 per cent of the people in the program have got alcohol and other drug issues, they've got multiple diagnostic categories and have really got challenges in their lives. Our feature programs tend to be adults and young people between the ages of 16-24.

Q. But it's correct, isn't it, that anyone with a mental illness can come to Wellways?
A. Yes, yes.

Q. And you support people with all types of acute mental illness?
A. Yes.

Q. How are clients introduced to Wellways? How do they get to you?
A. Because we've focused on people who have got significant illnesses, often through hospital referrals, through clinic referrals, through families, through themselves, through community health: you name it, people come to us.

If there's a specific program, it may be through primary health networks, or it may be in some programs - not here, but certainly in ACT through the forensic system, so people get to us in a range of ways.

Q. Could you explain to us what Wellways' model is for community inclusion, please?
A. We believe that people are not their illness, people have more to them than their illness, and so, we believe that the solutions for people are in the community.

We believe that supporting people where they live is going to get better community tenure than creating mini-institutions in the community. We think that the community should be resourced rather than having the paucity of support that are there.

We've just interviewed 100 people in the last month and they tell us that there is so little between themselves in the community or the GP and acute end of the need - of hospital, and so, our belief is that the solutions are in the community; that the community needs to be enabled to exercise opportunities, such as the real estate agents that I've talked about before. And, just don't build things, build processes within the communities.

There needs to be a process where some of this is all joined up. At the moment it's all, there's a bit here, there's a bit there, there's a bit somewhere else funded by some group or other and it creates enormous fragmentation that the community says, oh, it's all too difficult, and go to the hospital.

And so, our view is that creating community connections, supporting people in the community, supporting

people in their interest groups and connecting people has a major impact on health.

Q. You also stated that community mental health services provide early intervention when people become unwell. Can you talk about how Wellways does that?
A. Yeah, I'll just give you one example. Out Together is a program that we run in Geelong and it's a program specifically designed for LGBTI participants. It's creating an opportunity where people with those interests can come together and design activities that have meaning for them and creating networks and creating opportunities to discuss the issues that they have, to share what solutions have worked for each other, and to look at things early on rather than things getting too unwell.

It also allows peers to say, I don't think you're travelling so well, have you got a GP, have you got a psychiatrist, maybe you need to go see them; so it offers very much those peer interventions.

Q. And that's a program for the LGBTIQ community?
A. Yes.

Q. You've also mentioned that there are community-based collaborative care models; can you explain what those kind of models involve?

Q. Well, they're in my mind, I don't know that they're designed yet. Our issue is that programs are funded in streams. The government identifies what it wants to fund and different parts of government fund that bit. They're very clear what's in and what's out. Unfortunately, there's a person at the end of that and, if you just miss out, well, you miss out altogether.

So, the ideas that we have - there was a program called personal - PIR and I can't think of the name of it - PIR.

COMMISSIONER FELS: Partners in Recovery.

THE WITNESS: Partners in Recovery, thank you very much, whereby it was specifically designed to help people who had significant difficulties in joining the dots in their treatment to bring together the needs that they have, so bring together the needs and the interventions that they

required.

And so, what we see is a program that has an IT into it. When I was in the UK, in Scotland, we saw these booths on the street that people could link into: they were at universities, they were at train stations, they were at all sorts of places that talked about the services that were in those areas. We don't have anything that people can link into here.

There was also processes where there was a connector that would go into - that was in the community, that was known of the community, and they became known through Rotary clubs, or they became known through school groups or whatever, that could make a relationship with a person and intentionally build on those connections.

Now, it might be as simple as looking at developing the connections and preventing the isolation, or it might be as significant as holding a postgraduate degree and working to connect that person with the services that they need and using psychological mechanisms.

So, we've just got to get better at linking services and we're not: you've got this, you've got that, and there are awful gaps between what's available.

Q. In terms of the gaps, can you talk to us about the scale of unmet need in Victoria for psychosocial services?
A. I reckon I'm about the 56,000th person that's tried to do that. I don't know, around about 140,000 in this state and, you know, my contention is that, first of all when the de-institutionalisation occurred it addressed the people that were in care; it didn't address the emerging need, and so, what the actual need is, is very unclear. So, I'm with many, and using the numbers that are out there, but there is huge need and it gets bigger when you don't address it.

Q. I want to return to something you said about the lenses. You said in your statement:

> "The current model presumes that the only determinant of mental illness is health. Mental illness is a consequence of related factors including early childhood trauma and social factors like housing, isolation, employment and community. It follows that

a good system design should address these factors."

Can you elaborate on how you think that should happen?

A. Yes. You know, the irony of all of this is that people with severe and enduring mental illnesses lose capacity to make connection, and that they're expected to visit a health practitioner, go out of that office and then make the connections that they need. Well, in fact, part of the problem that they have is that they've lost that capacity. So that, there needs to be a process and staffing that will help to join those services together, or navigators, if you like.

And, if you build connection - again, I say - and if you build hope within somebody, they are more likely to make that first step. People aren't going to make multiple jumping leaps, but one step at a time and experience success with that is really important. If you don't have a job you can't pay for your housing. If you don't have a job, you've got nothing to do during the day, so you can go score some alcohol or some marijuana or whatever it is.

You spend your day in bed if you don't have a job. You're not going to go when your teeth are rotting to the dentist, you're not going to go when your toes are not working properly because you've been sleeping rough. So, you're not going to go and access the very services - they're all available, but you haven't got the capacity nor the interest in doing it.

And, NDIS has made it doubly worse. Can you have a double worse? Well, it's a double worse.

Q. I'll ask you some questions about NDIS, let's turn to that now. In your experience what's that meant for access, what has NDIS meant for access to psychosocial support programs?

A. I absolutely support NDIS, I think it's a fabulous program, but it has been, I think, in its introduction misunderstood. State Government here defunded psychosocial, for the most part, not all of it, but defunded psychosocial rehabilitation programs when NDIS was brought in and put that money into NDIS.

So that, people were offered NDIS services. Many people don't get it. Others don't get the psychosocial

rehabilitation, what they get is a different product. What they get is a service that supports people's needs and disabilities.

So, they have somebody to help wash them, they have somebody that does travel training, they have somebody that does very, very defined tasks, but where the person is in all of that is not visible.

What psychosocial rehabilitation did was work with psychological phenomenon to build those activities that I've just talked about. What NDIS does is supports people getting from A to B.

Q. How has the introduction of NDIS affected Wellways?
A. Totally. We were an organisation, as I said, that employed degree-qualified staff. Big deal. But what did they do? They worked with psychological factors and motivators and helped people build their capacities.

What NDIS meant was that, formerly we were paying staff around about $70 an hour. NDIS were paying $27 an hour. So, the staff and the activities that they performed were very different. Are those staff terrific? Yeah, they are. Have we built our business? Yes, we have. 50 per cent of our business is NDIS today, and some people are doing really, really well, others are not.

We made a lot of our staff redundant and we employed a new group of staff at Certificate III. 65 per cent - actually not 65, 63 per cent of our staff are casual, and we had to move from a bulk-funded or grant-funded system to a commercial system where we would book an hour for a person, we would charge them, they would sign it off and then we would send off the bill. So, there was no working up of what that person needs. The decision of offer came off the menu that NDIS had decided was the issue for that person.

Q. Can I ask you some questions about PARCs?
A. Yeah.

Q. What, in brief compass, is a PARC?
A. Well, they're called Prevention and Recovery Care Centres, they're not these glorious green things, but they were designed to be small home-like units as an alternative to hospitalisation. So that, when a person was becoming

unwell, instead of going into a formal hospital ward which is difficult to access, they were able to go to these units.

Generally about 10 beds, very home-scale and focused not on illness but focused on, what is it that you need to be able to achieve that's going to keep you well in the community?

Q. What's Wellways' role in the PARCs?
A. We principally focus on the rehabilitation activity, so that, what's going to keep you well, what do you need, what's your budgeting, are you looking at jobs, how are your families going, and we focus on accommodation, keeping that, so it's the housing and the rehabilitation elements.

Q. Wellways is involved in six PARCs?
A. In Victoria six, yes, we have others in other states.

Q. Of the six PARCs in Victoria that Wellways is involved in, are they operating as intended?
A. Yeah, there's some pressures. To have a PARC that is person-centred, home-scaled, home-like, it has some characteristics. Over time those characteristics have changed ever so slightly because they're managed by hospitals. Hospitals have got an absolute accountability for making places safe, fire proof and appropriate to the health and safety standards of the hospital. That is at times at odds with what a home-like environment is.

Secondly, hospitals are under terrible pressure, and we will often get telephone calls on Friday night or Friday afternoon saying, "We've got people who are in hospital who need come to the PARC."

Now, Friday afternoon has a meaning for people working in health.

Q. What's the meaning?
A. The meaning is that there's going to be not as many staff at the weekend within the hospitals or the rest of the services, and that we need to have beds in the hospital to be available for people who need to come into hospital. So, people will, without much planning, there will be a request to come into a PARC on a Friday afternoon without the appropriate supports that people need to establish themselves.

Q. Can I turn to the issue of reform. In your statement you've said:

> "In my opinion part of the difficulty is that systems are designed to look at streams, housing, employment, health and this is underpinned by straight political tensions about each department coming in on budget."

Can you explain how that creates a problem for an effective mental health system?

A. Let me give you one example - I can give you a million, but the one example that I'll give you is the Doorway Program. We found this program that was operating internationally and we wanted to bring it here. So, we went to Health and we said, "Hey look, we can bring this program to you and it's going to save you money and it's going to be effective." "No, no, go away, that's Housing." So, we went to housing, and housing said to us, "No, no, no, no, no, go away, go to mental health." And that is exactly the same story over, and over, and over again.

When the budgets are looked at, they're in streams, so what is the funding outcome for health, for mental health? What happens in forensics? Is that the same? If people end up in forensic care, is that a cost for health, or mental health, or is that a cost to forensics? If the PHN - sorry, the Primary Health Network is funding something, is that a cost to the PHN or is that a cost to general health?

So the funding comes down, as it should do in terms of accountabilities, in streams, but then as I said earlier, those streams are created into tenders, and those tenders are managed according to the outcomes within those tenders. And, within all of that, the person that I said who's living homeless who's got sore feet or feet that are really not working, that has got poor teeth, and the other issues and not attending the service is lost because each of these services are focused on a different part of the system, not the person.

Q. I want to ask you a question about the tendering. In your statement in relation to a question from us as to how the system could be improved in terms of strengthening the

NGO sector, you've said:

> "One of the major issues is the decentralised tendering processes which have the effect of splitting the community creating more space between one service and another."

Can you elaborate on what you mean by that and what problems that creates?
A. Yeah. I mean, it's just that conversation again: the tenders have sharp edges and the people that put out the tenders are very clear what KPIs they want. And so, for example, if you believe that somebody has - not if you believe - if a person's needs extend past that tender, it has to be handed on to somebody else to deal with it. If there is nobody else to hand it on, you either do it and fund it yourself or it doesn't get handled.

What I've suggested is that all tenders should have a proportion of their funding allocated specifically for linking to other tenders. Now, I don't quite know how you do that, because I'm not a tender formulator, but there needs to be a part of it that forces linkages between each of the tenders, otherwise you're just going to have these separate streams, like different roads, going to different places.

Q. Finally, in terms of how the Royal Commission can make more than an incremental change you have said:

> "The Royal Commission needs to be bold."

Can you explain how the Royal Commission needs to be bold; in what ways do you mean it needs to be bold?
A. And courageous. Because we have focused on the availability or the limited availability at the acute end, that's where the money has gone. If you keep on funding only the acute end, you're going to end up in exactly the same space. That's why I say that people are more than their illness. They are people who have families, if they're still intact. They're people who need jobs. They're people who have a whole range of other interests and capacities and, if we only keep on focusing on hubs and hospital admissions, and other ends, CATT Teams and other parts of the system, we're going to create exactly the same.

Goodness sake, am I saying that we don't need those things? No, I'm not, but what I am saying is, fund the community activities, fund the linkage, and then you won't have everybody driving to the ED. Because, when you're in strife, the only thing you're going to look at is the thing you know. If you haven't had any opportunities to see, oh well, there are these other things in the community: that's why I say, get with the modern world, get into IT, get interconnectedness.

Does it cost? Yeah, it does. But I tell you what, it costs more doing what we're doing, but we just don't count it. Because, as I said, it goes into forensics, it goes into housing, it goes into all sorts of other departments and not into where the person needs it.

MS BATTEN: Thank you, Ms Crowther. Chair, are there any questions from the Commissioners for Ms Crowther?

COMMISSIONER FELS: Q. I had one question. You talked about homelessness, and there's a little bit of a tendency even recently in the media to talk about the Australian Bureau of Statistics definition of homelessness and the 110,000 or whatever, and then to break that down into the roofless and then couch-surfers and others. What is your perspective on the accommodation problems? Do they go beyond that statistical category into people who aren't technically homeless but have fairly bad accommodation in boarding houses and so on? Is the problem wider than the statistical homeless population?
A. I absolutely believe it is. You know, I have a person in my mind when I talk about this, and she's a woman of about 55, and she had never had a home of her own. Now, was she street homeless? No, she wasn't. But did she move around and couch-surf, and did she live in really tenuous places with inappropriate cooking arrangements? Yes, she did. Would she have been classified as street homeless? No, she wouldn't, but she was in that broader group of people, and at 55 she had never had a place that she could call her own home where she could exercise power over who entered, who didn't enter, who lived with her, who didn't live with her, when she got a meal or when she didn't get a meal, what type of a meal.

So, that is my expectation. I mean, I use - sorry, but I use the definition of Chamberlain and others as that

definition.

CHAIR: Q. Ms Crowther, I'd like to ask one other thing. I saw in your submission you talked about the fact, in your first cohort of 50 people in 2011 who came through the Doorway Program, 80 per cent of those people who had previously been homeless are now living independently, I thought it was a very impressive outcome.

You've also talked passionately about the need to support people in the community, to give them a sense of connection. I noticed in the case study that you attached to your formal submission you illustrated that with the importance of transitioning someone into independent living.

How important is that element of the outreach of support and outreach in providing support to people as they go through that process, mindful as I am that you say now 50 per cent of your work is directed to NDIS? Are you still able to provide for that sort of support you historically have?

A. It's more limited. What you can't do in the NDIS is the community development; we fund that ourselves. So, it's that community development that's absolutely critical.

You know, I illustrate it via the real estate agents. Real estate agents don't have a reputation of being soft and furry people. However, real estate agents, having had the opportunity to understand what the issues are and meet people, have a very different view.

If we don't do the community work, we're going to be really in this situation again, so it has to be funded. NDIS does not fund it. And agencies like us begin to run out of dough, so it has to come from the State.

CHAIR: Thank you.

MS BATTEN: Thank you. If there's no further questions, may Ms Crowther please be excused?

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

MS BATTEN: Thank you, Chair, may we adjourn for lunch please?

<**THE WITNESS WITHDREW**

CHAIR: Yes, let's adjourn.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH:

MS BATTEN: Commissioners, the next witness is Mr Peter Ruzyla. I call Mr Ruzyla.

<**PETER RUZYLA, sworn and examined:** **[2.00pm]**

MS BATTEN: Q. Mr Ruzyla, with the assistance of the Royal Commission's legal team, have you made a witness statement to the Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0001.0030.0001] Mr Ruzyla, could you please describe your current roles?
A. I'm currently the CEO of EACH Social and Community Health Services, and also the CEO of EACH Housing Limited, which is a subsidiary of EACH.

Q. Could you please explain for us what EACH is and what services it provides?
A. EACH is one of the community health services. There are 84 community health services in the state. Basically, one covers each municipality in Victoria. So, we're one of the registered or independent community health services.

We provide a range of physical health, mental health, psychosocial support, disability support services, child and family support services, so it's a very broad range of primary and secondary level supports that are available and provided in the community through the community health sector.

Each also receives a range of funding specifically for mental health services as part of the suite of services that we provide.

One of the things that we attempt to do is to integrate those services so that people receiving one type of service, whether it's for say chronic disease management like diabetes, they can receive a range - a suite of other

services to support them.

Mental health is quite unique in that regard and quite well supported in that regard because we can also provide dental services, access to dieticians, physiotherapists and, in our case, housing support as well.

There's a range of other, what I'd regard as mental health-related services, such as drug and alcohol service, including a residential rehab and recovery, problem gambling services, family violence support services, so it's quite a broad suite of services that's available at the community level.

Q. Could you please give us some more detail about some of the mental health services that EACH provides?
A. The mental health services really depend on how the agency is funded. So, mental health services are provided generally through a competitive tendering process, and therefore there will be - in our case for example, mental health community support services which we've delivered over the last several years, which are of course being decommissioned as part of the transition to NDIS. Partners in Recovery, personal helpers and mentors, day-to-day living.

We've also recently, as a result of the Victorian Government's initiative, just commenced the early intervention psychosocial initiative which is an interface between the community mental health support services and the hospital-based services.

I forgot to mention that there are four Headspaces that we operate for young people. Of course, as we have started to transition to NDIS, I'm sort of not sure whether to call that a mental health service, but it's certainly psychosocial disability support, and we provide services in that space as well.

There are a couple of programs which we self-fund out of our work: one is called COPES, which is Carers Offering Peer Education and Support, and that locates a peer worker in the hospital to support carers as they're coming in with their loved one, often mostly usually as a result of an admission.

There's a program called SKIPS, which is Supporting

Kids in Primary School which is aiming to address - provide a mental health education program at a primary school level to Grade 5 and 6 children trying to deal with the issue of stigma.

Q. You described a range of services there and across a range of ages. Who does each aim to serve? Who are your clients?
A. So, while as a community health organisation we don't turn people away, so they are able to be accessed by anyone in the community, predominantly our focus is on the most vulnerable and disadvantaged populations or sectors in the community.

Those which I can list are: predominantly people with low income, homeless people, people with a forensic background or who have interactions with the justice system, recently arrived refugees, people with severe and enduring mental illness, people with addictive behaviours, people living with a disability, Aboriginal and Torres Strait Islander communities, and other groups who experience stigma and social isolation, such as the LGBTQI community, so it really is targeted at those populations because they're obviously - perhaps not so obviously - but often the people most in need and whose health and wellbeing is most compromised.

Q. You provide a community-based service. Can you explain the links to the clinical services that you have?
A. Our focus is on community-oriented services where people - we try to actually provide those services in settings which are more like a home or a GP practice and not clinically-oriented at all. But obviously, the populations that we work with often do find their way into the tertiary sector and that's where having strong partnerships and relationships with tertiary providers, the hospitals in particular in the case of people with mental illness, is an important partnership and an important relationship.

So, being able to work in - and I know the term step-down has been used in relation to PARCs, but you know if they're not going into a PARC, but being discharged from hospital, being discharged to a community mental health support team, does mean that we're in a good position to provide ongoing support to those individuals.

Q. You've said in your statement you've recently got funding to assist people who are discharged from acute admissions. Has that commenced, that program?
A. Yes. Up until this point, or very recently, it was more of an informal relationship with the hospital setting, so hospital clinical mental health workers would make recommendations to some of their patients that they're discharging to attend one of our programs or make a formal referral into, say, a personal helpers and mentors program or a day program or something like that. But it really depended on the clinical mental health workers and the relationship with our organisation.

More recently the state funding that I referred to has been quite specifically targeted to making that a more structured approach, so that, the hospital would identify those people who they wished to refer to us. We would then pick them up and our clinical governance would also be done hand-in-hand with the clinical mental health system, so there's more of a structured approach to people transitioning from the hospital system to ourselves.

I think in that context I'd also like to mention that the other tertiary system, which is the police and the justice system, really does rely on those informal partnerships and relationships, so that, having a good working relationship with, say, the Knox Police Station is really critical to the wellbeing of some of our people in both directions: being able to support people who have come to the attention of the police, and the police being able to ring us and say, look, this person is clearly unwell, can you help us out here, and through to the other end when people are coming out from detention, being able to be referred into a service has been really important for their wellbeing.

Q. Can I turn to the issue of funding. How is EACH funded?
A. I made mention of the competitive approach to tendering. If I focus predominantly on the mental health side of things?

Q. Yes, please.
A. There's a variety of ways in which we get funded. The majority is through Commonwealth and state funding, programs are tendered and, like anyone else in the not-for-profit sector, we consider what options we have to

put forward and we apply for those.

What it means is that there's a good deal of insecurity in our funding, and that insecurity flows into our staffing, it also flows down into the consumer, because they're hopefully divorced from all of that machinations that goes on in the background. But, nevertheless, the staff themselves know that they may have a short three-year contract, for example, because that's the length of time of the funding.

It also means that the suite of services that you provide may not - it's not what I'd call a mental health service per se: what it is, it's a suite of mental health programs. So, it's almost, the programs are a proxy for a cohesive or coherent set of mental health services.

It also means that, depending on which programs we happen to be funded for and what the consumer might require, it may mean that to provide a holistic approach we may also need to transfer or refer on the consumer to other parts of the service system that might have other things that they would benefit from.

For example, if the person would benefit from attending a group activity or a day program in the past, they may come in and join us at the day-to-day living, because that's what we've been funded for, but because we're not funded for Partners in Recovery, but if they needed more intensive mental health key worker or case management, then we'd make a referral there.

Some of those processes can become quite anxiety-provoking for consumers who have created a link to a particular key worker in one organisation, but generally I would say that the not-for-profit sector or the NGO sector works really collaboratively and recognises that the core interest is in creating smooth referrals or warm referral transfers so that people don't experience a disjunction in the way in which they're receiving their services.

It does mean that - you know, I'd describe it as a funding-driven system rather than a consumer-centric response to people's needs.

Q. You referred to the fact that, there being programs

rather than a mental health service: what is the impact for the person in terms of the treatment and the support that they receive?

A. Well, it really starts from the beginning in terms of their referral into a service. First of all, because the system - if I call it that - is highly fragmented, and each of those services will have their own unique entry or eligibility criteria, you first of all have to find out what it is that you're eligible for. And so, hunting around in the system to find out, where's my starting point, is very frustrating and anxiety-provoking for consumers.

If I go into that area again, one of the other complications is that everything from drug and alcohol services, to problem gambling services, to family violence, mental health and so on, including primary healthcare, all have a unique phone number. So, you may start the merry-go-round with one phone number and then be told, "Um, look, yes, I can see that that's something, but it's probably not your top priority; here's another number."

We did a survey some years ago which led us to an initiative where I basically coined the report, "For God's sake don't give me another phone number", because that's what people would be saying as they're put on this merry-go-round of finding the phone numbers, where they might have need for all three of those services, and it's serendipitous as to where they happen to start: whether they started with a mental health service or a drug and alcohol service for example.

So we commenced a single phone number intake which has sitting behind it all the eligibility criteria for all of those types of specialist services, as well as quite an advanced database so that we could make referrals to other agencies where it was clear that we didn't have a service that we could offer.

But it is a problem which we're trying to do a workaround really to address a fragmentation in the system which really is very frustrating for us, and almost impossible for consumers to negotiate.

Q. The eligibility criteria is specific for each program and that derives from the funding stream; is that right?

A. That's right.

Q. And then each program determines its own intake criteria?
A. Yes, that's right. So, the intake criteria will be derived from the specifications in the contract.

Q. Attached to the funding?
A. That's right, yes.

Q. And then there may be a specific number for that specific program?
A. That's right, yes.

Q. But that's only one source of support or treatment?
A. Yes, that's correct.

Q. You've provided in your statement some examples of the complexities faced by individuals trying to navigate the system. Can you explain in some more detail the situation with the young man in his 20s?
A. Yes. I selected that particular instance because it was brought to my attention and I had some interaction with the young man.

Here's a young man in his early 20s, had lived most of his life in out-of-home care, so he was already in a very vulnerable position, and the average number of placements for children who end up being - still being in out-of-home care at the age of 18 is something like 40. So, over that period of time, and I didn't ask him specifically how many changes of placement he had, but that seems to be the number.

So, here's a young man over the age of 18, so he's no longer in out-of-home care, with no familial support or a backbone of support behind him. He contacted us because he happened to meet one of our managers at a forum, and they exchanged discussion and there must have been a - there was an email exchange.

He contacted our organisation saying he was deeply distressed, he didn't know where to turn, a very close friend had recently suicided - I believe she was also someone who he knew through his history in out-of-home care. He also had a grandmother who was in hospital and he literally didn't know what to do or where to turn to.

He also had an NDIS package and had been to a Headspace. The Headspace had said, look, we've provided you with a mental health plan and the 10 sessions of psychosocial counselling that's available through the GP initiated mental health plan, and that was about as far as they could take it. He didn't re-engage with them and he didn't see that the NDIS was an appropriate place to turn to.

What that highlighted for me is the serendipitous nature of getting support for that young man. So, there was no system there that he could turn to, or that even when he had accessed different parts of the system, they seemed to be unable to - you know, once they reached the limit of what they were able to do, that seemed to be the end of it.

Mind you, had he re-engaged they may have followed it up, I don't know that, but the fact that he didn't see it as a system that he could re-engage with was deeply concerning.

But we were able to put him back in touch with a community mental health worker and put him on some sort of response pathway, so that was an important element.

But I just wanted to emphasise, it's not a system if it relies on a chance meeting with someone, and particularly for the most vulnerable people. Many people in the community probably have access to family, friends, supportive, knowledgeable people who can actually get you started, but when you're a recently arrived refugee or a young person who's been in out-of-home care, or a homeless person, you really don't know how you could ever possibly find what I called the bull's-eye, which is, what's the service that's going to help me?

Q. In your statement you refer to young people being at a stage where they're prone to the break down in protective factors for mental illness, so at a particularly vulnerable phase. Can you just expand on, what are those protective factors and why at that point can they break down?
A. I think the way I think about it is that, because we know that the majority of serious mental illness starts or becomes apparent in late teens or early adulthood, and if we think about that period of time in life, it's when people are beginning to leave home or create their own

independent identities, they've started a new circle of friends, they've either started a career or a job or they've gone onto other educational pursuits.

When mental illness strikes - and I'll use that term - those supports start breaking down. People, first of all, start losing their friends because their behaviour becomes not like the rest of the group. They compromise relationships with their family, because parents are often pushed to a limit where they don't feel they can cope. If they can't maintain their employment or their education, then they're also pushed into a cycle of poverty really and disconnection from the hygiene factors in life, which is that backstop of support from family, support from friends, self-efficacy, feeling empowered, feeling that you know where you're going.

We know from the social determinants of health that the most disadvantaged people are those who are born into a postcode where they are more likely to have insecure housing, lower levels of educational attainment, higher levels of family and social dysfunction and so on. But even without being born into those postcodes you can see how the onset of severe mental illness starts breaking down those very important - the fabric, the healthy fabric that actually can hold those things together.

So, people can end up in a situation where, they're not able to rely on a trusted friend, they have to rely on a system which I've just indicated - and I think we all know - isn't there and it's not coherent, it's not easy to find and, if you do find it, you might end up having to do a merry-go-round before you can actually find what suits you best.

Q. Can I ask you about delivering local services. Why do you say it's important to understand the local community in the way that you deliver services?
A. It's important to recognise that communities across Melbourne, as well as across everywhere really, differ in their socio-demographic makeup and also their cultural patterns of belief, the populations that are there.

For example, in the outer urban fringe of Melbourne, in the eastern fringe of Melbourne, a place where - EACH offers services is in Healesville, and it's an urban fringe area, public transport is really difficult or non-existent,

high Aboriginal population. There's a poor availability to GPs and other helping professions. So, working as a mental health provider in that area, you have to really adopt understanding of the local factors that people living in that community will experience: lower access to - there's no easy access to support.

On the other hand, one of the other areas we work in is in the Box Hill area, so that's got a high Chinese population, and much greater access to different types of services, particularly GPs compared to the urban fringe, but at the same time you have to understand that cultural conceptualisation of things like mental health and even things like counselling are very different to Chinese or other, Sudanese groups, for example, that we've worked with.

So, providing a mental health service during the bushfire recovery period in that urban fringe area was part of what we had to do, at the same time as we also provide services in that Box Hill and other urban areas. As an organisation, and I think not-for-profit organisations work in that sort of field, of having to adapt their service and being able to interpret the various funding lines that they have according to what the local needs are and hire people who are from those communities or know those communities well, for example.

Q. In response to our question, "What is the scale of unmet need in Victoria, you've said:

> "In my view the acute and clinical system is overburdened. Even with more funding I think this system will never meet the level of demand for people experiencing acute symptoms of mental illness."

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

A. Yes, there's a circular argument that's happening: if you don't prevent people getting to the acute stage, then it's almost inevitable that there will be a much greater demand on the acute system.

So, we're in a situation where the interventions that could be made available at the early identification stage are becoming highly fragmented or even decommissioned and,

in the case of an NDIS replacement, quite inappropriate to meeting those needs.

We're seeing more people being referred to the clinical mental health system, and of course that's screaming out for more resources, and that's the natural place where governments want to - it's the squeaky wheel sort of argument. But really, there's no end to that if you're not doing something to prevent that happening in the first place.

And so, our view is very much that, we have lots of examples of ways in which - and there are case studies that we've submitted which indicate that very effective interventions with people who are quite unwell but who are able to manage their symptoms with appropriate supports.

One of the examples that we put in our case submission was of someone who had been supported to manage the voices in his head and then, when those support services were taken away and replaced with an NDIS worker, the NDIS workers are not really skilled at managing that, and you could see the trajectory there of that man increasingly referring to the acute system.

I do think it's a circular argument: you can keep putting more money at it but that's not really a systematic response to the problem.

The other thing I would say about that is, surely that's not a socially acceptable response for us either as a community, to think that we should fix or address mental health needs by trying to repair people when they're really, really unwell instead of doing something at an earlier stage, because we do know that recovery-oriented services improve health, wellbeing and fulfilling lives. It's not really a fulfilling life to be left dangling, wondering if there is going to be a support service for you and knowing that your own history tells you that you're going to end up in this traumatic situation of re-entering the acute system.

I think we have to also recognise that it is a traumatic experience and that people's recovery from, once they come out of hospital, is slower - for many people - is slower and longer than if they're supported before going in or even in the example that I gave of people who have

stepped up into a PARC - I think the Commission knows what a PARC is, yes, because I can't remember what it stands for right now.

COMMISSIONER FELS: Prevention and Recovery Care.

THE WITNESS: That's right. So, being able to support people in the community with an occasional placement in a PARC, when it's apparent, means that they stabilise much better, much more quickly when they return back to where they're living. Compared to our experience of when they've had to go into an acute setting and come out, it's actually a lot harder and it takes longer to settle and get back to your functional best after that experience.

MS BATTEN: Q. You've mentioned in the course of your evidence the NDIS. Can I ask you specifically, in your experience what has the commencement of the NDIS meant for access to psychosocial support services.
A. Before we became part of the NDIS we had a thousand consumers who we were supporting through our community mental health support services, we had approximately 150 trained and skilled community mental health workers. As our community mental health system has been decommissioned, we're currently supporting about 850 people through NDIS packages, and that's across a range of intellectual, physical and psychosocial disability, but we've still managed to maintain support for a predominantly psychosocial disability cohort.

But we're down to about 30 or so community mental health workers as the funding levels in the NDIS haven't been able to sustain the levels of salary that a community mental health worker requires as part of the award. What's that meant is that, not only have we been extremely financially impacted by trying to maintain that 150 workers for a long period of time, we maintained that for almost 12 months, but finally we had to begin to replace them with disability support workers.

One of the things that our Clinical Governance Committee noted was that we had a trend rate going up in terms of complaints and, when we looked at it, it was complaints in relation to NDIS. So, some of those are just the teething problems with the NDIS per se, but it was also about people with a mental illness who'd previously come to expect certain things from their key worker, and they

weren't getting that from their new workers, and were sometimes putting in complaints to us, at other times to the Mental Health Complaints Commission.

So it's been a really difficult adjustment period through adjusting to the NDIS. A lot of the staff have said, well, even if I was paid at that rate, at my existing mental health community support rate, I don't really want to do that work because it's very limited, very constrained; if it's not in the plan, you don't deliver it.

I had an example of a staff member just last week saying, "I've started to work with a person, but there's no incentive for that person on an NDIS plan to work on his recovery goals, because the plan just keeps paying for whatever it is that's in the plan." Whereas previously there was a compact that you would have with your client about, what are the recovery goals that we need to work on together? What can I help you with? And there was a real incentive and pressure that he was able to bring into that situation, or momentum I suppose, to keep the person encouraged and engaged with their plan.

There was another example given where the NDIS plan, planner, had decided to fund a person to have his lawn mown and to have assistance in shopping. The recovery worker was horrified because it had taken them 12 months for this agoraphobic person to actually get around to mowing his own lawn and doing his own shopping, so you had a perverse outcome of a plan for a person who'd actually made some great steps forward in their recovery.

Q. And so, has the NDIS meant that each delivers a different type of service?
A. Well, yes. If you try to deliver something which is outside of the formula that's in the plan, you actually can't get funded. So, we've submitted invoices, for example, to NDIA and find that they're rejected because it wasn't actually in the plan.

When people's mental health changes - so if the plan was developed when the person was very well, then it may reflect the best part of their recovery. If the plan was written at a time when they were very unwell, it will tend to reflect the needs at that time.

The thing is, we know that people's needs change and

they fluctuate: sometimes they need more support, sometimes they need different types of support but, if it isn't in the NDIS plan, it's very difficult to make those changes in a timely manner. So, it's the timeliness of getting this whole bureaucracy of planning to shift in line with the consumer's changing needs.

The community mental health approach is very much relational - it relies on the relationship between the key worker and the person that they're supporting, and the importance of the key worker understanding the customer's needs, but also the customer really developing a trusting and confident relationship, and that's really not part of the NDIS, as we've experienced it so far. I'm hoping that that's changing.

Q. Just finally, Mr Ruzyla, based on your experience, what are some of your recommendations for reforming the mental health system?

A. Because I was particularly asked to focus on access of the system, I guess one of the things in thinking that through, one of the things that I wanted to highlight was the fact that we do have a uniform platform in Victoria of the community health services that are used to working in a holistic way and invariably have an intake system which we've perhaps put more resources and investment into to try to make it into the service access system that we currently have.

We currently take 3,000 calls a month and are able to divert those to the most appropriate service. I think it would be worth considering that, while we have a fragmented system, we at least ought to make access as simple as possible, and so, that would be a useful place to start.

The other thing that I've commented on that contributes to the fragmented nature of the services is the way in which funding is being allocated. So, we currently have a situation where, it's great that the PHNs are rolling out money, but the impact is that it seems to be stop gap measures, that there's amounts of money being put into different elements which are seen as, look, there's a gap there, we'll plug that with a particular funding bucket.

I think the stepped mental health care fundamentally is a good, sound framework to consider, but currently the

system that we're experiencing is quite - it's extremely turbulent and I'm hoping that that is just a transitionary stage, but we're experiencing a lot of turbulence with staff leaving the system, customers being concerned, and I think we need to do something to create more capacity for mental health services to stretch their response across a wider range of things without being restricted to these sort of criteria.

I've mentioned the impact of NDIS planners. Obviously, getting more skilled NDIS planners would be of assistance.

I think two areas I haven't mentioned sufficiently is the drug and alcohol services and the family violence services: I think they're a really important and critical element to Victoria's mental health system and have tended to sit somewhat parallel to the mental health system, relying on good informal relationships.

And yet, when we did an audit of case files we found that around 40 per cent of people, our clients with a mental illness, also had a drug and alcohol problem, and it was about the same percentage who talked about at some point in their case plan, talked about being victims of violence, so the experience of trauma in relationships, and so I think the importance of that needs to be picked up.

Carer support is absolutely critical, and I've mentioned the COPES Program of, we locate a peer worker in the hospital to be able to support carers as they come in. I think that they go home without their loved one not knowing what's happening, what's going to happen, what has his life got in store for him in the future, and I think increased focus on that is really critical.

But finally, the overarching view that I'd like to put to the Commission, if I may, is that it's really a transformational change that's required. We need to recognise that education, housing, employment, the justice system, are all part of a well-functioning mental health support system in the community. So, just focusing on the health aspect is not enough. I recognise, in saying that, that it's also the biggest challenge to Victoria's and the Commission's recommendations.

I remember the comment that was made that, in order to

get a change in one part of the system, whether it's health, you might need to invest horizontally in other parts of the system like housing and education, and I think that that's the challenge. I think that is really where the big gain will be made in terms of the mental health system. I think it will be a generational change, it will be a generational transformational change, but in the meantime there is a lot that can be done at that more micro level and mezzo level of improving access to the resources that we do have available.

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

COMMISSIONER FELS: Q. Thank you for your comprehensive overview. I had a couple of points to add to your long list. You just mentioned in passing problem gambling and mental illness. Could you give us a minute on that, please?
A. Sorry, could you?

Q. Problem gambling and the mental illness connection, could you just add a couple of comments on that, please?
A. Problem gambling, I did only mention in passing because we didn't do the file audit on those, but certainly one of the things that is evident from our work in the problem gambling area, is that, depression and particularly in the older population around bereavement is one time where people find themselves susceptible to developing problem gambling. So, the older population can easily slip into problem gambling, particularly through the pokies, as a result of bereavement and unmanaged grief.

At the other end, the changes in the trajectory of gambling with the focus on young people is one which I don't feel qualified to comment on, but it's certainly something we notice. I will create a connection to young people increasingly sitting in front of their computer screens and having the ability to gamble popped up in front of them all the time.

So, young people who are retreating into their own homes and sitting for hours on end - and I think things like bullying, failure to achieve at school and so on can contribute to susceptibility to problem gambling.

Q. You also have mentioned housing at various points and

your own role in this. Do you agree that the NDIS does not provide housing funding for the mentally ill?
A. So there's two elements to the housing question: one is the housing itself. There is a process through the Special Disability Accommodation, the SDA, but that's targeted at people with very extreme, and particularly physical, acquired brain injury and things like that, but the availability of housing for people with mental illness is not supported through the NDIS.

The other element to the housing question is, the housing support workers aren't there either. An example is, we have tenancy workers who are there to support the housing associations and housing providers to make sure the tenants are paying their rent, basically living appropriately in the tenancies.

But one of the services that we used to provide which has been dismantled is housing support workers who would specifically work with people with mental illness to manage their symptoms, to ensure that they were able to cope with their neighbours, and the neighbours were able to cope with them, to encourage them out of their social isolation. Because one of the things that we find is that people with mental illness, you can put a roof over their heads, but unless you actually get them out, they sit there quietly and become more unwell as a result of the impact of social isolation, which we're beginning to realise is a problem.

We also had housing workers who would go in periodically, knock on the door, meet someone on a regular or on an as agreed basis and they'd be able to monitor how well or unwell the person was beginning to be and be able to either increase the number of visits, make some suggestions about what we could do, and it could be as basic as things like someone whose voices - and this is an actual case - so someone whose voices tell them not to clean the house. And having a mental health worker come in understanding that this person hears voices, and having the trusting relationship to be able to develop some strategies around that and actually roll up their sleeves and work with them on maintaining their household. That's gone, we don't have that any more, we have no capacity for that, the NDIS does not fund that sort of an approach.

COMMISSIONER FELS: Thank you.

CHAIR: Q. Thank you very much, Mr Ruzyla. I've also got two questions. The first one was, I noticed in the very beginning you said EACH is one of 29 independently governed community health centres out of the total of 84, with the others being governed by hospitals. Is there anything different other than the governance arrangements between the community health centre you run than those others that you've referenced?
A. I think that is a question that I probably can't answer with a great deal of confidence other than to say, from what I understand - and the VHA, Victorian Healthcare Association, has more insight into that than I do - the way in which the budgets are managed, and the focus that the hospital-governed community health centres are focused on is more on something like an outpatient, allied health clinical type of support service.

Whereas, the independently registered organisations do have a broader scope to get into things that some of the other community health centres possibly may not depending on their governance, but I don't want to speculate too far on that.

Q. Thank you. You did however give an example where you said at your health centre you had decided to create this single intake number. I think you described the fact that you had different programs, different phone numbers, different funding sources and different eligibility criteria, and you then said, so you designed a workaround effectively, backed up by data and information for your intake people.

Can I assume that that process would be replicated across each of those different service providers than your other 84 community health centres if a centre like yours had to do that for yourselves? Is there any common sharing of that sort of system that's being developed?
A. I don't see any reason why that can't be replicated across all of those community health services, and in fact they will all have some form of a common intake system because they will be running counselling, allied health, physiotherapy, they may have a GP clinic, they'll have a dental program, and so there will be some way in which the local community will know, oh, ring our community health centre and they'll put you through to the right department; or, if they're more developed, they will also actually be able to give you an appointment.

We've taken it a step further, we've actually commissioned some software to help us integrate our telephony and our client information management system, plus we maintain a database across all the contracts that we do hold; because we hold over 150 contracts, that's how fragmented the system is. I hate to say it, I think it's actually over 200 contracts because some of the contracts are quite minute.

You need to have some way of doing that, of making it easy for customers to ring in and say, look, I understand that you - can I get a dentist, I've got a problem with my child who won't get out of bed in the morning, who can I speak to? So you need to be able to put those sorts of questions - some of them are quite specific, you know, I need a dentist, and some of them are quite vague, like, I've got a 15-year-old son who's staying up late and I can't get him out of bed in the morning and I'm starting to worry about him and his friends.

Every community needs to be able to go to some place and just check that out, without having to go to your GP, because I think that that's not necessarily the best place to go with those general enquiries.

The system that we have, as I said, we actually receive funding from DHHS to invest in the software development around that. We're just at stage 2 of that. So, we've done proof of concept and have shared where we're up to with the Victorian Healthcare Association so that it is actually available.

Q. So your intention would be that it's replicable and could be potentially used by other services?
A. Yes.

Q. Thank you.
A. I certainly don't want them to go through the same software agents, you know, it's shopping for the right solution.

MS BATTEN: Thank you, Chair. If there's no further questions for Mr Ruzyla, may he please be excused?

CHAIR: Thank you very much for your evidence today, Mr Ruzyla.

<**THE WITNESS WITHDREW**

MS BATTEN: The final witness for today is Ms Ingrid Amann. I call Ms Amann.

<**INGRID AMANN, affirmed and examined: [2.53pm]**

MS BATTEN: Q. Thank you, Ms Amann. Have you, with the assistance of your legal team, made a witness statement to this Royal Commission?
A. Yes, I have.

Q. I tender that statement. [WIT.0002.0009.0001] Could you please briefly outline for the Commission your background and experience?
A. Yeah. So, I'm a counsellor, but I've been working in various roles for Wellways since 2007. So, Wellways is a not-for-profit organisation that has had numerous collaboration and partnerships with clinical services as well as other community support services.

Q. What's your current role?
A. So, I'm currently the program coordinator for North Fitzroy PARC.

Q. So, PARC's been mentioned a bit in the course of the hearings but you're the first witness we've heard from who works at a PARC. Can you tell us from your perspective what a PARC is?
A. Yep. So, PARC is an acronym that stands for Prevention and Recovery Care. So, PARC's purpose was either a step-up, so individuals in the community that may not be travelling so well and requiring support but not in crisis, could step up into a PARC, or individuals that have had a period of time in acuity, in crisis, that could step down to PARC from acute inpatient services.

Q. You're at the North Fitzroy PARC?
A. That's correct.

Q. Can you describe the physical set up of that PARC, please?
A. Our building's very urban being in North Fitzroy, so it's a double-storey purpose-built, 10 bedroom with ensuite bathroom, and sort of communal or community breakout areas.

Q. Who uses the PARC, who comes to your service?
A. All of our referrals come from St Vincent's Hospital, so either the acute inpatient service or the clinics which are located in Hawthorn and Clarendon in East Melbourne. Our PARC actually accepts outside referrals from private psychiatrists or GPs, and we look at those on an individual basis.

Q. Can you please step us through the referral process. This PARC is a collaboration between Wellways and St Vincent's, that's right?
A. M'mm.

Q. You referred to the inpatient unit. Can you explain the referral process from that unit, please?
A. If somebody has been in the acute inpatient service for a little while it may be deemed that going home, that potentially they're not quite ready. Being in an acute inpatient service can impact somebody's confidence. They also might be experiencing some deskilling in terms of managing their home environment, so the acute inpatient service will give the PARC program a call, have a conversation with the St Vincent's clinicians regarding a referral. The acute inpatient service will put in a referral and discuss it with the Wellways program coordinator, myself or another senior team member, and we would call that person in for an assessment and then they're able to come into PARC.

Similarly in the community a case manager may be of the belief that somebody's either isolating themselves or not travelling so well in the community, then the community team will call North Fitzroy PARC and discuss a referral, and then we'll call that person in for an assessment.

Q. So, you discuss the referrals with the clinicians?
A. Yeah.

Q. But ultimately who decides who gets a bed in the PARC?
A. It's a joint decision, yeah. So, we do the assessments together, a St Vincent's clinician and either myself or a key worker.

Q. Does each part of that, the clinician and you, have equal weight in the decision-making process?
A. At North Fitzroy PARC that's the case but I am aware that that's not the case at all PARCs.

Q. How are you aware of what's the case at other PARCs?
A. I'm after hours on-call for two other Wellways PARCs within Victoria, and I've also been part of a PARC network meeting where all the coordinators from PARCs got together and it was a point of discussion.

Q. What's the situation at some of the other PARCs?
A. At some of the other PARCs what's happened is, they've become very clinically-heavy. So, due to the pressures with the acute inpatient service there's a need to clear beds at times, and what happens is, if a PARC has a vacancy then individuals will be sort of shuffled off to a PARC bed without following process, sometimes without an adequate referral process and assessment.

Q. Do you know what happens in those situations in terms of whether a PARC is an appropriate setting for that person?
A. Well, what a consequence of that is, participants don't necessarily benefit from the preventative and the therapeutic interventions from the multidisciplinary team because their acuity is so much so that they're still in crisis, and that also impacts potentially nine other people in a 10 bed PARC from experiencing their own therapeutic interventions.

Q. If we go back to the North Fitzroy PARC, do you get more step-downs from the inpatient units or more step-ups from the community services?
A. Yeah, North Fitzroy PARC, we're predominantly step-up.

Q. What are the waiting times for a bed in the PARC?
A. At North Fitzroy PARC, we don't do an assessment, we don't call somebody in for an assessment until we know a bed will become available. So, the longest waiting time is 7-10 days, and so, our waiting lists - we don't actually hold long waiting lists at all.

Q. Are there particular points in the year where there is a longer waiting period?
A. Yeah, certainly around Christmas and Easter, there's a much greater demand during those times and that's often due to a lot of community services that are closed down over holiday periods, so that's very triggering for individuals in the community.

Q. Once a person's referred to a PARC, you said in your statement they have a behavioural and symptom identification scale questionnaire. Can you explain what that is and what that's designed to achieve?
A. Yeah. So, everybody that we accept into PARC, we encourage them to do what's called a BASIS-32, and it's a series of 32 questions where the individual has an opportunity to rate the level of difficulty they're experiencing in their lives, and the questions are arrayed over 32 areas.

Q. Can you give us some examples of some of the areas?
A. So, it could be something like relationship with family and rate your level of difficulty with interpersonal relationships. Rate your level of difficulty with day-to-day stressors. Rate your level of difficulty with your symptoms, auditory hallucinations, things like that.

Q. So they complete that referral questionnaire, and does that feed into the approach that's taken for that particular individual?
A. Yeah. So, it is a focus point for key workers to sit with the individual and discuss, particularly where it's around the extreme levels of difficulty, and a discussion around how you manage that at home currently, is that a trigger for you at home. So, from there there's an individual approach on how to best support somebody for their return home.

Q. In your statement you've given some examples of the individualised approach, I'd just like to ask you some more details about those. The first one is if they have, as you've just said, issues at the home and issues where they live. Can you give some examples of what the PARC worker might do to try and address those issues?
A. Yeah, so housing is a major issue which is going to probably come up quite a bit. So, where somebody experiences overwhelm and stress due to their living environment, at PARC we will assist to develop an individualised approach on how to actually manage best for when they do move back home.

So it could be that we may support somebody to manage their locks at home. We might do some sensory modulation work to support somebody to reduce noise, interpersonal skills to manage the interactions that they're having within their environment. We may be able to support going

on different housing lists so there's hope for the future in terms of potentially changing housing should that become available. So, it's a very much holistic view: how do you keep yourself well given the stressful environment that you're living in.

Q. Another example that you gave of the individualised approach is if a person's struggling with their medication. What kind of support would you provide in that situation?
A. So, validating somebody's experience of the treatment that's offered with their mental health is really important. So, again, some interpersonal skills on how to navigate and negotiate that with the clinical teams and be able to voice what's actually going on in terms of the medication.

The importance of giving medication some time before making decisions to stop, to cease taking medications. And, if somebody's wanting to go off medication, how do we discuss that with your clinical team to perhaps trial new medications. We'll develop more strategies, so you could be taking potentially a lower dose, but practising things that will help you in accompaniment with the medication.

Q. You stated that you, the PARC, is not an accommodation option. Can you clarify what you mean by that?
A. Part of the entry criteria is that people need to have accommodation to be exited to, and where somebody is homeless, we set up very robust plans with the Homeless Outreach Team to support that person to exit PARC.

If somebody doesn't have accommodation or is using PARC as an accommodation option, they're also less likely to engage in therapeutic work, because they're living there. So, yeah, it's not an accommodation option for that reason.

Q. And there's a time limit for how long people can stay in the PARC; is that right?
A. Yeah, so 28 days is the maximum with our PARC.

Q. What's the mentality behind that limitation?
A. Well, the average length of stay is around 19 days, and we review week-by-week with individuals coming in. What we're doing at PARC is really concentrating on the focus of somebody's stay; that it's for this period of time that we can be working on that, and what we encourage is

even overnight leave when somebody's staying at PARC so they can practice the strategies that were put in place and they have time to come back to PARC and work with their key worker on troubleshooting, how that went, and what may be required.

28 days is for that stay to work on preventative care, and that is with the knowledge that, should you feel as if you're deteriorating further in the future, to think about coming into PARC as a preventive measure before you go into crisis. So, part of the preventative work is identifying when you're not travelling so well as early as possible.

Q. And the option of coming back to PARC may be included in a mental health plan; is that right?
A. Yes, for some people we've very much become part of their mental health plan. So, they may have it scheduled every three months or four months or every six months that they will be coming into PARC to consolidate the strategies and skills that they've developed. What we have found is those individuals have not had a hospital admission since PARC has become part of their preventative plan.

Q. Have they necessarily needed to use all their PARC admissions or has it reached a point where they no longer needed it at that frequency?
A. Yeah, and that's something that's been interesting for us to observe as well, that they've naturally extended the time of coming into PARC, so they've not needed it as frequently as what was initially anticipated and it's gone a lot longer, and a couple of people have not returned to PARC and they've not had hospital admissions either.

Q. You also refer to the fact that you engage with family and carers. Can you explain what that involves?
A. Certainly, wherever family holds the burden, and we always offer - we talk to the participants of our program that we would like to offer education support for families which Wellways offers, which is a peer-led education support on how families can keep themselves well given that they're looking after somebody that is experiencing mental health issues.

At North Fitzroy PARC we also do midway reviews with each of our participants, so families can be invited to that as well, so they're part of the plan of somebody returning home.

Q. You refer in your statement to the group sessions; what do the group sessions involve?
A. So, the groups at North Fitzroy PARC, they're optional. We consider them an opportunity to try different things that may support you in your recovery. So, if we're encouraging individuals to attend a group and we would like buy-in for that, it needs to be optional, it needs to be choice and they have that choice and control over that.

With our groups, what we have experienced is our peer-led groups. So, we have a peer workforce within North Fitzroy PARC too, that with our peer groups, there's always a very high attendance because there's a degree of understanding within those groups that occurs, being with somebody who has a lived experience of mental health concerns.

So, we have peer-led groups that look at joint wellness plans, but we also have other groups that are about positive psychology, basic cooking skills, skill development, positive psychology group, we have art therapy and we have music therapy, and we have de-stress and mindfulness groups also.

Q. You said, to deliver the different programs at the PARC, you try and capitalise on the skill set of the team that you have. Can you just explain to us who the team is, what backgrounds do they have, what are their roles?
A. So all the team members are tertiary qualified, some people are art therapists, some people have a specific interest in positive psychology and have some psych degrees as well. We also have social workers. But by utilising the skills of the workforce and encouraging them to research further and develop programs for the individuals that access the service really encourages that buy-in and enriches the multidisciplinary team, so yeah.

Q. You've referred to having a non-active shift overnight. What is that and why do you have to have that?
A. Because PARC is about prevention, we only have one staff member that is on overnight, and they're a non-active shift, so they actually sleep through the night. We let participants know about that. This is not like the hospital, we don't have nurses up through the night, there's no medications as required. They're called PRNs, we don't have any sleepers or medications here to support

you with that. Prevention is very much about using your strategies to help you get through the night.

Having said that, we have a non-active shift. We have somebody that's on overnight and they're really there as a security, that they know somebody is there, and obviously if the fire alarm went off or something like that, they're ensuring that everyone's safe and is able to get out of the building, but that's the purpose of the non-active shift; it's just that there's somebody there, but they're not on the ground working.

Q. You've also referred to the fact that North Fitzroy PARC is a dry site. Why is that important and how do you manage that?
A. So, it's something that we discuss at the assessment, and there are individuals that struggle with substance use as a way of managing their mental health concerns. And so, when we say to them, PARC is a dry site, there's no drugs and alcohol allowed on site, individuals are not to return substance affected. We then say, having said that, what this means is, we'd like to work with transparency, so if you feel as if you're going to use, if you are struggling with withdrawals or you're struggling with wanting to use, we just ask for a transparent conversation about that so we can ensure that you're kept safe before, during and after you're use, and how are you going to manage your use whilst you're at PARC? So does that mean you choose to use on a Friday, take overnight leave on a Friday night, and then come back to PARC on a Saturday and we can discuss how that's impacted you and how that's going to impact you over the next few days, so you're allowing for those conversations around the substance use.

Q. How has that worked in practice; has it been effective?
A. It works very well at PARC, yeah. At North Fitzroy PARC we use - it's really easy, it's called a BDA tool, which is before during and after which just allows us to tease out the substance use and people's reasons for use and how to look after themselves within that.

Q. You referred to drug use. How at a general level do you work out a patient's level of risk to themselves and potentially to other residents?
A. So, this is why it's important that there's a joint assessment, and there's the clinical service and also the

community service that have an opportunity to sit with an individual to talk about that. So, what is it like for you if you use this substance? What happens for you? If it's somebody that, I always get into fights and end up in trouble, then we need to I guess be a little bit more rigid around, whilst you're at PARC you are unable to return after using those substances, so which day would you normally use? I use when I get paid.

So, then we may make an arrangement where they can come into PARC Monday, Tuesday, Wednesday, and they discharge after that, but it's given them three days of potentially having a good experience in a prevention environment for them to consider for future.

Q. What level of risk is PARC comfortable holding in terms of patient risk?
A. So, that's another reason why the joint assessment is really important. If we, as a collaboration as a partnership, felt that a team member, a staff member would be at risk with that individual there and that we're potentially not having a transparent discussion with that individual, then they wouldn't be eligible for the prevention program.

Q. You referred to levels of acuity, so is there a certain point of a level of acuity that you're not comfortable holding?
A. To access PARC there needs to be a degree of someone having the ability to manage their safety independently. So, they either need to have the ability to help seek, or know that they're not coping and that there may be behavioural issues and not stay, so exit themselves or understand that PARC is not the space for them.

PARC is a voluntary program, so people are free to come and go. So, if we're unable to set up a robust plan and an agreement with an individual that we're uncertain about, then they wouldn't be able to come in, because it's about staff risk and it's also about other participants' risks: they're coming into a preventative environment, a prevention environment that is to be therapeutic and it will certainly impact that.

Q. Two final questions. In your view, what makes the PARC model successful?
A. The key to a successful PARC is absolutely the

partnership and the collaboration between clinical services and the community team. There needs to be absolutely consultation, joint assessments, supporting each other with education too, and really an understanding that the holistic view of the multidisciplinary team is what contributes to the therapeutic environment and the prevention aspect of PARC: that is its intention.

Q. Are there any aspects of the PARC model that you think could be changed or enhanced to better deliver the service it's aiming to provide?
A. Absolutely, we need more beds. I don't know that an increase in beds in the existing PARCs is the answer; I think we actually need more PARCs altogether. 10 beds is a good ratio for staffing and participants and to maintain the therapeutic environment. If you had more numbers than that within a building, I think that would impact the therapeutic environment. But key is the ongoing understanding within the clinical and the community teams.

MS BATTEN: Thank you, Ms Amann. Chair, are there any questions from the Commissioners?

COMMISSIONER FELS: Q. Yes, I have a couple of questions. Just, I don't know if on-the-spot you've considered this: what would be the advantages and disadvantages of having separate facilities for step-up versus step-down in general, or what is the case for putting them together, if you know; is there a case for separating them? And is that case affected a little bit by the fact that there seems to be a lot of downloading people with severe acuity into PARCs at the moment: is that also having an effect on the model?
A. The last comment that you made, it's certainly having an impact on the model, the flow-through of an increased acuity.

In terms of separating the step-downs and the step-up: it's been my experience at PARC that it's the peer relationships that occur within PARC that also adds to the therapeutic environment, and so, if there was a separation of that I feel like something may be lost. But thinking about it, I can appreciate there probably is a greater need for more beds in a step-down capacity, but short-term.

Q. My other question is, in a comprehensive system that addressed housing, PARC is an important element. There are

probably some people who go through PARC who have a longer-term need for therapeutic and other forms of treatment, so PARC is a pretty important innovation, but it's probably not the only thing required and possibly some people go through PARC and they need something continuing. Do you have any thoughts on that?
A. Certainly, with the implementation of the NDIS, there was a great loss of residential rehabilitation programs, if that's what you're referring to. My experience has been with Wellways, that with the closure or ceasing of the block funding for a residential rehabilitation program having gone to the NDIS, there has been opportunities for people to enter into an NDIS package that's called SIL, Supported Independent Living. The challenge that they're experiencing there is, they have vacant beds, they have eligible people to come in but NDIS don't deem them as eligible, so they're unable to fill these beds.

So, yeah, certainly there is a need for an extended psychosocial support, but I'm not sure that it should be sitting in the NDIS space. It used to sit within the clinical partnerships and community services, where people who are case managed were referred and assessed, and there was a more transparent and comprehensive flow-through, so that did exist but it was decommissioned, but I couldn't be clearer with you now on why it was decommissioned and what the robust reasons for that were.

COMMISSIONER FELS: Thank you.

CHAIR: Q. I have one other follow-up question, Ms Amann, thank you very much for your evidence. Can you give us a sense of: you've got a very wide age group of people eligible to come into a PARC, 16-64: mixed genders, different step-up, step-down. How do you manage that age spread and what's the feedback you get, for example, from younger and older consumers?
A. Again, for North Fitzroy PARC, the age difference - because our focus is very much on transferable skills and normalising life, it allows for those conversations within the PARC setting around, any challenges that come up, we have the opportunity to work through that and put strategies in place and discuss that.

I'm reluctant to think about setting up PARCs where everyone's kind of the same: you want the difference. To a degree, if individuals experience triggers within PARC,

that's where you want them to experience triggers, that's where you want individuals to experience their stressors, so you're there firsthand to work with that individual and develop strategies to manage that.

So for us, we don't see it as being a barrier or a concern, it's really opportunities to - because individuals will face this in the community, they'll face this in their housing where there is no choice, so developing skills to navigate and manage where it may not be settled as such, we would see that as an opportunity rather than something that isn't workable.

CHAIR: Thank you.

MS BATTEN: If there's no further questions, may Ms Amann please be excused?

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

<**THE WITNESS WITHDREW**

MS BATTEN: Ms Amann was the final witness for today, so may we please adjourn till tomorrow, please, Chair?

CHAIR: Yes, we're adjourned.

AT 3.25PM THE COMMISSION WAS ADJOURNED TO THURSDAY, 11 JULY 2019 AT 10.00AM

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