ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Tuesday, 23 July 2019 at 10.00am

(Day 16)

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

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

MS NICHOLS: Good morning, Commissioners. You'll hear from six witnesses today. Katerina Kouselas is a community witness. She will share her story of how the mental health system failed her husband, Bill.

John McLaren is Community Manager at St Vincent's Area Mental Health. He will describe the work undertaken by his team in particular in relation to HOPE, a program which specialises in dealing with consumers who present with suicidal attempts.

Ms Anne Lyon is Executive Director of the Mental Health and Alcohol and Other Drugs at Eastern Melbourne Primary Health Network. That network has two place-based suicide prevention trials at Whittlesea and Maroondah. Ms Lyon will give evidence about what those trials have involved to date and how they're being used to inform suicide prevention strategies.

Ms Louise Flynn is the Manager of Support After Suicide. She'll explain what that program entails and what it means to be bereaved by suicide and how that experience is different from other forms of bereavement.

Associate Professor Peter Burnett is Director of Clinical Governance at NorthWestern Mental Health. He will give evidence about how the risk of suicide is assessed and the limitations of the assessment tools. He is also a member of the Mortality Benchmarking Group which collects data on reportable deaths. Associate Professor Burnett will explain the role of this group and how data is used.

Bruce Crossett is the Acting CEO of the Transport Accident Commission. He will discuss TAC's Towards Zero strategy for road safety. That's a long-term systematic approach to reducing the road toll that's been implemented now in Victoria for some time. It's a multi-agency approach which involves many aspects of government agencies.

Now, of course, not all elements of that strategy will apply directly to suicide prevention, nor could they, but we are calling evidence from Mr Crossett because we want to understand the relevance and importance of a systems-wide approach that takes a long-term vision.

I'll mention once again that the evidence today may be

confronting and I'll repeat the remarks I made yesterday which reflect the comments made by the Chair: that the Commission appreciates the courage of people who are here today to tell their stories and also being here to listen to the evidence, and understands the pain of those who have lost loved ones.

There are supports, please use them. There are counsellors here today at the Town Hall. Lifeline is available on 13 11 14; Beyond Blue on 1300 224 636. Ms Batten will call the first witness.

MS BATTEN: Thank you, Commissioners. The first witness is Katerina Kouselas. I call Katerina.

<**KATERINA KOUSELAS, sworn and examined: [10.05am]**

MS BATTEN: Q. Thank you, Katerina. Have you, with the assistance of the Royal Commission's legal team, made a witness statement to the Commission?
A. Yes, that's correct.

Q. I tender that statement. [WIT.0001.0051.0001] Katerina, can you please tell the Commission your story?
A. Thank you. I want to skip to the end. My husband Bill - sorry - passed away on 22 January 2016. He ended his life. I believe the mental health system failed him, and it might be failing lots of other people we do not know about. Excuse me for a second.

I met Bill when I was 18. We were so much in love. We got married when I was 21 and he was all I ever wanted in my life. Bill had depression for nine to 10 years prior to his death, but we had no experience of the mental health system until six months before he died.

He lost his job in the middle of 2015 and that started it all. I thought it was a good thing because he didn't enjoy his work. He took it deep and bad and couldn't come out of it. He was the breadwinner and it was a big shock to him. He lost his job and then Bill was home alone every day for six months.

Bill couldn't get into my local GP because there were too many patients and she couldn't take anyone else on. Bill had made appointments with a mental health triage centre and called Beyond Blue regularly. I would arrive

home from work and there would be people in my living room talking to Bill. I think he called them because he didn't want to burden me.

The GP sent him to a private psychiatrist, but they were a waste of money, no-one helped. Bill spent five months in the adult PARC Centre. They were amazing, they really included me. Speaking to the spouse is an important thing, because I have been there for everything and knew what Bill was going through and could describe to them what he was feeling. It was also important for me to understand what they were doing to Bill.

I was at the PARC Centre every day, I didn't leave Bill's side. Sometimes I wondered why I just didn't leave him at the PARC Centre for a lot longer. About a day after he left the PARC Centre he started deteriorating. He was very anxious, he was paranoid, it was like he was having a panic attack that he couldn't stop. He was also doing a hell of a lot of sleeping, but then, when he would wake up, it was in a panic.

He had been prescribed Valium which calmed him down, but then he would sleep even more and wake up the same or even worse. In all our years of marriage, I'd never seen him like that.

I wanted to take him back to the PARC Centre but they told me that once someone has been released, you cannot go back to the bottom - you have to go back to the bottom of the waiting list. I don't know how long the wait would have been, but they said it wasn't very good. So, because he'd already been through all the process, the CAT Team, the PARC stay, they said it would be at least a couple of weeks and he would be at the bottom of the list.

So, I took him to Emergency. We had to go through Emergency, which is something that concerns me. People who are suffering mental issues should not be waiting in emergency with all the people that have got broken legs, have got a cold, it should be in a specialised area. Bill was very paranoid and there were lots of people in Emergency that just kept looking at him and making it worse for him.

The finale was the psych ward; Bill was put in there through the Emergency with people who were a lot worse than

him; people with more extreme illnesses, some who might be really unpredictable. You don't always know what they're gonna do, which is really hard for someone who is really very anxious. Bill was out of his mind, he was just depressed; they just put all of them together in the same group.

I took Bill to the Emergency - sorry, I'm going back to that again - and I told them that he was unwell. He was admitted through to the psych ward. I then got a call two days later to say that Bill was agitated and he wanted to leave. I told them I didn't want him to come home if he was unwell. Of course, I wanted him home, I loved him, he was my soul mate, but I didn't want him home if he was not well enough to be home.

They said, "Katerina, Bill doesn't look suicidal. We have given him psychosis medication and he is ready to go home", on that day. I thought that was strange, he'd never had that medication before but I trusted that they knew what they were talking about. All they gave him was an appointment for two days later.

I was there when they discharged him, they asked Bill four questions: he gave them one word answers and then they sent him home. All they gave him was an appointment. He came home and seemed on top of the world and I thought this medication is amazing, but that Friday he took his own life.

I'm 100 per cent sure that, whatever the drug was they gave him, it changed my husband. He'd been home alone for six months and not done anything - and then after a couple of days Bill took his own life - of being given that medication.

I do not understand why you would not have procedures in place to monitor someone, when you put them on new medication. You do not know how people are going to react after a couple of days, and you should keep them there and monitor them, like they do for every other medication.

I did not think about that at the time. I would never have left him alone if I thought he was suicidal. The experts said he was fine with the drug.

I still wanted to know what happened, so I asked the

Coroner to look into Bill's death. I have not received the report yet, but I hope it gives me some answers. We had been married for 32 years when Bill passed away. I will never come to terms with that. We were together since we were 18, we have a beautiful daughter, Natalie, and it took my life away and my heart and it will never be okay.

No-one understands it unless you have lost someone to suicide. It's very isolating, it's not like you're losing a loved one to something else, it's like you have a big sign on your back saying, people don't know what to say to you, so what they do is they avoid you at all costs.

My daughter and my son-in-law and my friends have been amazing together, but some people don't know what to say, they avoid you. Now I talk about Bill as much as I can and I try to make people aware of his suicide - it's my passion.

I'm hoping that with all the information that is put in, and some procedures, it might save someone else. I want people to know what it's all about and hopefully how to prevent all of this. I do not know what else I can do to talk for Bill, but his death has to make it matter now. Thank you.

Q. Thank you very much, Katerina. In your statement you mention a couple of things about the system that you would like to change. Would you like to talk about any of those?
A. Yeah, I just feel that, if you're admitting someone into a new ward, or a psych ward, and you are giving him new medication that they've never ever had before, they should be monitoring him. It's like anything, when they give you something in the hospital, they say, look, we'll just wait 24 hours, 48 hours and we'll see how you go with that: I just feel like that was the biggest let down.

Q. You've also said that family and carers should be given information?
A. Definitely.

Q. In your view, it's important for them to be involved?
A. Definitely, yeah, correct. The PARC Centre was pretty good, but a lot of the other places, they just don't give you a lot of information, and they talk to the person that's suffering the illness, which is great, but a lot of times they don't know how to react, what to say, so we need

to be involved with all of that. We need to know, because we're with them 24/7, we know how they're feeling, and if they're slightly fibbing or, you know, just to make it look good for everyone else, so I think we need to be a part of that definitely.

Q. Is there anything else that you wanted to say today?
A. I just wanted to say, I hope this can make a difference for a lot of people out there which we could save. It didn't save my husband and Natalie's dad, so we have to endure this for the rest of our life, but let's hope that we can make a change. So, thank you.

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

CHAIR: Q. There's just one. Thank you very much Katerina for coming and being prepared to share that with us, and we appreciate how important it is for you to do so.

You've talked about an issue that we've heard a lot about in this Royal Commission which is when people are admitted into an acute inpatient unit such as occurred with Bill and being there for two days; you've explained a bit about not wanting to take him home if he wasn't unwell. Could you just reflect further in terms of, what was the hospital saying to you about why they felt it was okay for him to be discharged after two days?
A. Because he was agitated on that day. He'd been agitated the whole time he was there, so that's why they gave him the psychosis medication on the day that he was let home. But they kept saying to me, "Look, Bill wants to go home", and I said, "Well, Bill can't go home, it's not up to Bill." He has to be not 100 per cent, because I know he wouldn't have been 100 per cent leaving the psych ward, but he has to be a lot better than what he is at the moment before I'm happy to take him home. You're the experts, you need to tell me.

So, when they told me that the medication they had given him was - they tried to compare it to someone who had schizophrenia. So, they said, we normally administer 600 milligrams of this medication, we've only given Bill 25. And I said, "Oh well, he's never had this before", but I could see my husband, he was just still on edge, you know.

The whole time they interviewed us to let Bill go

home, I was there, but he was only giving them one word answers; there was nothing elaborate, you could tell he was hiding a lot just to get out of there. And I kept saying to them through the whole time, the whole time we were being interviewed there, "He just doesn't look right to me. I need you" - I actually even said, "Maybe it's better if he stays here and we have - maybe you can start shock treatments as well." That's one of the things I had mentioned at the PARC Centre as well. They said, "Oh, there's a procedure for all of that", and I said, "Well, start the procedure. I'm happy to leave Bill here and do whatever you have to do, but I will be here every day." So, they just ignored me. It was like, no, he's quite capable of going home, and then that was the two days later when he had the appointment which he never even made, I think he cancelled it, and no-one told me.

And that was the other thing too: so, after the appointment that he had, he cancelled it. No-one called his wife to tell me that he'd cancelled this appointment. Maybe then we could have acted on that as well, so there was a lot of gaps there.

CHAIR: Thank you. Thank you very much.

MS BATTEN: Thank you. May Katerina please be excused?

CHAIR: Yes, thank you for coming today.

<**THE WITNESS WITHDREW**

MS NICHOLS: The next witness is John McLaren, I call him now.

<**JOHN WILLIAM MCLAREN, affirmed and examined: [10.22am]**

MS NICHOLS: Q. Mr McLaren, are you the Community Manager at St Vincent's Area Mental Health?
A. Yes, I am.

Q. Are you also a registered nurse?
A. I am.

Q. Have you worked in mental health for over 30 years?
A. Yes, I have.

Q. Have you prepared a witness statement which deals with

the HOPE program at St Vincent's?
A. I have.

Q. I tender the statement. [WIT.0002.0007.0001] Mr McLaren, can you please tell the Commissioners just a little bit by way of background what services are provided at St Vincent's Area Mental Health?
A. The first part of the services are triage services based in our Emergency Department, who provide advice and direction for clients seeking mental health support and help. We also have our acute inpatient service which is based in St Vincent's campus. With that, we also have our community-based teams. We've got the CAT Team which is a crisis team that visits client in their home, and there's a short-term follow-up to ensure their safety, and again, linking into major services and follow-up services as required.

Then we've got our community-based teams such as our Continuing Care Team, our Mobile Support Team and our Homeless Teams.

Q. Can you tell the Commissioners briefly what the Continuing Care Team does?
A. Continuing Care Team is a service that provides ongoing support for clients with enduring and serious mental health problems that get referred to our service. It's a service that our client will then be allocated what's called a case manager, and the case manager will be able to support that journey of the client in terms of monitoring a lot of their presentation, particularly signs of mental illness in terms of their treatment and their options available for their treatment. And, once treatment has been provided, monitoring that treatment to ensure things like side-effects of the medication are addressed.

The other aspect is also looking at the psychosocial aspect of the client. Often the mental health part can be - signs and symptoms can be dealt with quite quickly, but the psychosocial issues that face some of our clients are quite extreme. Things like employment, housing, relationship, connection to community, problems with drugs and alcohol, trouble with finance, they're the major issues that are facing a lot of the clients that we case manage, so we look at supporting and navigating them through the very difficult system of accessing support for those needs.

Q. We'll get to the HOPE program in a moment, but can I just ask you a little bit about navigating that very difficult system and how you go about it from your services perspective to help your clients.
A. In terms of accommodation, if we start with that: that's very difficult. In my experience there is a lack of affordable suitable safe accommodation for clients that often have serious mental illness and living in the community, so we look at how we can manage that as best we can.

So, we have certain linkages with accommodation services, such as Launch Housing for instance, which is quite a major organisation that deals with mental illness, specialises with supporting those needs and there's other services around, so we make sure we try to link in as many agencies as we can.

Unfortunately, the majority of accommodation is usually more crisis accommodation, short-term accommodation and unsuitable accommodation as well, but nevertheless, we can try to look at the best options.

We also had a partnership with Doorways which is part of Wellways NGO, looking at supporting tenancies for private rental, so that's something that's been a successful part of the service that we've been providing.

In terms of some of the other psychosocial needs, we work in collaboration with other NGOs such as Mind and also with Wellways, just to provide some of those support systems, support in the community, being able to provide some linkage into community, and also to do some of the monitoring and support the case manager.

Current obviously one of the big changes that happened with the psychosocial element is the introduction of the NDIS program. So, our services, we're navigating our way through that and we do find there's a lot of challenges that we face with that in terms of the psychosocial need.

So St Vincent's at the moment in our community, we went into partnership with Mind to provide a year-long service, the funding's for a year in terms of providing some of those psychosocial supports whilst people are accessing the NDIS if they can access that.

Q. You say, with people who use service through your community-based service, do they tend to stay with you over a long period of time?
A. It varies. We'll have some clients that will be case managed maybe for three to six months; often they will be linked into the appropriate services they need, they'll have had that short-term management and support and follow-up and they don't need our service any more and we feel confident that their GP or their private psychiatrist or private psychologist in the community can manage that person successfully.

But we do have a lot of other clients that we can case manage for a longer period of time. At the moment I've got a number of clients that we've been case managing for 10-15 years.

Q. Can I ask you about the HOPE program: can you tell the Commissioners what it is?
A. HOPE stands for Hospital Outreach Post-Suicidal Engagement, part of the Victorian Suicide Prevention Framework that came into operation in 2016. We're one element of that strategy. We are a service that provides three months' support to clients who present to St Vincent's in person with suicidal thoughts, thinking or behaviour.

The remit of the service is that they have to attend a hospital-based service in the first place to access help, such as attending our triage service, being looked after by our CATT, or in our inpatient service.

Clients who are in the general side of the hospital can also access through or consultation liaison service into the HOPE team. So, once those clients have been identified, the HOPE team then looks at providing a three-month package of care to look at, initially their safety. The key thing is to assess their risk and the safety of repeated suicide or behaviours or thoughts, and then we have a systematic approach for the first period of that three months, leading to linking them into appropriate follow-up services at the end.

Q. Thank you. Let's just go back to the beginning. So, clients who present in person to a hospital-based service, are they referred by a clinician to HOPE?
A. Yes, they are, yes.

Q. What services does HOPE actually provide? Can you tell the Commissioners what kinds of people work at HOPE?
A. We're a multidisciplinary team. It's a small team at this stage. We have a consultant psychiatrist, we have a trainee senior registrar, we have a senior psychologist, a senior social worker, and a senior occupational therapist that were funded. We're actually part of a slightly bigger team, so we've actually joined in with other services that are managed to provide that multidisciplinary aspect.

Q. Does the service operate seven days a week?
A. It does.

Q. 24-hours a day?
A. No, it's just office hours, 8.30 till 9, which is not ideal but at least we have the weekend working; that seven-day approach. Outside of the normal working hours there's our CAT Team if we need them, and they support to provide any supervision of some of our clients and we can access them straight away.

Q. Is there a particular focus on the first seven days within discharge from hospital?
A. Yes, there is. That's the most vulnerable time. People experience the support when they're discharged from hospital. So ideally we'll meet the client before they get discharged from - the nominated clinician will go to the inpatient ward or to the Emergency Department where the referral will come if it's within office working hours, they will introduce themselves to the client and make an appointment for a follow-up within three days of them being discharged from hospital. During that time we will also provide some hospital support by telephone call over that period of time.

Q. Can you just say a little bit more about that: how does the support work within the first three days?
A. We provide a safety plan for the client in terms of providing numbers that they can contact if they're in crisis and if they need some help, including St Vincent's Hospital triage, but also other resources such as Beyond Blue, Lifeline or the crisis kind of support services.

We also give them information about our telephone numbers and how to contact us over those three days, and we will give them a check in telephone call just to see how

they're going, how they're progressing.

We do the intake assessment within that three days. Obviously, we're a very small team and we have a lot of referrals, so capacity has to be taken into consideration, so ideally we would like to see them straight away and do the full assessment but that's not always possible, so our KPI, our target is within the first three days but usually we'll do that before then. So, we'll do a full assessment of their needs and look at the gaps that haven't been assessed through either their inpatient stay or the connection with the service, and start working towards a goal-orientated action plan for that client to work with in their recovery.

Q. So, the patient's journey is, a personal meeting while they're in hospital?
A. Ideally if we can manage that, but often a lot of the presentations are 10 o'clock, 2 o'clock in the morning, so we will aim the next day to be able to visit the inpatient ward if they've been referred to us at that particular time. Obviously, if they're sent home we're not able to do that follow-up. But obviously, if somebody's in crisis the CAT Team will have followed that person up until they start to be engaged with us formally.

Q. Once they engage with you and you've done an assessment, what happens after that?
A. The assessment's reviewed by our clinical team. We identify a safety plan with the client. We use what's called the Collaborative Assessment and Management of Suicidality Model, which is a clinical based model specifically designed to work with clients with suicidal tendencies.

So, we follow that structured approach. The first part of it, like I said earlier, is identifying a support plan for the client, that provides safety, trying to identify what resources are available for that client to turn to when they haven't got access to any other kind of services such as family, friends, people that they work with, people that they can have that immediate support.

We work with their suicidality in terms of what they're experiencing at that particular time; why have they looked at wanting to take their life, what are the reasons behind that, what are the strategies we can put in place to

prevent them from doing that again in the future? So it's a systematic way that we approach that in a clinical way.

Q. Is that model of care something that your team came up with yourselves?
A. As Manager, I looked at a number of models of care, which there isn't a lot to be honest, you know, dealing with this particular aspect of intervention. I was advised by a clinical psychologist who was a senior lead that this was a good model and it was starting to develop an evidence-based approach. We looked at that and, although it's a sophisticated model it's quite an easy to use model and easy to train staff, new staff, how to use that. I also felt that the model provided quite a structure for the client in terms of working with their suicidality, so yes, that was the advice of senior clinicians who had experience in that area.

Q. In terms of the way your staff interact with your patients, what's the difference between what they do and what your Continuing Care Team is able to do?
A. We're able to offer more intensive support, is the main thing. We can see a client in the first period of their suicidality two, three, four, five times a week if necessary. Whereas someone working within CCT will probably just see somebody a minimum of once a week. So, it depends on the severity where we're got that resource available to do that.

Also, all our staff are trained in certain intervention techniques, like cognitive behaviour therapy, which is one of the key intervention therapies that we support our clients with. Although we do have that approach in CCT, our staff in HOPE are more experienced and more highly trained in those areas of practice.

Q. So, are there really two differences: one, you have lower caseloads and you are therefore able to spend more time with each patient?
A. Yes.

Q. Elaborating on that, what are the differences between the caseloads in the HOPE team and the caseloads in the community care team on average?
A. On average, with the HOPE team, we have 24 clients in our small team, which is about eight per clinician. Within our Continuing Care Team, we can have anything between 25

and 30 clients per clinician, so you can see there's a difference in that, three times as many in Continuing Care.

Q. Is that an important feature of the HOPE Program?
A. It is, yes.

Q. The other feature being that your staff are particularly well trained and qualified in the techniques that they apply?
A. Yes, absolutely.

Q. You mentioned that the period of time is three months: why is it a three-month period?
A. That was defined by the department when the program was set up, so I had no control over that matter. I think it was a consensus that, for clients that required it, the support that the HOPE team could provide, they would probably not need any more than three months. If they did need that more support, then we'd probably be linking them into our Continuing Care Team for that longer term support.

Q. What's your assessment about whether the patients your service sees actually do need more support than three months or could do with more support than three months?
A. There's a few avenues that we assessed and looked at. A number of our clients, a small proportion, will probably need to be transferred and referred into our Continuing Care Teams for that longer term support, and that's quite an easy process and we've done that, and they're mainly due to their mental health conditions at the time in terms of their safety, so we'll make sure that that continuation is provided.

The other clients that come to the end of their term, they often don't require that level of supervision and support due to their safety and their support needs. So we try to look at linking them in more with either a private psychologist, a private psychiatrist, or working a bit more closely with their GP in terms of managing their presentation and their long-term supports. That's not always straightforward and easy to provide and that linkage is sometimes a challenge for us to do and often we're not able to do that. We are on a lot of occasions but other times we can't.

Q. Just to get some clarification: a three-month period

of time is a resource issue and that's the maximum period of time for which the service is available?
A. At this point, yes.

Q. At this point, and you don't have any discretion about that. In terms of the clinical outcomes, would you like to have more flexibility about the length of time over which the program is available?
A. I think the three-month period, in my experience over the last couple of years of working with the HOPE team, is probably good, is probably realistic for the majority of the clients that access our service, that they don't need that level of intent. A lot of our clients are discharged from the service before the three months because we don't need to provide them that service. And I think we've also got that mechanism of providing a referral into our CCT, so there's a number of avenues there that are fine.

There is a small cohort of our clients in that team that wouldn't fit that pathway, and will struggle to because of finance or accessibility to other services in the community, so maybe there needs to be some kind of alternative in terms of managing that client which at this stage I don't know the answer to.

Q. That's a present gap in the system, dealing with the clients you need to refer on after three months that don't readily fit into another service?
A. That's right.

Q. Including because --
A. It's more accessing the service rather than fitting in. One of the examples is, if we look at accessing a psychologist with the speciality of working with clients that require that kind of support: often their availability is limited, long waiting lists to access that person, and often they charge what's called a gap fee, which some of our clients just can't afford to do, so accessing those services are challenging, likewise with psychiatrists.

We've looked at having a database ourselves of psychologists that we've worked with, but again they get full, you know, they can't take on any other clients because we know that they're good, we know that they offer the service, but there are just not enough to go round.

Q. How important is the multidisciplinary nature of the

care that you are able to provide in the HOPE program?
A. Very important. The service was initially set up as a psychosocial service. However, from a governance point of view we're working with highly risky clients that are attempting to take their own lives, so we have to have some clinical support systems in place, and that was the decision why we made sure we had medical staff available to make sure we were providing treatment for the medical health side of the presentation.

I think also having a variety of different specialities, such as social workers providing support to the team regarding issues regarding family violence, working with children, accommodation, finance - you know, is very valuable in terms of providing that extra support.

The occupational therapist, for instance, provides advice to the rest of the teams about functionality in terms of the client's daily living issues and be able to provide support, and obviously the psychologists come with an extensive experience of psychological interventions and supervising the rest of the team in terms of delivering those interventions. So, they work very well together in terms of planning, giving different opinions in terms of some of the issues that might come up with a client in promoting a bit more of - rather than coming from a medical model or one other model, it's more of a generalised, consistent bringing together all of the facts and issues onto the table.

Q. So, the way the program is set up and resourced allows different practitioners to communicate with each other about the patients?
A. At the moment, from a clinical stance, yes, I would say that that's well supported. I suppose, if we look at the other parts of the multidisciplinary team, there's two things that I'd say that we're lacking that we would like further support in the future for funding: that's a peer support worker, somebody that's got a lived experience would be ideal for this team.

When I set the team up originally, I was given limited funding and I had to make a decision about, do I have a lived experience person or do I have a family support worker? One of the main objectives of the framework is to look at working with families which is so important with people presenting with these difficulties, so we made the

decision to go down the family support. At this time it's a family support worker who's not necessarily qualified but has a lived experience of working as a carer, and has had some other training in terms of working with families.

We would like, though, to look at a family therapist. We do feel that a lot of the challenges of supporting clients is often the breakdown of relationships that they have and working with their families or working with their partners. They are just a couple of other examples of people that we would like in the team.

I suppose the other issue that, on reflection on the last couple of years of working with the team, is that we would like some specialist training or clinicians working in what's called a dialectic behaviour therapy. This is a highly specialised approach of working with personality disorders and particularly personality disorders with high tendency of suicidal behaviours. So, that would be something in an ideal world, if I could get funding for that, which would be great.

Q. Speaking of funding, is the funding for your particular program going to continue, do you know?
A. At this stage, I don't know the answer to that. We were set up for four years. Our funding is due to the end of June 2020, and we haven't had any indication that that funding is actually going to continue. However, in last year's budget there was six further HOPE sites established across Victoria, but they came with permanent funding.

So, we've got two sides: we've got six HOPE teams that are still waiting to find out whether their funding is going to continue or not, whereas the other new six, they're quite happy and secure, and that does come with implications as well in terms of, if we don't get the long-term funding.

Q. Can you say what those implications are?
A. I'm beginning to see that some of my staff are looking for other jobs, for instance, because of the security, they're looking for permanency and security which I can't offer them in this particular environment. And obviously, replacing those staff is quite a challenge, because we look for skilled staff with experience working in this area, and the pool is quite small, and also, people are not going to

be attracted for a six or seven month contract if we don't know we've got the funding.

And also, it will have an impact that we'll have less clients that can be referred into the service until we can have full staffing again. We are working with St Vincent's Emergency Department and mental health services to develop what's called a Mental Health Alcohol and Drug Crisis Hub, and we do feel that the HOPE Team will be quite a centralised part of that process, it will look at more responsive care and, if the funding's not forthcoming, then again, that will put that part of the project in jeopardy and we'd have to look at alternative ways of managing that.

They're just some of the - and it's also the speciality. General mental health services are not set up to work in a special way with people with suicidality, it's more of a generic approach, so we'll lose that. It could have other implications, I don't know.

Q. Do you have any sense about the extent to which people who would want to or would need to be seen by your program can't because there's not enough capacity, so is there a waiting list?
A. A waiting list?

Q. Yes.
A. For the HOPE Team, we've not had a waiting list, no.

Q. You are able to see people within your three-day window?
A. I think we've met our target for that, yes. I mean, there would be extreme examples that it would be the consumer that's accessing that service is not available in that three days, so that would be the time that we probably wouldn't meet that target, but generally because we're a seven-day service we'll plan that, yes.

Q. Has there been any formal evaluation of the success of the program so far?
A. We're currently undergoing that evaluation with the department. So, we're working with an outside agency, KPMG, who have put a framework together to look at how the program is evaluated. That was commenced in 2017, however that was delayed for quite some time only until a few months ago that it started to then be delivered as an evaluation framework.

Q. Do you know why it was delayed?
A. I'm not 100 per cent certain. The feedback I have had from the department is that they were going through their own internal processes to acquire the contract for the external agencies to be able to do the evaluation, so I think that was the time delay, but that's now all in place and we have now started to put that evaluation in place.

Q. You said in your statement that, based on clinical data that you've been recording since April 2017, most consumers haven't re-presented to the HOPE Team. What does that tell you about how the program's working?
A. I think it's working pretty good, actually. I'm quite pleased that, for the first time in my career of working in a service like this, and I'm quite passionate about it, and I do feel that the clients benefit an awful lot from that short-term work and service that we give.

We do an evaluation internally as well from our consumers and we get feedback, and some of the feedback is just amazing that they say about the service, compared to other feedback I would get from other parts of my services.

Q. Can you tell us a bit more about that positive feedback? What kinds of things are your clients saying?
A. Things like, "What a great service." "What a good process to go through to get the support that I've not been able to get anywhere else." "Felt very warm, welcomed and supported over that period of time", you know, it's just very, very good feedback, and we've not once yet - we've been open for over two and a half years - that we've had any negative feedback from any of our consumers.

Q. What's your assessment about the extent to which the program is able to make a difference to people who might re-attempt suicide?
A. It's hard to qualify that in a lot of ways. I can just go in terms of the clients that have gone through the program. We have anecdotally felt that we've had a high success rate in terms of people not re-presenting. However, we're waiting until the evaluation which will look at other data across the state in terms of those outcomes. Although I can feel that it's very positive and beneficial, I still have to wait for that official outcome from the department.

Q. Do you know when the evaluation will be completed?
A. The initial evaluation looking at that data is expected to be done by the end of September.

Q. Of this year?
A. Of this year.

Q. Okay, thank you. You mentioned earlier on that the program is intended to work alongside other programs, including the new Mental Health and Alcohol and Other Drugs Hub in the Emergency Department. Can you just tell us briefly what that program is?
A. The Crisis Hub is a new initiative for St Vincent's, it's going to be based in our Emergency Department. It's a six bedded area for clients with a mental illness, a facility that we don't have at the moment. It's for clients that access the service that don't necessarily need an acute inpatient part of their care, but they probably need one or two days assessment and support.

A number of our clients will present to our Emergency Department also with physical illnesses that may have a comorbid mental health illness, so that would be an ideal place for them to get both their treatments at the same time. It would be a good place for clients to experience support for their drug and alcohol, which is not a specialist that we would provide in inpatient services, although we have good links.

So, it's a short-term, it's an alternative space in terms of being dragged into mainstream mental health services, so it's a real good initiative and it's going to be staffed by a number of clinicians 24/7, which will do that quick assessment turnaround and be a lot more responsive to the needs.

The second element of that is to provide some short-term assertive outreach for those clients that then need some support back in the community.

Q. How will your team who work in the HOPE program interrelate with the Alcohol and Other Drugs Hub?
A. We'll have a daily presence there at this stage. We haven't worked through exactly how that is going to work, but we will probably have one of our clinicians based in the Hub on a daily basis, just to assess any of the clients that are coming through that meet our criteria and to be

able to do that assessment a lot quicker, be more responsive to their care, and to start working with them on their safety planning and some of the interventions that would probably be delayed a few days if we didn't have that Hub in place.

Q. Thank you. We've asked you some questions about what you think can be done better in Victoria to support people who are at high risk of suicide or self-harm. One of the things you said in your statement is that there needs to be a more coordinated approach:

> "There are numerous initiatives that have been implemented, some long-term and others short-term, but they do not operate consistently across Victoria [or] in a cohesive manner."

Can you say something more about why you think a coordinated approach and operating consistently across Victoria is important?

A. I think from a practical sense, as a manager I don't know what services are out there; we don't really know across Victoria what other services are doing and what we can refer into, what we can't and what we can access, so from that point of view it would be very good to have some kind of coordinated database and resources to be able to draw upon which we don't have at the moment.

Also starting to look at a more consistent intervention model in the future. I feel that, with the Suicide Prevention Framework we're now starting to look at joining up services to work more collaboratively together rather than silos in a way, and the framework is promoting that to a large extent. It just means a bit more responsive access to services for the clients that either pre access our service or discharge afterwards, follow up, so that coordinated service is just vital basically: just making sure that we're all doing similar things, we all have mechanisms to be able to support.

Q. Thank you. We've asked you about the most significant challenges facing the mental health system in supporting people at high risk of suicide or self-harm, and the number one thing you've named is accommodation, I think you've said something about that before.

A. Yes.

Q. Why is that so important?
A. I think accommodation is - you know, stable accommodation is - I mean, there's a lot of accommodation available but it's not necessarily the right accommodation for the clients that have a lot of risks associated with their mental health problems, and finding that accommodation is so difficult.

If somebody's in stable accommodation, it's a good start to starting a normal pattern of life again, rather than being in transient accommodation or short-term accommodation; it alleviates some of those pressures that might be facing them and they can start to look at building their lives in a different way, in a different journey.

You know, accommodation is so key: I just feel, if I didn't have accommodation, where would I be? What would I be doing? I'd probably be a bit more prone to being anxious or a bit more depressed, or a bit more lonely. You know, it's just a foundation of, you know, it's a basic need that people need, is that stable accommodation.

I do feel it would also bring down a lot of presentations in terms of access to services in the future.

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

CHAIR: Dr Cockram.

COMMISSIONER COCKRAM: Q. You mentioned the differences between CCTs and the HOPE Program. Could you just talk us through a little bit more about how the CAT Team and the HOPE Program interact, and how do you find the benefit of keeping those two separate?
A. At the moment the CAT Team is very crisis-driven, is a short-term support system for clients that require immediate follow-up because of their safety need. It's not designed to look at managing clients over a longer period of time that the HOPE Program does.

We work quite closely with the CAT Team on a daily basis, so we actually meet up with them on a handover at 2 o'clock every day and we look at all the referrals that have gone through, who are the people that the CAT Team are looking after, is anybody suitable for our intervention,

our program. So, we do have that close connection with them.

Maybe in the future there might be that kind of thinking that maybe some of the services might join up and look at maybe offering that longer-term crisis support, but at this particular time we don't provide that.

What was the other part about CCT?

Q. That answers the first part of the question. The second part is, how many people that are coming through the HOPE in your experience have been a part of some of the rest of the system and are therefore getting transferred between teams for clinical engagement?
A. Well, 100 per cent of our clients actually have to be hospital-based, so all our referrals come from people that have actually presented either through CAT, through our triage, through our inpatient service or any of the other parts of the hospital: they've actually had a physical presence and treatment.

But during the period of the HOPE in the three-month program there will be times that we need to ask our CAT Team for extra support out of hours in terms of some of our clients that may have crisis, and we're looking at averting an inpatient service.

Q. Do clients describe that sense of having to transfer their engagement across between different parts of the service and duplicating storytelling and all of those sort of things, or are they finding it quite easy to transfer between clinicians?
A. Although there's similarity in the services that we offer, and we actually offer a slightly different service: the HOPE Team is providing that kind of specialised intervention therapy in a program systematic way using a model of care. The CAT Team is set up to look at somebody's safety and assessing safety and providing that short-term safety.

In terms of when we've talked to some of our clients, that's not been a barrier or issue that I've had feedback at this stage. But I suppose that's not a question I've asked through our evaluation.

COMMISSIONER McSHERRY: Q. Just one question. How many

of your clients that go through the HOPE Program are compulsory patients under the Mental Health Act, any?
A. No, none. A number of clients may have been on an assessment order at the beginning of their presentation to St Vincent's, either been admitted to our inpatient service, but then after that we wouldn't accept anybody on a treatment order. If they needed that level of care, then they would automatically be referred to our Continuing Care Team for longer term service.

CHAIR: Q. Thank you for your evidence. I'd like to ask two things, one goes to the question of involvement of family. I noticed in your statement you talked about, when you were doing that initial three-day assessment, or in that three-day period, you say if available and with the client's consent the clinician will seek to obtain information from the client's family members.

I noticed in the brochure that you attached to your witness statement you talk about a very family-centred approach to your practice. How important is it in your model of care to have extended family members engaged wherever possible
A. I found that, if family carers or if the support mechanisms aren't fully involved in a consumer's care, then I think the recovery takes a lot longer in terms of being able to get that immediate support.

We have a family-driven approach when we talk to our clients to encourage them to access other supports. Some of the difficulties that we face, though, to get that collaborative working with the family and the consumer is often that the consumer doesn't want it, and usually it's more to do about how they're feeling: they're feeling a bit ashamed about what they've done, don't want anyone to know, so that initially is quite a challenge for our workers to get that approved. But usually by the time we've engaged and got the trust of the client we've managed on most occasions to get that collaborative approach with the family. We can't do anything unless the client gives their consent, unless there's a high risk that the family need to know about.

Q. The other issue I wanted to ask about is, we've heard during the course of this Royal Commission the complexity in assessing suicidality and suicide risk. I noted that you talk about the particular methodology that you've

adopted through this collaborative assessment and management of suicidality model.

That's a model that St Vincent's has developed for its HOPE Program, so am I right in assuming that each of the other HOPEs might - I think you said there's now 12 in the state?

A. There's 12 HOPE teams.

Q. Could they each be using a different assessment tool?

A. Each HOPE team will have their own criteria, their own assessment tool and their own intervention, yes.

Q. Why is that? I guess that's something we're trying to grapple with in mental health, because we hear, you said there's not a very substantial body of knowledge about the preferred models of practice, but diversity is one thing but inconsistency, I guess, is - why wasn't that an element of the HOPE models that was determined in terms of its roll out?

A. I don't know the reason why it wasn't part of the model. All I can say is that, having pilot programs with different models may produce different results and develop an evidence base in terms of looking at suicide prevention strategies. I would hope in the long term that the evaluation structure of the HOPE team would look and take those into consideration to look at some consistency about risk assessment and about the interventions and the follow-up services that the model of each service would do.

Even though the 12 HOPE teams are using a different model by name, the elements of the model are usually pretty similar. Usually we all have a very clear assessment process to assess somebody's mental illness, we all use the same pattern in terms of assessing somebody's suicidality risk, and we also then have a safety planning process in place in terms of how we support that client, so all the HOPE teams will have that in place.

They will also have that psychological intervention model, and we all use the CBT framework. I'd be surprised if any of them didn't because that provides that intervention and support system. So, even though the models might be called different, there's a lot of similarities within them.

Q. Yesterday we heard from another witness at this Royal

Commission that, because of the complexity in assessing risk in suicide, that all people who are presenting with suicide ideation or are in deep distress and therefore we need a service model that ensures that there is follow-up care and support for each of those individuals who are presenting; would that be consistent with your view?
A. I would say so. I think at St Vincent's we have a standardised assessment process that we use across the service, whether you're in the CAT Team, HOPE Team, inpatient service or in the community, we'll have that standardised approach in terms of assessing the mental health, assessing the risk, assessing the suicidality.

I think the follow-up would be, is then, where does that person get signposted in terms of the care that they need? So that's where, like, the HOPE Team will come into operation in terms of working with the clients that have got a higher level of risk associated to their suicide behaviour and thoughts. The other clients that don't necessarily meet that threshold would probably be signposted to other services such as our extended triage service or our primary mental health network.

Q. Finally, you mentioned the fact that if you had your ideal HOPE model you would include a clinician who could provide a specialist intervention for those diagnosed with a borderline personality disorder to manage their suicidality. Can you just talk about what sort of model of service - again to make sure I understood what you were saying about them - therapeutic model you think is important in that case?
A. I'm not an expert on personality disorders, but I know that working with personality disorders with suicidal behaviour there's a model called dialectic behavioural therapy. I don't know an awful lot about that, I'm not trained in that, but I have been advised by my senior clinicians that that's the way forward in terms of supporting clients who present to our service with that.

It's a highly specialised training that the people have to undergo. They also need to have a lot of supervision and support and linked into all the personality disorder services to make it effective.

Services such as Spectrum, which is a statewide service for personality disorders, they will have people trained in them, and that's good and we can at times access

their service, but it would be ideal to have our own internal one, to provide a bit of therapy, but also to provide some training and some in-house support to our staff working with personality disorders a little bit more than what we get at the moment.

CHAIR: Thank you very much.

MS NICHOLS: May Mr McLaren please be excused?

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

<**THE WITNESS WITHDREW**.

MS NICHOLS: Chair, is it convenient to take the 15 minute break?

CHAIR: Yes, thank you.

SHORT ADJOURNMENT

MS BATTEN: The next witness is Ms Anne Lyon, I call Ms Lyon.

<**ANNE KATHERINE LYON, sworn:** **[11.30am]**

MS BATTEN: Q. Thank you, Ms Lyon. Have you, with the assistance of the Royal Commission team, prepared a witness statement for this Commission?
A. I have.

Q. I tender that statement. [WIT.0001.0060.0001] Could you start by explaining to us what your current role and your responsibilities are, please?
A. I'm the Executive Director of Mental Health, and Alcohol and other Drugs Programs at the Eastern Melbourne PHN, and that encompasses the planning and procurement of mental health services in the community, the development of strategic partnerships, delivery against our commitments with the Commonwealth through our funding agreements, and as part of the suicide prevention trial hosting the suicide prevention team as part of the trial and they form part of our directorate.

Q. When you say the suicide prevention trial, you're referring to the place-based suicide prevention trial?

A. Yes, I am.

Q. Could you explain to us what they are, what is a place-based suicide prevention trial?
A. So, the place-based suicide prevention trials form part of the Victorian Government's suicide prevention framework, and that is one of five objectives of the framework. What it entails is working in two identified sites to develop an understanding of issues around suicide and suicidality in a particular area, and to then develop a response to those issues that you find and deliver a range of activities against those.

Q. We'll go through some of those aspects in detail. Just to clarify, are there two place-based suicide trials run by - I'm going to call it EMPHN?
A. Yes.

Q. And they are Whittlesea and Maroondah?
A. Correct.

Q. Why were those two sites chosen?
A. They were chosen - before I actually commenced at Eastern Melbourne PHN, based on some initial data that was seen, and also particular issues around the sociodemographic elements of the population.

So, for instance, in Whittlesea, we know that that's an area where there's been a lot of growth, not a well developed service system and encompasses quite a different demographic from an urban community.

Q. What about Maroondah, what are the factors with Maroondah?
A. Maroondah had a high level of suicide rate at one time and it is also the site of a HOPE trial.

Q. When you referred to their place-based suicide approach, you said that it's a systematic coordinated approach: can you explain what you mean by that?
A. Yes, so that's a way of delivering a range of interventions that seek to connect the community and address particular identified needs. So, some of that encompasses capacity building, training, media and communication, so elements of what we see in the Life framework that has been developed by Black Dog.

Q. We'll come to the LifeSpan framework in a minute. With those elements that you were just talking about, wasn't that already happening before you were doing the place-based trials?
A. To a degree, but not with the intensity. So, what the place-based trials allow you to do is to get a deeper understanding of what the particular issues are in the community, to make strong connections within the community, not only with the service sector but also people with lived experience, and I think this is one of the things that has been incredibly valuable as part of the trials, is we've been able to hear that voice.

Q. Just to understand the context before we go into more detail of what the trials actually involve, could you tell us what staff you have working on the trials?
A. We have two staff: one is a coordinator and one is a project officer who are actually out in the field working as part of the trials, and then they are supported internally through line management and the organisational structures.

Q. So, that's two staff members and they work across both Whittlesea and Maroondah, there's not four in total? Just two in total?
A. No, just two in total.

Q. You've given us an overview of what the suicide prevention trials consist of. Can we go through the three phases and understand what's involved at each phase?
A. Yes.

Q. Starting at Phase One, you've referred to there being three workshops for Phase One. Can you explain to us what Phase One involved?
A. So, Phase One was essentially an information-gathering exercise to understand what the issues were, to make connections within the community, to draw on people's experience, and we use a framework called Collective Impact, and that is developing a common agenda, having a backbone organisation which has been the Eastern Melbourne PHN, looking at the structures and supports that you need to tap into in particular communities. So, that was basically what Phase One has entailed, to get that deep understanding of what was going on.

Q. You did that through workshops and through one-on-one

consultations; is that right?
A. Yes, that's correct.

Q. Who was involved? Who are you consulting with?
A. A range of people: so, primarily people with lived experience were a strong feature when we were able to tap into that group. That was initially a little bit difficult, but it came to fruition.

Q. Sorry, why was it difficult?
A. Well, I think that people have often experienced significant stigma related to the loss of someone as a result of suicide, but I think, once we made those connections, that moved very well.

So, working with local mental health services, particularly those who are providing community-based services; the hospital networks, so Eastern Health particularly in the Maroondah catchment; the general practitioners, local government. We have started to in more recent times work with police and the emergency services, and they form a very important part of developing a systematic response.

Q. Is that pretty much what was involved in Phase One?
A. Yes.

Q. Can we move to Phase Two --
A. And forming those partnerships, so you're actually developing the foundations and the base from which to take your work forward.

Q. Thank you. Can we move to Phase Two, and we have an infographic that may assist you, explain to us what Phase Two involved. May we have the infographic? Thank you. [WIT.001.0060.0029]

Sorry, before we come to Phase Two, did Phase One reveal to you anything that you didn't already know?
A. We probably had a bit of an understanding but I think it gave us a much deeper understanding of what the issues were. Things like how disconnected the system is, so that has been highlighted in both catchments, and the lack of awareness and knowledge of what's available to people for both community members, but also practitioners and mental health clinicians.

The stigma: that people experience knowing how to speak about the suicide and their experience of it. I think also the deep pain that people who have experienced the loss through suicide, or those people who have a lived experience of self-harm, that their pain and grief is profound.

We've also, I think, discovered that more needs to be done around building the capacity of communities to know where they can get help, but how they can be part of a solution. So, for people with lived experience, this has actually been an opportunity to harness their grief and pain to make a contribution, and that was something that we have seen very strongly.

Q. Thank you. Can we move to Phase Two, and could you tell us what Phase Two involved?
A. Yes. So, we went back to the community and the stakeholders to confirm what we had heard, and were these the primary issues, and that was so, and from that we developed a response which was simple. So, it was training and education, understanding the service system, and how we could address the issue of stigma and how we can connect people better to services.

Q. What did the training and education involve?
A. So, there have been a range of workshops - training: so, the ASIST suicide training, capacity building amongst community members and mental health clinicians, learning how to speak and address suicide.

Q. You also, in Phase Two, have referred to a number of awareness-raising activities: could you tell us about the awareness-raising activities you engaged in?
A. Yes. So, that has been through conducting a number of events in the community which have also - so, out in Maroondah we had The Ripple Effect, and I think that's been spoken about before; they've used an arts and culture approach for that.

We've had a number of media events, where we've engaged with local groups: so, men's health and wellbeing forums, the training through sporting venues. We've also had community wellbeing events. One of those in the Whittlesea catchment involved a youth forum, so it was bringing together a range of youth services and providers in that catchment to raise awareness of the trials, but

also what services are currently being delivered and how they can better be connected.

Q. And then, finally, Phase Three, what does Phase Three involve?
A. Phase Three involves consolidating what you've learnt and developing an action plan. So, across the trials people are at different stages, but for us in the Eastern Melbourne PHN, Phase Three has involved being informed about the suicide prevention service that we have commissioned. So, we have taken the learnings of the trial, and we also ran another four workshops to confirm that the model we were proposing could be an effective way of addressing suicide, and we have commissioned that model and that commenced in April this year.

Q. I do want to ask you some questions about the model but I'm going to come to that in a moment, because my understanding is that's separate from the place-based trials?
A. Yes.

Q. It's informed by, but the delivery of the model is not part of the place-based trials; is that correct?
A. No, that's quite separate.

Q. So, the place-based trials do not deliver services as such?
A. Not per se, it delivers a range of activities that are consistent with the LifeSpan model.

Q. With the funding for the two trials, DHHS funded $1.36 million over four years?
A. Yes.

Q. And then the Commonwealth funded $880,000 over four years?
A. Yes.

Q. So, that's a total of $2.43 million for the four years of the trials, 2016-2020?
A. Yes.

Q. So, that's half a million dollars each year, $560,000 each year. Have you spent all of the money each year?
A. Not each year, and we had the ability to carry funds over. So, through our - we have actually co-commissioned

with the Department of Health and Human Services, so that's allowed us to use some of those funds to support the model as it's being implemented. Concurrently the trial will continue to operate and staff will remain employed in the trial for the remainder of this financial year. I think what we see as a real benefit is that we've been able to co-invest in a model that we believe will start to address issues around suicide.

Q. Just so that I'm clear, some of that funding you're using to implement the model that you've developed as a result of the learnings?
A. Yes.

Q. Not necessarily doing the place-based trial work as such; is that right?
A. Well, it will be both actually.

Q. Okay.
A. So, the staff who are funded through the trial, or co-funded through DHHS and the Commonwealth funding, will continue to work in the trials, but we will be operating the service model which has been developed as a result of some of those preliminary learnings.

Q. Can you please explain to the Commissioners what you see as some of the benefits of doing a place-based trial?
A. It's given us a much more nuanced understanding of what the issues are around why people may self-harm or take their own lives. It's given us an insight into what potentially can work, what is useful to people. It has given people with a lived experience a voice and, through their grief and pain, they have been, I think, supported to actually be part of the solution, and that's what they've told us, they needed to be part of the solution.

We've been able to harness the collective efforts of the community and service providers. So, a few things that will spin-off from this: we'll look at developing a suicide prevention protocol up in the north-east, in the Whittlesea catchment; that is still early days. It has shown us that the pathways for people trying to access services is very poor, people feel very, very disconnected.

A couple of the other things that have shown us: that we need to build people's ability to be able to speak about suicide in a good manner consistent with what we call the

Mindframe guide.

Also, I think we've learned that, if you bring together services in a meaningful way, they will want to be part of an improved service system, and we know currently it does not operate that well.

Q. Thank you. Can I turn to the issue of data to understand what you're collecting in relation to the trials? So, you've said that data is provided to DHHS for the purpose of evaluating the model of the place-based trial.
A. Yes.

Q. You've identified a number of forms of data that are provided to DHHS. The first one is activity and outcome data: what is that and what is it measuring?
A. So, we collect information on what activities have occurred during the course of a two, three-month period, and then who are the stakeholders that have been involved, who may have attended particular events, what those events entailed, and we report that as part of our activity, and also, what we may have learnt through those events or activities.

Q. What is the annual most significant change process?
A. That's some of the things that stand out to you in a particular period. I think, if we have seen something, what we will consider moving forward if we've had difficulty in engagement with particular communities or organisations, that may form part of that significant change.

Q. You've also referred to annual in-depth interviews with key influencers: who are the key influencers for the purposes of the trials?
A. They would be management, so that's formed part of the evaluation as well, to speak with those people who are directly involved in the trials. It would also involve significant community members, where there's a willingness to be involved in those sort of interviews.

Q. At this stage does the data measure the effectiveness of the trials?
A. I think suicide is such a complex issue, so it is very difficult to look at attribution from the things that you have done in a particular period, and I think it's way too

early for us to make those assumptions. As I've said, we've had some learnings and understanding to guide our actions and I think at this point of the trials it's somewhat premature to draw conclusions.

Q. I do want to ask you a bit more about that, but before we get there, are there any gaps in the data? Is there any more data that would be useful for you to inform what you need to do going forward?
A. I think more timely data around suicide rates: that's always been problematic with the lag time of information coming from the Coroners Court, because sometimes that can be 12 months or longer before you understand the cause of someone's death and what have been the contributing factors.

The Department of Health and Human Services has recently undertaken some work to develop an MOU with the Coroners Court and emergency services, particularly Ambulance Services, to bring that data together so we will have more up-to-date and relevant information in a timely manner

Q. Are you involved in that process?
A. No, not directly.

Q. You mentioned that it's premature to know whether things are effective at this point, and also acknowledge that suicide prevention is a very difficult issue. Can you just clarify for us, is there an evaluation of the suicide prevention trial?
A. Yes. So, the Department of Health and Human Services have commissioned the Sax Institute to undertake an evaluation of the trials and that has already commenced.

Q. And so, what stage is the evaluation at?
A. That's in three phases: an establishment phase, a formative phase and a summative phase. So, they have just completed their first report on the establishment phase, and they're now moving - so, the establishment phase talks about what needs to be done; the formative phase is about, is it working? And the summative are your final results.

Q. The establishment phase is what needs to be done in the place-based trials; is that right?
A. Yes. So, as I previously mentioned, part of that initial Phase One of the trials was about information

gathering and trying to understand the deep issues within a community that may contribute to suicide, what's working and what isn't working. So, the establishment phase of the evaluation looked at that.

Q. When will the evaluation of what's been done overall in the trials be completed, do you know?
A. July 2021, I believe.

Q. So that will be after the end of the place-based trial?
A. Yes. So, the place-based trial has been funded for four years, so they finish - due to finish in June 2020.

Q. In your view, do you need the evaluation to know whether what you're doing is effective?
A. I think that will be very, very helpful. As we have commissioned a service, we will also evaluate its effectiveness. So, it's those two things that we talked about earlier: one is activities that you deliver as part of a trial and how you understand issues, so I think the formal evaluation being conducted by DHHS will be very helpful for that and to inform future policy and planning and we will look at our own evaluation of how effective the service model that we have adopted is working.

Q. Is your evaluation complete?
A. No, we're just starting on that model.

Q. Thank you. You mentioned some of the key learnings of the trial: were there any other key learnings that you haven't mentioned that you wanted to draw the Commission's attention to?
A. Yes. What we know is that transitions of care for people need to improve; so, people leaving particularly acute health services, they need to have a transition into community-based support services with good information.

The continuity of care for people needs to be supported; so, when they move between services or practitioners, that there is an ongoing story and a pick up of what their needs are.

And people should have a safety plan in place: this is a way of giving people strategies to understand, as their anxiety or issues escalate, how they can deal with those, but importantly, who they should contact to get further

assistance and how they can re-enter back into the service systems should they need to.

The other thing I would say is, we need improved clinical governance, and that entails people working within their scope of practice, continuing professional development, good clinical risk assessment, case reviews and client reviews, is the treatment working, and good data and monitoring systems and where they're reviewed.

So, as part of the - I'll come back to some of the other learnings in a moment - but as part of the Fifth National Mental Health Plan, primary health networks have been required to develop a regional integrated mental health and suicide prevention plan. We've actually included alcohol and other drugs in ours, but this is a way of getting a more systems-wide appreciation of what is happening and what are the gaps and how we can best support those gaps, and I think it provides a basis to have a regional approach to clinical governance around what is working and what is not working well in services.

The other things we've learnt is, there needs to be an alternative to the Emergency Department. There are models that are available like Safe Haven. We also need, as we've touched on, better data to understand the effectiveness of what is happening, and I think a continuation of some of the activities that we've talked about today.

Q. Are there limitations of the place-based suicide prevention trials?
A. Yes.

Q. What do you see as some of the limitations?
A. So, it takes you a while to establish those relationships and connections within communities, so they are something that needs time to develop and formulate. Also, it's very hard to get attribution: so, you might do X, Y and Z, but does it produce A, B and C.

I guess we are hopeful that some of the things that we have put in place will work. I think, from our learnings plus developing a model, that starts to set you on a good path. It certainly has highlighted to us the need for better connections and service system functioning.

The other important aspect is about information; so,

information to consumers in the community, but also to treating practitioners, because they are often at a loss of where to advise people or give them a referral to. So, those systems need to be strengthened.

Q. You've said one of the benefits of the place-based suicide prevention trial is a focus on the local community. Can the place-based trials, the learnings from them, be extrapolated to other communities or do you need to have a place-based trial in each separate community?
A. I think in part, that some of those activities have been very effective, and they've been running different trials and they seem to address particular issues, so I think there can be some extrapolation.

But one of the things that we have found more recently, particularly working in the Whittlesea community, is there appears to be an emerging group where there are issues and we would not have understood that if we hadn't been working so intensely with the community, and that's come about through our relationship with the police, so a small working group has been formed to address that.

So I think that, again, emphasises the importance of that place-based approach. What I would say is that, you can do place-based approaches for a period of time, and the community will be very generous in giving of themselves and working with you, but they will want to see action, and I think it is incumbent upon us to take our learnings and do something with those learnings in an endeavour to improve the system.

Q. You've touched on this before, this is the LifeConnect model which is the ultimate action: can you just finally briefly tell us what that model involves and what are some of the activities that you're going to deliver?
A. So, that will involve capacity building of the community, education sessions for - particularly in Life Assist with clinicians, particularly GPs; better pathways and connections across the system. It also includes wellbeing events and postvention services for those who are bereaved as a result of suicide; that will be part of that service model.

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

CHAIR: Q. I've just got one, thank you very much. I'm trying to get my head around what is being commissioned through these, because you said in your witness statements that the opportunity for the PHN and DHHS to co-commission suitable services to address community need; is that what you refer to in the LifeConnect program?
A. Yes.

Q. So that's the type of service?
A. That's been commissioned.

Q. So, what level of funding needs to go to that sort of initiative, is what I'm interested in understanding?
A. Well, at the moment we've got approximately $900,000 invested over 15 months. Our base funding from a PHN perspective is around half a million dollars, a bit more. So, once we go to a new funding year, we will be back to that because the investment from DHHS will have concluded.

Q. Will have concluded?
A. Yes.

Q. Then, in terms of the model that you've used for the trial, I understand you've based it in part on the Black Dog Institute's model?
A. Yes.

Q. And the nine elements?
A. Yes, that's correct.

Q. But is it fair to say that you're not focused on - are you focused on all nine elements of their model or just some elements of their model?
A. No, we haven't picked up all of them, but certainly a number of them.

Q. Because I'm interested in things like, you said one of the areas of learning was about the need to improve clinical governance, and so I'm trying to get clear in my head how would you, through an initiative like this, do something like improve clinical governance?
A. Well, we would try to pick that up as part of our regional integrated mental health plan, so that provides us with an opportunity to do that and to work with health services and mental health services around that. So, we have an understanding of the capacity of clinicians in the system and what are the emerging issues and how they can be

responded to.

Q. Because the reason I ask that is because, from the Commission's point of view, we've heard a lot about the fragmentation of the mental health service and partly the challenge is how not to create further fragmentation through any of the initiatives, how do we consolidate some of those functions. So, how important has that been to your thinking about - given you acknowledge that one of the key insights was how fragmented the service system is. In terms of your insights so far, how do you think we could streamline that?
A. I think we have developed some systems, so we have a system called Health Pathways, and that's a clinical pathway but it also provides a service pathway. It's developed for the mental health service, but also suicide prevention. So, making sure that's available to all treating clinicians in the service system, so that will help create better connections.

I think developing those pathways as people leave, particularly acute services and move to the community, so there is a clear pathway of who they go to, how they should be supported, and that there is adequate information available to the clinician who then picks up the support for that person.

CHAIR: Thank you.

MS BATTEN: Thank you. May Ms Lyon please be excused?

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

<**THE WITNESS WITHDREW**

MS BATTEN: The next with witness is Ms Louise Flynn. I call Ms Flynn.

<**LOUISE MARY FLYNN, affirmed and examined: [12.07pm]**

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

Q. I tender that statement. [WIT.0001.0032.0001] Could

you start, please, by explaining to us what your current role is and what the responsibilities of that role are?
A. Certainly. I'm a psychologist by training, and currently I work for an organisation called Jesuit Social Services and I manage a program, or I'm the manager of a program called Support After Suicide. So, that involves the management of the program, but I'm also involved in the day-to-day work of the program: counselling, running groups, education and training, yeah.

Q. We will come to the program. Before we get there, could you just briefly outline for us what Jesuit Social Services is?
A. Yeah. I guess it's a not-for-profit organisation, it's an incorporated organisation, it's a registered charity, so it's a welfare agency that has a wide range of programs, some of them in the area of mental health.

Q. What are the mental health programs that it delivers?
A. There's five in total: Support After Suicide is one of those. There's a program called Connexions which supports young people with mental health and drug and alcohol issues. There's another called The Outdoor Experience which engages young people with complex issues in adventure programs, therapeutic adventure programs.

There's another program called Artful Dodger Studios, and that's an arts and music studio for young people, and it's a great space for young people to build their sense of connection and engage. Often they're very disengaged young people who attend that program.

There's a program called Individual Support Program, and that provides intensive support to young people with very complex needs.

Q. Thank you. You started to explain what the Support After Suicide program was, but could you explain what that program involves in detail for us?
A. Yes. I guess it's a suicide postvention program, which essentially is suicide bereavement, so we support people after someone important to them has ended their life.

Our day-to-day work with people is counselling, quite a lot of counselling; group support is a very important part of our program. Also, we have developed quite a wide

range of resources and information that's very helpful and relevant to people, so we have that available online to give people. So, it's essentially that counselling group and online resources of relevant information to people about the experience of losing someone to suicide.

Most of the team are psychologists and social workers, but we also have an extensive volunteer program. So, we have over 50 peer support volunteers, so people who are bereaved by suicide, many of whom have been our counselling or group clients in the past, and so, we run some training and then they are able to co-facilitate or facilitate peer support groups, and also many of those people also speak at events for us. So that, we might ask them to speak to other bereaved people about their experience because they're a bit further along.

Q. You've referred to a number of programs, one of them is the Early Bereavement Group, could you explain what that program involves, please?
A. Yeah, so many of the group programs we run are what would be sort of more open groups monthly: so there's a group for parents, a group for partners, for siblings, and we've got a specific group program for men and also for children and young people. But the Early Bereavement Group is for people who are between three and 18 months bereaved, and it's a much more intensive and focused group program, so it's facilitated by two of the team, the staff, and it's a more structured program, but we encourage peer support, but it has a bit more structure in it.

One of the things that we've learned about groups over the years is that people bereaved by suicide, it is mostly better for them if they're in groups with other people bereaved by suicide. Sometimes people can have a negative experience if they're in a general bereavement group. There can be sometimes insensitive attitudes to people who have lost someone to suicide, so we've learned that bringing people together in homogeneous groups, which is people bereaved by suicide, is very helpful.

But that structured program means that eight people meet for eight weeks. We've evaluated that group ourselves and it's demonstrated to be incredibly beneficial for people: close bonds form and it is very helpful.

Q. What's the rationale between the three months and the

18 months bereaved?
A. Three months we chose - I mean, this is I guess our assessment or our judgment about what is helpful, and we sometimes move those around, but three months is about some of the initial intense trauma having subsided, so that people are able to be in a room with another seven people and hear their stories.

Each person is dealing with their own grief and trauma, and so, initially some people won't be able to hear anybody else, it's too much. So that's the three months, So, some of that initial trauma may have subsided.

The 18 months is, sometimes we have people up to about two years, but it's about not exposing some people who perhaps are just starting to feel like maybe they're recovering, not putting them in a room with people who are still at that terrible early point of being very traumatised.

Q. Why is it limited to eight people? Why don't you have more people in there?
A. There's a couple of reasons. It's making sure that people aren't exposed to too much because of the level of trauma, and also, it's just simply making - so there's enough time and space for people to really be able to talk about their own experience, so I think that's why we've limited it to eight.

Sometimes we have increased the number and we've thought that it wasn't the best thing to have done. We have found eight to be a good number, yeah.

Q. You also referred to running information sessions and providing education for other professionals: what does that involve?
A. A few times a year we run information sessions for community. So, sometimes we'll get asked by a community to go in and run one, but we also run them at our central office in Richmond, and that's providing information to bereaved people about grief and trauma and stigma and suicide, so it's very much information about those experiences.

Many people find when they're bereaved by suicide, that they simply have got so much to deal with, and they don't actually know a lot about those things - grief,

trauma and suicide - so we give people information that is very helpful.

And also, we provide information about loss, grief, trauma and suicide to other professionals to really, I suppose, increase the capacity, increase the knowledge about that experience. It's a very complex experience, losing someone to suicide, it's also very prolonged; it takes a long time for people to kind of get on their feet again, and so, we're really trying to educate about those experiences, yeah.

Q. With the people who come to your service, where do they come from?
A. Somewhere between 40 and 50 per cent of people come to us through Victoria Police. Victoria police have, in their database, an eReferral system. They refer to a wide range of services and when they're attending or meeting up with someone who's bereaved by suicide, they'll ask their permission to refer them, so they come through VicPol. And then it's a really wide range: there's our website, coroners, mental health, community health, GPs, psychologists, schools, and Headspace refer to us as well.

Q. Do you have capacity to assist more people than you're currently assisting?
A. Look, unfortunately, we're pretty stretched, yeah, yeah.

Q. Can you explain to us how the program is funded? Where does the money come from?
A. Currently we're funded by four of the Victorian primary health networks and that's Federal Government funding, so at the moment we don't receive any funds from the State Government, so it's Federal funds coming to the primary health networks.

Q. You've referred to the fact that each of those four primary health networks have different criteria and it creates administrative challenges?
A. Yes, it does.

Q. Could you explain that to us?
A. Yes. Initially, for the first few years of our funding, we received the money just directly from Canberra, and so, that meant there was one funding body, so one contract, one work plan, and then one reporting regime.

What's happened now is that that's now much more. So, we now have four contracts, four work plans to develop, four reporting regimes, four evaluation regimes, and each primary health network has its own way that they want us to do all those things.

We're a small program, so it's quite an administrative burden, actually. I think there's value in - you know, we have actually valued the relationship that we have with the primary health networks, because it's enabled us to develop more of that local knowledge and to respond locally, but the challenge of it is that administrative burden which has been significant.

Q. You've referred a number of times to "being bereaved by suicide": can you clarify for us who that encompasses, who are you talking about there?
A. Yeah. It's basically a person who has lost someone to suicide and who is significantly and acutely affected. Most of the people that we meet would be, or are, first degree relatives: so parents, partners, siblings and children, but we also do meet and see friends and other relatives.

There's been some research in the United States which suggests that, for each death by suicide, there's 135 people affected; not all of those people will be acutely affected, but it is certainly someone whose level of distress is acute, level of trauma is acute, and also where the functioning is significantly debilitating. So, someone who's having trouble with getting back to work, or engaging in social activities and community life, so the people that we meet with are those who are significantly distressed and their life is disrupted.

Q. In your experience, are there differences between the experience of people bereaved by suicide and those bereaved by other modes of death?
A. Yeah, there's a number of different ways of looking at that. Firstly, there is some research that's been done, and that's in comparison to other bereavements. So, there tends to be a higher rate of some mental health issues, like anxiety and depression.

There's some research which talks about, say, employment and social engagement, so for instance there was

one study which talked about workplace dropout. So, people who are bereaved by suicide were more likely than others to actually not be able to continue in the workforce. And also, difficulties in social engagement. So, there's those two aspects of it.

The third aspect is - again, it's compared to other bereavements - there is amongst people bereaved by suicide a greater risk of suicide. So, they're some important or very important differences.

Then there's just that very sort of, I guess, psychological or emotional experience of shame, really very distressing experiences of not understanding how it could have happened, feeling perhaps that they were to blame, that they should have been able to do something, so there's lots of very difficult experiences: feeling responsible, guilt, shame.

I think bereavement after suicide has a very undermining effect on someone. So, people will be doubting themselves, doubting themselves as a mother or a father; thinking that they obviously weren't good enough; thinking that, I thought we had a close family, and so that this person would actually let us know if there was something going on and it didn't happen. So, it has quite an undermining effect, and that's because the death was suicide. So, there's quite a lot of very difficult experiences that people have.

There's also research that - and this is about the social aspect of losing someone to suicide - which is that people tend to be, it's certainly not universal, but people will feel isolated by their social network. There's research evidence about people who have lost someone to suicide being viewed more negatively, being avoided, and the deceased person not being mentioned, their name not being mentioned, so there's this kind of awkwardness that then surrounds people. So, very silent, a lot of social awkwardness; the person who's died not being mentioned, or there being negative attitudes about the person who's died, yeah.

Q. Is that consistent with your experience? I think you've mentioned that you've had people who have participated who have lost a loved one and there's been one mode of friends and family support, and then when they've

had somebody who they've lost to suicide, it's been a very different experience?
A. Yeah, that's right. So, some of the people who we've met with have themselves experienced an earlier loss, a death by some other cause, and really felt that sense of being surrounded by people, and then when they've lost someone to suicide it's a really stark difference, and so, they often can be left more alone.

There's certainly research, but certainly very much we hear from people: less social support given to people who have lost someone to suicide. And again, that's not everybody, but it's certainly common enough that we hear about it very regularly, yeah.

Q. You've referred in your statement to a report that you're preparing that will document the experience of the health and mental health system before the person died. Could you explain to us what the report is and what you're trying to do?
A. Yeah. Support After Suicide has been operating since July 2004, and in that time we've heard many, many stories of experiences of what happened for the person and for the family before they died, in terms of their contact with the health system and their contact with the mental health system.

We, for a number of years, have wanted to document and share those experiences, because we think that they're valuable in terms of what needs to happen, what changes need to be made in terms of the mental health system.

So, we developed a methodology, and we're grateful to one of our clients, she wanted to fund this research. Her son took his own life and she was unhappy with some of the things that occurred before he died. He had a diagnosis of bipolar disorder. He was an inpatient. Because of his health issues, physical health issues, he was taken off medication and then soon after was discharged without any contact with the family.

His mother had been very involved with his care up until then, but in the last few weeks of his life she was not - excluded, basically, from knowing about his care, and so, soon after he was discharged he took his own life.

So, she wanted to fund this research so she gave us a

donation so that we could set up an online survey and a 146 people responded to that, and then we've conducted interviews with about 30 people to get much more in-depth sorts of experiences and descriptions of what happened.

Q. Are you able, without identifying anyone, to give us some examples of what you've learned through this project?
A. Yeah, sure. Some of the things make for harrowing reading, actually. I phoned a couple of people and asked them if it was okay - without identifying them, if it was okay if I told something about their experience, so I've got two examples.

This is a woman whose husband had been unwell for some time and was being visited regularly by a Crisis Assessment Team, a CAT Team. She believed that his health, his mental health, was deteriorating and she said to them that she thought that he needed to be hospitalised; she thought that he was at risk of taking his own life.

Some of the things that were said to her: she was insistent in a phone call that he be hospitalised. One of the things that were said to her was, did she want to get rid of him? And so, she said, no, that she didn't actually want to get rid of him, what she wanted for him was to be well and to be cared for.

She insisted that he was going to kill himself, she felt very sure about that, and she was told that she needed to trust him rather than her own experience. And, after that last interaction, within two days he had taken his own life.

A second example is a mother of a 17-year-old who'd had a history of mental health issues. She told us a range of experiences, but one that stands out was just before he died. He was an inpatient in a psych unit. She was told that he was being discharged and she needed to come and pick him up.

She said to them that she was very worried about him, she was quite upset and she said to them, "I'm very worried, I do think something's going to happen." So they insisted to her that she come and pick him up. She says in the interview she picked him up and he died on the day that she picked him up.

So, yeah, so I think that highlights a range of issues, but certainly families and carers not being included and not being listened to, and sometimes also being in a sense treated as if they're part of the problem, yeah; whereas, they're desperate.

Q. What are you hoping to do with the report?
A. What we want, what everybody I think wants is for things to change. We don't want a culture of blame and accusation and finger-pointing, we want it to change.

Because I think one of the things I've learned is that, unfortunately, the way the mental health system is, is not helpful to people, some people who are in a suicidal crisis and, if it was more helpful, there would be some people who would not die.

Q. In terms of people affected by suicide, you've said that there is research evidence that people bereaved by suicide are at an increased risk of suicide themselves, and you've also said:

> "While there is an acknowledgement of this in suicide prevention strategies it is not often given priority in funding."

First, can you explain the risks to people bereaved by suicide, and then we'll come to the funding issue?
A. Yes. There's some limited research, but the research that has been done has got some differing ideas, but certainly one research study, for instance, says that people who are bereaved by suicide are twice, or double the risk. There was another study done that actually indicated or suggested that people were actually eight times the risk of the general population, so there's a real sense that losing someone to suicide is an important risk factor that needs attention.

I think there's that research but we certainly see it day-to-day in our work. People who have not ever been suicidal can become suicidal after someone that they love has ended their own life.

A woman said to me years ago, she said, "I've never been suicidal before, never." But after someone very important to her took his own life, the way she put it was, "It's a door there that wasn't there before." So, it had

become an option to her. I think the level of grief feels unbearable for some people at some points, and life feels - and I guess this applies to other deaths - but life feels very difficult because they took their life in that way, and what people are dealing with too is also the ways that people end their own life as well as the fact that they took their own life.

Q. And so, you said in your experience that hasn't been a funding priority, looking after people who are bereaved by suicide?
A. Yeah. I think, just to say as well, that the risk of suicide isn't just in the immediate aftermath. I mean, what we see in our work is that sometimes the risk of suicide can occur sometimes years after, two, three, four years after the death, so I think that's an important thing in providing care as well.

I think there's a sort of idea that, if you give funding to postvention or to a program that's assisting people who are bereaved by suicide, that somehow it's too late; like, the suicide's already happened, there's sort of different sorts of attitudes.

But we do know that people who have lost someone to suicide are at risk. So, we certainly see our day-to-day work as suicide prevention, and not only suicide prevention but assisting people in their mental health and in their engagement in community life.

So I think because it's seen in some circles as, if we put all the money into prevention, then you don't need postvention; it's the wrong way to look at it. The effect of suicide on people is absolutely shattering, it's a devastating experience, and the risk to people is high in terms of a range of experiences, and so, it does need to be part of the suicide prevention strategy, yep.

Q. In terms of interventions for postvention, in your view, what are the interventions that are the most effective?
A. In our day-to-day experience we see the beneficial effect of counselling, and that's very much about assisting people to deal with, I guess, the very sort of psychological affect of grief and trauma and suicide.

Group support is also incredibly important. Many

people talk about feeling very isolated in their grief, so bringing people together in groups is very powerful, very beneficial. People being able to be in a room with others and to see that other people just like them have had this experience. You know, I've heard people say things like, "They're normal people just like me. I'm not alone, I'm normal. I'm not a freak that this has happened to me or in my life." So, group support is incredibly important.

I think the other thing is information, so being provided with very accurate, up-to-date information about loss and grief, about trauma and about suicide is also very helpful and very important, so that people can start to grasp really what they're experiencing and why they're experiencing it and what might be helpful.

There's also a range of other things: I think sometimes, for instance, like counselling and group support - I mean, we have quite a few men who do attend our counselling in groups, but it's certainly a majority of women. So we do run other programs that are specific, like for men, that are more appropriate and that's quite well attended because we've adjusted the way we do things so that men feel it's more for them, it's more suited to the way that they grieve and the way they think about things. And again also for children and young people: trying to develop programs that are innovative. We've done some art space programs which are for young people that are particularly effective, but also for people sometimes that just counselling and group work don't quite fit, yeah.

Q. What are the programs for men and how are they different to the counselling in the group programs?
A. The way we run the men's program is, I think there's three sort of aspects to it: one is, we call it a program, not a group, we don't call it a support group. Rather than it's sort of sit around in a circle and talk about how you feel, that program has a guest speaker each time, someone who leads the discussion, so it's more kind of information-based.

The third aspect of it is that our bereavement counsellor who runs that program makes contact with men between the sessions, between the group sessions. So, there's very much building rapport, building an engagement, building a connection with it, so that we're sort of trying to lower the barriers to people actually - and men in

particular - coming.

So, it's those three things: it's that this is not about talking about how you feel. They do that actually but it's got a different sort of structure to it, and also, the very intensive work with engaging men so that they feel welcome and makes it easier for them to come along.

Q. You've referred in your statement to the feedback that you've received in relation to your programs: could you just briefly tell us how they're received, what do people that come say about the programs?
A. We've had quite a lot of feedback about our eight-week program, we always do an evaluation of that program. It tends to be, I guess, people are very appreciative of it. They speak about the connections they've made, how it's reduced the isolation, "I'm not alone. I understand more now about what's happening for me. I know more about how to deal with this."

I think the other thing is that people learn to be sort of - one way to put it is sort of literate about suicide, so how to talk about it; how to think about the person who's died; how to think about themselves, given that this is something that's happened in their life, so it tends to be very positive feedback that we get from that group program, yeah, and others, people are very appreciative.

Q. You referred briefly to stigma: in your experience, is stigma still an issue in relation to suicide?
A. It is. I imagine it's changed over the years, but we do still meet with people who have, for instance, not told anyone outside the family. So, there's a tendency with some - and this was a minority for sure - but they will still conceal the cause of death, so they've got a lot of discomfort about saying, because they're worried about how they're going to be perceived by others, and also, sometimes it's about protecting the person who's died; so they don't want that person to be judged or condemned because they took their own life. So, there's that aspect of it.

And, as I said a bit earlier, people do experience being avoided, the name of the person not being mentioned, so it's those sorts of things which tell us that stigma is still present and difficult for people who are bereaved.

Q. Do the lack of social conventions or rules for discussing suicide feed into that and affect how people who are bereaved by suicide experience that bereavement?
A. Yes, I think it does, because it means that people around them don't know how to talk about suicide. I mean, no doubt you've heard over and over how suicide is complex, and it is, but there will be a tendency for most people to oversimplify why someone's ended their own life.

So it might be, a relationship might have ended, so it's like, that's the cause, and it's a misunderstanding of suicide. And so, not really understanding suicide, not knowing how to think about suicide, not knowing how to think about a family, that's all part of that sense of, people don't know how to talk about it.

The sort of norm about suicide I think that is still around is that someone who's ended their life is weak or cowardly or selfish, and that does still play out. People do still have people in their social networks saying those kinds of things to them.

Q. I have two final questions. The first one is, what needs to be done in Victoria to better assist people bereaved by suicide?
A. I guess there probably needs to be more funding, more services and more integration of services, so there's that sort of work similar to what we do in our service.

But also, in some communities they're developing what's called suicide postvention protocols, so that's a kind of community level response as well when someone dies in a community, so there's that aspect of it too which could be strengthened and in more communities. Yeah, I think that - yeah.

Q. The final question is about the key changes to the mental health system. In your statement you've given a couple of examples of what's been done elsewhere, and I wondered if you could just expand on three of them so that we can understand.

The first one is the Zero Suicide Framework, and you've referred to this in the context of implementing different models of care for people who are suicidal and who attend the Emergency Department. Could you just

explain for us what the Zero Suicide Framework is?
A. It was developed in the United States, and so, I've certainly done some reading on it and been to several conference presentations on what's called the Zero Suicide Framework. I mean, what they call it really is an approach and an approach to care, so it really is an overhaul of the way things are done in a mental health facility or in an Emergency Department, and also it's the way it's done but it's also the culture, so it's attitudes to suicide, attitudes to people who are suicidal; that there's training done for the staff to really shift attitudes.

It also relates to risk assessment. I remember at one of the conference presentations the Gold Coast Mental Health Unit has been implementing this for a number of years, and they said, you know, when we ask someone if they're suicidal, what we want to hear is "no" because it's scary. So, it's about changing that, changing that culture so that people are much more able to really work with people.

The other thing that they acknowledged was that, yeah, people don't want to hear it because they're scared - sorry, I've just lost my trail. But it is a sort of - it's a very different approach, so it's really an overhaul of the way things are done, and it's about spending time with someone, really talking to them. And it's an understanding that, in an Emergency Department or a psych unit, if you ask the question, you might want to hear "no" but also in that environment people are going to say "no". And it's a sense of, like, let's create an environment where people are going to say the truth, so they will say if they're suicidal, so you build different relationships with people that are much more compassionate, have much more empathy for the suicidal state that someone's in and will really work with them to understand that.

So that's kind of what the Zero Suicide Framework is, it's a real sort of overhaul of what's done and also the way it's done and the way people are treated.

Q. The second model that you've referred to is the Collaborative Assessment and Management of Suicidality, CAMS?
A. CAMS, yes.

Q. What's CAMS?

A. Again, this was developed in the United States by a clinical psychologist called David Jobes, and there's some other models but that's one I know a lot about, is that, when someone is suicidal, it gives a framework and a way of really working with someone, again getting very beside someone to understand how come you're suicidal, let's work out what the drivers of that suicidality are, how come, what are the triggers, what's your sort of spiral into getting into suicidality, so it's very much a way of working with someone who's suicidal.

There's many good - I mean, there's ASIST training and there's safeTALK and all those are excellent, but this is very much for people who are working with someone who is suicidal and really helping them understand themselves, how come, and what will help keep them safe, what they need to do to not become suicidal. So that again is a very good approach and it's very collaborative and very much about building rapport and having a good relationship with someone.

Q. The third and final model that you refer to is the Maytree in the UK: what does that model involve?
A. That's a residential house for people who are suicidal or in a suicidal crisis. So, it's not a medical environment, it's a place where people can go when they're suicidal and be safe and also work to understand what's happening for them.

So, that involves clinicians but also peer support. So, it's a very different: it's non-medical, it's much more into dealing with what's happening for someone, and again, what's increasing someone's suicidality and how can they be safe. But it's a way of people being safe that's a non-medical environment and residential.

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

CHAIR: Q. I have just a few. Could I start with the issue of funding. I notice in your submission you said, whilst you're service is currently funded by four of the PHNs, not all the costs are covered and Jesuit Social Services cross-subsidises that service, I gather?
A. That's right.

Q. How much does it have to subsidise the services to run

the model that you're running?
A. Sorry, I didn't quite hear that, sorry?

Q. How much is it cross-subsidised by Jesuit Social Services, self-funded?
A. Significantly, it's well over $100,000, yeah, that we're underfunded.

Q. Thank you. You've given us a very good and very compassionate overview of the impact of suicide on family and other members and I thank you very much for that, I think it's been very important for us to have that strong understanding and your proposals for change.

I noticed that you said that your programs are always full. Can I ask how you go about recruiting staff? Are you readily able to recruit staff in such a very intense environment, just not only for the participants but no doubt for your own bereavement counsellors, and what do you think is important for supporting people doing work in this field?
A. It's not easy recruiting suitably qualified and experienced staff. What we look for is people who've got - psychologists and social workers preferably - who have got some experience in loss and grief and trauma, or perhaps some significant experience in suicide. I think what we look for actually is particular qualities as well as that. So, when we're recruiting, we're looking for people who are sort of robust in themselves, and compassionate, so it's both those things: a real sense of compassion, but also people who can take care of themselves.

We are fortunate that we don't often have to recruit because staff tend to stay, and I think there's a number of things that are helpful in this, because there is always going to be a risk of vicarious traumatisation or burn out. So, I think when I'm asked about this, which is fairly often, it's working in an organisation that's got a good culture overall, which Jesuit Social Services does. It's also having good collegial relationships so the team is very cohesive and very supportive. So those things lay good groundwork for people to not be burnt out. And then it's supervision and also people knowing themselves enough to know when they need a break. So there's a range of sort of things, yeah.

CHAIR: Thank you very much for your overview and your

statement today.

MS BATTEN: Thank you. May Ms Flynn please be excused?

CHAIR: Yes, thank you.

<**THE WITNESS WITHDREW**

MS BATTEN: May we now adjourn to 2 o'clock, please.

CHAIR: Yes.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH

MS BATTEN: The next witness is Associate Professor Peter Burnett. I call Associate Professor Burnett.

<**PETER LEONARD BURNETT, affirmed and examined: [2.01pm]**

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

Q. I tender that statement. [WIT.0002.0017.0001] Before I ask you some questions about your statement, are there some opening remarks that you would like to make?
A. Yes, I would. The evidence that I've prepared in the statement is by its very nature somewhat dry and academic, and I would like to take the opportunity to say that, that evidence should be seen in the light or the perspective of the fact that suicide is always a very tragic event, and obviously particularly tragic for the individual concerned, but also very, very tragic for families and the effects of suicide, I have seen in my clinical career, ripple through families and into the next generation, and it's also very traumatic for staff who are involved in looking after someone who goes on to commit suicide. So I think, in looking at the evidence that I'm going to talk about, it's very important that we retain that perspective.

Q. You are the Director of Clinical Governance at NorthWestern Mental Health?
A. That's correct.

Q. Can you briefly outline what your responsibilities are in that role?
A. My major responsibilities are to ensure that we provide high quality clinical services, with a particular emphasis on safety and continuous quality improvement, on engagement with consumers and carers, and I've also spent a fair bit of time on medical management as well.

Q. Can we turn to the issue of suicide and individuals experiencing suicide. In your experience, how common is it for those individuals to give some indication of their intention?
A. I think, both from my clinical experience and from the literature, it's very common that people give some indication that they're feeling suicidal. The evidence is that, somewhere around 40 or 50 per cent of people will say something to a general practitioner, or mental health clinician or other healthcare clinician about their intentions, and many more people would also obviously speak with family and friends.

Q. In your view, does this present opportunities for intervention?
A. It does present the opportunities for intervention, and a lot of clinical work has gone into trying to work out what are the indicators that are most accurate at predicting who's at higher risk of suicide.

Q. In terms of indicators, do you means in terms of risk assessment?
A. In terms of risk factors within that individual or within - yes, the risk factors of the individual which might predict the likelihood of completing suicide.

Q. With those risk factors, are you referring to the ones that have ultimately gone into the risk assessment form that NorthWestern use?
A. So, our risk assessment form was compiled by looking at literature, looking at the indicators that are most reliable. Having said that, however, there are - as I will go on to talk about later - there are many difficulties with the accuracy of those measures; of any measure.

Q. Thank you, we will come to that. Thank you. To clarify, when in your view is a person considered at risk of suicide?
A. So, from a clinical perspective people are referred to

us often because they have voiced ideas of suicide, or because they're particularly depressed, or because other people have noted that their behaviour suggests that they may be feeling suicidal or having suicidal thoughts.

Q. Is it limited to suicidal thoughts, or does it also include thoughts of self-harm?
A. Well, thoughts of self-harm and suicide are related so, yes, thoughts of self-harm as well.

Q. Can I turn to the issue of assessment tools used by health services. In your statement you've said:

> "In Victoria different services have developed their own assessment tools which are generally variations on the standard psychiatric assessment supplemented by a form of risk assessment. Other jurisdictions, such as New South Wales, have a standard assessment form which is used by all services."

Are you able to explain to the Commission why it is that Victoria has different assessment tools across services?
A. Well, I think that's a consequence of the decision made in Victoria in the 1990s to devolve healthcare to local health networks, such as, say Melbourne Health is one such network, and Monash is another, The Alfred, St Vincent's and so on, there are many different health service providers, and the model that was used was to encourage services to be responsible for service provision within their own area and for the Health Department to have a role in setting standards and monitoring performance but not in actual service delivery. Other jurisdictions have retained a more traditional path where the state department is much more actively involved in the service provision side of things.

Q. Can we turn to the risk assessments within NorthWestern Mental Health. You've said:

> "Within NorthWestern Mental Health we have a detailed assessment form used for assessments of new consumers and risk assessment forms tailored for the different settings in which they are used; that is,

ED, inpatient unit, community, et cetera. Risk assessment forms must be tailored to the specific setting because the risk issues arising in an acute ward are often very different compared to, for example, a community clinic."

First, can you clarify for us, how are the risk issues different?

A. In an inpatient service, by definition the consumers who are admitted there are likely to be at a higher risk, they're likely to have a more acute presentation of a mental illness, and also, they're in an environment in which there is some ability to control their access to means of self-harm or suicide. So, being in an inpatient unit is safer in that sense, but also, it's a more at risk population. So, the risk assessment tools focus on keeping people safe in that environment are looking for indicators - looking for areas where we think there might be a risk of a person being suicidal or regressive or whatever else may be looked at.

On the other hand, in the community the risk factors are different because a person is in an uncontrolled environment where they have access to different means.

That said, the fundamentals of the suicide assessment are much the same: that the risk factors from the person's background, from any illness that they might be suffering from and the interplay of those predisposing factors with any acute stressors, those factors obviously apply to both settings. So, there is an overlap in the risk assessments, I'm just explaining why there are slightly different modifications of the risk assessment tool.

Q. If someone presents at the emergency department expressing risks of suicide, can you step us through the process for how the risk assessments are done for that person?

A. So, the first assessment would be done by the emergency department triage nurse who would look at the information and assign a category to that particular consumer, which might be ensuring that they were in a safe place while they were waiting to be seen.

They would generally at that point notify the emergency mental health team, and the person might also

have an assessment - generally would have an assessment from the emergency department staff. Then the emergency mental health team would do a specialist assessment which would be a mental health assessment, so looking for signs and symptoms of mental illness, and then they would do the particular risk assessment. Sorry, prior to that, if the person had come in expressing suicidal thoughts as part of the mental health assessment, they would explore that in some detail to get an understanding of how intense a person's thoughts of self-harm or suicide were; whether they had made any attempts, whether there were protective factors in their lives, whether there were acute stressors. These would be part of the general mental health assessment.

Then there would be a mental state examination which would look at signs of mental illness, and then the particular risk assessment would focus on recapping all of the factors which I've mentioned before: the predisposing factors to suicidal behaviour and any protective factors.

Q. Do you know whether anyone presents at the emergency department at risk of suicide who is not then referred to the emergency mental health team?
A. The decision about referral to the emergency mental health team is one for the emergency department medical staff. While the person is in the emergency department, the clinical governance for that person is with the emergency department until they're formally taken over by the mental health but referred to the mental health for admission or referred then for outpatient care if they're not admitted.

Q. And that's not something you have responsibility for, the emergency department?
A. No. Obviously, we work in collaboration with the emergency department, it's not like we're two completely separate entities, but technically the clinical governance is with the emergency department.

Q. For the people who are referred to the emergency mental health team, you referred to a clinical risk assessment and management form that is completed for those people.
A. Yes.

Q. There are suicide static factors?

A. Yes.

Q. And there are suicide dynamic factors?
A. Yes.

Q. So, the static factors: can you explain what the static factors are and why they form part of the risk assessment?
A. So, static factors are those factors in a person's background which have been shown to be associated with the risk of suicide. So, they may be things like having a family history of suicide, or having a serious mental illness, or having a serious physical illness. So, they're factors which are, in a sense, not changeable, they're static, they're part of a person's make up.

The dynamic factors are things that are happening in a person's life at that point in time: so they could be things like loss of a job or loss of a relationship, or some particularly acute interpersonal problem that they're dealing with.

Q. You've said in your statement:

"The optimal approach to assessment requires consideration of nuances that may inform the outcomes and whether hospital admission or community support may be more appropriate for the patient."

What does that involve, that assessment and consideration of nuances ?
A. It's about listening to what a person says and also what they do not say, and being attuned to subtle indicators. So, for example, a person might say, "I'm not feeling suicidal now." That might suggest they - obviously would suggest that they may have been feeling suicidal at some other time, so one would explore that with the individual and try and establish just how acute the current suicidal ideation is.

Other things that are perhaps in the area of nuance are information that they may have said to somebody else that they will then deny, or perhaps a person who says to you, "Well, I don't want you to talk to anyone about this because they're all very busy and I don't want to trouble them with my concerns." That's a legitimate thing for

someone to say, but obviously the assessment of the risk is incomplete if we're not able to speak to other persons in that individual's immediate environment. So, one's assessment might be that we need a more conservative outcome if we can't get what we would call collateral information about how an individual is travelling.

Q. I will return to the issue of collateral information, but before I get there I want to remain on the optimal approach. The Commission's heard a lot about the pressures on the mental health system. Do the pressures on the system have any impact on whether the optimal approach is always done?
A. That's a difficult question to answer, in the sense that, our clinicians I think always provide a good standard of assessment, and that may mean that as a consequence other people have to wait because the number of - I mean, even in very busy emergency departments, we have two clinicians rostered on at a time, so if both of those are doing assessments then there's going to be a delay for others to be seen. That is less than optimal. And obviously, if someone is very distressed and disturbed having to wait a long period of time is in itself upsetting and distressing.

So, in that sense I think that pressures lead to less optimal responses. However, I think the job of professional staff is to ensure that they always provide a good level of clinical care regardless of the pressures that they're under.

Q. You referred to the difficulty with sometimes getting collateral information. The risk assessment requires that the assessment be comprehensive and includes static and dynamic risk factors and be informed by relevant and collaborative information. What are some of the challenges in trying to get that collateral information?
A. Well, sometimes the challenges can be that the individual forbids you to access anyone and won't provide information of relevant people.

Q. And, if they forbid, that's the end point, there's nowhere to go?
A. No, we would try and encourage them to let us talk to someone that they would feel more comfortable us talking to. Sometimes it's the case that the person may give you a name but that person's unavailable, or that it's the middle

of the night and it's very difficult to access somebody; so in those circumstances, as I mentioned previously, we would be more likely to take a more conservative view of what management options are appropriate.

Q. In your view, how accurate are the current criteria in determining whether a person is at risk of suicide?
A. It's extremely difficult to predict the short-term risk of someone completing suicide. So, in that sense, no matter how good - how complete the list of indicators is, it's not going to give you very reliable information about who out of 20 people who come in with suicide ideation are actually likely to go on and make an attempt.

Q. You've said in your statement:

> "Unfortunately, there is no magic tool to identify suicide risk. There is evidence that a good psychiatric examination undertaken by skilled clinicians with attention to risk issues performs better than most specific suicide interviews."

First, can you clarify for us, what is a specific suicide interview?
A. I'm thinking of experimental or research interviews which have tried to identify which risk factors are the most likely to lead to an actual attempt of suicide.

Q. Then, can you elaborate for us, what is the evidence that a good psychiatric examination with attention to risk performs better?
A. The evidence is a series of studies of outcomes, which I've mentioned some of those in my statement, given some references to those, and it's generally most suicide experts would have the view that a good psychiatric assessment is as good as any other method.

Q. You referred to the difficulty in predicting who is going to complete suicide and when. Can you explain for us how a sudden change in a person's mental state can limit the usefulness of the assessment tools?
A. Yes. I think, as I mentioned, the dynamic factors are particularly important in a person making a decision to actually make an attempt on their life. So, many people may have the same static factors, the same predispositions to suicidal behaviour, but it's the acuity of the current

stress and also feelings of hopelessness and feelings that this will never go away that lead a person to think that suicide might be a better option.

So, the example that I gave in the statement was of a person not at our health service, but at another health service a colleague was talking about, where a person had been very depressed, had had a hospital admission, had made a good recovery and was feeling much more positive about life and then was preparing to be discharged, went to the cafeteria for lunch, didn't come back and was found having attempted to hang himself in the hospital stairs.

Fortunately, he survived and he was able to tell staff that the reason he'd done that was that he'd felt so confident that he tried to make contact with an estranged family member and that person had not reciprocated his contact, so he felt that everything he'd done had not been worth it and he became acutely distressed and attempted to kill himself.

Now, if we had done a risk assessment of that person an hour before he went out on leave, we would have had no concerns at all about his risk status, and yet, an hour later he was acutely suicidal. So, that's an illustration of how difficult prediction can be and how vulnerable some people can be to unexpected changes that happen to them.

Q. You've referred to the fact that the data available is usually a lifetime risk.
A. Yes.

Q. Can you elaborate on that: what's the lifetime risk?
A. So, that data came about because the ability to clinically predict suicide was not very strong, so the researchers then looked at whether there were - if you studied large numbers of people and looked for the occurrence of multiple different risk factors, whether that might provide a more accurate prediction of who was likely to actually go on and attempt or commit suicide.

While it does identify people who are at risk, it does so in a very non-specific manner. So, there might be hundreds of thousands of people who have those particular characteristics, and it's true that that group will have a higher risk of suicide than a group of people who don't have those characteristics. However, those figures are

determined by how many people commit suicide over the course of their lifetime, so that information is helpful but not particularly helpful in deciding who is at particular risk in the next few days or the next few weeks.

Q. In your view, do the pressures on the mental health system impact on suicide rates?
A. I think, again, it's difficult to establish scientifically that there's a direct correlation. It makes common sense that a system which is under pressure, where people have to wait long periods as I've said, that for people who are very distressed, that extra waiting and the uncertainty of what the service may be able to offer them, that they are additional stress factors that they really don't need at that point in their life. So, I believe that there is some affect from that.

Certainly, services are under very, very considerable pressure for inpatient beds in Victoria. I'm sure this has been talked about in some of the submissions, that we have a very, very low rate of beds per population, and so, people have much shorter stays in hospital than in some other jurisdictions or in other countries.

It's likely that, because of that, that people are discharged when they are not 100 per cent better. The question of when people should be discharged of course is a difficult question, but these external pressures do mean that people are moved through the system more quickly than they might otherwise be.

There's also some evidence from studies in America that rapidly reducing beds has been associated with an increase in the number of suicides, but again, there are many factors that could be affecting that, so I think it would be difficult to state with certainty that lack of beds causes an increase in suicide, but it's certainly a plausible line of enquiry.

Q. I want to ask you more about the beds in terms of inpatient admission. You've said that:

> "Inpatient admission is often useful in containing a suicidal crisis but there is no evidence that it is an effective treatment of suicidal behaviour in the longer term."

Can you explain what you mean by that?

A. So, if a person is very acutely distressed and actively planning suicide, then almost all clinicians would recommend that person be admitted to hospital for a period to contain that acute risk and to begin the process of engaging them in longer-term treatment which is necessary to try and tackle the kind of problems with thinking and handling conflict or handling interpersonal crises: that's the kind of work that is necessary to help them in the longer term, but you can't do that straight away if they're at imminent risk. So, in that sense hospitalisation is useful.

However, inpatient wards are very busy places, noisy and lots of very disturbed people, so it's not an environment conducive to psychological therapies or for people to stay for a long period of time to work on these problems.

Q. In your experience, what are some of the barriers to people who are at risk of suicide receiving appropriate treatment at a systematic level?

A. I think we could look at a whole range of issues with barriers. So, I guess the first one is access to services. So, we know that some populations of people are at higher risk than others in terms of completing suicide; particularly Aboriginal and Torres Strait Islander people LGBTIQ people; various age groups, men between 25-44; younger teenage people; there are high risk groups, some of whom find it difficult to go to a health service and request help. So, the first problem is access, people feeling comfortable to come and seek help.

The second group of problems is the issues that we've spoken about with regard to the pressure on the system and the demand and the rapid throughput in the system. The way that services are structured is a necessary consequence of the environment in which we work, but it may be that many people with a whole range of mental health problems fair better with continuity of treatment, with seeing the same person over a period of time - I'm thinking the outpatient phase of treatment now the community phase of treatment - and sometimes our services are not as good at providing that as we might like them to be because, if people are working shift work or if there's a high turnover of staff, then getting continuity of care becomes difficult, so they

also impact on outcome.

Q. I have two final topics to address with you: the first is the Mortality Benchmarking Group. Could you explain to us what that group is?
A. That's a group of eight different mental health services in Victoria which got together 11 years or so ago with a view to understanding better what the data was telling us about the number of people who committed suicide or who had what we call reportable deaths, so not just suicide but also unexpected and unnatural deaths; with the aim that this might help us identify services that were doing particularly well or services that were doing not very well, to see whether there might be things that we could learn from that to try and reduce the risk of suicide in our own services.

Q. What has the group established? Are there differences between particular services?
A. Yes, there are differences, but there are much more similarities than differences. So, we haven't established that any one service has markedly better outcomes than another, or markedly worse outcomes than another.

What we do see is that, for any individual service the numbers can vary quite a bit from one year to another, but if you look at it over a period of eight or 10 years as we've been able to now, it tends to even out.

There are differences in services that are close to the centre of the city and have a lot of more sporadic engagement with people who may be homeless or are at high risk of self-harm or suicide, whereas regional services or perhaps outer urban services are less, have lower numbers overall, but on the whole it hasn't found an answer that we can generalise.

From the point of view of my own service, looking at that data and presenting the data to our own board governance committees has certainly provided a focus on the number of people who commit suicide and has led to some independent external reviews of the service to look at how we're doing and what things we might be able to do better.

Q. Have you implemented changes as a result of those reviews?
A. Yes, we have, and we've identified particular areas,

some of the areas I've mentioned already: so access, areas of transfer between services or when a person leaves the service and then is referred back to primary care or to another provider, are all very high risk areas and they tend to be recommendations from those kind of reviews.

Q. My final question is, what changes do you think would bring about lasting improvements to help people at risk of suicide, particularly in relation to accessing treatment or getting help earlier?
A. Yes, I think accessing treatment is particularly important. Perhaps even before that, there's some evidence that what we might think of more kind of population-based initiatives can be helpful: so, training community leaders in awareness about suicide, and raising the profile of - raising the awareness of people to seek help earlier and encouraging others to avoid stigma and that it's okay to talk about some of these things; there's evidence that those things are helpful.

There's definitely evidence that reducing the means to commit suicide in the community results in reduction in suicide rates: so, particularly access to firearms, access to high bridges and cliffs and things like that; fencing off The Gap in Sydney resulted in a reduction in suicides at that time. So, those kind of preventive measures on a population level are helpful.

Then the access issues which I mentioned before, so particularly for communities who don't enjoy good access to health services currently, they are helpful. Improving the quality of the psychiatric mental state examination and the history taking, and improving clinicians' ability to ask the right questions.

Again, we can't show scientifically that that improves the outcome, but it's certainly, from all we know about suicide, it's likely that that is an effective treatment plan and that's one that we've done in my own service where we rolled out an intensive suicide awareness training for all of our clinical staff.

MS BATTEN: Thank you very much, Associate Professor Burnett. Are there any further questions?

COMMISSIONER COCKRAM: Q. Associate Professor Burnett, you were highlighting the difference between making

assessments in different settings, and we've been struck by evidence from a number of directions about people being at risk during periods of transition, especially at discharge from a ward, discharge from the emergency department.

I guess the question then raises, is it an effective assessment at all to be assessing somebody at the point of discharge from an inpatient unit rather than at the point of when they're in their community setting: how valid can we make an assessment in that context given the evidence we've been hearing?

A. Well, I think it depends on how we look at the data. So, the vast majority of people who are referred from one service to another make that transition without a bad outcome, but for those who do have a bad outcome that is a high risk period, so I think it depends which way around we look at the problem.

As in the clinical example that I gave, it's very difficult to predict what's going to happen to a person after they leave your service. There are no tools that tell us what it will be like for that person if something goes wrong a few days later. We can say based on everything we've seen they're doing very well, they're certainly ready to go home, they're no longer detainable under the Mental Health Act, if they ever were, so they have that right to choose to leave hospital.

In general I think our assessments are as good as we can do, they're as thorough as anyone in the world would do. The problem is that the phenomenon that we're talking about is mercurial: that people, obviously they retain their static risk factors and, if a new event occurs, then they may feel that their coping capacities are overwhelmed and they experience that feeling of distress and hopelessness which might lead to an attempt or a completed suicide.

COMMISSIONER COCKRAM: Thank you.

COMMISSIONER McSHERRY: Q. I note in your statement, and in your statement to us just before, that you say there are currently no reliable assessment tools, but you carry out, I suppose, some sort of structured professional judgment when you're assessing.

A. Yes.

Q. You've also mentioned a study by Matthew Large, and I know that he and some of his colleagues have argued that, in terms of mental health laws, we really shouldn't be emphasising assessment of risk, we should be getting away from that. I just wondered what your view would be on that?
A. Well, that's a very controversial topic. I think that his views about risk assessment are consistent with the literature, but they're not very useful for clinicians who are faced with a clinical problem in real life.

So, I think clinicians need guidelines to follow in order to feel comfortable making an assessment and doing the best clinical job that they can. If we were to say that obviously risk assessment is a very inexact science, therefore we shouldn't bother doing it, the question would be, what would we do instead? And I think that would be a worse situation than we're in now.

I think it's really about the question of, medicine is both an art and a science, and psychiatry I think even more so. So, we absolutely must be guided by the science, we must learn from what happens, we must remain open to changing what we do when we see advances in the science; but on the other hand, if the science can't tell us where to go, then I think we have to use our clinical skills to make the best judgment that we can. I think that's what our clinicians do all the time and if we had better tools to guide us, we would love to have them and we would love to use them, but I wouldn't say do nothing because those tools don't yet exist.

Q. But could there be a possibility of an alternative framework based on what the individual needs and what the individual wants, rather than so much emphasis placed on trying to assess risk of serious harm?
A. Yes I think clinically - and I can't prove this scientifically - but I think clinically things like engagement and hope are very important. One of the roles of a clinician dealing with someone who is very actively suicidal or distressed is to provide a sense of hope, you know, to provide - "yes, I've been with people who feel just like you do now and they have managed to get better, they have managed to get through this crisis." So, the role, that therapeutic role of the clinician I think is very important. So, in a sense that's using a different framework from the framework of a risk assessment

management.

CHAIR: Q. I just have a few issues I'd like to follow up on. It was very helpful in terms of your witness statement, some of the details you gave us about the other studies that have been done.

We heard in evidence before this Commission how frequently people have dealt with GPs or other practitioners fairly proximate to the time that they have been in deep distress. But I noted in your witness statement you said there was a UK study that said 47 per cent of patients with a history of mental illness who suicided were in contact with their GP in the previous month, and 16 per cent in the previous week.
A. Yes.

Q. But so suicidal intent was communicated in less than a fifth of the final consultations, which I think goes to your point about the difficulty in assessment and also the rapid de-escalation that can happen with some life stressors.

How well informed do you think treating practitioners are about some of those complexities? Because a lot of the focus on suicide prevention is about education, awareness-raising, but some of it is very complex education and awareness-raising.
A. It is indeed. I think there is some evidence that upskilling general practitioners and other primary healthcare providers is useful, it does at least perhaps lead to a better pick up of people who are at higher risk.

But perhaps even more so, or perhaps in parallel with that, is the training of community people to be aware of suicide risk in workplaces and so on. I think one of the more powerful studies was an American study looking at service personnel in the United States, where they very actively trained officers and non-commissioned officers to be sensitive to people displaying any signs of suicidal thinking and having a very active campaign to then get them into some kind of treatment.

So, again, that's a slightly unusual environment, in that they had a workplace where they could issue commands and set up a pathway that everyone would follow, but it does perhaps give some indication of models that might be

useful.

Q. Then, going to your benchmarking study, I take it that that initiative that I think you said has now been in place for 8-10 years?
A. 11 years.

Q. 11 years, was an initiative of the eight health services?
A. Yes.

Q. And have now been participating in that. I noted in your witness statement you said that there was some interest in the Chief Psychiatrist and others in maybe taking over that function and incorporating it into work that's been done with the Coroners Court.
A. Yes.

Q. What would you see as the benefit, if any, of that, or would you still think it's important that health services have I guess that responsibility to assess their own performance and opportunities for improvement?
A. I think the health services should always be responsible for looking at their own performance, but the bigger the group that you're benchmarking, the better the data will be. I guess the gold standard is, the United Kingdom has a confidential national inquiry into suicide and homicide, and in the last 10 years suicide rates in the UK have gone down and suicide rates in consumers attending mental health services have all gone down, which is different from other jurisdictions.

They've also shown that - this is a very comprehensive process where, whenever a person is thought to have died from suicide and been in contact with a service, the clinicians have to fill out a very lengthy questionnaire, and then that goes to the confidential inquiry, and then when the Coroners report confirms that it is suicide, then it enters their database.

As a result of that study or that database, they've been able to make recommendations to services in particular cases, and they've shown that services who adopt their recommendations have had a change in their suicide rates over time. So, clearly there is an improvement, a positive change - so clearly there is some power in having that sort of a database, but obviously that's because it's a

requirement of services in the UK across the whole country to do that.

Q. Thank you, we may follow up. Did you reference that particular piece of work?
A. I can't recall, but I can send it to you if I have it.

CHAIR: If not, then that might be helpful if you could give us that reference point, that would be very useful. Thank you for your evidence.

MS BATTEN: Thank you. May Associate Professor Burnett be excused?

CHAIR: Yes, thank you very much.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Bruce Crossett of the Transport Accident Commission. Before I call Mr Crossett, just to add to what I said this morning, Mr Crossett is clearly not an expert in suicide and nor is the Transport Accident Commission, but they have engaged in a systems approach to a widespread problem that causes great social harm, and they've done so over a number of years.

And, whilst it's not suggested by Counsel Assisting that the road toll or the systems or issues affecting it are a proxy for or the same as those factors affecting suicides, nevertheless there are potentially some significant learnings to be gained from the approach that TAC has taken.

Also before I call Mr Crossett, there's an appearance on behalf of the Transport Accident Commission.

MR MARTIN: If the Commission pleases, I'm Mr Martin. I appear on behalf of the Transport Accident Commission.

MS NICHOLS: I call Mr Crossett.

<**BRUCE DOUGLAS CROSSETT, sworn and examined: [2.48pm]**

MS NICHOLS: Q. Mr Crossett, are you the Acting Chief Executive Officer of the Transport Accident Commission?
A. That's correct.

Q. And you're also the Chief Strategy Officer for the Transport Accident Commission?
A. That's correct, yes.

Q. Can I ask you, what is the Towards Zero strategy, in brief?
A. Yeah, so essentially the Towards Zero strategy, which was established back in 2015/2016, was the first long-term strategy into road trauma prevention, a State Government initiative, and through the TAC and its partner organisations, Victoria Police, VicRoads, Department of Justice and Department of Health and Human Services, established the strategy which really takes a system approach as you said in your opening, looking at all elements of road trauma and how can we treat at that point in time still close to 300 people losing their lives on our roads in Victoria.

That system approach was borne out of a model from Sweden which was established in 1997, Vision Zero, and so, that was the originator of that system approach to prevention and looking at the four key elements which are: safer roads, safer speeds, safer vehicles and safer people.

Q. Can I just take you back a little bit. The systems approach, does that include these concepts: safe systems which we'll go to; a long-term vision; a basis in analytical modelling or evidence; ministerial responsibility; and significant financial investment?
A. Absolutely. So, it encompasses all of those elements in terms of how the strategy was set up and the level of responsibility from the establishment for the first time at that time of a Minister for TAC and a Minister for Road Safety in particular, as well as significant investments in things like infrastructure to support the strategy.

Q. You mentioned before the elements of the safe system, those being safe roads, safe speeds, safe vehicles and safe people. Can you just say a little bit briefly about what each of those means?
A. Yeah. So, essentially it's thinking about prevention in this particular case and saying that humans will make mistakes and that the road system, for example, needs to take that into account.

And so, in terms of what treatments we put in place,

for example safer roads, the flexible wire rope barriers that are now being installed across our state, that takes into account that people will make mistakes.

In terms of vehicles as an example say for people: people are vulnerable and, for example, if a person as a pedestrian is struck by a vehicle at more than 30 kilometres per hour, they're likely to be seriously injured or potentially lose their life. So, the elements of the safe system take that into account, that people are vulnerable, there are tolerances to what people can withstand as well as the other elements of that program.

Q. So, is it correct to say that the safe roads, safe speeds, safe vehicles elements of the strategy go well beyond attempting to modify people's behaviour and to put in place other safeguards?
A. Exactly. I think, if we think about the history of road safety and prevention in Victoria, back in the late 70s, early 80s, we had just over a thousand people losing their lives on our roads each year, and at that time in around 2015/2016, we'd plateaued in terms of lives lost around 300, and so, really this safe system approach was to take us to the next level of having an impact and saying that zero was really the only acceptable outcome.

Q. So, does that represent sort of a philosophical approach backed by a suite of practical measures?
A. That's right, so it's really saying that no-one deserves to die on our roads and therefore zero is the only acceptable target, and that if we were to make significant further gains, we'd need to look at the road system as a system in terms of, whether it's behaviours or speeds or vehicles or the road network itself, look at all elements and put in place treatments to address those areas.

Q. Before this significant investment was made, or rather before making it, did it draw upon some well-established bodies of evidence that were available to TAC through its and its predecessor's work over the last few decades in relation to road safety?
A. That's right, and the Monash Accident Research Centre, which was established back in 1987, is considered one of the leading research accident prevention centres in the world now. So, it drew heavily on evidence base as well as modelling as you mentioned earlier to say, if we put these initiatives in place, this is the amount of impact,

positive impact we can have on road trauma, both lives lost and serious injuries.

Q. And that modelling really went to road safety aspects, so making modifications to roads and vehicles; is that right?
A. Yeah, exactly.

Q. Was there some economic modelling that went to develop the business case which put to government the benefits of investing heavily in this program?
A. That's correct. So, there was economic modelling around the savings to the community in reducing road trauma through the investments, for example in infrastructure, as well as other significant savings in the impact on Victorians of losing a loved one or the associated medical and health costs.

Q. Was there also, in launching the campaign, some market research about how it should be described and how the public would receive the, for example, what it was called?
A. Yes.

Q. And the way it was portrayed in the media?
A. Yes, and I think that was an important point: in developing the strategy the research had shown that, in the context here in Victoria that it was unlikely the community would accept at that time that Vision Zero, which is what the Swedish model was, was going to be accepted here.

So, through further research, having a Towards Zero goal was considered to be acceptable and was more action-orientated, and in the end was how the strategy has been described, and since that time we've had - now we're at a point where about 50 per cent of the community in the testing and surveying we do now say that zero is the only acceptable target that we should aim for, and that it is possible one day. So, we've still got more work to do, but there's been significant embracing from parts of the community that that is possible.

Q. So, that aspect of the program that you're discussion now is about community buy-in to the philosophy, not only as it underlies the program, but as it's expressed in the public promotion of the strategy?
A. Yes, that's correct.

Q. Was it thought that you needed to have a program that people would resonate with and agree with and that you were to assess that by doing constant market research?
A. That's correct, yes.

Q. You mentioned before that the aspects of Towards Zero include the understanding of the consideration of the road network as a system in which we all use the components, the roads we design and build, the vehicles that drive on the roads, the people who use the roads and drive the vehicles and the speed at which we travel on the road network.

So, is that concept of a system central to the strategy?
A. Absolutely, and again, as we say, there is clear evidence around the world in Sweden, and even in the UK now, who are achieving reductions in lives lost at a better level than here in Australia and that's through the application of the safe system approach and those four pillars that we've talked about.

Q. Is it understood why Sweden is achieving such good results?
A. There are a number of factors, but one in particular is that they started the journey much earlier than we did here in Victoria, so culturally there's already an acceptance around speed and things like the separation of motor vehicles with cyclists. So, we know we've still got quite a bit of work to do in areas like that from a cultural point of view here in Australia. But areas like that in Sweden, countries like that, they have made further gains at this point, but we continue to look at how we can bring those changes about as well.

Q. Presently do key aspects of Towards Zero include an initially large investment of $340 million towards safety infrastructure on rural and regional roads?
A. Yes.

Q. $380 million worth of improvements on the road networks across metropolitan and regional Victoria under the Safe System Road Infrastructure Program?
A. Yes, that's correct.

Q. $60 million to support safer intersections and traffic calming treatments at locations in local street networks?
A. M'mm.

Q. $100 million of improvements to infrastructure for pedestrians and cyclists. $146 million to implement a young driver safety package?
A. Yes.

Q. Which is an education program; is that correct?
A. Yes, that's correct.

Q. And $26 million on a range of vehicle, behavioural and other research measures?
A. Correct.

Q. Was that just the initial investment or the investment to date?
A. So, the investment overall is $1.4 billion over the five-year period of the strategy to 2020, and the target associated with that investment is to reduce lives lost to below 200 lives lost, and a 15 per cent reduction in serious injuries on our roads as well, which has a significant ongoing lifelong impact for Victorians that are seriously injured. So, all of those investments are looking to achieve those targets.

Q. Were those investments decided up-front at the launch of the program in conjunction with its objectives?
A. They were, and they were also modelled, as you mentioned earlier, in terms of our probability of achieving those outcomes through these mechanisms, so there's very clear modelling behind all of those initiatives.

Q. Does TAC continually measure its own performance against its targets?
A. Yes, we do, and our road safety partners do it as well in terms of these measures. The headline measure, as you would expect, is the reduction in lives lost and then the serious injury measure as well, the 15 per cent reduction.

The other way we measure the impact of the initiatives is through community sentiment, asking the community regularly whether they believe the initiatives we're putting in place are going to make a difference, and their view about whether zero is possible one day.

Q. And so, is it an essential part of the program that there is continual self-assessment of how it's travelling?
A. Absolutely, it's a critical part of the strategy is

constant evaluation and then, in the case of this year as an example where we've had a result tragically well above where we would expect to be at the moment, further strategies and treatments/mitigations are put in place to hopefully get us back on track to where we're aiming for.

Q. You referred to the result this year, and of course every life that's lost is a tragedy.
A. Absolutely.

Q. What sort of approach does TAC take to the timeframe over which success should be measured?
A. Yeah, I think that's a really important question. That Towards Zero strategy was always a long-term strategy and looking over a five to 10 year horizon, and the next strategy beyond 2020 is already under development.

So, a year like 2018 where we had our record low lives lost, tragically still 213 people lost their lives on our roads, but this year we're very likely to be well above that figure. The experts would say that you should not respond in isolation to one year's results, you should continue to look over a longer period; make appropriate adjustments along the way, but overall look at a longer horizon with such a complex challenge in our community and how to address it over the longer term.

Q. Can I ask you about the importance of TAC's public education campaigns as part of its strategy.
A. Yes, I think, as we talked about earlier, public education is still a key element of the strategy, and it works in conjunction with the other elements of the safe system approach. There are a range of public education programs that TAC and its partners continue to implement and also monitor the effectiveness of those programs when they are implemented: how much the community understands and how much ultimately behaviour may change as a result of those programs.

Q. What sorts of media does TAC use to educate the public?
A. Yes. Well, we obviously use a range of media platforms as well as partnerships, corporate partnerships, grassroots community activities, and even through our local government areas. We have had quite a bit of success in recent years in getting local government to take up the Towards Zero vision, and in some councils to announce that

they are Towards Zero councils now and put in place their own actions to lower speeds in their region or other activities that are helping us get towards zero.

Q. Do you know what sort of activities might occur at a local level?
A. Yeah, so for example the Mornington Peninsula Council had lowered all their local road speeds from 100 originally down to 80 kilometres. We know from the evidence that that has a significant reduction in lives lost and serious injuries, and they've also taken up some of our grants that we offered the local government to put in place speed reduction activities in built-up areas in their community with great success in terms of reduction of serious injuries and, in some cases, zero lives lost for a long period of time.

Q. So, was it an affirmative strategy of TAC to engage local government?
A. Yes, it was, and still more work to be done there, but certainly it was a clear part of the strategy that we had.

Q. Can I ask you about the program, the outreach program you have with the Melbourne Museum?
A. Yeah. So, part of the package around our young drivers or future drivers, last year we established the Towards Zero Road Safety Education Complex at Melbourne Museum, and in the first 12 months we've had 45,000 visits to that state of the art education complex. It's really an immersive interactive exhibition particularly for Year 9, 10 and 11 students to attend and really understand the safe system approach to road safety, but in a way that really engages with them in different ways.

Also part of that is an outreach program to regional Victoria, so recognising that not all of our community can come to a complex in Melbourne. We have an outreach program that's doing the same thing but in our regional areas in Victoria to make sure that we're getting that message out to all of our young drivers, future drivers.

Q. How does TAC itself go about coordinating the various parts of its activities that form part of the system?
A. It's really a unique partnership through the TAC, as I mentioned earlier, the Department of Transport, VicRoads, Department of Justice, Victoria Police and Department of Health and Human Services, and each of those partners

understands what their role is in that partnership.

It has three levels of governance: so we have the ministerial level where all of the ministers in charge of those departments meet quarterly to discuss the road safety Towards Zero strategy and how we're tracking and where do we need to potentially make adjustments to the strategy.

Then there's an executive level meeting all of the relevant heads of those departments or CEOs to also more critically analyse the detail around those strategies.

Then there's working groups that sit beneath those, and that approach, that partnership approach, is something that was established in Victoria many years ago and is now recognised as a key element of the success in reducing trauma, even though we're clearly not where we would like to be yet, but other states in Australia and other countries have replicated that model as a way to coordinate, share knowledge and get better outcomes.

Q. In terms of assessing how the program is tracking, you've mentioned two things in your statement: one is measures and the other one is milestones. That's at paragraph 47. What's the difference between measures and milestones and what do they each mean?
A. I think, when we talk about measures, they're really the key elements of the strategy and the platforms; for example, the 20 high risk roads that we're currently treating with flexible wire rope barriers and other improvements.

Whereas, the milestones are sort of a subset of that in terms of the road safety complex that we've talked about, or the enhanced crash investigation study, which is a very comprehensive study of 400 individual accidents that will soon be published around what were the causes, the root causes of each of those accidents, and how can that feed into our future thinking around our strategy. So, the milestones are a range of initiatives that complement the overall measures.

Q. So, are the measures, apart from being things that you actually do, are they a means of those running the program and governing it to ascertain how it's tracking?
A. Yes, that's right.

Q. So, they're performance measures?
A. Yes, absolutely.

Q. In relation to the partnership, why is it important that there be a multi-agency strategy?
A. So I think, as I mentioned earlier, a good example of that approach and why it's important is when we were dealing with the problem of drinking and driving. And just as an example the TAC obviously put that on the agenda in the public domain through its public education program, so that was TAC's role in that partnership.

Victoria Police conducted very widespread breath testing, as we know, to enforce the behaviour change in that regard, and VicRoads as part of that partnership ensured that legislation supported the appropriate penalties when they were applicable.

And so, that partnership approach and each of the agencies understanding the evidence, and where we can make our largest gains in what we're trying to achieve, and then what their role is in that process were really critical to the success of what's been achieved to date and what we aim to achieve in the future.

Q. So, you have a partnership, but is TAC the lead agency for this program?
A. No, not necessarily, particularly now with the Department of Transport established, so there will be a lead agency there, Road Safety Victoria which has just recently been established, and TAC plays a critical role, but along with each of the other partners who are just as important in that partnership.

Q. So, it's a genuine partnership?
A. Absolutely.

Q. How is the community involved in implementing Towards Zero?
A. Yeah, I think there's a range of public education programs. We've talked about commercial and community-based partnerships. One of the successful engagements that we've had with the community is the Learner to Probation Program. So, that's a program where disadvantaged youth who don't have someone, a family member who may be able to help them do their 120 hours learner driving before they get their licence, we established a

mentor program, so volunteers that across the state provide that learner driving experience so they can achieve that 120 hours before they get their licence.

That program's been hugely successful, so 1,600 people every year in that disadvantaged situation can now have the training they need before they become a road user, and it's rewarding and beneficial in other ways for the mentors involved in the program. But it's just one example, I suppose, of how we we're always looking for different ways to engage the community in the topic of road safety, and the training and education is a really important element of that.

Q. Does TAC have its own staff who specifically are dedicated to this program?
A. Yeah, absolutely. So we have a group of staff, and again, in the partnership model for example, we have staff co-located with the VicRoads staff who are working collaboratively on how, for example, to roll out the most efficient and effective wire rope barrier system across the state. So, we have our own staff, but they also work very closely with the other partnership players as well.

Q. Are the outcomes against the milestones and measures reported?
A. Yes, absolutely. So, they're reported in the partnership, in the Ministerial Council as it's called when they come together, but they're also very closely monitored, for example, by the TAC Board of Management, its independent board. So there's a range of ways in which those indicators are monitored regularly and assessed whether we're on track or not.

Q. Is it fair to say that the program receives attention at the highest levels of governance within TAC and its partner agency?
A. Absolutely, yeah.

Q. Is that an important part of what you regard as its success?
A. Yeah, definitely. That appropriate scrutiny and challenge throughout the process has been very important.

Q. One of the things you emphasise in your statement is the importance of the Victorian community better understanding the key messaging for the program, and you've

mentioned this a few times, but you've given an example of some of the ways in which you do that, one being through mass media campaigns.

I'm going to ask you to show an example in a moment, but can you just speak to how important mass media is in your strategy?

A. Yes. I think the example we're just about to show, going back to the commencement of the Towards Zero strategy, recognising that a lot of the community at the beginning of the establishment of that strategy would not potentially feel that zero, for example, was achievable; we came up with the Man on the Street campaign, as it was called, and this is a person who volunteered to be part of that program and talk about what's an acceptable number of people losing their life on our roads each year, and that person, as you'll see when we play this short video, how he responds to the situation, and it really created a conversation in the community around shifting the thinking at the beginning of that, and then since then we've been able to build upon, I suppose, that momentum that was kicked off by this campaign.

Q. Alright. Well, let's have a look at it and then we'll return to what the momentum has been. Can we play the video, please.

(Video played.)

Q. So, what momentum have you been able to build from that?

A. So I think the main statistic around that is that at that time around 70 per cent of the community believed that zero was possible and a target that we should aim for. As I mentioned earlier, I think that's now up around 50 per cent.

We also recently had some community forums in regional Victoria that our Minister had conducted, and with roughly 100 leaders from those communities or community members in general, and they essentially were around about 98 per cent of the people in that room now believe that Towards Zero or achieving that one day is possible.

It's probably also worth mentioning that there are other jurisdictions that have now put a target on the table by 2050 that zero is achievable in a jurisdiction in

Australia and overseas, so that's something that we'll be considering in Victoria and a matter for the government to consider in the next strategy.

Q. What was the thinking behind engaging the community with the notion that zero is possible or achievable?
A. Well, I think it was really back to, I suppose, the first point about Vision Zero being something that the community, we knew, would not be able to make a leap straight to zero as a number that is achievable, and it was more about Towards Zero is really the critical element of getting at least the dialogue - having the community think about what is possible and then since then building upon that. Nuancing the message through different campaigns has seen that understanding and then belief build over time.

Q. So, without trying to descend too much into psychology, is the thinking that, if the community buys into the program, accepting it, believing it is genuine and will make a difference, you'll get buy-in in terms of people's conduct?
A. Yeah, I think that's right, it's into behaviour but it's into also understanding other things like speed in terms of a conversation around speed and where they are vulnerable, and there will be further campaigns coming out shortly to continue to help educate people about the trade-off between getting somewhere five minutes quicker versus the speed that you travel getting from A to B destination, so there's continuing education around those elements as well.

Q. Mr Crossett, we've asked you how you think awareness and traction for preventative action can be built across government and across society, and you've listed a number of factors in your statement. I'd like to take you briefly through each of them, and you've mentioned several already, but just to recap.
A. Yes.

Q. The first one is that:

> "Where we're attempting to change attitudes and behaviour to any social issue, we need to take a long-term sequential approach that builds year-on-year to increase understanding and desired actions."

A. Yep, absolutely. So, that taking a long-term view, in our case, we believe has been a big part of the success so far.

Q. Has that enabled you to sustain the agenda and to sustain investment in the program?
A. Absolutely, yeah, that's correct.

Q. The next one is agenda setting: what do you want to say about that?
A. Really that having that clear agenda and then putting it on the table, having the public discourse around that, has been again, I think from what we've talked about already, the example, has been a key part of the success of building understanding, awareness and then momentum towards a goal.

Q. In service of agenda setting, you've mentioned mass media campaigns which we've already discussed.
A. Yeah.

Q. You then say:

> "Having set the agenda the community needs to see action happening."

A. Yeah, and I think that's obvious to suggest that the community expects to see action being taken once the agenda has been set, what actions are being taken by the government agencies to move towards the target that we have.

Q. The next point is that:

> "The community needs to be aware of what their role is in helping achieve change."

A. Yeah, and I think that's a continuing journey for us to, as I mentioned earlier, to educate the community, help them understand things like speed and the impact that may have, so that role is critical to success, yeah.

Q. And then you say:

> "It is most likely that the first agenda setting campaign will be very high level."

What do you mean by that?

A. Yeah, so for example, speed is a good example where originally high level speed became an unacceptable element in our community, but then there was still a lot of people in the community doing low level speeding, so the Wipe Off 5 Campaign that's mentioned there is a good example where that next level down of nuancing of messaging needed to be put out in the community for people to understand, there's still a level of risk being taken when low level speeding is involved, and so, that proved to be a successful campaign to educate the community at that next level down.

Q. Finally, you've listed four points right at the very end of your statement about the key elements of the strategy. Do you want to summarise those?

A. Yeah, I think just to finish there really, as we've talked about, the key to the success of the strategy so far has been that coordinated approach and from the very top-down, from the government level down. Taking the systems approach is clearly something that we believe, and in other countries has proven to be successful.

The evidence: having clear evidence around what are the areas that are driving the challenges and where can treatments be put in place.

The communication approach is really important. And, in the case of road prevention, the targets have been a very tangible way, for example, to set a target of less than 200 lives being lost on our roads in Victoria by 2020, it really galvanised the partnership back in 2015/16 to set out an ambitious program of work to achieve that goal. So, in our context, we believe that that has been important.

And then the final point there is around evaluation, so again, quite logical that everything that is being done needs to be carefully and robustly evaluated so that you know that it's actually going to achieve the outcome you're aiming for.

Q. Thank you very much, Mr Crossett. Chair, do the Commissioners have any questions?

CHAIR: Q. Yes, I have a number. Thank you very much for your overview. The first one I guess is to comment on the fact that you've been able to achieve a very

substantial reduction in the road toll over decades now, from I think you said 1,000 down to the goal being under 200.
A. Yes.

Q. And that's in a rising Victorian population.
A. Yes.

Q. So I guess that's an aspiration. I think that the other thing that's important is, at this Royal Commission we've heard in mental health about the fact that we haven't had long-term consistent approaches to issues such as the prevention of suicide.
A. Yes.

Q. And so, when we note that example you gave, it's now several decades informed by research that in your witness statement said started at Monash in 1987, I think.
A. 87, yes.

Q. How important is the statewide nature of your programs and initiatives? Because, in mental health we've heard at this Royal Commission there are many, many pilots. A witness described, "It's more like an airport with how many pilots we have in mental health."

By contrast, have you done that? Have you been able to initiate new things but not just pilots?
A. It's a good question. I think the statement also talks to innovation and as we know that's always very important in any strategy. So, we continue to have pilots in some regards, particularly with automated vehicles that are mentioned in the statement, but overarching that is the long-term strategy with very clear evidence and with, I suppose, more significant initiatives that come together to achieve the goal that we're aiming for.

So, I think that is the overarching primary focus, is those initiatives: for example, enforcement as we know or the infrastructure roll out, they're significant investments and they're a long way from a pilot, but also obviously we'd like to continue to innovate and trial things at the same time as we're rolling out those major programs of work that are evidence-based and we know will deliver the outcomes that we're aiming for.

Q. The level of investment that you've had is very

substantial.
A. Yes.

Q. I think $1.4 billion you said for that current strategy. The robustness of the modelling and the business case that was required to justify that level of investment, how did you go about doing that?
A. I think that's a really good point. We were obviously in a fortunate position with the establishment of MUARC from several decades before to have a very well established mechanism to create that information, that data, that evidence and we relied on them heavily, and continue to, to provide very clear evidence around where we'll make investments, whether it will provide the return that we expect.

So, I think having that well-established already, as opposed to starting that off at the beginning of the Towards Zero journey in 2015/16, that would have been a very different challenge for the road safety partners, but we were very fortunate that we had already had that well-established research arm which could provide that evidence, that really strong evidence, from my understanding, to a 95th probability, 95th percentile probability of success.

MS NICHOLS: May Mr Crossett be excused?

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

<**THE WITNESS WITHDREW**

MS NICHOLS: That concludes the evidence today, Chair.

CHAIR: Thank you.

AT 3.30PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 24 JULY 2019 AT 10.00AM

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