

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

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

5
6 John McLaren is Community Manager at St Vincent's Area
7 Mental Health. He will describe the work undertaken by his
8 team in particular in relation to HOPE, a program which
9 specialises in dealing with consumers who present with
10 suicidal attempts.

11
12 Ms Anne Lyon is Executive Director of the Mental
13 Health and Alcohol and Other Drugs at Eastern Melbourne
14 Primary Health Network. That network has two place-based
15 suicide prevention trials at Whittlesea and Maroondah.
16 Ms Lyon will give evidence about what those trials have
17 involved to date and how they're being used to inform
18 suicide prevention strategies.

19
20 Ms Louise Flynn is the Manager of Support After
21 Suicide. She'll explain what that program entails and what
22 it means to be bereaved by suicide and how that experience
23 is different from other forms of bereavement.

24
25 Associate Professor Peter Burnett is Director of
26 Clinical Governance at NorthWestern Mental Health. He will
27 give evidence about how the risk of suicide is assessed and
28 the limitations of the assessment tools. He is also a
29 member of the Mortality Benchmarking Group which collects
30 data on reportable deaths. Associate Professor Burnett
31 will explain the role of this group and how data is used.

32
33 Bruce Crossett is the Acting CEO of the Transport
34 Accident Commission. He will discuss TAC's Towards Zero
35 strategy for road safety. That's a long-term systematic
36 approach to reducing the road toll that's been implemented
37 now in Victoria for some time. It's a multi-agency
38 approach which involves many aspects of government
39 agencies.

40
41 Now, of course, not all elements of that strategy will
42 apply directly to suicide prevention, nor could they, but
43 we are calling evidence from Mr Crossett because we want to
44 understand the relevance and importance of a systems-wide
45 approach that takes a long-term vision.

46
47 I'll mention once again that the evidence today may be

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

7

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

12

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

15

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

17

18 MS BATTEN: Q. Thank you, Katerina. Have you, with the
19 assistance of the Royal Commission's legal team, made a
20 witness statement to the Commission?

21

22 A. Yes, that's correct.

23

24 Q. I tender that statement. [WIT.0001.0051.0001]

25

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

32

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

38

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

45

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

1 home from work and there would be people in my living room
2 talking to Bill. I think he called them because he didn't
3 want to burden me.
4

5 The GP sent him to a private psychiatrist, but they
6 were a waste of money, no-one helped. Bill spent
7 five months in the adult PARC Centre. They were amazing,
8 they really included me. Speaking to the spouse is an
9 important thing, because I have been there for everything
10 and knew what Bill was going through and could describe to
11 them what he was feeling. It was also important for me to
12 understand what they were doing to Bill.
13

14 I was at the PARC Centre every day, I didn't leave
15 Bill's side. Sometimes I wondered why I just didn't leave
16 him at the PARC Centre for a lot longer. About a day after
17 he left the PARC Centre he started deteriorating. He was
18 very anxious, he was paranoid, it was like he was having a
19 panic attack that he couldn't stop. He was also doing a
20 hell of a lot of sleeping, but then, when he would wake up,
21 it was in a panic.
22

23 He had been prescribed Valium which calmed him down,
24 but then he would sleep even more and wake up the same or
25 even worse. In all our years of marriage, I'd never seen
26 him like that.
27

28 I wanted to take him back to the PARC Centre but they
29 told me that once someone has been released, you cannot go
30 back to the bottom - you have to go back to the bottom of
31 the waiting list. I don't know how long the wait would
32 have been, but they said it wasn't very good. So, because
33 he'd already been through all the process, the CAT Team,
34 the PARC stay, they said it would be at least a couple of
35 weeks and he would be at the bottom of the list.
36

37 So, I took him to Emergency. We had to go through
38 Emergency, which is something that concerns me. People who
39 are suffering mental issues should not be waiting in
40 emergency with all the people that have got broken legs,
41 have got a cold, it should be in a specialised area. Bill
42 was very paranoid and there were lots of people in
43 Emergency that just kept looking at him and making it worse
44 for him.
45

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

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

7
8 I took Bill to the Emergency - sorry, I'm going back
9 to that again - and I told them that he was unwell. He was
10 admitted through to the psych ward. I then got a call two
11 days later to say that Bill was agitated and he wanted to
12 leave. I told them I didn't want him to come home if he
13 was unwell. Of course, I wanted him home, I loved him, he
14 was my soul mate, but I didn't want him home if he was not
15 well enough to be home.

16
17 They said, "Katerina, Bill doesn't look suicidal. We
18 have given him psychosis medication and he is ready to go
19 home", on that day. I thought that was strange, he'd never
20 had that medication before but I trusted that they knew
21 what they were talking about. All they gave him was an
22 appointment for two days later.

23
24 I was there when they discharged him, they asked Bill
25 four questions: he gave them one word answers and then they
26 sent him home. All they gave him was an appointment. He
27 came home and seemed on top of the world and I thought this
28 medication is amazing, but that Friday he took his own
29 life.

30
31 I'm 100 per cent sure that, whatever the drug was they
32 gave him, it changed my husband. He'd been home alone for
33 six months and not done anything - and then after a couple
34 of days Bill took his own life - of being given that
35 medication.

36
37 I do not understand why you would not have procedures
38 in place to monitor someone, when you put them on new
39 medication. You do not know how people are going to react
40 after a couple of days, and you should keep them there and
41 monitor them, like they do for every other medication.

42
43 I did not think about that at the time. I would never
44 have left him alone if I thought he was suicidal. The
45 experts said he was fine with the drug.

46
47 I still wanted to know what happened, so I asked the

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

7
8 No-one understands it unless you have lost someone to
9 suicide. It's very isolating, it's not like you're losing
10 a loved one to something else, it's like you have a big
11 sign on your back saying, people don't know what to say to
12 you, so what they do is they avoid you at all costs.

13
14 My daughter and my son-in-law and my friends have been
15 amazing together, but some people don't know what to say,
16 they avoid you. Now I talk about Bill as much as I can and
17 I try to make people aware of his suicide - it's my
18 passion.

19
20 I'm hoping that with all the information that is put
21 in, and some procedures, it might save someone else. I
22 want people to know what it's all about and hopefully how
23 to prevent all of this. I do not know what else I can do
24 to talk for Bill, but his death has to make it matter now.
25 Thank you.

26
27 Q. Thank you very much, Katerina. In your statement you
28 mention a couple of things about the system that you would
29 like to change. Would you like to talk about any of those?

30 A. Yeah, I just feel that, if you're admitting someone
31 into a new ward, or a psych ward, and you are giving him
32 new medication that they've never ever had before, they
33 should be monitoring him. It's like anything, when they
34 give you something in the hospital, they say, look, we'll
35 just wait 24 hours, 48 hours and we'll see how you go with
36 that: I just feel like that was the biggest let down.

37
38 Q. You've also said that family and carers should be
39 given information?

40 A. Definitely.

41
42 Q. In your view, it's important for them to be involved?

43 A. Definitely, yeah, correct. The PARC Centre was pretty
44 good, but a lot of the other places, they just don't give
45 you a lot of information, and they talk to the person
46 that's suffering the illness, which is great, but a lot of
47 times they don't know how to react, what to say, so we need

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

6

7 Q. Is there anything else that you wanted to say today?

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

13

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

16

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

20

21 You've talked about an issue that we've heard a lot
22 about in this Royal Commission which is when people are
23 admitted into an acute inpatient unit such as occurred with
24 Bill and being there for two days; you've explained a bit
25 about not wanting to take him home if he wasn't unwell.
26 Could you just reflect further in terms of, what was the
27 hospital saying to you about why they felt it was okay for
28 him to be discharged after two days?

29 A. Because he was agitated on that day. He'd been
30 agitated the whole time he was there, so that's why they
31 gave him the psychosis medication on the day that he was
32 let home. But they kept saying to me, "Look, Bill wants to
33 go home", and I said, "Well, Bill can't go home, it's not
34 up to Bill." He has to be not 100 per cent, because I know
35 he wouldn't have been 100 per cent leaving the psych ward,
36 but he has to be a lot better than what he is at the moment
37 before I'm happy to take him home. You're the experts, you
38 need to tell me.

39

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

46

47 The whole time they interviewed us to let Bill go

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

17

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

23

24 CHAIR: Thank you. Thank you very much.

25

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

27

28 CHAIR: Yes, thank you for coming today.

29

30 <THE WITNESS WITHDREW

31

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

34

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

36

37 MS NICHOLS: Q. Mr McLaren, are you the Community
38 Manager at St Vincent's Area Mental Health?

39 A. Yes, I am.

40

41 Q. Are you also a registered nurse?

42 A. I am.

43

44 Q. Have you worked in mental health for over 30 years?

45 A. Yes, I have.

46

47 Q. Have you prepared a witness statement which deals with

1 the HOPE program at St Vincent's?

2 A. I have.

3

4 Q. I tender the statement. [WIT.0002.0007.0001]

5 Mr McLaren, can you please tell the Commissioners just a
6 little bit by way of background what services are provided
7 at St Vincent's Area Mental Health?

8 A. The first part of the services are triage services
9 based in our Emergency Department, who provide advice and
10 direction for clients seeking mental health support and
11 help. We also have our acute inpatient service which is
12 based in St Vincent's campus. With that, we also have our
13 community-based teams. We've got the CAT Team which is a
14 crisis team that visits client in their home, and there's a
15 short-term follow-up to ensure their safety, and again,
16 linking into major services and follow-up services as
17 required.

18

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

22

23 Q. Can you tell the Commissioners briefly what the
24 Continuing Care Team does?

25 A. Continuing Care Team is a service that provides
26 ongoing support for clients with enduring and serious
27 mental health problems that get referred to our service.
28 It's a service that our client will then be allocated
29 what's called a case manager, and the case manager will be
30 able to support that journey of the client in terms of
31 monitoring a lot of their presentation, particularly signs
32 of mental illness in terms of their treatment and their
33 options available for their treatment. And, once treatment
34 has been provided, monitoring that treatment to ensure
35 things like side-effects of the medication are addressed.

36

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

47

1 Q. We'll get to the HOPE program in a moment, but can I
2 just ask you a little bit about navigating that very
3 difficult system and how you go about it from your services
4 perspective to help your clients.

5 A. In terms of accommodation, if we start with that:
6 that's very difficult. In my experience there is a lack of
7 affordable suitable safe accommodation for clients that
8 often have serious mental illness and living in the
9 community, so we look at how we can manage that as best we
10 can.

11
12 So, we have certain linkages with accommodation
13 services, such as Launch Housing for instance, which is
14 quite a major organisation that deals with mental illness,
15 specialises with supporting those needs and there's other
16 services around, so we make sure we try to link in as many
17 agencies as we can.

18
19 Unfortunately, the majority of accommodation is
20 usually more crisis accommodation, short-term accommodation
21 and unsuitable accommodation as well, but nevertheless, we
22 can try to look at the best options.

23
24 We also had a partnership with Doorways which is part
25 of Wellways NGO, looking at supporting tenancies for
26 private rental, so that's something that's been a
27 successful part of the service that we've been providing.

28
29 In terms of some of the other psychosocial needs, we
30 work in collaboration with other NGOs such as Mind and also
31 with Wellways, just to provide some of those support
32 systems, support in the community, being able to provide
33 some linkage into community, and also to do some of the
34 monitoring and support the case manager.

35
36 Current obviously one of the big changes that happened
37 with the psychosocial element is the introduction of the
38 NDIS program. So, our services, we're navigating our way
39 through that and we do find there's a lot of challenges
40 that we face with that in terms of the psychosocial need.

41
42 So St Vincent's at the moment in our community, we
43 went into partnership with Mind to provide a year-long
44 service, the funding's for a year in terms of providing
45 some of those psychosocial supports whilst people are
46 accessing the NDIS if they can access that.

47

1 Q. You say, with people who use service through your
2 community-based service, do they tend to stay with you over
3 a long period of time?

4 A. It varies. We'll have some clients that will be case
5 managed maybe for three to six months; often they will be
6 linked into the appropriate services they need, they'll
7 have had that short-term management and support and
8 follow-up and they don't need our service any more and we
9 feel confident that their GP or their private psychiatrist
10 or private psychologist in the community can manage that
11 person successfully.
12

13 But we do have a lot of other clients that we can case
14 manage for a longer period of time. At the moment I've got
15 a number of clients that we've been case managing for
16 10-15 years.
17

18 Q. Can I ask you about the HOPE program: can you tell the
19 Commissioners what it is?

20 A. HOPE stands for Hospital Outreach Post-Suicidal
21 Engagement, part of the Victorian Suicide Prevention
22 Framework that came into operation in 2016. We're one
23 element of that strategy. We are a service that provides
24 three months' support to clients who present to St
25 Vincent's in person with suicidal thoughts, thinking or
26 behaviour.
27

28 The remit of the service is that they have to attend a
29 hospital-based service in the first place to access help,
30 such as attending our triage service, being looked after by
31 our CATT, or in our inpatient service.
32

33 Clients who are in the general side of the hospital
34 can also access through our consultation liaison service
35 into the HOPE team. So, once those clients have been
36 identified, the HOPE team then looks at providing a
37 three-month package of care to look at, initially their
38 safety. The key thing is to assess their risk and the
39 safety of repeated suicide or behaviours or thoughts, and
40 then we have a systematic approach for the first period of
41 that three months, leading to linking them into appropriate
42 follow-up services at the end.
43

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

47 A. Yes, they are, yes.

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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

1 they're going, how they're progressing.

2

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

15

16 Q. So, the patient's journey is, a personal meeting while
17 they're in hospital?

18 A. Ideally if we can manage that, but often a lot of the
19 presentations are 10 o'clock, 2 o'clock in the morning, so
20 we will aim the next day to be able to visit the inpatient
21 ward if they've been referred to us at that particular
22 time. Obviously, if they're sent home we're not able to do
23 that follow-up. But obviously, if somebody's in crisis the
24 CAT Team will have followed that person up until they start
25 to be engaged with us formally.

26

27 Q. Once they engage with you and you've done an
28 assessment, what happens after that?

29 A. The assessment's reviewed by our clinical team. We
30 identify a safety plan with the client. We use what's
31 called the Collaborative Assessment and Management of
32 Suicidality Model, which is a clinical based model
33 specifically designed to work with clients with suicidal
34 tendencies.

35

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

43

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

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

3
4 Q. Is that model of care something that your team came up
5 with yourselves?

6 A. As Manager, I looked at a number of models of care,
7 which there isn't a lot to be honest, you know, dealing
8 with this particular aspect of intervention. I was advised
9 by a clinical psychologist who was a senior lead that this
10 was a good model and it was starting to develop an
11 evidence-based approach. We looked at that and, although
12 it's a sophisticated model it's quite an easy to use model
13 and easy to train staff, new staff, how to use that. I
14 also felt that the model provided quite a structure for the
15 client in terms of working with their suicidality, so yes,
16 that was the advice of senior clinicians who had experience
17 in that area.

18
19 Q. In terms of the way your staff interact with your
20 patients, what's the difference between what they do and
21 what your Continuing Care Team is able to do?

22 A. We're able to offer more intensive support, is the
23 main thing. We can see a client in the first period of
24 their suicidality two, three, four, five times a week if
25 necessary. Whereas someone working within CCT will
26 probably just see somebody a minimum of once a week. So,
27 it depends on the severity where we're got that resource
28 available to do that.

29
30 Also, all our staff are trained in certain
31 intervention techniques, like cognitive behaviour therapy,
32 which is one of the key intervention therapies that we
33 support our clients with. Although we do have that
34 approach in CCT, our staff in HOPE are more experienced and
35 more highly trained in those areas of practice.

36
37 Q. So, are there really two differences: one, you have
38 lower caseloads and you are therefore able to spend more
39 time with each patient?

40 A. Yes.

41
42 Q. Elaborating on that, what are the differences between
43 the caseloads in the HOPE team and the caseloads in the
44 community care team on average?

45 A. On average, with the HOPE team, we have 24 clients in
46 our small team, which is about eight per clinician. Within
47 our Continuing Care Team, we can have anything between 25

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

3
4 Q. Is that an important feature of the HOPE Program?

5 A. It is, yes.

6
7 Q. The other feature being that your staff are
8 particularly well trained and qualified in the techniques
9 that they apply?

10 A. Yes, absolutely.

11
12 Q. You mentioned that the period of time is three months:
13 why is it a three-month period?

14 A. That was defined by the department when the program
15 was set up, so I had no control over that matter. I think
16 it was a consensus that, for clients that required it, the
17 support that the HOPE team could provide, they would
18 probably not need any more than three months. If they did
19 need that more support, then we'd probably be linking them
20 into our Continuing Care Team for that longer term support.

21
22 Q. What's your assessment about whether the patients your
23 service sees actually do need more support than
24 three months or could do with more support than
25 three months?

26 A. There's a few avenues that we assessed and looked at.
27 A number of our clients, a small proportion, will probably
28 need to be transferred and referred into our Continuing
29 Care Teams for that longer term support, and that's quite
30 an easy process and we've done that, and they're mainly due
31 to their mental health conditions at the time in terms of
32 their safety, so we'll make sure that that continuation is
33 provided.

34
35 The other clients that come to the end of their term,
36 they often don't require that level of supervision and
37 support due to their safety and their support needs. So we
38 try to look at linking them in more with either a private
39 psychologist, a private psychiatrist, or working a bit more
40 closely with their GP in terms of managing their
41 presentation and their long-term supports. That's not
42 always straightforward and easy to provide and that linkage
43 is sometimes a challenge for us to do and often we're not
44 able to do that. We are on a lot of occasions but other
45 times we can't.

46
47 Q. Just to get some clarification: a three-month period

1 of time is a resource issue and that's the maximum period
2 of time for which the service is available?

3 A. At this point, yes.
4

5 Q. At this point, and you don't have any discretion about
6 that. In terms of the clinical outcomes, would you like to
7 have more flexibility about the length of time over which
8 the program is available?

9 A. I think the three-month period, in my experience over
10 the last couple of years of working with the HOPE team, is
11 probably good, is probably realistic for the majority of
12 the clients that access our service, that they don't need
13 that level of intent. A lot of our clients are discharged
14 from the service before the three months because we don't
15 need to provide them that service. And I think we've also
16 got that mechanism of providing a referral into our CCT, so
17 there's a number of avenues there that are fine.
18

19 There is a small cohort of our clients in that team
20 that wouldn't fit that pathway, and will struggle to
21 because of finance or accessibility to other services in
22 the community, so maybe there needs to be some kind of
23 alternative in terms of managing that client which at this
24 stage I don't know the answer to.
25

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

29 A. That's right.
30

31 Q. Including because --

32 A. It's more accessing the service rather than fitting
33 in. One of the examples is, if we look at accessing a
34 psychologist with the speciality of working with clients
35 that require that kind of support: often their availability
36 is limited, long waiting lists to access that person, and
37 often they charge what's called a gap fee, which some of
38 our clients just can't afford to do, so accessing those
39 services are challenging, likewise with psychiatrists.
40

41 We've looked at having a database ourselves of
42 psychologists that we've worked with, but again they get
43 full, you know, they can't take on any other clients
44 because we know that they're good, we know that they offer
45 the service, but there are just not enough to go round.
46

47 Q. How important is the multidisciplinary nature of the

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

10
11 I think also having a variety of different
12 specialities, such as social workers providing support to
13 the team regarding issues regarding family violence,
14 working with children, accommodation, finance - you know,
15 is very valuable in terms of providing that extra support.
16

17 The occupational therapist, for instance, provides
18 advice to the rest of the teams about functionality in
19 terms of the client's daily living issues and be able to
20 provide support, and obviously the psychologists come with
21 an extensive experience of psychological interventions and
22 supervising the rest of the team in terms of delivering
23 those interventions. So, they work very well together in
24 terms of planning, giving different opinions in terms of
25 some of the issues that might come up with a client in
26 promoting a bit more of - rather than coming from a medical
27 model or one other model, it's more of a generalised,
28 consistent bringing together all of the facts and issues
29 onto the table.
30

31 Q. So, the way the program is set up and resourced allows
32 different practitioners to communicate with each other
33 about the patients?

34 A. At the moment, from a clinical stance, yes, I would
35 say that that's well supported. I suppose, if we look at
36 the other parts of the multidisciplinary team, there's two
37 things that I'd say that we're lacking that we would like
38 further support in the future for funding: that's a peer
39 support worker, somebody that's got a lived experience
40 would be ideal for this team.
41

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

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

5
6 We would like, though, to look at a family therapist.
7 We do feel that a lot of the challenges of supporting
8 clients is often the breakdown of relationships that they
9 have and working with their families or working with their
10 partners. They are just a couple of other examples of
11 people that we would like in the team.

12
13 I suppose the other issue that, on reflection on the
14 last couple of years of working with the team, is that we
15 would like some specialist training or clinicians working
16 in what's called a dialectic behaviour therapy. This is a
17 highly specialised approach of working with personality
18 disorders and particularly personality disorders with high
19 tendency of suicidal behaviours. So, that would be
20 something in an ideal world, if I could get funding for
21 that, which would be great.

22
23 Q. Speaking of funding, is the funding for your
24 particular program going to continue, do you know?

25 A. At this stage, I don't know the answer to that. We
26 were set up for four years. Our funding is due to the end
27 of June 2020, and we haven't had any indication that that
28 funding is actually going to continue. However, in
29 last year's budget there was six further HOPE sites
30 established across Victoria, but they came with permanent
31 funding.

32
33 So, we've got two sides: we've got six HOPE teams that
34 are still waiting to find out whether their funding is
35 going to continue or not, whereas the other new six,
36 they're quite happy and secure, and that does come with
37 implications as well in terms of, if we don't get the
38 long-term funding.

39
40 Q. Can you say what those implications are?

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

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

3
4 And also, it will have an impact that we'll have less
5 clients that can be referred into the service until we can
6 have full staffing again. We are working with St Vincent's
7 Emergency Department and mental health services to develop
8 what's called a Mental Health Alcohol and Drug Crisis Hub,
9 and we do feel that the HOPE Team will be quite a
10 centralised part of that process, it will look at more
11 responsive care and, if the funding's not forthcoming, then
12 again, that will put that part of the project in jeopardy
13 and we'd have to look at alternative ways of managing that.

14
15 They're just some of the - and it's also the
16 speciality. General mental health services are not set up
17 to work in a special way with people with suicidality, it's
18 more of a generic approach, so we'll lose that. It could
19 have other implications, I don't know.

20
21 Q. Do you have any sense about the extent to which people
22 who would want to or would need to be seen by your program
23 can't because there's not enough capacity, so is there a
24 waiting list?

25 A. A waiting list?

26
27 Q. Yes.

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

29
30 Q. You are able to see people within your three-day
31 window?

32 A. I think we've met our target for that, yes. I mean,
33 there would be extreme examples that it would be the
34 consumer that's accessing that service is not available in
35 that three days, so that would be the time that we probably
36 wouldn't meet that target, but generally because we're a
37 seven-day service we'll plan that, yes.

38
39 Q. Has there been any formal evaluation of the success of
40 the program so far?

41 A. We're currently undergoing that evaluation with the
42 department. So, we're working with an outside agency,
43 KPMG, who have put a framework together to look at how the
44 program is evaluated. That was commenced in 2017, however
45 that was delayed for quite some time only until a
46 few months ago that it started to then be delivered as an
47 evaluation framework.

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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.

1 Q. Do you know when the evaluation will be completed?

2 A. The initial evaluation looking at that data is
3 expected to be done by the end of September.

4
5 Q. Of this year?

6 A. Of this year.

7
8 Q. Okay, thank you. You mentioned earlier on that the
9 program is intended to work alongside other programs,
10 including the new Mental Health and Alcohol and Other Drugs
11 Hub in the Emergency Department. Can you just tell us
12 briefly what that program is?

13 A. The Crisis Hub is a new initiative for St Vincent's,
14 it's going to be based in our Emergency Department. It's a
15 six bedded area for clients with a mental illness, a
16 facility that we don't have at the moment. It's for
17 clients that access the service that don't necessarily need
18 an acute inpatient part of their care, but they probably
19 need one or two days assessment and support.

20
21 A number of our clients will present to our Emergency
22 Department also with physical illnesses that may have a
23 comorbid mental health illness, so that would be an ideal
24 place for them to get both their treatments at the same
25 time. It would be a good place for clients to experience
26 support for their drug and alcohol, which is not a
27 specialist that we would provide in inpatient services,
28 although we have good links.

29
30 So, it's a short-term, it's an alternative space in
31 terms of being dragged into mainstream mental health
32 services, so it's a real good initiative and it's going to
33 be staffed by a number of clinicians 24/7, which will do
34 that quick assessment turnaround and be a lot more
35 responsive to the needs.

36
37 The second element of that is to provide some
38 short-term assertive outreach for those clients that then
39 need some support back in the community.

40
41 Q. How will your team who work in the HOPE program
42 interrelate with the Alcohol and Other Drugs Hub?

43 A. We'll have a daily presence there at this stage. We
44 haven't worked through exactly how that is going to work,
45 but we will probably have one of our clinicians based in
46 the Hub on a daily basis, just to assess any of the clients
47 that are coming through that meet our criteria and to be

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

6
7 Q. Thank you. We've asked you some questions about what
8 you think can be done better in Victoria to support people
9 who are at high risk of suicide or self-harm. One of the
10 things you said in your statement is that there needs to be
11 a more coordinated approach:

12
13 "There are numerous initiatives that have
14 been implemented, some long-term and others
15 short-term, but they do not operate
16 consistently across Victoria [or] in a
17 cohesive manner."

18
19 Can you say something more about why you think a
20 coordinated approach and operating consistently across
21 Victoria is important?

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

29
30 Also starting to look at a more consistent
31 intervention model in the future. I feel that, with the
32 Suicide Prevention Framework we're now starting to look at
33 joining up services to work more collaboratively together
34 rather than silos in a way, and the framework is promoting
35 that to a large extent. It just means a bit more
36 responsive access to services for the clients that either
37 pre access our service or discharge afterwards, follow up,
38 so that coordinated service is just vital basically: just
39 making sure that we're all doing similar things, we all
40 have mechanisms to be able to support.

41
42 Q. Thank you. We've asked you about the most significant
43 challenges facing the mental health system in supporting
44 people at high risk of suicide or self-harm, and the number
45 one thing you've named is accommodation, I think you've
46 said something about that before.

47 A. Yes.

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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,

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

3

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

8

9 What was the other part about CCT?

10

11 Q. That answers the first part of the question. The
12 second part is, how many people that are coming through the
13 HOPE in your experience have been a part of some of the
14 rest of the system and are therefore getting transferred
15 between teams for clinical engagement?

16

17 A. Well, 100 per cent of our clients actually have to be
18 hospital-based, so all our referrals come from people that
19 have actually presented either through CAT, through our
20 triage, through our inpatient service or any of the other
21 parts of the hospital: they've actually had a physical
22 presence and treatment.

23

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

29

30 Q. Do clients describe that sense of having to transfer
31 their engagement across between different parts of the
32 service and duplicating storytelling and all of those sort
33 of things, or are they finding it quite easy to transfer
34 between clinicians?

35

36 A. Although there's similarity in the services that we
37 offer, and we actually offer a slightly different service:
38 the HOPE Team is providing that kind of specialised
39 intervention therapy in a program systematic way using a
40 model of care. The CAT Team is set up to look at
41 somebody's safety and assessing safety and providing that
42 short-term safety.

43

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

48

49 COMMISSIONER McSHERRY: Q. Just one question. How many

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

10
11 CHAIR: Q. Thank you for your evidence. I'd like to ask
12 two things, one goes to the question of involvement of
13 family. I noticed in your statement you talked about, when
14 you were doing that initial three-day assessment, or in
15 that three-day period, you say if available and with the
16 client's consent the clinician will seek to obtain
17 information from the client's family members.

18
19 I noticed in the brochure that you attached to your
20 witness statement you talk about a very family-centred
21 approach to your practice. How important is it in your
22 model of care to have extended family members engaged
23 wherever possible

24 A. I found that, if family carers or if the support
25 mechanisms aren't fully involved in a consumer's care, then
26 I think the recovery takes a lot longer in terms of being
27 able to get that immediate support.

28
29 We have a family-driven approach when we talk to our
30 clients to encourage them to access other supports. Some
31 of the difficulties that we face, though, to get that
32 collaborative working with the family and the consumer is
33 often that the consumer doesn't want it, and usually it's
34 more to do about how they're feeling: they're feeling a bit
35 ashamed about what they've done, don't want anyone to know,
36 so that initially is quite a challenge for our workers to
37 get that approved. But usually by the time we've engaged
38 and got the trust of the client we've managed on most
39 occasions to get that collaborative approach with the
40 family. We can't do anything unless the client gives their
41 consent, unless there's a high risk that the family need to
42 know about.

43
44 Q. The other issue I wanted to ask about is, we've heard
45 during the course of this Royal Commission the complexity
46 in assessing suicidality and suicide risk. I noted that
47 you talk about the particular methodology that you've

1 adopted through this collaborative assessment and
2 management of suicidality model.

3
4 That's a model that St Vincent's has developed for its
5 HOPE Program, so am I right in assuming that each of the
6 other HOPEs might - I think you said there's now 12 in the
7 state?

8 A. There's 12 HOPE teams.

9
10 Q. Could they each be using a different assessment tool?

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

13
14 Q. Why is that? I guess that's something we're trying to
15 grapple with in mental health, because we hear, you said
16 there's not a very substantial body of knowledge about the
17 preferred models of practice, but diversity is one thing
18 but inconsistency, I guess, is - why wasn't that an element
19 of the HOPE models that was determined in terms of its roll
20 out?

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

30
31 Even though the 12 HOPE teams are using a different
32 model by name, the elements of the model are usually pretty
33 similar. Usually we all have a very clear assessment
34 process to assess somebody's mental illness, we all use the
35 same pattern in terms of assessing somebody's suicidality
36 risk, and we also then have a safety planning process in
37 place in terms of how we support that client, so all the
38 HOPE teams will have that in place.

39
40 They will also have that psychological intervention
41 model, and we all use the CBT framework. I'd be surprised
42 if any of them didn't because that provides that
43 intervention and support system. So, even though the
44 models might be called different, there's a lot of
45 similarities within them.

46
47 Q. Yesterday we heard from another witness at this Royal

1 Commission that, because of the complexity in assessing
2 risk in suicide, that all people who are presenting with
3 suicide ideation or are in deep distress and therefore we
4 need a service model that ensures that there is follow-up
5 care and support for each of those individuals who are
6 presenting; would that be consistent with your view?

7 A. I would say so. I think at St Vincent's we have a
8 standardised assessment process that we use across the
9 service, whether you're in the CAT Team, HOPE Team,
10 inpatient service or in the community, we'll have that
11 standardised approach in terms of assessing the mental
12 health, assessing the risk, assessing the suicidality.

13
14 I think the follow-up would be, is then, where does
15 that person get signposted in terms of the care that they
16 need? So that's where, like, the HOPE Team will come into
17 operation in terms of working with the clients that have
18 got a higher level of risk associated to their suicide
19 behaviour and thoughts. The other clients that don't
20 necessarily meet that threshold would probably be
21 signposted to other services such as our extended triage
22 service or our primary mental health network.

23
24 Q. Finally, you mentioned the fact that if you had your
25 ideal HOPE model you would include a clinician who could
26 provide a specialist intervention for those diagnosed with
27 a borderline personality disorder to manage their
28 suicidality. Can you just talk about what sort of model of
29 service - again to make sure I understood what you were
30 saying about them - therapeutic model you think is
31 important in that case?

32 A. I'm not an expert on personality disorders, but I know
33 that working with personality disorders with suicidal
34 behaviour there's a model called dialectic behavioural
35 therapy. I don't know an awful lot about that, I'm not
36 trained in that, but I have been advised by my senior
37 clinicians that that's the way forward in terms of
38 supporting clients who present to our service with that.

39
40 It's a highly specialised training that the people
41 have to undergo. They also need to have a lot of
42 supervision and support and linked into all the personality
43 disorder services to make it effective.

44
45 Services such as Spectrum, which is a statewide
46 service for personality disorders, they will have people
47 trained in them, and that's good and we can at times access

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

6
7 CHAIR: Thank you very much.

8
9 MS NICHOLS: May Mr McLaren please be excused?

10
11 CHAIR: Yes. Thank you very much, Mr McLaren, for your
12 evidence today.

13
14 <THE WITNESS WITHDREW.

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

18
19 CHAIR: Yes, thank you.

20
21 **SHORT ADJOURNMENT**

22
23 MS BATTEN: The next witness is Ms Anne Lyon, I call
24 Ms Lyon.

25
26 <ANNE KATHERINE LYON, sworn: [11.30am]

27
28 MS BATTEN: Q. Thank you, Ms Lyon. Have you, with the
29 assistance of the Royal Commission team, prepared a witness
30 statement for this Commission?

31 A. I have.

32
33 Q. I tender that statement. [WIT.0001.0060.0001] Could
34 you start by explaining to us what your current role and
35 your responsibilities are, please?

36 A. I'm the Executive Director of Mental Health, and
37 Alcohol and other Drugs Programs at the Eastern Melbourne
38 PHN, and that encompasses the planning and procurement of
39 mental health services in the community, the development of
40 strategic partnerships, delivery against our commitments
41 with the Commonwealth through our funding agreements, and
42 as part of the suicide prevention trial hosting the suicide
43 prevention team as part of the trial and they form part of
44 our directorate.

45
46 Q. When you say the suicide prevention trial, you're
47 referring to the place-based suicide prevention trial?

1 A. Yes, I am.

2

3 Q. Could you explain to us what they are, what is a
4 place-based suicide prevention trial?

5 A. So, the place-based suicide prevention trials form
6 part of the Victorian Government's suicide prevention
7 framework, and that is one of five objectives of the
8 framework. What it entails is working in two identified
9 sites to develop an understanding of issues around suicide
10 and suicidality in a particular area, and to then develop a
11 response to those issues that you find and deliver a range
12 of activities against those.

13

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

17 A. Yes.

18

19 Q. And they are Whittlesea and Maroondah?

20 A. Correct.

21

22 Q. Why were those two sites chosen?

23 A. They were chosen - before I actually commenced at
24 Eastern Melbourne PHN, based on some initial data that was
25 seen, and also particular issues around the
26 sociodemographic elements of the population.

27

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

32

33 Q. What about Maroondah, what are the factors with
34 Maroondah?

35 A. Maroondah had a high level of suicide rate at one time
36 and it is also the site of a HOPE trial.

37

38 Q. When you referred to their place-based suicide
39 approach, you said that it's a systematic coordinated
40 approach: can you explain what you mean by that?

41 A. Yes, so that's a way of delivering a range of
42 interventions that seek to connect the community and
43 address particular identified needs. So, some of that
44 encompasses capacity building, training, media and
45 communication, so elements of what we see in the Life
46 framework that has been developed by Black Dog.

47

1 Q. We'll come to the LifeSpan framework in a minute.
2 With those elements that you were just talking about,
3 wasn't that already happening before you were doing the
4 place-based trials?
5 A. To a degree, but not with the intensity. So, what the
6 place-based trials allow you to do is to get a deeper
7 understanding of what the particular issues are in the
8 community, to make strong connections within the community,
9 not only with the service sector but also people with lived
10 experience, and I think this is one of the things that has
11 been incredibly valuable as part of the trials, is we've
12 been able to hear that voice.
13
14 Q. Just to understand the context before we go into more
15 detail of what the trials actually involve, could you tell
16 us what staff you have working on the trials?
17 A. We have two staff: one is a coordinator and one is a
18 project officer who are actually out in the field working
19 as part of the trials, and then they are supported
20 internally through line management and the organisational
21 structures.
22
23 Q. So, that's two staff members and they work across both
24 Whittlesea and Maroondah, there's not four in total? Just
25 two in total?
26 A. No, just two in total.
27
28 Q. You've given us an overview of what the suicide
29 prevention trials consist of. Can we go through the three
30 phases and understand what's involved at each phase?
31 A. Yes.
32
33 Q. Starting at Phase One, you've referred to there being
34 three workshops for Phase One. Can you explain to us what
35 Phase One involved?
36 A. So, Phase One was essentially an information-gathering
37 exercise to understand what the issues were, to make
38 connections within the community, to draw on people's
39 experience, and we use a framework called Collective
40 Impact, and that is developing a common agenda, having a
41 backbone organisation which has been the Eastern Melbourne
42 PHN, looking at the structures and supports that you need
43 to tap into in particular communities. So, that was
44 basically what Phase One has entailed, to get that deep
45 understanding of what was going on.
46
47 Q. You did that through workshops and through one-on-one

1 consultations; is that right?

2 A. Yes, that's correct.

3

4 Q. Who was involved? Who are you consulting with?

5 A. A range of people: so, primarily people with lived
6 experience were a strong feature when we were able to tap
7 into that group. That was initially a little bit
8 difficult, but it came to fruition.

9

10 Q. Sorry, why was it difficult?

11 A. Well, I think that people have often experienced
12 significant stigma related to the loss of someone as a
13 result of suicide, but I think, once we made those
14 connections, that moved very well.

15

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

24

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

26 A. Yes.

27

28 Q. Can we move to Phase Two --

29 A. And forming those partnerships, so you're actually
30 developing the foundations and the base from which to take
31 your work forward.

32

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

37

38 Sorry, before we come to Phase Two, did Phase One
39 reveal to you anything that you didn't already know?

40 A. We probably had a bit of an understanding but I think
41 it gave us a much deeper understanding of what the issues
42 were. Things like how disconnected the system is, so that
43 has been highlighted in both catchments, and the lack of
44 awareness and knowledge of what's available to people for
45 both community members, but also practitioners and mental
46 health clinicians.

47

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

7
8 We've also, I think, discovered that more needs to be
9 done around building the capacity of communities to know
10 where they can get help, but how they can be part of a
11 solution. So, for people with lived experience, this has
12 actually been an opportunity to harness their grief and
13 pain to make a contribution, and that was something that we
14 have seen very strongly.

15
16 Q. Thank you. Can we move to Phase Two, and could you
17 tell us what Phase Two involved?

18 A. Yes. So, we went back to the community and the
19 stakeholders to confirm what we had heard, and were these
20 the primary issues, and that was so, and from that we
21 developed a response which was simple. So, it was training
22 and education, understanding the service system, and how we
23 could address the issue of stigma and how we can connect
24 people better to services.

25
26 Q. What did the training and education involve?

27 A. So, there have been a range of workshops - training:
28 so, the ASIST suicide training, capacity building amongst
29 community members and mental health clinicians, learning
30 how to speak and address suicide.

31
32 Q. You also, in Phase Two, have referred to a number of
33 awareness-raising activities: could you tell us about the
34 awareness-raising activities you engaged in?

35 A. Yes. So, that has been through conducting a number of
36 events in the community which have also - so, out in
37 Maroondah we had The Ripple Effect, and I think that's been
38 spoken about before; they've used an arts and culture
39 approach for that.

40
41 We've had a number of media events, where we've
42 engaged with local groups: so, men's health and wellbeing
43 forums, the training through sporting venues. We've also
44 had community wellbeing events. One of those in the
45 Whittlesea catchment involved a youth forum, so it was
46 bringing together a range of youth services and providers
47 in that catchment to raise awareness of the trials, but

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

3

4 Q. And then, finally, Phase Three, what does Phase Three
5 involve?

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

16

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

21 A. Yes.

22

23 Q. It's informed by, but the delivery of the model is not
24 part of the place-based trials; is that correct?

25 A. No, that's quite separate.

26

27 Q. So, the place-based trials do not deliver services as
28 such?

29 A. Not per se, it delivers a range of activities that are
30 consistent with the LifeSpan model.

31

32 Q. With the funding for the two trials, DHHS funded
33 \$1.36 million over four years?

34 A. Yes.

35

36 Q. And then the Commonwealth funded \$880,000 over
37 four years?

38 A. Yes.

39

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

42 A. Yes.

43

44 Q. So, that's half a million dollars each year, \$560,000
45 each year. Have you spent all of the money each year?

46 A. Not each year, and we had the ability to carry funds
47 over. So, through our - we have actually co-commissioned

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

9
10 Q. Just so that I'm clear, some of that funding you're
11 using to implement the model that you've developed as a
12 result of the learnings?

13 A. Yes.

14
15 Q. Not necessarily doing the place-based trial work as
16 such; is that right?

17 A. Well, it will be both actually.

18
19 Q. Okay.

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

25
26 Q. Can you please explain to the Commissioners what you
27 see as some of the benefits of doing a place-based trial?

28 A. It's given us a much more nuanced understanding of
29 what the issues are around why people may self-harm or take
30 their own lives. It's given us an insight into what
31 potentially can work, what is useful to people. It has
32 given people with a lived experience a voice and, through
33 their grief and pain, they have been, I think, supported to
34 actually be part of the solution, and that's what they've
35 told us, they needed to be part of the solution.

36
37 We've been able to harness the collective efforts of
38 the community and service providers. So, a few things that
39 will spin-off from this: we'll look at developing a suicide
40 prevention protocol up in the north-east, in the Whittlesea
41 catchment; that is still early days. It has shown us that
42 the pathways for people trying to access services is very
43 poor, people feel very, very disconnected.

44
45 A couple of the other things that have shown us: that
46 we need to build people's ability to be able to speak about
47 suicide in a good manner consistent with what we call the

1 Mindframe guide.

2

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

7

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

13 A. Yes.

14

15 Q. You've identified a number of forms of data that are
16 provided to DHHS. The first one is activity and outcome
17 data: what is that and what is it measuring?

18 A. So, we collect information on what activities have
19 occurred during the course of a two, three-month period,
20 and then who are the stakeholders that have been involved,
21 who may have attended particular events, what those events
22 entailed, and we report that as part of our activity, and
23 also, what we may have learnt through those events or
24 activities.

25

26 Q. What is the annual most significant change process?

27 A. That's some of the things that stand out to you in a
28 particular period. I think, if we have seen something,
29 what we will consider moving forward if we've had
30 difficulty in engagement with particular communities or
31 organisations, that may form part of that significant
32 change.

33

34 Q. You've also referred to annual in-depth interviews
35 with key influencers: who are the key influencers for the
36 purposes of the trials?

37 A. They would be management, so that's formed part of the
38 evaluation as well, to speak with those people who are
39 directly involved in the trials. It would also involve
40 significant community members, where there's a willingness
41 to be involved in those sort of interviews.

42

43 Q. At this stage does the data measure the effectiveness
44 of the trials?

45 A. I think suicide is such a complex issue, so it is very
46 difficult to look at attribution from the things that you
47 have done in a particular period, and I think it's way too

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

5
6 Q. I do want to ask you a bit more about that, but before
7 we get there, are there any gaps in the data? Is there any
8 more data that would be useful for you to inform what you
9 need to do going forward?

10 A. I think more timely data around suicide rates: that's
11 always been problematic with the lag time of information
12 coming from the Coroners Court, because sometimes that can
13 be 12 months or longer before you understand the cause of
14 someone's death and what have been the contributing
15 factors.

16
17 The Department of Health and Human Services has
18 recently undertaken some work to develop an MOU with the
19 Coroners Court and emergency services, particularly
20 Ambulance Services, to bring that data together so we will
21 have more up-to-date and relevant information in a timely
22 manner

23
24 Q. Are you involved in that process?

25 A. No, not directly.

26
27 Q. You mentioned that it's premature to know whether
28 things are effective at this point, and also acknowledge
29 that suicide prevention is a very difficult issue. Can you
30 just clarify for us, is there an evaluation of the suicide
31 prevention trial?

32 A. Yes. So, the Department of Health and Human Services
33 have commissioned the Sax Institute to undertake an
34 evaluation of the trials and that has already commenced.

35
36 Q. And so, what stage is the evaluation at?

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

43
44 Q. The establishment phase is what needs to be done in
45 the place-based trials; is that right?

46 A. Yes. So, as I previously mentioned, part of that
47 initial Phase One of the trials was about information

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

5
6 Q. When will the evaluation of what's been done overall
7 in the trials be completed, do you know?

8 A. July 2021, I believe.

9
10 Q. So that will be after the end of the place-based
11 trial?

12 A. Yes. So, the place-based trial has been funded for
13 four years, so they finish - due to finish in June 2020.

14
15 Q. In your view, do you need the evaluation to know
16 whether what you're doing is effective?

17 A. I think that will be very, very helpful. As we have
18 commissioned a service, we will also evaluate its
19 effectiveness. So, it's those two things that we talked
20 about earlier: one is activities that you deliver as part
21 of a trial and how you understand issues, so I think the
22 formal evaluation being conducted by DHHS will be very
23 helpful for that and to inform future policy and planning
24 and we will look at our own evaluation of how effective the
25 service model that we have adopted is working.

26
27 Q. Is your evaluation complete?

28 A. No, we're just starting on that model.

29
30 Q. Thank you. You mentioned some of the key learnings of
31 the trial: were there any other key learnings that you
32 haven't mentioned that you wanted to draw the Commission's
33 attention to?

34 A. Yes. What we know is that transitions of care for
35 people need to improve; so, people leaving particularly
36 acute health services, they need to have a transition into
37 community-based support services with good information.

38
39 The continuity of care for people needs to be
40 supported; so, when they move between services or
41 practitioners, that there is an ongoing story and a pick up
42 of what their needs are.

43
44 And people should have a safety plan in place: this is
45 a way of giving people strategies to understand, as their
46 anxiety or issues escalate, how they can deal with those,
47 but importantly, who they should contact to get further

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

3
4 The other thing I would say is, we need improved
5 clinical governance, and that entails people working within
6 their scope of practice, continuing professional
7 development, good clinical risk assessment, case reviews
8 and client reviews, is the treatment working, and good data
9 and monitoring systems and where they're reviewed.

10
11 So, as part of the - I'll come back to some of the
12 other learnings in a moment - but as part of the Fifth
13 National Mental Health Plan, primary health networks have
14 been required to develop a regional integrated mental
15 health and suicide prevention plan. We've actually
16 included alcohol and other drugs in ours, but this is a way
17 of getting a more systems-wide appreciation of what is
18 happening and what are the gaps and how we can best support
19 those gaps, and I think it provides a basis to have a
20 regional approach to clinical governance around what is
21 working and what is not working well in services.

22
23 The other things we've learnt is, there needs to be an
24 alternative to the Emergency Department. There are models
25 that are available like Safe Haven. We also need, as we've
26 touched on, better data to understand the effectiveness of
27 what is happening, and I think a continuation of some of
28 the activities that we've talked about today.

29
30 Q. Are there limitations of the place-based suicide
31 prevention trials?

32 A. Yes.

33
34 Q. What do you see as some of the limitations?

35 A. So, it takes you a while to establish those
36 relationships and connections within communities, so they
37 are something that needs time to develop and formulate.
38 Also, it's very hard to get attribution: so, you might do
39 X, Y and Z, but does it produce A, B and C.

40
41 I guess we are hopeful that some of the things that we
42 have put in place will work. I think, from our learnings
43 plus developing a model, that starts to set you on a good
44 path. It certainly has highlighted to us the need for
45 better connections and service system functioning.

46
47 The other important aspect is about information; so,

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

5
6 Q. You've said one of the benefits of the place-based
7 suicide prevention trial is a focus on the local community.
8 Can the place-based trials, the learnings from them, be
9 extrapolated to other communities or do you need to have a
10 place-based trial in each separate community?

11 A. I think in part, that some of those activities have
12 been very effective, and they've been running different
13 trials and they seem to address particular issues, so I
14 think there can be some extrapolation.

15
16 But one of the things that we have found more
17 recently, particularly working in the Whittlesea community,
18 is there appears to be an emerging group where there are
19 issues and we would not have understood that if we hadn't
20 been working so intensely with the community, and that's
21 come about through our relationship with the police, so a
22 small working group has been formed to address that.

23
24 So I think that, again, emphasises the importance of
25 that place-based approach. What I would say is that, you
26 can do place-based approaches for a period of time, and the
27 community will be very generous in giving of themselves and
28 working with you, but they will want to see action, and I
29 think it is incumbent upon us to take our learnings and do
30 something with those learnings in an endeavour to improve
31 the system.

32
33 Q. You've touched on this before, this is the LifeConnect
34 model which is the ultimate action: can you just finally
35 briefly tell us what that model involves and what are some
36 of the activities that you're going to deliver?

37 A. So, that will involve capacity building of the
38 community, education sessions for - particularly in Life
39 Assist with clinicians, particularly GPs; better pathways
40 and connections across the system. It also includes
41 wellbeing events and postvention services for those who are
42 bereaved as a result of suicide; that will be part of that
43 service model.

44
45 MS BATTEN: Thank you very much, Ms Lyon. Chair, are there
46 any further questions for Ms Lyon?

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

7 A. Yes.

8

9 Q. So that's the type of service?

10 A. That's been commissioned.

11

12 Q. So, what level of funding needs to go to that sort of
13 initiative, is what I'm interested in understanding?

14 A. Well, at the moment we've got approximately \$900,000
15 invested over 15 months. Our base funding from a PHN
16 perspective is around half a million dollars, a bit more.
17 So, once we go to a new funding year, we will be back to
18 that because the investment from DHHS will have concluded.

19

20 Q. Will have concluded?

21 A. Yes.

22

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

26 A. Yes.

27

28 Q. And the nine elements?

29 A. Yes, that's correct.

30

31 Q. But is it fair to say that you're not focused on - are
32 you focused on all nine elements of their model or just
33 some elements of their model?

34 A. No, we haven't picked up all of them, but certainly a
35 number of them.

36

37 Q. Because I'm interested in things like, you said one of
38 the areas of learning was about the need to improve
39 clinical governance, and so I'm trying to get clear in my
40 head how would you, through an initiative like this, do
41 something like improve clinical governance?

42 A. Well, we would try to pick that up as part of our
43 regional integrated mental health plan, so that provides us
44 with an opportunity to do that and to work with health
45 services and mental health services around that. So, we
46 have an understanding of the capacity of clinicians in the
47 system and what are the emerging issues and how they can be

1 responded to.

2

3 Q. Because the reason I ask that is because, from the
4 Commission's point of view, we've heard a lot about the
5 fragmentation of the mental health service and partly the
6 challenge is how not to create further fragmentation
7 through any of the initiatives, how do we consolidate some
8 of those functions. So, how important has that been to
9 your thinking about - given you acknowledge that one of the
10 key insights was how fragmented the service system is. In
11 terms of your insights so far, how do you think we could
12 streamline that?

13 A. I think we have developed some systems, so we have a
14 system called Health Pathways, and that's a clinical
15 pathway but it also provides a service pathway. It's
16 developed for the mental health service, but also suicide
17 prevention. So, making sure that's available to all
18 treating clinicians in the service system, so that will
19 help create better connections.

20

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

27

28 CHAIR: Thank you.

29

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

31

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

34

35 <THE WITNESS WITHDREW

36

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

39

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

41

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

45 A. I have.

46

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

1 you start, please, by explaining to us what your current
2 role is and what the responsibilities of that role are?

3 A. Certainly. I'm a psychologist by training, and
4 currently I work for an organisation called Jesuit Social
5 Services and I manage a program, or I'm the manager of a
6 program called Support After Suicide. So, that involves
7 the management of the program, but I'm also involved in the
8 day-to-day work of the program: counselling, running
9 groups, education and training, yeah.

10
11 Q. We will come to the program. Before we get there,
12 could you just briefly outline for us what Jesuit Social
13 Services is?

14 A. Yeah. I guess it's a not-for-profit organisation,
15 it's an incorporated organisation, it's a registered
16 charity, so it's a welfare agency that has a wide range of
17 programs, some of them in the area of mental health.

18
19 Q. What are the mental health programs that it delivers?

20 A. There's five in total: Support After Suicide is one of
21 those. There's a program called Connexions which supports
22 young people with mental health and drug and alcohol
23 issues. There's another called The Outdoor Experience
24 which engages young people with complex issues in adventure
25 programs, therapeutic adventure programs.

26
27 There's another program called Artful Dodger Studios,
28 and that's an arts and music studio for young people, and
29 it's a great space for young people to build their sense of
30 connection and engage. Often they're very disengaged young
31 people who attend that program.

32
33 There's a program called Individual Support Program,
34 and that provides intensive support to young people with
35 very complex needs.

36
37 Q. Thank you. You started to explain what the Support
38 After Suicide program was, but could you explain what that
39 program involves in detail for us?

40 A. Yes. I guess it's a suicide postvention program,
41 which essentially is suicide bereavement, so we support
42 people after someone important to them has ended their
43 life.

44
45 Our day-to-day work with people is counselling, quite
46 a lot of counselling; group support is a very important
47 part of our program. Also, we have developed quite a wide

1 range of resources and information that's very helpful and
2 relevant to people, so we have that available online to
3 give people. So, it's essentially that counselling group
4 and online resources of relevant information to people
5 about the experience of losing someone to suicide.
6

7 Most of the team are psychologists and social workers,
8 but we also have an extensive volunteer program. So, we
9 have over 50 peer support volunteers, so people who are
10 bereaved by suicide, many of whom have been our counselling
11 or group clients in the past, and so, we run some training
12 and then they are able to co-facilitate or facilitate peer
13 support groups, and also many of those people also speak at
14 events for us. So that, we might ask them to speak to
15 other bereaved people about their experience because
16 they're a bit further along.
17

18 Q. You've referred to a number of programs, one of them
19 is the Early Bereavement Group, could you explain what that
20 program involves, please?

21 A. Yeah, so many of the group programs we run are what
22 would be sort of more open groups monthly: so there's a
23 group for parents, a group for partners, for siblings, and
24 we've got a specific group program for men and also for
25 children and young people. But the Early Bereavement Group
26 is for people who are between three and 18 months bereaved,
27 and it's a much more intensive and focused group program,
28 so it's facilitated by two of the team, the staff, and it's
29 a more structured program, but we encourage peer support,
30 but it has a bit more structure in it.
31

32 One of the things that we've learned about groups over
33 the years is that people bereaved by suicide, it is mostly
34 better for them if they're in groups with other people
35 bereaved by suicide. Sometimes people can have a negative
36 experience if they're in a general bereavement group.
37 There can be sometimes insensitive attitudes to people who
38 have lost someone to suicide, so we've learned that
39 bringing people together in homogeneous groups, which is
40 people bereaved by suicide, is very helpful.
41

42 But that structured program means that eight people
43 meet for eight weeks. We've evaluated that group ourselves
44 and it's demonstrated to be incredibly beneficial for
45 people: close bonds form and it is very helpful.
46

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

1 18 months bereaved?

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

8

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

13

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

20

21 Q. Why is it limited to eight people? Why don't you have
22 more people in there?

23 A. There's a couple of reasons. It's making sure that
24 people aren't exposed to too much because of the level of
25 trauma, and also, it's just simply making - so there's
26 enough time and space for people to really be able to talk
27 about their own experience, so I think that's why we've
28 limited it to eight.

29

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

33

34 Q. You also referred to running information sessions and
35 providing education for other professionals: what does that
36 involve?

37 A. A few times a year we run information sessions for
38 community. So, sometimes we'll get asked by a community to
39 go in and run one, but we also run them at our central
40 office in Richmond, and that's providing information to
41 bereaved people about grief and trauma and stigma and
42 suicide, so it's very much information about those
43 experiences.

44

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

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

3
4 And also, we provide information about loss, grief,
5 trauma and suicide to other professionals to really, I
6 suppose, increase the capacity, increase the knowledge
7 about that experience. It's a very complex experience,
8 losing someone to suicide, it's also very prolonged; it
9 takes a long time for people to kind of get on their feet
10 again, and so, we're really trying to educate about those
11 experiences, yeah.

12
13 Q. With the people who come to your service, where do
14 they come from?

15 A. Somewhere between 40 and 50 per cent of people come to
16 us through Victoria Police. Victoria police have, in their
17 database, an eReferral system. They refer to a wide range
18 of services and when they're attending or meeting up with
19 someone who's bereaved by suicide, they'll ask their
20 permission to refer them, so they come through VicPol. And
21 then it's a really wide range: there's our website,
22 coroners, mental health, community health, GPs,
23 psychologists, schools, and Headspace refer to us as well.

24
25 Q. Do you have capacity to assist more people than you're
26 currently assisting?

27 A. Look, unfortunately, we're pretty stretched, yeah,
28 yeah.

29
30 Q. Can you explain to us how the program is funded?
31 Where does the money come from?

32 A. Currently we're funded by four of the Victorian
33 primary health networks and that's Federal Government
34 funding, so at the moment we don't receive any funds from
35 the State Government, so it's Federal funds coming to the
36 primary health networks.

37
38 Q. You've referred to the fact that each of those four
39 primary health networks have different criteria and it
40 creates administrative challenges?

41 A. Yes, it does.

42
43 Q. Could you explain that to us?

44 A. Yes. Initially, for the first few years of our
45 funding, we received the money just directly from Canberra,
46 and so, that meant there was one funding body, so one
47 contract, one work plan, and then one reporting regime.

1
2 What's happened now is that that's now much more. So,
3 we now have four contracts, four work plans to develop,
4 four reporting regimes, four evaluation regimes, and each
5 primary health network has its own way that they want us to
6 do all those things.

7
8 We're a small program, so it's quite an administrative
9 burden, actually. I think there's value in - you know, we
10 have actually valued the relationship that we have with the
11 primary health networks, because it's enabled us to develop
12 more of that local knowledge and to respond locally, but
13 the challenge of it is that administrative burden which has
14 been significant.

15
16 Q. You've referred a number of times to "being bereaved
17 by suicide": can you clarify for us who that encompasses,
18 who are you talking about there?

19 A. Yeah. It's basically a person who has lost someone to
20 suicide and who is significantly and acutely affected.
21 Most of the people that we meet would be, or are,
22 first degree relatives: so parents, partners, siblings and
23 children, but we also do meet and see friends and other
24 relatives.

25
26 There's been some research in the United States which
27 suggests that, for each death by suicide, there's 135
28 people affected; not all of those people will be acutely
29 affected, but it is certainly someone whose level of
30 distress is acute, level of trauma is acute, and also where
31 the functioning is significantly debilitating. So, someone
32 who's having trouble with getting back to work, or engaging
33 in social activities and community life, so the people that
34 we meet with are those who are significantly distressed and
35 their life is disrupted.

36
37 Q. In your experience, are there differences between the
38 experience of people bereaved by suicide and those bereaved
39 by other modes of death?

40 A. Yeah, there's a number of different ways of looking at
41 that. Firstly, there is some research that's been done,
42 and that's in comparison to other bereavements. So, there
43 tends to be a higher rate of some mental health issues,
44 like anxiety and depression.

45
46 There's some research which talks about, say,
47 employment and social engagement, so for instance there was

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

6
7 The third aspect is - again, it's compared to other
8 bereavements - there is amongst people bereaved by suicide
9 a greater risk of suicide. So, they're some important or
10 very important differences.

11
12 Then there's just that very sort of, I guess,
13 psychological or emotional experience of shame, really very
14 distressing experiences of not understanding how it could
15 have happened, feeling perhaps that they were to blame,
16 that they should have been able to do something, so there's
17 lots of very difficult experiences: feeling responsible,
18 guilt, shame.

19
20 I think bereavement after suicide has a very
21 undermining effect on someone. So, people will be doubting
22 themselves, doubting themselves as a mother or a father;
23 thinking that they obviously weren't good enough; thinking
24 that, I thought we had a close family, and so that this
25 person would actually let us know if there was something
26 going on and it didn't happen. So, it has quite an
27 undermining effect, and that's because the death was
28 suicide. So, there's quite a lot of very difficult
29 experiences that people have.

30
31 There's also research that - and this is about the
32 social aspect of losing someone to suicide - which is that
33 people tend to be, it's certainly not universal, but people
34 will feel isolated by their social network. There's
35 research evidence about people who have lost someone to
36 suicide being viewed more negatively, being avoided, and
37 the deceased person not being mentioned, their name not
38 being mentioned, so there's this kind of awkwardness that
39 then surrounds people. So, very silent, a lot of social
40 awkwardness; the person who's died not being mentioned, or
41 there being negative attitudes about the person who's died,
42 yeah.

43
44 Q. Is that consistent with your experience? I think
45 you've mentioned that you've had people who have
46 participated who have lost a loved one and there's been one
47 mode of friends and family support, and then when they've

1 had somebody who they've lost to suicide, it's been a very
2 different experience?

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

9

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

15

16 Q. You've referred in your statement to a report that
17 you're preparing that will document the experience of the
18 health and mental health system before the person died.
19 Could you explain to us what the report is and what you're
20 trying to do?

21 A. Yeah. Support After Suicide has been operating
22 since July 2004, and in that time we've heard many, many
23 stories of experiences of what happened for the person and
24 for the family before they died, in terms of their contact
25 with the health system and their contact with the mental
26 health system.

27

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

32

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

41

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

46

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

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

5
6 Q. Are you able, without identifying anyone, to give us
7 some examples of what you've learned through this project?

8 A. Yeah, sure. Some of the things make for harrowing
9 reading, actually. I phoned a couple of people and asked
10 them if it was okay - without identifying them, if it was
11 okay if I told something about their experience, so I've
12 got two examples.

13
14 This is a woman whose husband had been unwell for some
15 time and was being visited regularly by a Crisis Assessment
16 Team, a CAT Team. She believed that his health, his mental
17 health, was deteriorating and she said to them that she
18 thought that he needed to be hospitalised; she thought that
19 he was at risk of taking his own life.

20
21 Some of the things that were said to her: she was
22 insistent in a phone call that he be hospitalised. One of
23 the things that were said to her was, did she want to get
24 rid of him? And so, she said, no, that she didn't actually
25 want to get rid of him, what she wanted for him was to be
26 well and to be cared for.

27
28 She insisted that he was going to kill himself, she
29 felt very sure about that, and she was told that she needed
30 to trust him rather than her own experience. And, after
31 that last interaction, within two days he had taken his own
32 life.

33
34 A second example is a mother of a 17-year-old who'd
35 had a history of mental health issues. She told us a range
36 of experiences, but one that stands out was just before he
37 died. He was an inpatient in a psych unit. She was told
38 that he was being discharged and she needed to come and
39 pick him up.

40
41 She said to them that she was very worried about him,
42 she was quite upset and she said to them, "I'm very
43 worried, I do think something's going to happen." So they
44 insisted to her that she come and pick him up. She says in
45 the interview she picked him up and he died on the day that
46 she picked him up.

1 So, yeah, so I think that highlights a range of
2 issues, but certainly families and carers not being
3 included and not being listened to, and sometimes also
4 being in a sense treated as if they're part of the problem,
5 yeah; whereas, they're desperate.
6

7 Q. What are you hoping to do with the report?

8 A. What we want, what everybody I think wants is for
9 things to change. We don't want a culture of blame and
10 accusation and finger-pointing, we want it to change.
11

12 Because I think one of the things I've learned is
13 that, unfortunately, the way the mental health system is,
14 is not helpful to people, some people who are in a suicidal
15 crisis and, if it was more helpful, there would be some
16 people who would not die.
17

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

22 "While there is an acknowledgement of this
23 in suicide prevention strategies it is not
24 often given priority in funding."
25

26 First, can you explain the risks to people bereaved by
27 suicide, and then we'll come to the funding issue?

28 A. Yes. There's some limited research, but the research
29 that has been done has got some differing ideas, but
30 certainly one research study, for instance, says that
31 people who are bereaved by suicide are twice, or double the
32 risk. There was another study done that actually indicated
33 or suggested that people were actually eight times the risk
34 of the general population, so there's a real sense that
35 losing someone to suicide is an important risk factor that
36 needs attention.
37

38 I think there's that research but we certainly see it
39 day-to-day in our work. People who have not ever been
40 suicidal can become suicidal after someone that they love
41 has ended their own life.
42

43 A woman said to me years ago, she said, "I've never
44 been suicidal before, never." But after someone very
45 important to her took his own life, the way she put it was,
46 "It's a door there that wasn't there before." So, it had
47

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

8
9 Q. And so, you said in your experience that hasn't been a
10 funding priority, looking after people who are bereaved by
11 suicide?

12 A. Yeah. I think, just to say as well, that the risk of
13 suicide isn't just in the immediate aftermath. I mean,
14 what we see in our work is that sometimes the risk of
15 suicide can occur sometimes years after, two, three,
16 four years after the death, so I think that's an important
17 thing in providing care as well.

18
19 I think there's a sort of idea that, if you give
20 funding to postvention or to a program that's assisting
21 people who are bereaved by suicide, that somehow it's too
22 late; like, the suicide's already happened, there's sort of
23 different sorts of attitudes.

24
25 But we do know that people who have lost someone to
26 suicide are at risk. So, we certainly see our day-to-day
27 work as suicide prevention, and not only suicide prevention
28 but assisting people in their mental health and in their
29 engagement in community life.

30
31 So I think because it's seen in some circles as, if we
32 put all the money into prevention, then you don't need
33 postvention; it's the wrong way to look at it. The effect
34 of suicide on people is absolutely shattering, it's a
35 devastating experience, and the risk to people is high in
36 terms of a range of experiences, and so, it does need to be
37 part of the suicide prevention strategy, yep.

38
39 Q. In terms of interventions for postvention, in your
40 view, what are the interventions that are the most
41 effective?

42 A. In our day-to-day experience we see the beneficial
43 effect of counselling, and that's very much about assisting
44 people to deal with, I guess, the very sort of
45 psychological affect of grief and trauma and suicide.

46
47 Group support is also incredibly important. Many

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

9
10 I think the other thing is information, so being
11 provided with very accurate, up-to-date information about
12 loss and grief, about trauma and about suicide is also very
13 helpful and very important, so that people can start to
14 grasp really what they're experiencing and why they're
15 experiencing it and what might be helpful.

16
17 There's also a range of other things: I think
18 sometimes, for instance, like counselling and group
19 support - I mean, we have quite a few men who do attend our
20 counselling in groups, but it's certainly a majority of
21 women. So we do run other programs that are specific, like
22 for men, that are more appropriate and that's quite well
23 attended because we've adjusted the way we do things so
24 that men feel it's more for them, it's more suited to the
25 way that they grieve and the way they think about things.
26 And again also for children and young people: trying to
27 develop programs that are innovative. We've done some art
28 space programs which are for young people that are
29 particularly effective, but also for people sometimes that
30 just counselling and group work don't quite fit, yeah.

31
32 Q. What are the programs for men and how are they
33 different to the counselling in the group programs?

34 A. The way we run the men's program is, I think there's
35 three sort of aspects to it: one is, we call it a program,
36 not a group, we don't call it a support group. Rather than
37 it's sort of sit around in a circle and talk about how you
38 feel, that program has a guest speaker each time, someone
39 who leads the discussion, so it's more kind of
40 information-based.

41
42 The third aspect of it is that our bereavement
43 counsellor who runs that program makes contact with men
44 between the sessions, between the group sessions. So,
45 there's very much building rapport, building an engagement,
46 building a connection with it, so that we're sort of trying
47 to lower the barriers to people actually - and men in

1 particular - coming.

2

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

8

9 Q. You've referred in your statement to the feedback that
10 you've received in relation to your programs: could you
11 just briefly tell us how they're received, what do people
12 that come say about the programs?

13 A. We've had quite a lot of feedback about our eight-week
14 program, we always do an evaluation of that program. It
15 tends to be, I guess, people are very appreciative of it.
16 They speak about the connections they've made, how it's
17 reduced the isolation, "I'm not alone. I understand more
18 now about what's happening for me. I know more about how
19 to deal with this."

20

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

29

30 Q. You referred briefly to stigma: in your experience, is
31 stigma still an issue in relation to suicide?

32 A. It is. I imagine it's changed over the years, but we
33 do still meet with people who have, for instance, not told
34 anyone outside the family. So, there's a tendency with
35 some - and this was a minority for sure - but they will
36 still conceal the cause of death, so they've got a lot of
37 discomfort about saying, because they're worried about how
38 they're going to be perceived by others, and also,
39 sometimes it's about protecting the person who's died; so
40 they don't want that person to be judged or condemned
41 because they took their own life. So, there's that aspect
42 of it.

43

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

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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

1 explain for us what the Zero Suicide Framework is?
2 A. It was developed in the United States, and so, I've
3 certainly done some reading on it and been to several
4 conference presentations on what's called the Zero Suicide
5 Framework. I mean, what they call it really is an approach
6 and an approach to care, so it really is an overhaul of the
7 way things are done in a mental health facility or in an
8 Emergency Department, and also it's the way it's done but
9 it's also the culture, so it's attitudes to suicide,
10 attitudes to people who are suicidal; that there's training
11 done for the staff to really shift attitudes.
12

13 It also relates to risk assessment. I remember at one
14 of the conference presentations the Gold Coast Mental
15 Health Unit has been implementing this for a number
16 of years, and they said, you know, when we ask someone if
17 they're suicidal, what we want to hear is "no" because it's
18 scary. So, it's about changing that, changing that culture
19 so that people are much more able to really work with
20 people.
21

22 The other thing that they acknowledged was that, yeah,
23 people don't want to hear it because they're scared -
24 sorry, I've just lost my trail. But it is a sort of - it's
25 a very different approach, so it's really an overhaul of
26 the way things are done, and it's about spending time with
27 someone, really talking to them. And it's an understanding
28 that, in an Emergency Department or a psych unit, if you
29 ask the question, you might want to hear "no" but also in
30 that environment people are going to say "no". And it's a
31 sense of, like, let's create an environment where people
32 are going to say the truth, so they will say if they're
33 suicidal, so you build different relationships with people
34 that are much more compassionate, have much more empathy
35 for the suicidal state that someone's in and will really
36 work with them to understand that.
37

38 So that's kind of what the Zero Suicide Framework is,
39 it's a real sort of overhaul of what's done and also the
40 way it's done and the way people are treated.
41

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

45 A. CAMS, yes.
46

47 Q. What's CAMS?

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

11
12 There's many good - I mean, there's ASIST training and
13 there's safeTALK and all those are excellent, but this is
14 very much for people who are working with someone who is
15 suicidal and really helping them understand themselves, how
16 come, and what will help keep them safe, what they need to
17 do to not become suicidal. So that again is a very good
18 approach and it's very collaborative and very much about
19 building rapport and having a good relationship with
20 someone.

21
22 Q. The third and final model that you refer to is the
23 Maytree in the UK: what does that model involve?

24 A. That's a residential house for people who are suicidal
25 or in a suicidal crisis. So, it's not a medical
26 environment, it's a place where people can go when they're
27 suicidal and be safe and also work to understand what's
28 happening for them.

29
30 So, that involves clinicians but also peer support.
31 So, it's a very different: it's non-medical, it's much more
32 into dealing with what's happening for someone, and again,
33 what's increasing someone's suicidality and how can they be
34 safe. But it's a way of people being safe that's a
35 non-medical environment and residential.

36
37 MS BATTEN: Thank you very much, Ms Flynn. Chair, are
38 there any questions for Ms Flynn?

39
40 CHAIR: Q. I have just a few. Could I start with the
41 issue of funding. I notice in your submission you said,
42 whilst you're service is currently funded by four of the
43 PHNs, not all the costs are covered and Jesuit Social
44 Services cross-subsidises that service, I gather?

45 A. That's right.

46
47 Q. How much does it have to subsidise the services to run

1 the model that you're running?

2 A. Sorry, I didn't quite hear that, sorry?

3

4 Q. How much is it cross-subsidised by Jesuit Social
5 Services, self-funded?

6 A. Significantly, it's well over \$100,000, yeah, that
7 we're underfunded.

8

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

14

15 I noticed that you said that your programs are always
16 full. Can I ask how you go about recruiting staff? Are
17 you readily able to recruit staff in such a very intense
18 environment, just not only for the participants but no
19 doubt for your own bereavement counsellors, and what do you
20 think is important for supporting people doing work in this
21 field?

22 A. It's not easy recruiting suitably qualified and
23 experienced staff. What we look for is people who've got -
24 psychologists and social workers preferably - who have got
25 some experience in loss and grief and trauma, or perhaps
26 some significant experience in suicide. I think what we
27 look for actually is particular qualities as well as that.
28 So, when we're recruiting, we're looking for people who are
29 sort of robust in themselves, and compassionate, so it's
30 both those things: a real sense of compassion, but also
31 people who can take care of themselves.

32

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

46

47 CHAIR: Thank you very much for your overview and your

1 statement today.

2

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

4

5 CHAIR: Yes, thank you.

6

7 <THE WITNESS WITHDREW

8

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

10

11 CHAIR: Yes.

12

13 **LUNCHEON ADJOURNMENT**

14

15 **UPON RESUMING AFTER LUNCH**

16

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

19

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

21

22 MS BATTEN: Q. Thank you associate professor. Have you,
23 with the assistance of your legal team, made a witness
24 statement for this Royal Commission?

25 A. Yes, I have.

26

27 Q. I tender that statement. [WIT.0002.0017.0001] Before
28 I ask you some questions about your statement, are there
29 some opening remarks that you would like to make?

30 A. Yes, I would. The evidence that I've prepared in the
31 statement is by its very nature somewhat dry and academic,
32 and I would like to take the opportunity to say that, that
33 evidence should be seen in the light or the perspective of
34 the fact that suicide is always a very tragic event, and
35 obviously particularly tragic for the individual concerned,
36 but also very, very tragic for families and the effects of
37 suicide, I have seen in my clinical career, ripple through
38 families and into the next generation, and it's also very
39 traumatic for staff who are involved in looking after
40 someone who goes on to commit suicide. So I think, in
41 looking at the evidence that I'm going to talk about, it's
42 very important that we retain that perspective.

43

44 Q. You are the Director of Clinical Governance at
45 NorthWestern Mental Health?

46 A. That's correct.

47

1 Q. Can you briefly outline what your responsibilities are
2 in that role?

3 A. My major responsibilities are to ensure that we
4 provide high quality clinical services, with a particular
5 emphasis on safety and continuous quality improvement, on
6 engagement with consumers and carers, and I've also spent a
7 fair bit of time on medical management as well.
8

9 Q. Can we turn to the issue of suicide and individuals
10 experiencing suicide. In your experience, how common is it
11 for those individuals to give some indication of their
12 intention?

13 A. I think, both from my clinical experience and from the
14 literature, it's very common that people give some
15 indication that they're feeling suicidal. The evidence is
16 that, somewhere around 40 or 50 per cent of people will say
17 something to a general practitioner, or mental health
18 clinician or other healthcare clinician about their
19 intentions, and many more people would also obviously speak
20 with family and friends.
21

22 Q. In your view, does this present opportunities for
23 intervention?

24 A. It does present the opportunities for intervention,
25 and a lot of clinical work has gone into trying to work out
26 what are the indicators that are most accurate at
27 predicting who's at higher risk of suicide.
28

29 Q. In terms of indicators, do you mean in terms of risk
30 assessment?

31 A. In terms of risk factors within that individual or
32 within - yes, the risk factors of the individual which
33 might predict the likelihood of completing suicide.
34

35 Q. With those risk factors, are you referring to the ones
36 that have ultimately gone into the risk assessment form
37 that NorthWestern use?

38 A. So, our risk assessment form was compiled by looking
39 at literature, looking at the indicators that are most
40 reliable. Having said that, however, there are - as I will
41 go on to talk about later - there are many difficulties
42 with the accuracy of those measures; of any measure.
43

44 Q. Thank you, we will come to that. Thank you. To
45 clarify, when in your view is a person considered at risk
46 of suicide?

47 A. So, from a clinical perspective people are referred to

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

5
6 Q. Is it limited to suicidal thoughts, or does it also
7 include thoughts of self-harm?

8 A. Well, thoughts of self-harm and suicide are related
9 so, yes, thoughts of self-harm as well.

10
11 Q. Can I turn to the issue of assessment tools used by
12 health services. In your statement you've said:

13
14 "In Victoria different services have
15 developed their own assessment tools which
16 are generally variations on the standard
17 psychiatric assessment supplemented by a
18 form of risk assessment. Other
19 jurisdictions, such as New South Wales,
20 have a standard assessment form which is
21 used by all services."

22
23 Are you able to explain to the Commission why it is
24 that Victoria has different assessment tools across
25 services?

26 A. Well, I think that's a consequence of the decision
27 made in Victoria in the 1990s to devolve healthcare to
28 local health networks, such as, say Melbourne Health is one
29 such network, and Monash is another, The Alfred, St
30 Vincent's and so on, there are many different health
31 service providers, and the model that was used was to
32 encourage services to be responsible for service provision
33 within their own area and for the Health Department to have
34 a role in setting standards and monitoring performance but
35 not in actual service delivery. Other jurisdictions have
36 retained a more traditional path where the state department
37 is much more actively involved in the service provision
38 side of things.

39
40 Q. Can we turn to the risk assessments within
41 NorthWestern Mental Health. You've said:

42
43 "Within NorthWestern Mental Health we have
44 a detailed assessment form used for
45 assessments of new consumers and risk
46 assessment forms tailored for the different
47 settings in which they are used; that is,

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

7
8 First, can you clarify for us, how are the risk issues
9 different?

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

22
23 On the other hand, in the community the risk factors
24 are different because a person is in an uncontrolled
25 environment where they have access to different means.

26
27 That said, the fundamentals of the suicide assessment
28 are much the same: that the risk factors from the person's
29 background, from any illness that they might be suffering
30 from and the interplay of those predisposing factors with
31 any acute stressors, those factors obviously apply to both
32 settings. So, there is an overlap in the risk assessments,
33 I'm just explaining why there are slightly different
34 modifications of the risk assessment tool.

35
36 Q. If someone presents at the emergency department
37 expressing risks of suicide, can you step us through the
38 process for how the risk assessments are done for that
39 person?

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

45
46 They would generally at that point notify the
47 emergency mental health team, and the person might also

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

15
16 Then there would be a mental state examination which
17 would look at signs of mental illness, and then the
18 particular risk assessment would focus on recapping all of
19 the factors which I've mentioned before: the predisposing
20 factors to suicidal behaviour and any protective factors.

21
22 Q. Do you know whether anyone presents at the emergency
23 department at risk of suicide who is not then referred to
24 the emergency mental health team?

25 A. The decision about referral to the emergency mental
26 health team is one for the emergency department medical
27 staff. While the person is in the emergency department,
28 the clinical governance for that person is with the
29 emergency department until they're formally taken over by
30 the mental health but referred to the mental health for
31 admission or referred then for outpatient care if they're
32 not admitted.

33
34 Q. And that's not something you have responsibility for,
35 the emergency department?

36 A. No. Obviously, we work in collaboration with the
37 emergency department, it's not like we're two completely
38 separate entities, but technically the clinical governance
39 is with the emergency department.

40
41 Q. For the people who are referred to the emergency
42 mental health team, you referred to a clinical risk
43 assessment and management form that is completed for those
44 people.

45 A. Yes.

46
47 Q. There are suicide static factors?

1 A. Yes.

2

3 Q. And there are suicide dynamic factors?

4 A. Yes.

5

6 Q. So, the static factors: can you explain what the
7 static factors are and why they form part of the risk
8 assessment?

9 A. So, static factors are those factors in a person's
10 background which have been shown to be associated with the
11 risk of suicide. So, they may be things like having a
12 family history of suicide, or having a serious mental
13 illness, or having a serious physical illness. So, they're
14 factors which are, in a sense, not changeable, they're
15 static, they're part of a person's make up.

16

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

22

23 Q. You've said in your statement:

24

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

30

31 What does that involve, that assessment and
32 consideration of nuances ?

33 A. It's about listening to what a person says and also
34 what they do not say, and being attuned to subtle
35 indicators. So, for example, a person might say, "I'm not
36 feeling suicidal now." That might suggest they - obviously
37 would suggest that they may have been feeling suicidal at
38 some other time, so one would explore that with the
39 individual and try and establish just how acute the current
40 suicidal ideation is.

41

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

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

7
8 Q. I will return to the issue of collateral information,
9 but before I get there I want to remain on the optimal
10 approach. The Commission's heard a lot about the pressures
11 on the mental health system. Do the pressures on the
12 system have any impact on whether the optimal approach is
13 always done?

14 A. That's a difficult question to answer, in the sense
15 that, our clinicians I think always provide a good standard
16 of assessment, and that may mean that as a consequence
17 other people have to wait because the number of - I mean,
18 even in very busy emergency departments, we have two
19 clinicians rostered on at a time, so if both of those are
20 doing assessments then there's going to be a delay for
21 others to be seen. That is less than optimal. And
22 obviously, if someone is very distressed and disturbed
23 having to wait a long period of time is in itself upsetting
24 and distressing.

25
26 So, in that sense I think that pressures lead to less
27 optimal responses. However, I think the job of
28 professional staff is to ensure that they always provide a
29 good level of clinical care regardless of the pressures
30 that they're under.

31
32 Q. You referred to the difficulty with sometimes getting
33 collateral information. The risk assessment requires that
34 the assessment be comprehensive and includes static and
35 dynamic risk factors and be informed by relevant and
36 collaborative information. What are some of the challenges
37 in trying to get that collateral information?

38 A. Well, sometimes the challenges can be that the
39 individual forbids you to access anyone and won't provide
40 information of relevant people.

41
42 Q. And, if they forbid, that's the end point, there's
43 nowhere to go?

44 A. No, we would try and encourage them to let us talk to
45 someone that they would feel more comfortable us talking
46 to. Sometimes it's the case that the person may give you a
47 name but that person's unavailable, or that it's the middle

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

5
6 Q. In your view, how accurate are the current criteria in
7 determining whether a person is at risk of suicide?

8 A. It's extremely difficult to predict the short-term
9 risk of someone completing suicide. So, in that sense, no
10 matter how good - how complete the list of indicators is,
11 it's not going to give you very reliable information about
12 who out of 20 people who come in with suicide ideation are
13 actually likely to go on and make an attempt.

14
15 Q. You've said in your statement:

16
17 "Unfortunately, there is no magic tool to
18 identify suicide risk. There is evidence
19 that a good psychiatric examination
20 undertaken by skilled clinicians with
21 attention to risk issues performs better
22 than most specific suicide interviews."

23
24 First, can you clarify for us, what is a specific
25 suicide interview?

26 A. I'm thinking of experimental or research interviews
27 which have tried to identify which risk factors are the
28 most likely to lead to an actual attempt of suicide.

29
30 Q. Then, can you elaborate for us, what is the evidence
31 that a good psychiatric examination with attention to risk
32 performs better?

33 A. The evidence is a series of studies of outcomes, which
34 I've mentioned some of those in my statement, given some
35 references to those, and it's generally most suicide
36 experts would have the view that a good psychiatric
37 assessment is as good as any other method.

38
39 Q. You referred to the difficulty in predicting who is
40 going to complete suicide and when. Can you explain for us
41 how a sudden change in a person's mental state can limit
42 the usefulness of the assessment tools?

43 A. Yes. I think, as I mentioned, the dynamic factors are
44 particularly important in a person making a decision to
45 actually make an attempt on their life. So, many people
46 may have the same static factors, the same predispositions
47 to suicidal behaviour, but it's the acuity of the current

1 stress and also feelings of hopelessness and feelings that
2 this will never go away that lead a person to think that
3 suicide might be a better option.
4

5 So, the example that I gave in the statement was of a
6 person not at our health service, but at another health
7 service a colleague was talking about, where a person had
8 been very depressed, had had a hospital admission, had made
9 a good recovery and was feeling much more positive about
10 life and then was preparing to be discharged, went to the
11 cafeteria for lunch, didn't come back and was found having
12 attempted to hang himself in the hospital stairs.
13

14 Fortunately, he survived and he was able to tell staff
15 that the reason he'd done that was that he'd felt so
16 confident that he tried to make contact with an estranged
17 family member and that person had not reciprocated his
18 contact, so he felt that everything he'd done had not been
19 worth it and he became acutely distressed and attempted to
20 kill himself.
21

22 Now, if we had done a risk assessment of that person
23 an hour before he went out on leave, we would have had no
24 concerns at all about his risk status, and yet, an hour
25 later he was acutely suicidal. So, that's an illustration
26 of how difficult prediction can be and how vulnerable some
27 people can be to unexpected changes that happen to them.
28

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

31 A. Yes.
32

33 Q. Can you elaborate on that: what's the lifetime risk?

34 A. So, that data came about because the ability to
35 clinically predict suicide was not very strong, so the
36 researchers then looked at whether there were - if you
37 studied large numbers of people and looked for the
38 occurrence of multiple different risk factors, whether that
39 might provide a more accurate prediction of who was likely
40 to actually go on and attempt or commit suicide.
41

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

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

5
6 Q. In your view, do the pressures on the mental health
7 system impact on suicide rates?

8 A. I think, again, it's difficult to establish
9 scientifically that there's a direct correlation. It makes
10 common sense that a system which is under pressure, where
11 people have to wait long periods as I've said, that for
12 people who are very distressed, that extra waiting and the
13 uncertainty of what the service may be able to offer them,
14 that they are additional stress factors that they really
15 don't need at that point in their life. So, I believe that
16 there is some affect from that.

17
18 Certainly, services are under very, very considerable
19 pressure for inpatient beds in Victoria. I'm sure this has
20 been talked about in some of the submissions, that we have
21 a very, very low rate of beds per population, and so,
22 people have much shorter stays in hospital than in some
23 other jurisdictions or in other countries.

24
25 It's likely that, because of that, that people are
26 discharged when they are not 100 per cent better. The
27 question of when people should be discharged of course is a
28 difficult question, but these external pressures do mean
29 that people are moved through the system more quickly than
30 they might otherwise be.

31
32 There's also some evidence from studies in America
33 that rapidly reducing beds has been associated with an
34 increase in the number of suicides, but again, there are
35 many factors that could be affecting that, so I think it
36 would be difficult to state with certainty that lack of
37 beds causes an increase in suicide, but it's certainly a
38 plausible line of enquiry.

39
40 Q. I want to ask you more about the beds in terms of
41 inpatient admission. You've said that:

42
43 "Inpatient admission is often useful in
44 containing a suicidal crisis but there is
45 no evidence that it is an effective
46 treatment of suicidal behaviour in the
47 longer term."

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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

1 also impact on outcome.

2

3 Q. I have two final topics to address with you: the first
4 is the Mortality Benchmarking Group. Could you explain to
5 us what that group is?

6 A. That's a group of eight different mental health
7 services in Victoria which got together 11 years or so ago
8 with a view to understanding better what the data was
9 telling us about the number of people who committed suicide
10 or who had what we call reportable deaths, so not just
11 suicide but also unexpected and unnatural deaths; with the
12 aim that this might help us identify services that were
13 doing particularly well or services that were doing not
14 very well, to see whether there might be things that we
15 could learn from that to try and reduce the risk of suicide
16 in our own services.

17

18 Q. What has the group established? Are there differences
19 between particular services?

20 A. Yes, there are differences, but there are much more
21 similarities than differences. So, we haven't established
22 that any one service has markedly better outcomes than
23 another, or markedly worse outcomes than another.

24

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

29

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

37

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

44

45 Q. Have you implemented changes as a result of those
46 reviews?

47 A. Yes, we have, and we've identified particular areas,

1 some of the areas I've mentioned already: so access, areas
2 of transfer between services or when a person leaves the
3 service and then is referred back to primary care or to
4 another provider, are all very high risk areas and they
5 tend to be recommendations from those kind of reviews.
6

7 Q. My final question is, what changes do you think would
8 bring about lasting improvements to help people at risk of
9 suicide, particularly in relation to accessing treatment or
10 getting help earlier?

11 A. Yes, I think accessing treatment is particularly
12 important. Perhaps even before that, there's some evidence
13 that what we might think of more kind of population-based
14 initiatives can be helpful: so, training community leaders
15 in awareness about suicide, and raising the profile of -
16 raising the awareness of people to seek help earlier and
17 encouraging others to avoid stigma and that it's okay to
18 talk about some of these things; there's evidence that
19 those things are helpful.
20

21 There's definitely evidence that reducing the means to
22 commit suicide in the community results in reduction in
23 suicide rates: so, particularly access to firearms, access
24 to high bridges and cliffs and things like that; fencing
25 off The Gap in Sydney resulted in a reduction in suicides
26 at that time. So, those kind of preventive measures on a
27 population level are helpful.
28

29 Then the access issues which I mentioned before, so
30 particularly for communities who don't enjoy good access to
31 health services currently, they are helpful. Improving the
32 quality of the psychiatric mental state examination and the
33 history taking, and improving clinicians' ability to ask
34 the right questions.
35

36 Again, we can't show scientifically that that improves
37 the outcome, but it's certainly, from all we know about
38 suicide, it's likely that that is an effective treatment
39 plan and that's one that we've done in my own service where
40 we rolled out an intensive suicide awareness training for
41 all of our clinical staff.
42

43 MS BATTEN: Thank you very much, Associate Professor
44 Burnett. Are there any further questions?
45

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

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

5
6 I guess the question then raises, is it an effective
7 assessment at all to be assessing somebody at the point of
8 discharge from an inpatient unit rather than at the point
9 of when they're in their community setting: how valid can
10 we make an assessment in that context given the evidence
11 we've been hearing?

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

18
19 As in the clinical example that I gave, it's very
20 difficult to predict what's going to happen to a person
21 after they leave your service. There are no tools that
22 tell us what it will be like for that person if something
23 goes wrong a few days later. We can say based on
24 everything we've seen they're doing very well, they're
25 certainly ready to go home, they're no longer detainable
26 under the Mental Health Act, if they ever were, so they
27 have that right to choose to leave hospital.

28
29 In general I think our assessments are as good as we
30 can do, they're as thorough as anyone in the world would
31 do. The problem is that the phenomenon that we're talking
32 about is mercurial: that people, obviously they retain
33 their static risk factors and, if a new event occurs, then
34 they may feel that their coping capacities are overwhelmed
35 and they experience that feeling of distress and
36 hopelessness which might lead to an attempt or a completed
37 suicide.

38
39 COMMISSIONER COCKRAM: Thank you.

40
41 COMMISSIONER McSHERRY: Q. I note in your statement, and
42 in your statement to us just before, that you say there are
43 currently no reliable assessment tools, but you carry out,
44 I suppose, some sort of structured professional judgment
45 when you're assessing.

46 A. Yes.

47

1 Q. You've also mentioned a study by Matthew Large, and I
2 know that he and some of his colleagues have argued that,
3 in terms of mental health laws, we really shouldn't be
4 emphasising assessment of risk, we should be getting away
5 from that. I just wondered what your view would be on
6 that?

7 A. Well, that's a very controversial topic. I think that
8 his views about risk assessment are consistent with the
9 literature, but they're not very useful for clinicians who
10 are faced with a clinical problem in real life.

11
12 So, I think clinicians need guidelines to follow in
13 order to feel comfortable making an assessment and doing
14 the best clinical job that they can. If we were to say
15 that obviously risk assessment is a very inexact science,
16 therefore we shouldn't bother doing it, the question would
17 be, what would we do instead? And I think that would be a
18 worse situation than we're in now.

19
20 I think it's really about the question of, medicine is
21 both an art and a science, and psychiatry I think even more
22 so. So, we absolutely must be guided by the science, we
23 must learn from what happens, we must remain open to
24 changing what we do when we see advances in the science;
25 but on the other hand, if the science can't tell us where
26 to go, then I think we have to use our clinical skills to
27 make the best judgment that we can. I think that's what
28 our clinicians do all the time and if we had better tools
29 to guide us, we would love to have them and we would love
30 to use them, but I wouldn't say do nothing because those
31 tools don't yet exist.

32
33 Q. But could there be a possibility of an alternative
34 framework based on what the individual needs and what the
35 individual wants, rather than so much emphasis placed on
36 trying to assess risk of serious harm?

37 A. Yes I think clinically - and I can't prove this
38 scientifically - but I think clinically things like
39 engagement and hope are very important. One of the roles
40 of a clinician dealing with someone who is very actively
41 suicidal or distressed is to provide a sense of hope, you
42 know, to provide - "yes, I've been with people who feel
43 just like you do now and they have managed to get better,
44 they have managed to get through this crisis." So, the
45 role, that therapeutic role of the clinician I think is
46 very important. So, in a sense that's using a different
47 framework from the framework of a risk assessment

1 management.

2

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

7

8 We heard in evidence before this Commission how
9 frequently people have dealt with GPs or other
10 practitioners fairly proximate to the time that they have
11 been in deep distress. But I noted in your witness
12 statement you said there was a UK study that said
13 47 per cent of patients with a history of mental illness
14 who suicided were in contact with their GP in the previous
15 month, and 16 per cent in the previous week.

16 A. Yes.

17

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

23

24 How well informed do you think treating practitioners
25 are about some of those complexities? Because a lot of the
26 focus on suicide prevention is about education,
27 awareness-raising, but some of it is very complex education
28 and awareness-raising.

29 A. It is indeed. I think there is some evidence that
30 upskilling general practitioners and other primary
31 healthcare providers is useful, it does at least perhaps
32 lead to a better pick up of people who are at higher risk.

33

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

43

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

1 useful.

2

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

6 A. 11 years.

7

8 Q. 11 years, was an initiative of the eight health
9 services?

10 A. Yes.

11

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

17 A. Yes.

18

19 Q. What would you see as the benefit, if any, of that, or
20 would you still think it's important that health services
21 have I guess that responsibility to assess their own
22 performance and opportunities for improvement?

23 A. I think the health services should always be
24 responsible for looking at their own performance, but the
25 bigger the group that you're benchmarking, the better the
26 data will be. I guess the gold standard is, the
27 United Kingdom has a confidential national inquiry into
28 suicide and homicide, and in the last 10 years suicide
29 rates in the UK have gone down and suicide rates in
30 consumers attending mental health services have all gone
31 down, which is different from other jurisdictions.

32

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

40

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

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

3

4 Q. Thank you, we may follow up. Did you reference that
5 particular piece of work?

6 A. I can't recall, but I can send it to you if I have it.

7

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

11

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

14

15 CHAIR: Yes, thank you very much.

16

17 <THE WITNESS WITHDREW

18

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

27

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

34

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

37

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

40

41 MS NICHOLS: I call Mr Crossett.

42

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

44

45 MS NICHOLS: Q. Mr Crossett, are you the Acting Chief
46 Executive Officer of the Transport Accident Commission?

47

A. That's correct.

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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,

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

4
5 In terms of vehicles as an example say for people:
6 people are vulnerable and, for example, if a person as a
7 pedestrian is struck by a vehicle at more than
8 30 kilometres per hour, they're likely to be seriously
9 injured or potentially lose their life. So, the elements
10 of the safe system take that into account, that people are
11 vulnerable, there are tolerances to what people can
12 withstand as well as the other elements of that program.

13
14 Q. So, is it correct to say that the safe roads, safe
15 speeds, safe vehicles elements of the strategy go well
16 beyond attempting to modify people's behaviour and to put
17 in place other safeguards?

18 A. Exactly. I think, if we think about the history of
19 road safety and prevention in Victoria, back in the late
20 70s, early 80s, we had just over a thousand people losing
21 their lives on our roads each year, and at that time in
22 around 2015/2016, we'd plateaued in terms of lives lost
23 around 300, and so, really this safe system approach was to
24 take us to the next level of having an impact and saying
25 that zero was really the only acceptable outcome.

26
27 Q. So, does that represent sort of a philosophical
28 approach backed by a suite of practical measures?

29 A. That's right, so it's really saying that no-one
30 deserves to die on our roads and therefore zero is the only
31 acceptable target, and that if we were to make significant
32 further gains, we'd need to look at the road system as a
33 system in terms of, whether it's behaviours or speeds or
34 vehicles or the road network itself, look at all elements
35 and put in place treatments to address those areas.

36
37 Q. Before this significant investment was made, or rather
38 before making it, did it draw upon some well-established
39 bodies of evidence that were available to TAC through its
40 and its predecessor's work over the last few decades in
41 relation to road safety?

42 A. That's right, and the Monash Accident Research Centre,
43 which was established back in 1987, is considered one of
44 the leading research accident prevention centres in the
45 world now. So, it drew heavily on evidence base as well as
46 modelling as you mentioned earlier to say, if we put these
47 initiatives in place, this is the amount of impact,

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

3
4 Q. And that modelling really went to road safety aspects,
5 so making modifications to roads and vehicles; is that
6 right?

7 A. Yeah, exactly.

8
9 Q. Was there some economic modelling that went to develop
10 the business case which put to government the benefits of
11 investing heavily in this program?

12 A. That's correct. So, there was economic modelling
13 around the savings to the community in reducing road trauma
14 through the investments, for example in infrastructure, as
15 well as other significant savings in the impact on
16 Victorians of losing a loved one or the associated medical
17 and health costs.

18
19 Q. Was there also, in launching the campaign, some market
20 research about how it should be described and how the
21 public would receive the, for example, what it was called?

22 A. Yes.

23
24 Q. And the way it was portrayed in the media?

25 A. Yes, and I think that was an important point: in
26 developing the strategy the research had shown that, in the
27 context here in Victoria that it was unlikely the community
28 would accept at that time that Vision Zero, which is what
29 the Swedish model was, was going to be accepted here.

30
31 So, through further research, having a Towards Zero
32 goal was considered to be acceptable and was more
33 action-orientated, and in the end was how the strategy has
34 been described, and since that time we've had - now we're
35 at a point where about 50 per cent of the community in the
36 testing and surveying we do now say that zero is the only
37 acceptable target that we should aim for, and that it is
38 possible one day. So, we've still got more work to do, but
39 there's been significant embracing from parts of the
40 community that that is possible.

41
42 Q. So, that aspect of the program that you're discussion
43 now is about community buy-in to the philosophy, not only
44 as it underlies the program, but as it's expressed in the
45 public promotion of the strategy?

46 A. Yes, that's correct.

47

1 Q. Was it thought that you needed to have a program that
2 people would resonate with and agree with and that you were
3 to assess that by doing constant market research?

4 A. That's correct, yes.

5

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

12

13 So, is that concept of a system central to the
14 strategy?

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

21

22 Q. Is it understood why Sweden is achieving such good
23 results?

24 A. There are a number of factors, but one in particular
25 is that they started the journey much earlier than we did
26 here in Victoria, so culturally there's already an
27 acceptance around speed and things like the separation of
28 motor vehicles with cyclists. So, we know we've still got
29 quite a bit of work to do in areas like that from a
30 cultural point of view here in Australia. But areas like
31 that in Sweden, countries like that, they have made further
32 gains at this point, but we continue to look at how we can
33 bring those changes about as well.

34

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

38 A. Yes.

39

40 Q. \$380 million worth of improvements on the road
41 networks across metropolitan and regional Victoria under
42 the Safe System Road Infrastructure Program?

43 A. Yes, that's correct.

44

45 Q. \$60 million to support safer intersections and traffic
46 calming treatments at locations in local street networks?

47 A. M'mm.

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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

1 constant evaluation and then, in the case of this year as
2 an example where we've had a result tragically well above
3 where we would expect to be at the moment, further
4 strategies and treatments/mitigations are put in place to
5 hopefully get us back on track to where we're aiming for.
6

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

9 A. Absolutely.

10
11 Q. What sort of approach does TAC take to the timeframe
12 over which success should be measured?

13 A. Yeah, I think that's a really important question.
14 That Towards Zero strategy was always a long-term strategy
15 and looking over a five to 10 year horizon, and the next
16 strategy beyond 2020 is already under development.
17

18 So, a year like 2018 where we had our record low lives
19 lost, tragically still 213 people lost their lives on our
20 roads, but this year we're very likely to be well above
21 that figure. The experts would say that you should not
22 respond in isolation to one year's results, you should
23 continue to look over a longer period; make appropriate
24 adjustments along the way, but overall look at a longer
25 horizon with such a complex challenge in our community and
26 how to address it over the longer term.
27

28 Q. Can I ask you about the importance of TAC's public
29 education campaigns as part of its strategy.

30 A. Yes, I think, as we talked about earlier, public
31 education is still a key element of the strategy, and it
32 works in conjunction with the other elements of the safe
33 system approach. There are a range of public education
34 programs that TAC and its partners continue to implement
35 and also monitor the effectiveness of those programs when
36 they are implemented: how much the community understands
37 and how much ultimately behaviour may change as a result of
38 those programs.
39

40 Q. What sorts of media does TAC use to educate the
41 public?

42 A. Yes. Well, we obviously use a range of media
43 platforms as well as partnerships, corporate partnerships,
44 grassroots community activities, and even through our local
45 government areas. We have had quite a bit of success in
46 recent years in getting local government to take up the
47 Towards Zero vision, and in some councils to announce that

1 they are Towards Zero councils now and put in place their
2 own actions to lower speeds in their region or other
3 activities that are helping us get towards zero.
4

5 Q. Do you know what sort of activities might occur at a
6 local level?

7 A. Yeah, so for example the Mornington Peninsula Council
8 had lowered all their local road speeds from 100 originally
9 down to 80 kilometres. We know from the evidence that that
10 has a significant reduction in lives lost and serious
11 injuries, and they've also taken up some of our grants that
12 we offered the local government to put in place speed
13 reduction activities in built-up areas in their community
14 with great success in terms of reduction of serious
15 injuries and, in some cases, zero lives lost for a long
16 period of time.
17

18 Q. So, was it an affirmative strategy of TAC to engage
19 local government?

20 A. Yes, it was, and still more work to be done there, but
21 certainly it was a clear part of the strategy that we had.
22

23 Q. Can I ask you about the program, the outreach program
24 you have with the Melbourne Museum?

25 A. Yeah. So, part of the package around our young
26 drivers or future drivers, last year we established the
27 Towards Zero Road Safety Education Complex at Melbourne
28 Museum, and in the first 12 months we've had 45,000 visits
29 to that state of the art education complex. It's really an
30 immersive interactive exhibition particularly for Year 9,
31 10 and 11 students to attend and really understand the safe
32 system approach to road safety, but in a way that really
33 engages with them in different ways.
34

35 Also part of that is an outreach program to regional
36 Victoria, so recognising that not all of our community can
37 come to a complex in Melbourne. We have an outreach
38 program that's doing the same thing but in our regional
39 areas in Victoria to make sure that we're getting that
40 message out to all of our young drivers, future drivers.
41

42 Q. How does TAC itself go about coordinating the various
43 parts of its activities that form part of the system?

44 A. It's really a unique partnership through the TAC, as I
45 mentioned earlier, the Department of Transport, VicRoads,
46 Department of Justice, Victoria Police and Department of
47 Health and Human Services, and each of those partners

1 understands what their role is in that partnership.

2

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

8

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

12

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

21

22 Q. In terms of assessing how the program is tracking,
23 you've mentioned two things in your statement: one is
24 measures and the other one is milestones. That's at
25 paragraph 47. What's the difference between measures and
26 milestones and what do they each mean?

27 A. I think, when we talk about measures, they're really
28 the key elements of the strategy and the platforms; for
29 example, the 20 high risk roads that we're currently
30 treating with flexible wire rope barriers and other
31 improvements.

32

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

42

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

46 A. Yes, that's right.

47

1 Q. So, they're performance measures?

2 A. Yes, absolutely.

3

4 Q. In relation to the partnership, why is it important
5 that there be a multi-agency strategy?

6 A. So I think, as I mentioned earlier, a good example of
7 that approach and why it's important is when we were
8 dealing with the problem of drinking and driving. And just
9 as an example the TAC obviously put that on the agenda in
10 the public domain through its public education program, so
11 that was TAC's role in that partnership.

12

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

18

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

25

26 Q. So, you have a partnership, but is TAC the lead agency
27 for this program?

28 A. No, not necessarily, particularly now with the
29 Department of Transport established, so there will be a
30 lead agency there, Road Safety Victoria which has just
31 recently been established, and TAC plays a critical role,
32 but along with each of the other partners who are just as
33 important in that partnership.

34

35 Q. So, it's a genuine partnership?

36 A. Absolutely.

37

38 Q. How is the community involved in implementing Towards
39 Zero?

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

1 mentor program, so volunteers that across the state provide
2 that learner driving experience so they can achieve that
3 120 hours before they get their licence.
4

5 That program's been hugely successful, so 1,600 people
6 every year in that disadvantaged situation can now have the
7 training they need before they become a road user, and it's
8 rewarding and beneficial in other ways for the mentors
9 involved in the program. But it's just one example, I
10 suppose, of how we we're always looking for different ways
11 to engage the community in the topic of road safety, and
12 the training and education is a really important element of
13 that.
14

15 Q. Does TAC have its own staff who specifically are
16 dedicated to this program?

17 A. Yeah, absolutely. So we have a group of staff, and
18 again, in the partnership model for example, we have staff
19 co-located with the VicRoads staff who are working
20 collaboratively on how, for example, to roll out the most
21 efficient and effective wire rope barrier system across the
22 state. So, we have our own staff, but they also work very
23 closely with the other partnership players as well.
24

25 Q. Are the outcomes against the milestones and measures
26 reported?

27 A. Yes, absolutely. So, they're reported in the
28 partnership, in the Ministerial Council as it's called when
29 they come together, but they're also very closely
30 monitored, for example, by the TAC Board of Management, its
31 independent board. So there's a range of ways in which
32 those indicators are monitored regularly and assessed
33 whether we're on track or not.
34

35 Q. Is it fair to say that the program receives attention
36 at the highest levels of governance within TAC and its
37 partner agency?

38 A. Absolutely, yeah.
39

40 Q. Is that an important part of what you regard as its
41 success?

42 A. Yeah, definitely. That appropriate scrutiny and
43 challenge throughout the process has been very important.
44

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

1 mentioned this a few times, but you've given an example of
2 some of the ways in which you do that, one being through
3 mass media campaigns.
4

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

8 A. Yes. I think the example we're just about to show,
9 going back to the commencement of the Towards Zero
10 strategy, recognising that a lot of the community at the
11 beginning of the establishment of that strategy would not
12 potentially feel that zero, for example, was achievable; we
13 came up with the Man on the Street campaign, as it was
14 called, and this is a person who volunteered to be part of
15 that program and talk about what's an acceptable number of
16 people losing their life on our roads each year, and that
17 person, as you'll see when we play this short video, how he
18 responds to the situation, and it really created a
19 conversation in the community around shifting the thinking
20 at the beginning of that, and then since then we've been
21 able to build upon, I suppose, that momentum that was
22 kicked off by this campaign.
23

24 Q. Alright. Well, let's have a look at it and then we'll
25 return to what the momentum has been. Can we play the
26 video, please.
27

28 (Video played.)
29

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

32 A. So I think the main statistic around that is that at
33 that time around 70 per cent of the community believed that
34 zero was possible and a target that we should aim for. As
35 I mentioned earlier, I think that's now up around
36 50 per cent.
37

38 We also recently had some community forums in regional
39 Victoria that our Minister had conducted, and with roughly
40 100 leaders from those communities or community members in
41 general, and they essentially were around about 98 per cent
42 of the people in that room now believe that Towards Zero or
43 achieving that one day is possible.
44

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

1 Australia and overseas, so that's something that we'll be
2 considering in Victoria and a matter for the government to
3 consider in the next strategy.
4

5 Q. What was the thinking behind engaging the community
6 with the notion that zero is possible or achievable?

7 A. Well, I think it was really back to, I suppose, the
8 first point about Vision Zero being something that the
9 community, we knew, would not be able to make a leap
10 straight to zero as a number that is achievable, and it was
11 more about Towards Zero is really the critical element of
12 getting at least the dialogue - having the community think
13 about what is possible and then since then building upon
14 that. Nuancing the message through different campaigns has
15 seen that understanding and then belief build over time.
16

17 Q. So, without trying to descend too much into
18 psychology, is the thinking that, if the community buys
19 into the program, accepting it, believing it is genuine and
20 will make a difference, you'll get buy-in in terms of
21 people's conduct?

22 A. Yeah, I think that's right, it's into behaviour but
23 it's into also understanding other things like speed in
24 terms of a conversation around speed and where they are
25 vulnerable, and there will be further campaigns coming out
26 shortly to continue to help educate people about the
27 trade-off between getting somewhere five minutes quicker
28 versus the speed that you travel getting from A to B
29 destination, so there's continuing education around those
30 elements as well.
31

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

38 A. Yes.
39

40 Q. The first one is that:

41
42 "Where we're attempting to change attitudes
43 and behaviour to any social issue, we need
44 to take a long-term sequential approach
45 that builds year-on-year to increase
46 understanding and desired actions."
47

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

4
5 Q. Has that enabled you to sustain the agenda and to
6 sustain investment in the program?

7 A. Absolutely, yeah, that's correct.

8
9 Q. The next one is agenda setting: what do you want to
10 say about that?

11 A. Really that having that clear agenda and then putting
12 it on the table, having the public discourse around that,
13 has been again, I think from what we've talked about
14 already, the example, has been a key part of the success of
15 building understanding, awareness and then momentum towards
16 a goal.

17
18 Q. In service of agenda setting, you've mentioned mass
19 media campaigns which we've already discussed.

20 A. Yeah.

21
22 Q. You then say:

23
24 "Having set the agenda the community needs
25 to see action happening."

26
27 A. Yeah, and I think that's obvious to suggest that the
28 community expects to see action being taken once the agenda
29 has been set, what actions are being taken by the
30 government agencies to move towards the target that we
31 have.

32
33 Q. The next point is that:

34
35 "The community needs to be aware of what
36 their role is in helping achieve change."

37
38
39 A. Yeah, and I think that's a continuing journey for us
40 to, as I mentioned earlier, to educate the community, help
41 them understand things like speed and the impact that may
42 have, so that role is critical to success, yeah.

43
44 Q. And then you say:

45
46 "It is most likely that the first agenda
47 setting campaign will be very high level."

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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

1 substantial reduction in the road toll over decades now,
2 from I think you said 1,000 down to the goal being under
3 200.

4 A. Yes.

5

6 Q. And that's in a rising Victorian population.

7 A. Yes.

8

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

14 A. Yes.

15

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

19 A. 87, yes.

20

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

26

27 By contrast, have you done that? Have you been able
28 to initiate new things but not just pilots?

29 A. It's a good question. I think the statement also
30 talks to innovation and as we know that's always very
31 important in any strategy. So, we continue to have pilots
32 in some regards, particularly with automated vehicles that
33 are mentioned in the statement, but overarching that is the
34 long-term strategy with very clear evidence and with, I
35 suppose, more significant initiatives that come together to
36 achieve the goal that we're aiming for.

37

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

46

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

1 substantial.

2 A. Yes.

3

4 Q. I think \$1.4 billion you said for that current
5 strategy. The robustness of the modelling and the business
6 case that was required to justify that level of investment,
7 how did you go about doing that?

8 A. I think that's a really good point. We were obviously
9 in a fortunate position with the establishment of MUARC
10 from several decades before to have a very well established
11 mechanism to create that information, that data, that
12 evidence and we relied on them heavily, and continue to, to
13 provide very clear evidence around where we'll make
14 investments, whether it will provide the return that we
15 expect.

16

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

26

27 MS NICHOLS: May Mr Crossett be excused?

28

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

30

31 <THE WITNESS WITHDREW

32

33 MS NICHOLS: That concludes the evidence today, Chair.

34

35 CHAIR: Thank you.

36

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

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