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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

WEDNESDAY, 22 JULY 2015

(8th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: Just before we begin, as I said when the Commission was opened the Inquiries Act permits the powers of the Royal Commission to be exercised by one or more Commissioners separately. Today two Commissioners are present at this hearing as Deputy Commissioner Faulkner could not be present.

I should also just remind any press who are present that a Restricted Publication Order has been made prohibiting the publication of any material which would enable the identification of the lay witness. Her pseudonym will be "Melissa Brown", and that's the pseudonym that will be used throughout the hearing. But any identifying material cannot be published.

Also, just for the sake of anyone who is watching the live streaming, there will be no live streaming of that portion of the evidence. Thank you, Ms Davidson.

MS DAVIDSON: Thank you, Commissioners. We outlined in our opening on the first day of the hearings some of the issues that arise both for victims and for perpetrators experiencing mental health issues. That's what we are intending to explore with the witnesses today.

The first witness will be Professor Patrick McGorry. After that we will hear from a lay witness, a woman who is a victim of family violence, and we will hear about her experiences of services as a woman who has a disability and also has experienced some mental health issues.

We will then break briefly before we convene with a panel of four expert witnesses: Dr Mark Oakley Browne, who is the Chief Psychiatrist; Professor Jayashri Kulkarni, who is a Professor of Psychiatry at Monash

Alfred Psychiatry Research Centre; and Dr Angelina Sabin Fernbacher, who is a women's mental health consultant and a project manager - she's at the Northern Area Mental Health Service; and Mr Drew Bishop, who is a senior social worker with the North West Area Mental Health Service.

It's intended that that panel will probably go well beyond the morning and well into the afternoon session. Mr Moshinsky will lead the evidence of Patrick McGorry first.

MR MOSHINSKY: Professor McGorry is in the witness box. If he could please be sworn.

<PATRICK DENNISTOUN McGORRY, sworn and examined:

MR MOSHINSKY: Professor McGorry, could you please outline what your current positions are?

PROFESSOR McGORRY: I'm Executive Director of Orygen, the National Centre for Excellence in Youth Mental Health, and Professor of Youth Mental Health at the University of Melbourne. Those are my substantive positions.

MR MOSHINSKY: I note that you have prepared a witness statement. Are the contents of your witness statement true and correct?

PROFESSOR McGORRY: Yes, they are.

MR MOSHINSKY: In your witness statement, which will become available, you've set out your background and qualifications, and attached your CV. I won't go into that detail now. Could I ask you to start by indicating what your main area of practice is in terms of mental health?

PROFESSOR McGORRY: For the last 25 years I have focused originally on more serious forms of mental illness in young people - psychotic illnesses, schizophrenia and so

on. But over the last probably 15 years that has broadened out into the full range of mental illnesses and mental ill-health in young people. Obviously, in the age group that we work with, the adolescents and young adults, the family issues are front and centre, really, with all of these patients that we see. So I would say early intervention and youth mental health is my main area of work.

MR MOSHINSKY: Would you be able to explain to the Commission the period of adolescence and young adulthood, and what are some of the mental health issues that can arise during this period?

PROFESSOR McGORRY: The transitional period between childhood and adulthood is obviously a critical period in the lifespan, and it's changed quite a lot probably over the last century but especially over the last few decades and become a much more complex and extended period of transition. It is also the period, probably not coincidentally, when all the major forms of mental ill-health tend to appear and become entrenched if that's what's going to happen.

So all the major adult forms of mental health appear from puberty through to the mid-20s, in some cases building on mental ill-health and mental health problems that have occurred in childhood. So obviously it is not a great preparation for adolescence if you have already developed mental health problems in childhood and often as a result of the sorts of things that this Commission is focusing on as risk factors.

But there is definitely a significant increase in incidence and prevalence beginning around the early teens

and peaking in the early 20s. What we see is the major adult disorders - depression, the mood disorders, the psychoses, the personality and substance use disorders, and eating disorders - all of the major potentially persistent illnesses or combinations thereof that we see in adult psychiatry will have appeared in 75 per cent of cases by the age of 25.

Obviously there are other - there's a smaller group that develop later in life, but I think that's a big difference between physical health, patterns of presentation and what we see in the mental health field. That's why some of the other things I have said in the submission - why we have put so much effort into building or trying to build a new system of care to address that, which was not in place previously.

MR MOSHINSKY: In terms of how our health system has traditionally compartmentalised different mental health issues, how has it historically been done and how are we moving to do it now?

PROFESSOR McGORRY: As probably everyone would appreciate, mental health is probably 20 or 30 years behind the rest of the health system in its evolution. It is only 30 years ago that we had a 19th century model of asylums. There has been a half-hearted attempt to replace that. We are probably, as I have said in here, slipping backwards even in that task at the moment.

The model that we tried to implement 20 years ago with the reforms was based on the general health system. We tried to implement a paediatric adult model of care which was focused on children and adolescents as one group, and that has been a sort of new specialty, really,

in psychiatry. It's only in the last few decades that's even appeared. In most countries in the world it is almost non-existent.

So the paediatric focus is a very small one. Then we have the adult one, which has really grown out of the old mental hospital system and been imported into the general health system. That's focused particularly on middle-aged adults. So the young people that we focus on now in our work missed out in both respects because they had a weak paediatrically orientated system focused particularly on younger children, and then the adult system wasn't particularly interested in the adolescents and the young adults as they were developing the problems. They had to really manifest severe and persistent problems before they really got secure access to any type of care. So there was a huge hole in the middle, and health planners have only just started to address that in the last 10 years or so, and it's still very early days.

MR MOSHINSKY: So is this an accurate summary, that historically when the health systems looked at mental health there's been a focus on children on the one hand and then adults over 18 on the other, but there hasn't been a focus on the puberty through to mid-20s age group?

PROFESSOR McGORRY: Yes. I think that's true. There are lots of other failures in the mental health system as well, and probably the more macro perspective on it is that it really was a very pessimistic 19th century sort of model until even the last couple of decades, and there's been sort of a poorly implemented attempt to try to build a modern system from that base, or rejecting that base and trying to build a modern health system - a mental health

system within the mainstream mental health system. But it's struggling, it's really struggling very seriously, and hasn't gone anywhere near to address the level of need that's there.

There is still a huge mismatch between investments in mental health care and what we see in the major physical illnesses like cancer, cardiovascular diseases and so on. There is probably a very good quality and access in those areas, but very poor and patchy quality in mental health.

MR MOSHINSKY: I might come back to some of those issues in a moment. Just before I do, just in terms of the mental health issues that arise for adolescents and young adults, what are some of the main issues that arise for that group?

PROFESSOR McGORRY: What we see typically, and we see in the Headspace setting, which is a primary care model, we see the very early stages of this now. We see young people coming in, some of them, probably about a third of them, would have had significant mental health problems in childhood, and then we see an evolution of that as they hit the early adolescent period. But there's a very big group of young people who have actually been pretty much okay in primary school and then they start to run into problems as they get into adolescence.

In the young women probably the most common presentation is anxiety, followed by depression, maybe in a subset of cases self-harm complicates that. In the young men, probably - you do see mood disorders that are a little bit more concealed in the young men, and behaviour and drug and alcohol problems seem to be the way that

young men cope with these sorts of problems as well.

So that's the mix. It's a mixture of anxiety, depression, substance misuse and then effects on personality, which I think is unfortunate because it's seen then as a character problem rather than a person trying to find their way in the world, a young person trying to find their identity and their way in the world, and it gets labelled as a personality disorder when actually it's just an attempt to cope with the onset of poor mental health, a very complex environment and a lot of stress that they experience.

So responding to that in a much more personal way at the right time is what we are trying to do in these settings. Of course then the other group of disorders that we see, particularly wearing my Orygen hat, in the more specialist side of the mental health system we see the more serious forms of psychosis, schizophrenia and related psychoses, severe mood disorders, bipolar. We see the more serious eating disorders, anorexia, equally serious to the psychotic illnesses, and are all complicated with substance misuse and the same sort of personality issues as well.

So the diagnoses, they are kind of shorthand for some very complex situations where you see mixtures of different syndromes as well.

MR MOSHINSKY: Generally speaking, when one is talking about adolescents and young adults, are there differences between males and females in the types of mental health issues that arise?

PROFESSOR McGORRY: Yes. I think - these are generalisations, and I'm sure Professor Kulkarni will be talking about this

later, but there are differences. The presentations in the males and females are somewhat different. But it's the same mix of syndromes, really, and, as I say, sometimes the mood disorders in the young men are disguised by and misinterpreted as behavioural problems or character problems, whereas in fact quite often they are covering up quite a significant mood and anxiety problem underneath.

MR MOSHINSKY: You referred to intervening at the right time. Can you explain the concept of early intervention and what that means?

PROFESSOR McGORRY: Early intervention is obviously a key principle in health care, early diagnosis. As long as you have something to offer in terms of treatment, then the logic follows from that that you should try to treat the problem as soon as it appears. That's obviously well accepted in areas like cancer, cardiovascular medicine, diabetes - every other area of health care, early intervention is completely not controversial. It's just a practical problem about how to do it and how to do it in a safe way so that you don't overtreat people but you actually treat people at the right time with the right sort of treatment.

In psychiatry, because of the incredible pessimism that was associated with it until very recently, that idea struggled to really gain any ground, even though there were clearly effective treatments and a review in The Lancet a couple of years ago measured the effectiveness of mental health treatments against physical health treatments and found them to be just as good in an evidence based sense.

But, despite that reality, there's been this idea in mental health that we can't really change the course of these illnesses and the onus of proof has been much higher, I think, to convince people about the value of early intervention.

But it's been a real growth point in mental health research in the last 20 years to actually be able to show that this is actually the case, that you can intervene early, even in the most severe forms of psychiatric illness like schizophrenia, and change the early course of these illnesses by timely and careful multi-disciplinary treatments. So I think it's an area that's gained a lot of support and ground, and it has its detractors as well. But it's something that's really an essential principle of modern mental health care that we have to build on and extend it across the diagnostic spectrum.

I suppose what we have to do to make that possible is to make access to care possible in the early stages of these problems. That obviously involves a whole series of investments and then evaluations of these sorts of approaches, and also the development of new and safer treatments.

So it's really the hope of better outcomes and also I suppose seeing mental health as an investment in the health care rather than a cost because of what I said earlier, the timing and the life cycle of the onset of these mental health problems means that, if the person does not get better and they develop a chronic illness or a persistent illness and they end up on the disability support pension or in prison, perhaps, increasingly,

that's a huge cost to society. So if we can actually more effectively treat people because of intervening earlier and more consistently then this is an investment that will reap major rewards in terms of economic savings.

That's not the case with most health conditions. Most of the non-communicable diseases are in older people, with much less of their working lives ahead of them, if any. So investments in the more medical non-communicable diseases are much more truly a cost to the health system than investments in mental health care. So early intervention is actually an incredibly powerful and important thing for us to be developing, and it necessarily means not a total but a predominant focus on this age group.

MR MOSHINSKY: I would like now to turn to issues of family violence and particularly with the adolescent and young adult age bracket. Through the course of the community consultations the Commission has heard a number of people talking about a number of cases where adolescents or young adults may engage in violent behaviour sometimes to other family members, be they parents or siblings or others. Are you able to comment from your perspective of how well the system as a whole is handling those types of situations?

PROFESSOR McGORRY: That's obviously a key side of - one side of the coin that we see in clinical practice, the fact that - and I would say it would be more common in males than females, family violence perpetrated by adolescents and young adults. That is naturally often seen as a criminal justice issue quite often.

But of the young people that we see coming into

our service, particularly with the more serious forms of illness, a significant percentage of them would have been involved in aggressive or violent behaviour during the period when they were untreated. I might make an aside. This might be a bit of a controversial one, but some very important research was done in Sydney in recent years by Matthew Large and Olaf Nielson, and they looked at homicides carried out by or committed by psychotic patients, and 60 per cent of these homicides were committed by people who had never previously been exposed to any form of mental health treatment.

So the period of untreated illness prior to the first psychotic episode is an incredibly risky period, not just for homicides, obviously, but for a whole range of aggressive or violent behaviour, particularly in males. It's a manifestation of untreated illness rather than primarily a justice issue, because if these people are treated then that risk of aggression and violence recedes very, very dramatically.

So that's the more extreme end of the - but, more widely, aggression, the whole maturation of the individual and even of the brain, the brain development during this period is obviously continuing and the frontal lobes are - the prefrontal lobes are the part of the brain that is developing. So impulse control and the ability to control emotions is not fully matured during this period. So that's why you see more of it in the under 25s than perhaps in the over 25s. So it's a complex sort of situation.

MR MOSHINSKY: If in some of these cases where you have an adolescent or young person using violence, if there were

mental health issues, how well is our system identifying those or finding the person the right supports?

PROFESSOR McGORRY: I think it's extremely difficult because what should happen in those situations is what sort of used to happen more commonly maybe 15 years ago when CAT teams and - we have a team at Orygen called the Youth Access Team. But their job was to go to home situations and deal with these - make an assessment and actually try to work out whether there was a mental health problem and, if so, intervene and even treat the person in the home environment. That was an optimal way to work, and that was the goal of mental health services at that time.

But the failure to resource that and actually the reduction in resources for those activities and the retreat of those types of services back into emergency departments has been a really awful development and preventing them being dealt with in a much more appropriate way.

Now, if there were issues of risk involved, in those days the police would often come with the CAT team or with the YAT team, and that was a good way of handling it, the police in the background and the mental health professionals in the foreground. Now it's the exact opposite. It is almost impossible to get mental health professionals to go to those sort of situations and to work in that way.

There's a kind of a reverse situation called PACER, which the police have set up and brought mental health professionals with them to these sort of situations, which is exactly the wrong way around to be doing it. Police often are necessary, but the way the

police are involved is a very - it has to be a very sophisticated and skilled thing to make it work. That was - that is a much more optimal way to do it. I think the ambulance are also heavily involved, overinvolved, where they shouldn't need to be, because mental health professionals have taken the back seat partly from resourcing and partly from work practice issues.

MR MOSHINSKY: So in terms of how you would ideally like these situations to be handled you have indicated it's very much a criminal justice response at the moment. Have you got any sort of models that you would refer to as how perhaps it should be done?

PROFESSOR McGORRY: We have been involved in training the police actually at Orygen, especially after some unfortunate incidents. They came to us and asked us for our help in I suppose doing what we could to train police officers in approaching people with mental illness, particularly young people, particularly impulsive and potentially aggressive young males. We did what we could.

The police I think approached that in a pretty genuine sort of way. But their protocols are very strict and very rigid in a way, and there are certain things that they believe they can't change in the way they approach people potentially with mental illness. That's what we have to work with if the police are the first responders.

But mental health professionals are supposed to be able to engage and manage distressed people in a much more skilful way. They have had many years in training in doing this. I remember when this was a going concern, this way of working, that there were tremendous skills and talents on show from very high-quality mental health

professionals in these settings which averted many tragedies and also protected the police.

So I think we have got it completely the wrong way around at the moment, and the kind of centre of gravity of mental health care has retreated back into major institutions, no longer the old mental hospitals but now the big acute hospitals and in the ED. If anyone has been to an ED lately and seen people with mental ill-health presenting there, it's not the ideal place for them to be seen either. They have very bad experiences quite often, despite the best efforts of the staff. The whole security guard issue - if we could have imagined 20 years ago that we would end up in this situation after mainstreaming of mental health care, we would have been very depressed. So it's something that the review of this mainstreaming policy is probably about 10 years overdue.

MR MOSHINSKY: You referred to the emergency department and it being the wrong place for this to happen. What happens in an emergency department, and why is that the wrong place?

PROFESSOR McGORRY: The person only makes it to the emergency department - gets through the triage systems and gets through perhaps the first responder system - they only get to the emergency department when they are in a very extreme and acute state of mental ill-health. So already they are in a bad place from a mental health point of view.

Sometimes they are seen, depending on the emergency department, by mental health professionals fairly quickly; otherwise they are seen by general health staff, who quite often - and I have heard this from many patients - regard them as not genuine patients. Their

issues are sort of seen as less important than the more deserving medical patients. You can sort of understand that in one way. If someone is being brought in after a car accident or they are about to die from a heart attack, well, someone who is suicidal or distressed or psychotic, it looks like that maybe can wait a little while.

But the trouble is waiting a little while when you are in that form of mental state allows the situation to escalate. The person gets very frustrated and might become aggressive, and then the security guards descend on the person. They end up shackled and sedated. You couldn't imagine a system designed in a worse way, to be honest.

I'm not saying you could completely do without it, because there are always going to be extreme and emergency situations and there has to be somewhere to go, but at the moment it's the channel of choice, it's the pathway of choice for acute situations, whereas, as I say, in the past we had much better ways of handling that, and they should have been built on and extended for the protection of the Victorian community.

COMMISSIONER NEAVE: Can I just ask you about the effect of drugs in combination with mental illness and what that gives rise to in emergency departments?

PROFESSOR McGORRY: Yes; thank you. I think obviously stimulant drugs - obviously ice is the most topical one at the moment but it's not new in a way. We have had to deal with stimulants for years. The combination of illicit drugs and alcohol, for that matter, when combined with mental illness and mental distress is like pouring petrol onto the embers of a fire. It makes things a lot worse

and much more difficult to deal with, and definitely increases the risks of violence.

MR MOSHINSKY: Can I ask you, Professor McGorry, about when the mental health profession is working with an adolescent or a young person who is affected by family violence, to what extent is the history of family violence or the recent family violence form part of the treatment of the person?

PROFESSOR McGORRY: I think it's not given due attention. I think I have said that in my statement. I think that's partly because particularly in the adult mental health system generally the focus is a very individual one these days. So the person is assessed as an individual and not properly in the context of their family or their community.

That's despite I think the best intentions of a lot of mental health professionals, who have often been trained in a more holistic way. But I suppose the pressures of the system, a combination of things, mean that there's a very individual focus and there's not enough weight given to the context and the risks even in that way .

Again going back to the earlier point, when you do a home visit, which I did last Saturday week in Preston actually for a patient, and you go into the home and you see and meet all the other members of the family, you get an instant understanding and picture of what is actually happening, which you do not get when you are sitting in a little cubicle in an emergency department or in a clinic. With the funding structures and the way the state and federal health systems are organised, you don't get the opportunity really to see the family, even in the clinical

situation, even in the clinic. It doesn't favour your opportunity to even meet and see these family members.

On the other side of the coin you could say if there's a history of violence and risk, because the public mental health system is almost totally focused on risk these days or at least in showing that it has actually considered risks - whether it actually deals with them or not is another question, but it's very risk focused. So it might be the case that superficial or formal assessments of these risks are made and then documented. But in my experience not enough is done about dealing with those risks or actually helping people to minimise them.

MR MOSHINSKY: I think you have indicated that working with the whole family can be desirable in dealing with mental ill-health issues with adolescents and young adults. Are there confidentiality issues that create barriers to working with the whole family?

PROFESSOR McGORRY: Before I address that, could I make just a comment on the workforce again. I think a lot of the workforce doesn't necessarily have the confidence to embrace and work with other family members. They see it as more complexity as well. I referred in my statement to a period when we probably had a lot more training in working with families in a more systemic or holistic sort of way. So we had a lot more confidence, often with a co-worker, to actually work with the family. That sort of training is much less available or routine in the training of mental health professionals as well.

In terms of confidentiality, that's obviously something we think about a lot with young people who are trying to develop their own identity and their own

independence from family as part of the transition to adulthood. It is often used by professionals as an excuse, in my experience, not to engage with the family - "Because I have to develop my relationship with the young person, they have to trust me, so I can't see the family." Particularly once they turn 18 that's almost a routine excuse, in my experience.

I think it's a big problem because the vast majority of the young people we see are quite happy for us to actually see and engage and work with their family members. Obviously there's a subset where that's very difficult. But even there we still often say to the young person, "If we are going to work with you and help you, we have to work with your major scaffolding, which is your family, for better or worse."

The main thing we agree with the young people then, and it's nearly always okay, is we negotiate what we actually are able to share in terms of knowledge and content with family members. That might be a lot or it might be almost nothing. But at least we can still meet and support with the families and assess the family's situation. So it is an issue that is seen as a barrier but can nearly always be worked around.

MR MOSHINSKY: Moving to the sort of more macro issues, and you have touched on some of these already, but in terms of the overall mental health system what are some of the long-term trends that we have seen and where do we stand now?

PROFESSOR McGORRY: As I said, we had a period of reform which started about 20, 25 years ago at the state level which was assisted by Commonwealth investments which is a very

positive first and I think it was around the time of the Burdekin Inquiry, which really opened the lid on what was actually happening in mental health.

Unfortunately that lost momentum fairly quickly around Australia at the state level. Victoria was a state which made a lot of progress and probably was the jewel in the crown, I think, in terms of mental health reform for a while. But it got very, very complacent. So what we have seen in more recent years is a receding of that sort of reform. It's in every state; probably worse in some states than others. Victoria has dropped from top level of per capita investment in mental health to near the bottom, I think, over that period, reflecting that complacency.

So at the state level we have seen this attempt to deinstitutionalise and then mainstream, integrate with the health system. So the acute units and the other units are linked to general hospital systems and under the governance and financial control of acute hospitals. Initially a community mental health system which involved the mobile teams and the case management was set up, but it's languished and it's kind of almost undergone involution in some places. Every year we experience cuts. I won't go into analysing why the cuts occur, but it's a mixture of acute hospital issues and central departmental issues; two sets of contributors to that. So that's the state level.

That was never really fit for purpose in terms of its scale, in terms of the unmet need that it was meant to deal with. So it defined serious mental illness in such a way that a whole group of people with complex and serious

mental illness were excluded from it and again favoured late intervention as a result. It was coming off a low base, you could say; but that base should have been grown.

On the other side of the coin you have the Federal Government, which has actually continued with reform over the last 10 years or so. It has set up programs like Better Access which has added to the strength of primary care. It has added allied health professionals to work with GPs. So that was a positive step. It established Headspace, which we have mentioned already, which is like a form of multi-disciplinary enhanced primary care for young people, because young people had very poor access to traditional primary care. So there have been some positive developments on the federal side.

But in the middle, between the sort of people who can be managed in the federally funded system, including private psychiatry, you could say, although that's a bit of a more complex thing too, there's a huge gap between what that will cover and what the state funded public mental health system will cover. So there's a whole bunch of people in the middle, including people who have been in the state public mental health system and have had an episode of care, who are then discharged back to the primary care level. There's a very large group of people, probably millions in Australia, who don't get the multi-disciplinary, continuing secure care that they really need to remain well and to recover.

The unmet need in mental health, it's at least 50 per cent of the people who need care are not getting it. That is not the case in cancer. It's not the case in

cardiovascular disease. It's something that we have been obviously advocating and campaigning to have addressed.

MR MOSHINSKY: Can I just ask you one particular question. In paragraph 32 of your statement you refer to the block funding in hospitals and how that works in a different way for mental health care. Could you just explain that?

PROFESSOR McGORRY: Sure. Obviously state governments run hospitals, so it's a bit of a stretch for them to also think that they could run a community mental health system as well as the bed based services, and that's what's proving to be the problem.

In the acute hospitals the medical beds and the surgical beds are run on an activity based model. Even then it's obviously short of cash a lot of the time, and that's one of our problems as well. The mental health budget is still funded in a block format. So the beds are funded as a block grant. The bed day rate currently is - quite consciously the health department knows that it 's underfunding the cost of those beds. So there's a shortfall just from the bed day block grant every year in those hospitals. It also funds resources for community mental health care case management and so on and mobile - community based care, which is also a block grant. It is not activity based either.

From the perspective of the hospital CEO, he sees this quite large chunk of budget coming in each year into the hospital which is not tied to activity. It's not sufficient to provide the services that the health department thinks it's buying because of the funding of the bed day rate and also because the EBAs that are negotiated in terms of pay rises for the clinical staff

are deliberately underfunded by the health department every time one of those is negotiated. So the hospital then has to find the shortfall for what they have to pay their staff. So those are two contributors to why the mental health budget is not sufficient to provide the services that are even expected to be provided with the money.

The third thing is - and this will be the controversial one which most hospital CEOs will deny is happening - money is diverted from the mental health budgets to prop up other parts of the hospital budgets. It's hard to prove that, but I can tell you that it happens.

So three sources of undermining of even the existing and inadequate budgets happen every single year. We are subject to that in our own services. It's been happening annually for the last few years. That means more of these seriously ill patients are turned away, and the patients are demonstrably at high risk. Our suicide rates have increased significantly in the last year or so, something we never really saw before. It's finally hit that critical point, that the morale and capacity of the service is really not able to respond.

This is not just us. It is not special pleading. It is happening across the public mental health system. It is happening in every state in Australia. Mental health is extremely vulnerable under these governance and financial arrangements in this mainstream model. It would be easy to ring-fence it and protect it and to prevent the CEOs from doing what they do. The health department could actually appropriately fund the level of care that they

say they are buying from the hospitals. But that again has politically been seen as too hard.

COMMISSIONER NEAVE: Can I just follow up with that because I'm not sure that I quite understand. The activity based funding that is provided for physical care, when you say activity based it is this hospital will treat this number of patients who will occupy this number of bed days and there's some specification of the conditions, the conditions for which they are being treated; is that what activity based funding means in this context?

PROFESSOR McGORRY: That's pretty much right. For example, the hospital will perform 50 hip replacements. The cost of a hip replacement is X dollars. So the hospital will get as many dollars for as many hip replacements as it actually does. So there is an incentive to do more and they will be paid an agreed amount per piece of activity within the hospital.

COMMISSIONER NEAVE: Whereas in the mental health area the hospital gets a specified sum for mental health. Does that specify the number of people who have to be seen or number of bed days or anything like that?

PROFESSOR McGORRY: No. The number of beds that are actually operating in the hospital, and it might be worked out in terms of occupancy rates, they are given a block amount of money for the number of beds and the assumed occupancy. So the throughput is not a factor. There have been attempts in the last few years to try to bring activity based funding into the mental health system within the hospitals, but so far that has not happened. People are very worried about it happening if it's done just for the inpatient component and not for the community based

component because then there will be even more drag on the funding for cross-subsidisation of the community for the acute.

COMMISSIONER NEAVE: I know you are making a general argument, not about Headspace, but is your funding derived through a hospital or is it separately funded as a particular project?

PROFESSOR McGORRY: Headspace is a federally funded program. So it is linked to primary care. All Headspace is is a youth version of multi-disciplinary primary care. It has a different sort of style and culture. But in terms of the financial drivers of it it's just an elaborate form of multi-disciplinary primary care.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Could I just follow on from that. Could you just expand a bit on what Headspace is? How does it operate? Where is it? What does it provide? What level of care are we talking about with Headspace?

PROFESSOR McGORRY: Headspace operates, or will be by next year, in 100 sites around Australia. We calculated that for full national coverage, for every community to be covered and for the level of unmet need to be covered, we would need closer to 200. So it's probably getting close to 50 per cent of coverage of the Australian community.

It's typically located in a shop-front type set of premises, in a suburb or in a regional town. It has a combination of GPs, allied health professionals, often youth workers, sessional psychiatry in some cases. I work in a sessional way in a number of Headspaces myself.

The other two pillars are supposed to be drug and alcohol and vocational experts working on site in the same

location. That's not as well developed as the other elements. But in the latest federal budget there's an investment in the vocational workers. So it's gradually being built.

The style of it is meant to be of a youth drop-in centre, youth cafe sort of feel. That's what it's supposed to feel and look like for the young person. It is variably successful in that. But I think there's a general sense that there's a lot of youth input into the way that the thing operates and the way it actually feels and is designed.

So I suppose it's an attempt to provide a stigma-free primary care model. It's broader than just medical. It's a social model as well as a health model. The person doesn't have to justify why they are turning up. Unlike with our mental health triage systems which are designed to keep people out as much as get people in, Headspace cannot refuse people on the basis of the nature of their presentation. It's just like going to a normal GP. A GP doesn't screen you to see whether you are a deserving customer or not. The GP will see you if you want to see the GP. Headspace is like that or meant to be like that.

MR MOSHINSKY: What level of care? Does Headspace refer out more serious issues?

PROFESSOR McGORRY: That's a great question because it should be able to do that because it is capable of providing I would say still reasonably specialised care, more than your standard GP, because you do have mental health professionals and sometimes psychiatrists as well as the GP. So it can handle a reasonable level of

complexity, I would say.

What it doesn't have is case management capacity. So it can't actually see people for - in the case of the mental health professionals - more than 10 sessions because it's funded by Better Access. It's office based. It is not mobile and it is not able to spend large amounts of time with each person. So it does have limitations, and it is really just an enhanced primary care model.

I work in a Headspace that doesn't have a specialised youth mental health service working closely with it such as we have with Orygen and the Headspaces in the north-west. I work up at Coffs Harbour once a month. That service deals with incredible complexity because the local hospital and its capacity to provide specialist mental health care is very poor. So we have to hang on to much more complex cases in that Headspace environment, or they go nowhere.

That is the problem. That would be the problem I would say in adult psychiatry too. There's this great group of people in the middle that are too complex for the primary care and even the private psychiatry sort of system, and yet the specialist acute public hospital system is only able to deal with life threatening and very extreme cases. So there's a great bunch of people in the middle that are really not getting the right care.

MR MOSHINSKY: Can you explain what Orygen is and what level of care Orygen provides and whether that type of support is available in other parts of Melbourne?

PROFESSOR McGORRY: Orygen was established in the early 2000s as a broadening of our original focus on early intervention for psychosis. So we broadened out

diagnostically and we tried to develop more specialised programs for complex mood disorders, for severe personality disorders, and eating disorders and substance abuse. So we weren't able to get the resources for the last two to develop that. But we have developed programs for complex mood disorders, psychoses and personality disorders.

The other difference about Orygen from the rest of the public mental health system is that it covers the teenage and young adult period; the rest of the public hospital system still is probably mostly child, adolescent and adult. So it does bridge this age group. We cover a region of about a million people in the north-west of Melbourne. We see about 700 new patients a year. We estimate the number of young people in that region with mental health needs is about 40,000 to 50,000. So we knew that we were only dealing with the tip of the iceberg, and that's why we decided to try to create something like Headspace to deal with a much larger volume of young people.

The history of Orygen, it's been able to create a very large research program over that period. So now we have about 150 researchers working in different aspects of mental health care; also working clinically, some of those people. We have about a $25 million budget in research and training around the youth mental health idea. We still have our specialist youth mental health program and we run four Headspaces. It is like an integrated virtual system which is probably, I would say, about 50 to 60 per cent built across the north-west. We have an idea of what it should look like in the end, but there's

definitely some significant gaps in it still. But it is the beginnings of a comprehensive system for that region of Melbourne.

In recent years, as I have said in the submission, we have gone backwards from the State Government point of view because we have lost resources from the specialist side. Each year we seem to lose about half a million dollars in terms of recurrent funding, which means that roughly translates to another 100 of those 700 patients not being able to access and continue with the service.

So I'm worried about the, I suppose, longer term future. This has been a very important platform. We see it as an incubator or as a clinical laboratory to develop new treatments and develop new expertise and new workforces and spread them; and yet this kind of goose which has laid quite a few golden eggs in many ways in terms of new evidence and new treatments is getting a bit sick.

MR MOSHINSKY: Just finally, if I may, Professor McGorry, in your statement at paragraphs 41 to 43 you talk about a model which is a sort of youth version of Forensicare, where you bring together forensic and mental health responses. Can you just explain what that model would look like?

PROFESSOR McGORRY: One of the big successes of Victorian mental health reform I think going back 15 years or so, 20 years, was the development of Forensicare led by Paul Mullen. That actually for the adult population was a big step forward and very high quality care at that time.

MR MOSHINSKY: Can I just ask you to explain what that model

looks like?

PROFESSOR McGORRY: That was basically developing a specialist system, hospital based and also community based, of forensic mental health care for offenders who had mental illness of various kinds. So there's a hospital at Fairfield, the Thomas Embling Hospital. They run community clinics in different parts of Melbourne for adult offenders with mental illness.

But, as we all know, the curve for offending behaviour is very similar to the curve for onset of mental illness. It starts to take off at puberty and it peaks and starts to decline a bit after the age of 25. It is almost exactly the same curve as what we see in terms of the incidence of mental illness.

What we see - and we have referred to this already - is a lot of offending behaviour in young people who also have mental health problems. We are located very close to the Melbourne Juvenile Justice Centre. It is just across the road from our Orygen base. Some of our psychiatrists have done on-call for that centre over the years. We have made a couple of attempts to advocate for the development of a youth Forensicare, if you want to put it that way. We even had a small clinic at Orygen at one point, which was defunded by the health department. But we never really got off the ground in terms of getting a serious investment in a Forensicare dedicated to the adolescents and the young adults, which is obviously in a preventive sense incredibly important.

There have been some positive developments at the Juvenile Justice Centre in the last couple of years with the foundation of a new school there. There's an amazing

sort of educational facility that's been launched across the road. What these teachers tell us is that 60 per cent of these young people they see in the school have got very significant mental health problems, but the only health service that is provided to them is an adolescent focused health service which is very primary care, very generic and has very little mental health expertise in it. Again, the scale of the problem absolutely overshadows the resources that are being devoted towards it. So this is an obvious priority that needs to be addressed.

It would also have a community arm to it. It wouldn't just be resources devoted to the residents of the juvenile justice. There could be a much wider scope to that, allowing mental health and forensic expertise to come together in reducing the risks of recidivism in terms of offending and improving the outcomes in lots of ways for these young people.

MR MOSHINSKY: Thank you. Commissioners those are my questions. I don't know whether the Commissioners have any questions.

DEPUTY COMMISSIONER NICHOLSON: I have one question. Professor McGorry, do you see a role for perhaps specialist CAT teams for young people where those teams are capable of being the first responders, meeting the young people in their home?

PROFESSOR McGORRY: We did have that operating through our youth access team. It still does exist, but it doesn't function in that optimal way anymore. But I definitely think that would be the optimal thing. I worked on that team myself, and when it was working well it was just an absolutely optimal way to work. The sort of people that

were attracted to work in that mode were very special people as well. They had tremendous skills. They had great decision-making ability. They knew how to work with police. The police were very happy to work with them. The ambulances were the same. So I think it would be an excellent sort of statewide model to build in.

To be fair to the government, there was at least a notional reform to restructure the health system so that we had a nought to 25 and then a 25-plus approach to mental health. But so far that's largely on paper. There's been no real investment in putting the new resources on the ground to make that a reality. A team such as you describe would be an essential part of such a reform system.

COMMISSIONER NEAVE: Do you have any ideas about what that would cost to do that, just to have a specialist CAT team so that, for instance, a parent who was being beaten up by an adolescent with a mental health problem would have somewhere to go other than the police?

PROFESSOR McGORRY: You would probably have to link it to the structure of the nought to 25 system. So each region or each part of Melbourne would have to have one. Obviously if the region is too big you can't operate; the distance and the geography is too much. You have to think about it from that point of view; how many you would need to cover the metropolitan area, and then how you would do it in the regional and rural areas. I probably can't do it right now, but the exercise could be done very, very quickly because we have conducted similar exercises when advocating for further investment in the past. It could be very rapidly done.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Those are all the questions for Professor McGorry. If he may be excused, please.

COMMISSIONER NEAVE: Thank you very much, Professor McGorry.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: Commissioners, I understand for technical reasons it's desirable to have a five-minute break before we call the lay witness.

COMMISSIONER NEAVE: Yes. Thank you.

(Short adjournment.)

(CONFIDENTIAL SECTION FOLLOWS)

COMMISSIONER NEAVE: Ms Davidson.

MS DAVIDSON: Thank you, Commissioners. The next part of the day and really for the rest of the day we have a panel of four experts, and I would ask that they be sworn.

<ANGELINA SABIN FERNBACHER, affirmed and examined:

<JAYASHRI KULKARNI, affirmed and examined:

<DREW BISHOP, affirmed and examined:

<MARK ANTHONY OAKLEY BROWNE, affirmed and examined:

MS DAVIDSON: Can I perhaps start with you, Dr Oakley Browne. You are the Victorian Chief Psychiatrist?

DR OAKLEY BROWNE: I am.

MS DAVIDSON: Have you made a statement for the Royal Commission?

DR OAKLEY BROWNE: I have.

MS DAVIDSON: Can you confirm that that's true and correct.

DR OAKLEY BROWNE: I do so confirm.

MS DAVIDSON: Can I just get you to outline for - - -

DR OAKLEY BROWNE: Apologies, there is one minor correction. Paragraph 41, we quote a figure there where we quote 45 times the rate of presentation for Aboriginal women related to violence. The figure should be 40.

MS DAVIDSON: Forty, 4-0?

DR OAKLEY BROWNE: Yes.

MS DAVIDSON: Can I just get you to briefly outline your background and your role as Chief Psychiatrist?

DR OAKLEY BROWNE: The Chief Psychiatrist is the position which was created under the Mental Health Act 2014 in Victoria and assigned certain statutory responsibilities to the person who holds that, particularly has responsibilities for monitoring the use of the Act within publicly funded mental health services, with particular emphasis on the

use of restrictive practices. Restrictive practices are practices such as placing a person in a room by themselves with the door locked, which is called seclusion, or mechanical and physical restraint. I have responsibilities for monitoring the use of ECT, particularly in persons less than 18 years of age. I have responsibilities around notifiable deaths. These are deaths usually notified to the coroner occurring in public mental health services. I have responsibilities to do with standards of practice. So I contribute to publishing documents, directions, guidelines which inform the practice of health practitioners within mental health services, so a clinical leadership role.

MS DAVIDSON: Just to clarify, so it's primarily a clinical leadership role, but what is your role in relation to the development of policies, funding, those sorts of things?

DR OAKLEY BROWNE: Yes. So I contribute to policy discussions within the department, particularly when they relate to clinical practice within mental health services, and I provide advice to the Secretary and the Minister around mental health practice.

MS DAVIDSON: Thank you. Perhaps can I then go to you, Mr Bishop. You are a senior social worker with the North West Area Mental Health Service?

MR BISHOP: That's correct.

MS DAVIDSON: Have you made a statement in this proceeding?

MR BISHOP: I have.

MS DAVIDSON: Can you confirm that that is true and correct?

MR BISHOP: I can, yes.

MS DAVIDSON: Can you just describe for the Commission what your current role is?

MR BISHOP: I'm a senior social worker working in a community mental health team. On that team I'm the team leader, and I provide clinical leadership and guidance to the team around working with people with a major mental illness.

MS DAVIDSON: Professor Kulkarni, you have previously made a statement for the Commission?

PROFESSOR KULKARNI: Yes, I have.

MS DAVIDSON: Are you able to confirm that that's true and correct?

PROFESSOR KULKARNI: Yes, it is.

MS DAVIDSON: Can you just outline for the Commission your qualifications and your current role?

PROFESSOR KULKARNI: I'm a medical practitioner and a consultant psychiatrist. I'm also Professor of Psychiatry at Monash University, and I have worked in the area of women's mental health as my expertise. I have set up the Monash Alfred Psychiatry Research Centre, which I currently direct.

MS DAVIDSON: And you have a particular role in respect of a women's mental health clinic?

PROFESSOR KULKARNI: Yes. As part of my work I have set up a specialist women's mental health clinic. It is a second opinion clinic, and we have approximately five medical staff from different disciplines as well as other disciplinary background workers in that clinic. We see a number of women who have experienced violence, interpersonal violence, and the consequences of that in terms of trying to help their mental health.

MS DAVIDSON: Dr Fernbacher, can I get you to confirm that you have made a statement for the Royal Commission?

DR FERNBACHER: I have.

MS DAVIDSON: Are you able to confirm that that's true and correct?

DR FERNBACHER: I can.

MS DAVIDSON: Can you just describe for the Commission what your background is and your current role?

DR FERNBACHER: So my background is that I hold a Bachelor of Education and Masters in Gestalt Therapy as well as a Doctorate in Public Health. I work at the Northern Area Mental Health Service, which is a clinical mental health service in the northern suburbs of Melbourne. In a service development role it spans broadly three areas. One is women's mental health, families where a parent has a mental illness and also Aboriginal mental health.

MS DAVIDSON: You have also held some roles from time to time providing sort of more policy advice; is that correct?

DR FERNBACHER: That's correct, yes.

MS DAVIDSON: Can you outline that for the Commission?

DR FERNBACHER: Sure. I have been seconded into the Department of Human Services initially or the Department of Health and Human Services on three occasions. At the first instance I worked on a project that looked - it was a statewide project that looked at the current level of collaboration between mental health services, family violence and sexual assault services, which resulted in a report published by the department. The second secondment was to develop guidelines on gender sensitivity and safety for mental health services.

MS DAVIDSON: Perhaps if we could just start by getting some sort of understanding of the structure of mental health services and how they are delivered in Victoria. Perhaps I would ask you, Dr Oakley Browne, to give an overview of

how mental health services are structured in Victoria, where the funding comes from and how they operate.

DR OAKLEY BROWNE: There are two major sources of funding - ultimately all the funding comes from the Commonwealth, but there is an agreement between the states and the Commonwealth about distribution of funding for acute health services, including mental health services. So the Victorian state government has responsibility for running the acute services, hospital based services, and community services associated with that. Those services by and large provide care for people with severe mental health problems with significant degrees of disability.

In addition, the Commonwealth provides funding usually through primary care, to GPs and other community based services, to provide services usually for persons with what are called high prevalence conditions such as depression, anxiety and substance use disorders. So there are other sources of funding, but they are the two major streams.

MS DAVIDSON: Does anyone want to contribute to that or explain how their particular service fits within the mental health service delivery?

MR BISHOP: Sure. I can. My team is what's called a primary care model. So we are a community based team. We work with GPs to provide mental health services to the community for what we call high prevalence disorders such as anxiety and depression. We also see some people with psychotic disorders as well, but primarily our role is a shared care arrangement with GPs and other service agencies in the area, which in this instance includes family violence agencies as well.

MS DAVIDSON: Professor Kulkarni?

PROFESSOR KULKARNI: The particular clinic that I have described, which is a women's mental health clinic, runs on a Medicare rebate system. So it is outside of the standard sort of state public hospital funding model. However, it is attached by the research arm of the clinic to Monash University as well as to some of the Alfred Hospital facilities. So this is a different sort of model of treatment care, probably more closely aligned to private specialist work.

MS DAVIDSON: Dr Fernbacher, can you outline how the Northern Area Mental Health Service that you work in fits within the mental health service system?

DR FERNBACHER: Sure. So the Northern Area Mental Health Service is part of a broader mental health organisation called North West Area Mental Health, which is part of Melbourne Health. It's a clinical mental health service with a lot of the clinical mental health services, as Mark was alluding to, broadly consists of acute care, so Northern does a psychiatric inpatient unit, an emergency mental health team - used to be called CAT team - some community mental health centres and a prevention and recovery care service, which is also often referred to as a step up/step down facility which supports people or prevents - supports people, preventing them going into a psychiatric inpatient unit or when they are discharged back who may not be ready to go home with more intense support. That probably outlines it. And other clinic and mental health services are similarly organised with some more specialities in some areas.

MS DAVIDSON: I think, Dr Oakley Browne, you explain that the

service system response is based not on the type of illness that a person is suffering but the impact of that mental illness. Can you explain that?

DR OAKLEY BROWNE: Yes. It is based on three components, both the presence of a disorder but also the impact on the person's life and on other people's lives, so the degree of disability or problems associated with that. It is also based to some degree on acuity, so the level of severity of the symptoms, and the risk involved to the person and other people.

MS DAVIDSON: Dr Oakley Browne, I understand that you would like to respond to some issues that were raised by Professor McGorry. Are you able to do that now?

DR OAKLEY BROWNE: Yes. Professor McGorry raised a number of issues about the level of funding provided to mental health services. I think it would be true to say across the world that mental health services or response to mental health problems are underfunded compared to our response to other health problems. An important study called The Global Burden of Disease Study showed this quite clearly. The Global Burden of Disease Study looked at both mortality, that is premature death due to a condition, and morbidity, that is disability or other dysfunction resulting from the condition, such as not being in employment and not being able to pursue normal activities and so on.

For mental health problems, although mortality is low, morbidity is high, and that's principally because it occurs early in the person's life and for severe disorders follows an episodical chronic course, so it has a lasting impact on the person unless treated. The consequence of

that is, if you look at a developed economy like Australia, the burden due to mental health and other neuropsychiatric conditions is about 23 per cent of the total pie, but the level of funding isn't commensurate with that 23 per cent, and that's - - -

COMMISSIONER NEAVE: Can I just clarify that. So it is 23 per cent of the total burden of morbidity?

DR OAKLEY BROWNE: Of the total burden, yes, in a developed economy such as Australia. It will vary from country to country. But the level of funding isn't commensurate with that. That would be true not only of Australia but pretty much every nation. That is shifting because of the influence of studies like The Global Burden of Disease Study and the WHO, the World Health Organization, which has advocated for increase in funding.

Within Australia the prevalence of severe mental disorder, and I mean by that conditions such schizophrenia, bipolar disorder, severe depressive episodes, is about three per cent of the population. But the level of funding is probably only able to meet the needs of between one and 1.5 per cent of that population, so it is - in terms of the state funded services. So that's true, there is a global underfunding of mental health services.

I have had the privilege to serve now in two states as a senior medical administrator, Tasmania and Victoria, and under now I think five ministers of health; and I have had the good fortune over that period to have seen an increase of funding in each of those situations allocated to mental health. So I think there has - I have had the good fortune to serve under governments who have

had a genuine commitment and provided additional resources to mental health services, and that is the case at the moment for mental health in Victoria with the last two governments, that there's been an increase in funding, despite the significant financial pressures on the whole health service and the whole budget.

It would be true to say the total health budget is under significant pressure, and again across all developed countries. That's primarily for four reasons - one, the ageing population. Secondly, we can do more, so our technology has improved, and so we have more possibilities in terms of treating people, but that involves an increase in cost. The community's expectations have increased, and the cost of delivery of services have increased. The inflation rate for health services is greater than the national inflation rate, and that's generally true. So it means all governments of all persuasions are between a rock and a hard place when it comes to health spending and need to make hard decisions about allocation of resources because of that. However, it would be true to say, as I have said, in the two jurisdictions I have served mental health has been treated favourably in terms of modest increase in funding and programs where that's possible.

The other issue that Professor McGorry raised was - I should emphasise in my experience there hasn't been a systematic plan to reduce funding; quite the contrary. It's been a systematic plan to increase funding but done in a way which is likely to yield real benefits.

The other issue is at the hospital level has mental health been disadvantaged by being mainstreamed, so

included along with other health services. Again, in my experiences, no, that mainstreaming has been a major advantage for persons receiving health services. Prior to mainstreaming, when people were treated in large institutions, the level of care - and I remember those and had the misfortune - experience to work in those as a young practitioner - the level of care provided and the needs of a person was nowhere near what can be provided now. So I think mainstreaming has led to major advantage in terms of provision of care, and open and transparency and accountability about the provision of those services.

Having been a clinical director myself, I'm aware that from time to time we get suspicious because what happens is Mental Health, along with all other health services, contribute to the funding of the health service, and there are particular central costs - hotel costs, if you like - things like payroll, heating, laboratory costs, which are shared across all of the services and are usually done on a formula which is transparent and argued and goes through the board for approval, and Mental Health often has the sense that they have been disadvantaged by that formula. In the services where I have worked, although I have sometimes shared those suspicions, they haven't been shown to be true when I have looked into the matter and Mental Health usually makes an equitable contribution to those services.

So I think I would make those comments about funding. I am not aware - I'm not directly involved in funding decisions, but the level of cuts that Patrick McGorry is aware of, I'm not aware of the level that Patrick McGorry has suggested.

The second point I would make is Patrick McGorry raised issues about whether the formula for block funding as against activity based funding, which is the usual strategy in most of acute health, disadvantages mental health. Activity based funding works very well for procedures like surgery or medicine, where you can accurately predict what the costs will be associated with the provision of care, an episode of care for a person with a particular condition. But it doesn't work well for mental health. That's simply because diagnosis and factors related to diagnosis, which are usually called complexity, don't predict the cost of care in any degree of accuracy. So the variance around that cost is large.

So whenever other countries have looked at doing ABF based funding for mental health they have essentially backed off from that and decided it was unworkable, and gone to other types of formula, such as block funding, to arrive at ways of funding mental health.

It's not true to say that block funding in Victoria isn't outcome based. Health services are given a range of outcome measures which they have to perform to. Now, these are all subject to ongoing refinement, and you can make an argument that they are very crude and coarse measures, and I agree that they are. But they are in place, so health services have to account for their performance.

There's ongoing work at the Commonwealth level with making more sophisticated models which will enable us to look at not only the inputs in terms of delivery of health care but the outputs and the benefits, and attribute resources in a more precise manner, and that's

ongoing work.

I think the final issue about Patrick McGorry's evidence that I would like to emphasise - and I think it's a really important point because of the problem of family violence that the Commission is considering - Patrick McGorry quite rightly indicated that the bulk of mental health problems begin in young adulthood, late adolescence, 75 per cent occurring before the age of 25, about 50 per cent before the age of 50; and because of that the need for developmental appropriate services to be provided to people presenting, particularly the youth, so that the services are accessible, appropriate for them and provided care which they would find acceptable.

However, there are certain types of disorders which have their origin in early childhood which are particularly relevant to risk of developing a propensity for violence in adulthood. One particular disorder where there's a strong continuity between childhood problems and adulthood problems is what's called conduct disorder. Conduct disorder in layman's language would be a young child who presents with problems with being unduly aggressive, problems with following rules, problems in classrooms and so on.

These problems present very early. In fact, teachers can very accurately predict from a child's behaviour in a classroom their likely propensity to follow a particular trajectory of difficulties. They probably have their genesis even earlier than school age. They probably start in the forming of attachments with primary care givers like parents, and disruptions in those attachments can contribute to the likelihood of developing

these sorts of conduct problems.

The good news is that there is an emerging evidence base that intervention with conduct disorders can change that trajectory, and interventions which are at the child level and at the family level and with parents, to intervene and help shape behaviour which is more adaptive for the child and that they can lead to persistent benefit and a decreased likelihood for the sort of problems that you see in adulthood associated with violence.

I need to emphasise that in terms of prediction of violence, anti-social behaviours and sometimes what we call anti-social personality disorder is a strong predictor if we are looking at mental health problems of propensity for violence in adulthood.

So I just wanted to emphasise that latter point because it's probably an area which has been underinvested in and does need to be invested in, and is not particularly within a group that Patrick McGorry's services address, the youth group. It is actually in early and middle childhood that the interventions need to occur. Thank you.

MS DAVIDSON: Can I just pick up on that last point in relation to children and disorders such as conduct disorder and its potential link with attachment and early attachment. We heard in the first couple of days of - maybe on about Day 2 or Day 3 of the Commission's hearings about the impact that family violence can have on attachments and the relationship that that all has with potential development of all sorts of behavioural issues and disorders for children. Are you talking about conduct disorder as being separate from family violence, or do you

see that conduct disorder needs to be understood in the context of the potential for family violence to also be part of the contributing factors?

DR OAKLEY BROWNE: I'm not a child and adolescent psychiatrist, so you are asking me about an area that's not within my clinical expertise, but my understanding is disruptions in attachment can manifest in a variety of ways in children. So conduct disorder is not the only one. Children who have had disruptions with attachment can have problems with anxiety and depressive symptoms, learning difficulties and a range of other social behaviour and so on.

But conduct is important to know because it does predict a persistence of problems around management of aggression, which can persist into adulthood. There is a strong association. I'm not saying it is the exclusive outcome of disruptions in attachment. There are a range of other outcomes. But it is one. They should also be identified and treated of themselves, but conduct disorder is an important predictor of adult problems of aggression and violence.

MS DAVIDSON: Professor Kulkarni?

PROFESSOR KULKARNI: I just think one of the things that is missing in this discussion is it is as if there's been a horrible splitting of the violence and the mental health consequences and psychiatric illnesses and diagnoses. What we are seeing in the field, in my view, is that we have a group, usually psychiatrists and psychologists, who are focused on making a diagnosis of personality disorder, conduct disorder and other disorders, and often the actual antecedent family violence is kind of consigned to some

other person's purview to take that history and somehow magically deal with it. This is why I think we have an issue in the mental health ripples, which are very, very large and continue lifelong, of family violence. It is as if the mental health professions haven't caught up with taking very good histories and clear stories of the trauma and the violence, and then putting that together with the consequent diagnosis and then coming up with holistic treatment and management plans. That's both in a service sense in the public system, but also in the private - primary health and private specialist areas.

DR OAKLEY BROWNE: I agree with what my colleague is saying. I think Mental Health does have a role in terms of the response for - along with a number of other agencies and sectors in terms of violence. But I think I want to emphasise the principal consequence for mental health services of violence is not dealing with perpetrators of violence - that's an important part of our work, but not the sole part of work. A large percentage of people we see in our services have been victims of violence, and that violence has contributed to the onset of their mental health problems. Understanding that relationship between the violence and their mental health problems is crucial to providing an appropriate response. I think where we have not done as well as we could is understanding that connection and providing the appropriate response.

In fact - I don't know if you are going to - if you look at the evidence on population level of what contributes to violence on a population level, mental health problems is actually a small contributor to violence. In fact, other factors are more important than

mental health disorder in contributing to violence. Factors such as gender, age, use of substances, having had a prior history of violence, having been exposed to violence yourself as a child or a teenager - those factors are more powerful in predicting likelihood of violence than the actual presence of a disorder.

There is one exception to that. There are a group of severe disorders, such as schizophrenia and other psychosis, where there is a true increase in violence associated with that condition. That doesn't mean it's a causal relationship, but people with schizophrenia are about two to five times more likely to commit serious violence than the rest of the community. But, despite that, the majority of people with schizophrenia don't commit violence. That needs to be emphasised.

One figure my colleague Professor Mullen emphasises, just to bring this home, is that from studies they had they calculated a figure called population attributable risk, which is an epidemiological term which says, "If you could remove this condition from the community how much would the outcome drop?" If you were theoretically able to take all people who were diagnosed with schizophrenia and place them somewhere else the rate of homicide and serious violence in the community would only drop 7 per cent. This suggests that the majority of violence isn't associated with severe mental disorder; it is associated with other factors, other criminogenic factors.

However, we do have an important role. There are a group of people who have severe disorders where their violence is directly related to their illness, either

through delusions or hallucinations, where identification and treatment of the condition is very important.

There are another group of people who have violence - associated along with other factors who have violence who may have depression or anxiety and other factors which increase the likelihood of them acting violently, and treatment of that condition along with addressing the other factors reduces the likelihood. But there are a significant group of people who don't have a diagnosable mental disorder or, if they do have one, it's not incidentally related to their violence.

MS DAVIDSON: I will come back to the issue of how we might deal with people who are using violence and where mental illness might be a factor. I wanted to first explore with the panel the impact of family violence as a contributing or causal factor for developing mental illness, which I think each of you have addressed to some extent in your statement. I think it's led you, Dr Oakley Browne, to identify that family violence is in fact a major public health issue. Perhaps I could start with Professor Kulkarni and the work that you do in relation to women's mental health and the impact that family violence has for women.

PROFESSOR KULKARNI: Yes. In our clinic and in the research that we are doing we actually are looking at a number of different conditions that do have a very strong origin in family violence or violence of a number of different types, and that's physical violence, sexual violence, emotional violence and emotional deprivation, and they all fall into the category of violence.

One of the big conditions that we face in a

number of the psychiatric circles is a condition called borderline personality disorder and the recognition of the level of trauma and violence that women - and predominantly the diagnosis is given to women - who have this condition who have got a violent background or have had problems for many years is not recognised very well at all.

This is where I come to that point, that taking of a trauma history or the taking of a story about violence is not part and parcel yet of standard psychiatric practice. That's why I think certainly the College of Psychiatrists has put out a document, and I have had a look at that, and there are details in there about improving the education of psychiatrists and other health professionals about the relationship between trauma violence and this condition.

This condition is quite prevalent. The last estimates are that there's an expectation of about 28 per cent of the adult female population have some variation of this condition. It is called borderline personality disorder formally. There are a number of us who really dislike that particular term and we want it to be considered to be something like complex trauma disorder.

The ripples of this condition are quite profound in that there are many problems with relationships, with self-harm, with depression, with coincidental or overlying psychotic episodes as well. Then the other thing that our research has been showing us is the transmission to unborn foetuses in terms of brain chemistry changes. So we do have concerns that violence in the family sense or other

violence towards women can actually predispose to the next generation of mental illness even before the baby is born. So these are some of the things that we are really concerned about.

Also another level of concern is that at the moment the amount of training in our health professionals in psychiatrists to actually deliver the therapeutic measures that are required to help women who have this particular condition is not really there in the population in health professionals to the extent that we need the special skills.

I am concerned about the level of training that medical practitioners don't receive in terms of taking the trauma stories from their patients in the primary health sector as well as in the professional mental health sector. I think we really need to be able to improve these areas to provide a better outcome.

Overall, the focus on women's mental health has been quite abysmal. It has not received specific attention other than in the perinatal areas, and even there there is a considerable underresourcing of what's required for women in the antenatal and postnatal periods in terms of their mental health.

So this is a condition that does affect women more than men. That's not to say that men cannot experience borderline personality disorder, they certainly can, but we need to cope with the relationship between trauma and this condition and also the development of resources to better provide treatments for women experiencing this condition.

MS DAVIDSON: Dr Fernbacher, you have addressed in your

statement as well the relationship between family violence and mental illness and talked about how often it's likely to be that people suffering a mental illness who are receiving care are likely to have a background of trauma. Can you outline for the Commission how you see the relationship between family violence and mental illness?

DR FERNBACHER: Sure. As has been stated before, violence can be a causal or a contributing factor to developing mental illness, and a whole range of mental illness; often anxiety/depression is more commonly known, that it can be connected to any form of interpersonal violence. So when I talk about family violence - and I think we all do - we think about children, child abuse, child sexual abuse, physical violence and then violence experienced in adulthood in family violence.

So, whilst there is some debate about how much is causal and how much is contributing factor, when we look at the population of people who receive mental health care in clinic and mental health services or receive a mental health diagnosis the overwhelming number of women have experienced some form of interpersonal violence; most of the time more than once; often prolonged; often multiple times over their lifetime, depending on which area research has been conducted.

If we look at the more acute end of mental health, women or people who go to emergency departments or are seen by an emergency mental health team or end up in acute inpatient units, anything between 50 and up to 90 per cent of women have experienced some form of interpersonal violence that mostly happens within family violence.

Men have often been left out of those kind of studies. But there are a number of studies that also talk about men with a mental illness having experienced - up to 40 per cent of men having experienced childhood sexual abuse. So there are links. Links have been established. The sheer number should tell us that we do work with a population that has experienced often significant levels of abuse, as has been outlined, sometimes specifically around specific diagnosis, but not only. Again there is research that shows that people with schizophrenia or psychotic disorders, relatively high numbers of them have also experienced some form of abuse. It's one of the only areas I think where making an assumption can be helpful for people's practice as well as how we work with people who seek mental health care.

MS DAVIDSON: Dr Oakley Browne, you have also talked about in your statement the impact that family violence can have in terms of developing mental health issues, including also a relationship with drug and alcohol abuse. Can you expand on that for the Commission?

DR OAKLEY BROWNE: Yes. I think there's evidence that persons who are subject to domestic violence or abuse as a child can have the propensity to develop behaviours which don't serve them well later in life, including a tendency to use drugs. That can be an attempt to deal with the symptoms they have, but can lead to a self-maintaining cycle.

MS DAVIDSON: I think you talk about symptoms of PTSD. Can you expand on what you are talking about there?

DR OAKLEY BROWNE: I'm not sure which bit you are talking about.

MS DAVIDSON: I think it is paragraph 38 of your statement.

DR OAKLEY BROWNE: Yes, okay. So post-traumatic stress disorder is a disorder which describes a range of symptoms which can occur after someone's experienced a traumatic event in their life. Typically the key symptoms are recurrent memories about the event which are experienced as unpleasant and intrusive and can occur both in the waking state and as nightmares and dreams, but a range of other symptoms associated with that; anxiety and depressive symptoms. It can lead to withdrawal from everyday life and a sense of alienation from people and an inability to engage in normal social interactions with people. So it has a range of manifestations. But the core feature is memories about the event occurring and being experienced as distressing.

PTSD was mainly described originally in combat veterans, but in fact it's commonplace in civilian populations too. The most common reasons in civilian populations are exposure to violence; family violence being the leading cause, but also violence as a child. So it's one of the leading factors in civil populations for causing PTSD.

I'm talking about PTSD as a discrete diagnosis. There are variations. There are people who will have symptoms of post-traumatic stress which don't reach the threshold for disorder but are still significantly impacting on their life. Trauma can also lead to other types of disorder, not exclusively PTSD again, especially anxiety, depression and substance use again because people can use substances to manage their anxiety symptoms, for instance, or their other symptoms of dysphoria.

MS DAVIDSON: So what does this mean for all health

professionals who are faced with someone who perhaps is exhibiting that sort of behaviour, might be potentially quite difficult? I think, Professor Kulkarni, you have identified how often women with - if I may use the term - borderline personality disorder might be received by health professionals.

PROFESSOR KULKARNI: Yes, just as Mark has outlined, the diagnosis of post-traumatic stress disorder can be relatively easy to make if you have an immediate relationship between violence, and that is reported and that is acknowledged, and then the symptoms of post-traumatic stress disorder are apparent. So you have this kind of very close, tight connection between the trauma and then the symptoms.

The difficulty that we have for younger patients or younger women who might have a childhood story of trauma or witnessing family violence or experiencing it themselves is that you lose that tight connection between the trauma and then the symptoms. So it might be that she becomes a 14-year old and then has symptoms of deliberate self-harm, so she is slashing her wrists, or she has difficulties concentrating on school work, she has great trust problems with adults and so on. That disruption in what happened to her at a very early age which could be, you know, three, four, five years of age - so that link is lost often in time.

So what happens is she gets a diagnosis as she gets older of borderline personality disorder, when in fact inherent in that the origin of that problem is actually the family violence or the trauma that she experienced but we haven't got that immediacy to make that

link and therefore make that diagnosis.

The difficulties with the diagnosis of borderline personality disorder are several fold. One is it is a vague kind of disorder. It also carries a stigma. There's a sense of deliberate self-harm by slashing wrists or burning oneself is inflicted on oneself and therefore it's just bad behaviour. These patients are often seen as manipulative. They are often seen in emergency departments as clogging up the emergency department; they are not real patients.

The treatments are also not very clear because it's not like somebody who has a depression, there's an anti-depressant; somebody who has a psychosis, there's an anti-psychotic. There isn't for this group of patients a clear medication. There are treatments, the particular form of psychotherapy that seems to be effective, but again you need special training to engage the patient in that.

Meanwhile, she is also resisting your efforts to help her because there's a sense that she's a bad person. Often a child who has experienced family violence or who's the subject of sexual abuse or physical abuse by a family member carries with her the sense that she created this; this is punishment for being bad. That continues on throughout the adolescence and adult life as well. So again the person can be difficult to treat because they are not bringing themselves forward with their story or with the compliance to treatment.

So for all these reasons this particular disorder, which is very clearly in about 80 per cent of cases tied to violence in early life, is not receiving the

recognition by the diagnosis, which has a dumb name in my view, borderline personality disorder. Borderline kind of is like, "Well, is it or isn't it?" Personality disorder means, "There is something wrong with this person's character," which is a kind of way of saying, "You are not a good enough person." So it is a terrible name and it misses the point that this is actually a form of post-traumatic stress disorder, but with the distance in time of the event and then the consequences.

It ripples throughout adult life for this person. So this is the difficulty we have, as I mentioned, in the field of not having a trauma focus in our history taking. This is again an issue for training of mental health and health professionals, and also rethinking the diagnosis of borderline personality disorder, trying to de-stigmatise it because then you will actually be able to help this person if you see them as a victim of violence rather than the manipulative, bad person.

MS DAVIDSON: On this issue of trauma informed practice how good is the profession and the health profession generally at the moment about trauma informed practice? Are we starting from a low base or have we made some improvements?

PROFESSOR KULKARNI: I think we are starting from a very low base. There are good attempts being made now to improve the trauma informed care aspect of things. But we have started from a very low base. We conducted a study recently. We haven't published the data yet, but I can say in an audit of 100 files at a public hospital inpatients who actually have got borderline personality disorder, only in 49 per cent of those cases was there any

question about trauma.

One of the trainee psychiatrists stood up and said, "Well, I don't ask because I haven't been taught how to ask about trauma and, if I find trauma, I don't know what to do with it." This is also a common issue in the general practitioners, who have a very busy practice, they have a waiting room full of patients, and they also have commented about the difficulty of how to ask about trauma. "So therefore I'm not going to ask, because I also don't have time to deal with if she says, 'I have violence' or 'I am subject to violence.' What do I do then?" So those are the sorts of issues that are very real that we need to tackle in terms of education process. We also need a cultural change in our systems to actually bring about trauma informed care.

MS DAVIDSON: Dr Fernbacher?

DR FERNBACHER: I would agree that we are starting from a very low base. I think some of the issues have been raised here, that psychiatry traditionally has been very medically focused and has set aside those issues now. More and more research - we know that violence has a profound impact on most people. Not everybody who experiences violence develops a mental illness. However, usually most people and children and adults who experience family violence will have a temporary mental health impact. So when the violence ceases to happen or they are safe, for some that abates. But for many it manifests quite strongly.

So to make the connection as you were describing between something that happened a long time ago and how someone is feeling right now, their level of distress,

they are what within a trauma informed care framework or philosophy would be seen as a coping strategy. As Mark was pointing out, if someone is what's called being re-triggered, so the memories of the abuse, and often that may be at a pre-verbal age of a child or later on, are too overwhelming. So someone starts taking drugs or drinks or self-harms to actually either get the pain out of their body or actually do feel something, or behaves in ways which were described - it is a rethinking and reorientating of a whole range of services.

Mental health is not on its own. If we were serious about trauma informed care I think if the different sectors that people with a mental illness in this case, who we are talking about today, come in contact with homelessness services, family violence services, sexual assault services, we would all need to look at trauma informed care. It really is a reorientating of a service and a big cultural shift, for some larger than others, and mental health is probably a larger one.

I'm wanting to say catchphrase but that's almost doing it a disservice. One of the fundamental but very simple explanations about trauma informed care is to shift the focus on what is wrong with the person, so not saying to them, "What is wrong with you," but actually, "What happened to you," which goes a little bit to what you were saying about, is if it is historically taking - and even if it is not that, it is having conversations about what has occurred in people's lives.

Mental health clinicians take very personal details. They talk about very, very personal details about someone's life and things that have happened to

them, including self-harm, including suicide. We should be able to also ask those questions, sit with the discomfort that people often sit with, and not always think that something has to happen immediately. I think sometimes that is very true, and we heard earlier today from the incredibly brave woman, lay witness, that, yes, sometimes an intervention of course is required. Sometimes it's not. Sometimes someone has lived with the impact of what's happened to them for the last 20, 30, 40 years and they have managed as well as they have.

So there is a little bit of, I think, sometimes an idea by professionals that they have to, when they ask the question like you were describing, "I then have to act." Sometimes we don't. What survivors often talk about is that they want to be heard, they want to be listened to, they need to be believed, and they have a very, very attuned sense of if that is going to occur with the professional that they sit across from. So, whilst some of it is major changes and, yes, we are at the very beginning, some of it is attitudinal change to more integrated change. I think I will leave it there.

MS DAVIDSON: Mr Bishop, do you have anything to had?

MR BISHOP: I do, actually. I agree with my colleagues about starting from a low base. I guess traditionally mental health workers are not trained in therapeutic practices or trauma informed care. In fact it is probably something that they elect to do out of interest, but it is not necessarily part of the model of how they approach the situation.

Often, especially in an inpatient setting, workers or the nurses that work in the inpatient setting

will feel uneasy about talking to people about trauma because they are either not trained in it, unsure how to deal with it or they don't have the time to deal with it. They might feel uneasy or anxious about the content and worry about, colloquially we say, opening a Pandora's box. "What do we then do with the impact?" Some of the concerns include re-traumatising the person or then not being able to contain the situation afterwards with the family or whatever.

So I think that mental health workers themselves are geared towards possibly avoiding the content and maybe believing that someone else who is more experienced will pick it up along the way, and then no-one actually gets to that point or the services refer out to other professionals that they believe are better suited to be able to deliver the services that are required. So we do see this pattern of avoidance that happens with mental health workers around trauma.

Also what Professor Kulkarni was saying about trauma informed care and taking history, that mental health practitioners are not also very good at taking the history and understanding the depths of what they have to take in reference to history, and then how that links to mental health presentations.

So I would agree we probably need a lot more education with mental health services who are in the front-line and our medical practitioners to be able to assess the situation properly, especially around family violence, and then carry out appropriate treatments that incorporate holistic situations and psychosocial problems.

MS DAVIDSON: I think, Dr Oakley Browne, you identified that

there has been some trauma informed care education provided and it's been identified as a priority. It was provided in 2014; is that right?

DR OAKLEY BROWNE: Yes, that was part of the initiative about reducing restrictive interventions which the Chief Mental Health Nurse led, and in conversations with mental health services and clinicians trauma informed care was seen to be a very important part of improving our response to persons in care so we didn't use practices which re-traumatised them.

So one of the problems with use of restrictive practices like seclusion, mechanical and physical restraint is that we are dealing with a population which has a high rate of being a victim of violence or other forms of trauma. So those practices can inadvertently re-traumatise the person.

So looking at other tactics or options or ways of engaging with the person to minimise the likelihood of that happening was seen as a priority, and trauma informed care was seen to be the appropriate modality. So there's training now provided in trauma informed care through a number of options, but it would be true to say only a small minority of mental health care professionals have been through that training.

MS DAVIDSON: Unless there's further questions from the Commissioners on that topic, I was proposing to move to an issue that arose from the lay witness who gave evidence previously about the way in which her husband had used her mental illness as a way of perhaps inflicting further control and impacting upon her mental health.

Dr Fernbacher, this is an issue that you have identified

in your witness statement. Can you explain to the Commission what is often seen in relation to women with mental illness who are experiencing family violence?

DR FERNBACHER: Yes. As you were mentioning, the lay witness alluded to a couple of ways of how he either used the mental illness against her but also women and many people, men as well, with a diagnosed mental illness often say one of the things that happens to them is that, "Everything from here onwards gets seen through my mental illness. So if I have an angry outburst, it's because I have" whatever the mental illness is, or "If I'm upset, that's also because I have a mental illness," whereas many of us have an outburst and many of us get upset; you don't need a mental illness for that.

Also often people, or women, are not believed or questioned, as the lay witness said. "What have you done to lead him on?" Often within family violence we know that that occurs and that women get asked that question. However, that is much more likely to happen for women with a mental illness. As we have heard today, there's an incredible stigma still attached to mental illness and often within different types of mental illness, as we also heard, for example, borderline personality disorder, very stigmatised, someone with a psychotic disorder, very stigmatised. It might be easier these days for people to admit that they have anxiety, depression. So it carries a whole range of things with it.

The other thing that happens frequently is that mental illness becomes a tool of oppression within the family violence context. So in particular, and as we heard, when women have children their mental illness can

be used against them. There is already so much stigma about mental illness. Being a parent or a mother with a mental illness carries even more. People often question, "Can someone with a mental illness be a good parent?"

So using a woman's mental illness against her, threatening to have the children removed, undermining her mothering role whilst appearing helpful to professionals who, unless they sense it, unless they get a chance to talk to her on her own as she is ready to speak about the violence that is happening can just get missed. We heard how it got missed for the woman who was the lay witness.

There are particular strategies that perpetrators sometimes use within the context of mental illness. For example, colluding with her - if a woman has delusions, moving things around in the house and then saying, "I don't know what you are talking about." Self doubt creeps more and more in, and we know within family violence undermining someone's self-confidence and sense of self is so much part of family violence, and to add into a woman's distress and sense of reality in that way is a particular way to undermine her.

There are a number of other ways how it can be used. For example, and this occurred - I know by some colleagues talking to me where her partner was controlling what time of the day she was taking the medication, which meant that she was unable to function after a particular time of the day, and would go and control the meetings with her psychiatrist and sit in and would never, ever let her go on her own because he wanted to make sure that he could exert that level of control. There are a number of other kind of ways of how it is used.

MS DAVIDSON: I think you identify in your statement an example of workers in a family violence service not recognising or blaming a mental health issue for a woman who was complaining of being watched.

DR FERNBACHER: Yes. Thank you for the reminder. This is a woman who said, "I can't tell you what it is, but I feel watched. I feel watched constantly." She did have a mental illness. The family violence workers thought it was part of her delusion. Some years down the track it was found out that her husband had installed video cameras in the ceiling and was filming her. So her sense of what was going on was absolutely correct, but people didn't quite listen to her, and it was probably a difficult situation to find out, but she was correct. He was filming her every move.

MS DAVIDSON: If I can move on perhaps to the issue of the potential re-traumatising of patients who have a history of family violence within the mental health system. You have already identified it, Dr Oakley Browne, in relation to restrictive practices. Professor Kulkarni, you have also spoken about that issue and the need for segregated units for women and men in mental health services.

PROFESSOR KULKARNI: Yes. Actually we have been on various committees, the last one I think was three years ago, looking at providing better safety for women who are inpatients of psychiatric services. It really is a major problem because the bulk of women patients who have inpatient admissions for depression, psychosis, bipolar disorder or some other condition often do have violence in their background, trauma and violence in their background. So when they come into hospital and they are managed in

acute inpatient wards of the public system and the private system they are often in the mix with other patients who can be disinhibited, can be severely unwell. You don't get to be in an inpatient unit unless you are severely unwell. So the disinhibition can lead to further traumatisation with actual sexual assaults have been known to happen; fortunately not frequently, but they can happen.

So, with this in mind, the various governments had put forward - in fact I think in the 1990s we were involved with writing gender sensitivity policies. But when it comes down to it some of the basic principles of providing safe care can be as concrete as just building a wall in some of the wards and saying, "Here is the female area and here is the male area," because these are very mobile patients. Basically everyone is in together, which I think sometimes surprises the general public, that there isn't segregation of female and male patients. In some of the high dependency units, which is where people are managed who are very unwell, this can be a specific number of, say, three or four beds that are just in one area where you have the most acutely unwell people all together of both genders.

So I have attached to my statement a copy of a publication of research which we did looking at the incidence of sexual trauma in a situation of a gender specific ward compared to mixed gender wards. You don't need to have great research skills to note that the results show that basically in the single sex ward areas there were fewer incidents of trauma and violence.

I think this is an important step forward in

terms of diminishing the re-traumatisation of very vulnerable women. It's been pleasing that the work that's happened over the last five or six years has actually led to changes in the architecture of many of our inpatient units. So certainly newly built units do take this into consideration. But there are some still old units around where there is not female only areas.

The UK in particular passed legislation in 2006 making it mandatory that their inpatient units have segregation of the genders to actually provide better safety and privacy for their female inpatients.

MS DAVIDSON: Dr Fernbacher, I think both you and Dr Oakley Browne have identified the gender sensitivity and safety guideline. But I think you talk about the re-traumatising of patients in inpatient units, not just in terms of sexual assaults but in all sorts of ways. Can you expand on that for the Commission?

DR FERNBACHER: Some of it relates to what Mark was referring to about restrictive kind of practice and some of the practice, and people or women get re-traumatised because it might trigger a previous memory, it might be similar to something they had experienced before. However, also behaviour of other patients or inpatients can also be seen as threatening or re-traumatising.

So someone might have a loud argument, be slamming a door. As Jayashri was saying, you don't get into an inpatient unit unless you are really unwell. People are highly distressed and sometimes the way they express themselves can be rather loud or feel threatening to other people.

So what tends to happen, as so often in

situations like that, it's likely that the attention goes to the person who is loud or noisy or slammed a door or had a loud argument with someone else, but the person in the corner that's kind of more quiet and is hiding away is missed in a busy inpatient unit. We can understand why. However, that's probably likely the person that is re-traumatised and it might trigger some of their early memories and they may not be seen to. So it can be anything from - it doesn't have to be loud, but behaviour from people that can re-trigger someone.

That is difficult because it's a busy environment and people are really unwell. So it could occur about many different kind of - sorry, I'm not expressing myself very well. It can be a whole range of things. Some are more obvious than others. If someone is loud or noisy or aggressive or is following someone or is disinhibited in their interaction, they are the more obvious ones.

MS DAVIDSON: Dr Oakley Browne, did you want to add anything to that?

DR OAKLEY BROWNE: Yes. I think we have probably paid insufficient attention to the environment or the architecture of the units. There's been significant investment over the last two to five years in creating environments which are more gender safe. But there is always a problem with retrofitting old wards which are now 20 years old about how you can do that in a way which still maintains a therapeutic environment for all persons receiving care there.

As my colleague said, Professor Kulkarni, some of the newer units they have achieved this because they have been designed from ground up. I know some units which

I think are exemplars of what can be done with good design to enable people to have appropriate space and contributes to a therapeutic environment and minimises the risk to themselves and others.

I'm not sure I entirely agree that complete segregation is the answer. Most units haven't gone for complete segregation. They have allowed some flexibility and allowed for segregation when it's necessary for the concerns of the individual people, but allowed some flexibility about how rooms are used.

When a person gets admitted to a unit one of the core tasks would be assessing, "Where is this person most appropriately placed in the unit to ensure their safety, and what do we need to do to maintain their safety?" That's partly about where they are in the unit but also about nursing engagement and observation with the person.

MS DAVIDSON: I note the time. 1 o'clock. Perhaps we should adjourn for lunch until 2 pm.

COMMISSIONER NEAVE: I just had one question. As I understand it, there's no gender segregation now in the large public hospitals in relation to patients in there for physical conditions, is that right, or are there still some hospitals where there is gender segregation for physical care? I'm just interested in understanding the context.

PROFESSOR KULKARNI: There is less gender segregation now in, say, the general medical wards or general surgical wards. But there is still some consideration of privacy in curtains and so on. The other thing is that often they are not mobile patients. So they are bedbound or are not expected to be around. But you are right in that there has been a move away from female wards and male wards.

COMMISSIONER NEAVE: So the argument here is that in the context of mental health you really need to think about this differently because of the fact that many of these people will have suffered violence, family violence or other forms of violence.

PROFESSOR KULKARNI: Yes. I do agree with Mark in that it doesn't have to be completely a male ward and a female ward. But a female area to provide some privacy and safety seems to be the way that produces better results in terms of not re-traumatising patients.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: 2 o'clock?

COMMISSIONER NEAVE: 2 o'clock.

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

MS DAVIDSON: Just prior to the break we were talking about the issues of gender sensitivity and the guideline that has been produced. Dr Fernbacher, you raised some issues about how it might be best to implement those programs to ensure they embed a lot better in terms of actual practice. Can you identify for the Commission what you think it would be quite important in terms of ensuring either that practice or other sorts of practices that you would advocate being embedded into the actual treatment settings, how the Commission might go about making the recommendations that would assist in embedding that sort of practice?

DR FERNBACHER: The guideline on gender sensitivity and safety, for example, which is the latest one that the department had published, in my experience the challenge often with guidelines is that they guide, as their name says, and so they should, but they are not binding.

With these guidelines the department actually went a step further two other times and also funded the development of some training. That was then delivered to a select few staff in psychiatric inpatient units, so it was aimed at psychiatric inpatient units rather than the whole of the clinical mental health service, and touched on a range of issues around gender sensitivity and safety. Family violence, sexual assault and trauma were part of that, but there were other issues as well.

It was done on the "train the trainer" model. So more senior staff from inpatient units were trained across a number of modules and they were then given the responsibility to roll out their training in their own

inpatient units, and inpatient units also needed to commit to develop an implementation plan and feed that back through to the department.

So that actually went further than at other times when guidelines are put out and it is then left to the mental health services in this case. So that was really welcomed by many of us who worked in the sector because it gave more impetus and more responsibility, but also a feedback mechanism to the department that this training has occurred.

However, at the same time only doing training, as many of us I think will know, is not enough either. So as we were talking earlier about implementing, for example, something like trauma informed care is really a reorientating of services, so overall I think with any future strategies, if it is trauma informed care, if it is gender sensitivity and safety or other issues or indeed family violence, I think there need to be a number of layers, for example, a strategy, guidelines, but also some binding feedback mechanisms where mental health services would need to demonstrate how they have integrated those sentiments or the guidelines or the strategies into their service delivery. So training is one aspect, but how can you demonstrate that you have actually now either reorientated your service or that people are really practising in a different way. So, if that is through KPIs or other mechanisms, I think it would be important that that is part of any implementation.

COMMISSIONER NEAVE: Can I just ask you, you said that that was directed at inpatient services. Was participation on the basis of interest or did everyone go?

DR FERNBACHER: As far as I know, the training was rolled out to - all inpatient units were invited, and I think almost all - there are 21 clinical mental health services in Victoria, and I think all of them participated. Some might have only had one person attend from an inpatient unit. But, as far as I know, all did, yes, or close to all.

COMMISSIONER NEAVE: But not necessarily everyone in that unit?

DR FERNBACHER: It was limited to one or two people from that unit, who then were responsible for training their own staff. The next level down, how many people within each unit have been trained, I don't know. That information went back to the department. That's got its own challenges when you work with people on rosters, for example, and it takes a long time to really train everybody. You almost have to start again, because in my own service where we run a trauma informed care reflective practice group after having rolled out some trauma informed care training we keep getting people who - we thought we trained everybody, and at that time everybody or almost everybody was trained, and now we are realising that new staff are there all the time or sessional staff. So it has its own challenges working within that context.

MS DAVIDSON: In terms of the other panel members, do you also identify that there are some particular difficulties in embedding or improving practice at a statewide consistent sort of level, given the sort of structure for mental health services?

DR OAKLEY BROWNE: I agree with my colleague that providing training of itself doesn't guarantee to get sustained change in practice. If you are publishing a guideline or

other device to bring about change, it has to be part of a broader implementation plan which uses a range of strategies to embed and sustain the change. The sort of things you will be interested in is buy in at the Chief Executive and high level, so that it's clearly identified as a priority for the service, and endorsed by senior management.

You certainly want to provide training, but multi-modal training, using a range of training opportunities to get people involved. You need to identify local champions. Health care services, health care providers were very tribal in a way, and our practice is very much influenced by what respected other practitioners do. So social influence is very important in shaping practice. So having people who are regarded as good practitioners by people in the front line endorsing a particular practice is very powerful in bringing about change. So local champions is very important. I think that's what that program endeavoured to do, and that there were 74 train the trainers identified and they would be people who would be regarded as credible by their peers.

There are other things going to individual practitioners using a process called academic detailing, which is sitting down with the practitioner, talking about their practice and identifying their specific needs to provide a tailored response for them.

So you need to use a range of options, and you need to have clear follow-up with evaluation and some degree of measurement, and in certain cases you can incorporate the measurement into contractual requirements of the health services. For instance, in the effort to

reduce the use of restrictive practices, seclusion is now measured and the department gets rates from each service of the use of seclusion, has set targets to reduce the use of seclusion. That's the restricted practice where someone is placed in a room by themselves. That's now in the statement of priorities which boards and senior executives sign off on. So part of the way their performance was assessed is a clear statement about attaining certain targets around seclusion.

So I think you need to use a range of mechanisms like that to bring about change in a complex system and make sure the change is sustainable. So, while a guideline and training about a guideline is essential, it's not sufficient and other things need to be done as well.

COMMISSIONER NEAVE: That was a very good recipe for culture change within a profession, I think, what you have just articulated.

DR OAKLEY BROWNE: Yes, I agree. It is all implementation science or translational research, sometimes people - it is still a new science in health care and it is something that we need to know a lot about.

If I can diverge a bit and show you an example. Washing your hands after you have seen patients has been known since the 1700s to reduce infection rates in hospitals. But, still, if you do surveys in hospitals about washing hands you will find very low adherence rates. So science of itself doesn't drive behaviour change and you need to do a range of other things to bring about behaviour change.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Moving on to another issue that Professor McGorry raised and the way that CAT teams operate, and I think he talked about moving back into a hospital setting rather than going out to families and the consequences of potentially exacerbating someone's behaviour by requiring that they turn up to an emergency department. Perhaps, Mr Bishop, can you talk about how CAT teams work?

MR BISHOP: Sure. So traditionally CAT teams are like a hospital in the home type of focus. Usually it involves two clinicians who are multi-disciplinary, so they could be a psychiatric nurse, a social worker, psychologist or an occupational therapist. Sometimes a medical professional is also present. They would get I guess a notification from what we call the triage, which is the local telephone information and referral based service that takes psychiatric - what we call - emergency calls. They would then issue a referral to the local CAT team or what we call brief intervention team now. Then they would have to act within a certain time period given the rating that the triage service had given to them.

The triage scale comes out of the Department of Health and Human Services, and there's different criteria for when the CAT team needs to respond. The idea would be that they would attend in what we call a psychiatric emergency, so that person is either quite suicidal or they are experiencing acute psychosis or other types of presentations where violence might be a factor. The CAT team would then make an assessment on whether or not they needed police, and then they would organise for the police to come in.

Of late one of the problems has been with our

brief intervention team is that the police have been delaying their response, often taking multiple hours to actually attend and assist the workers to actually go down to the house. So when they feel that it's not safe. Ideally, the workers, with police in attendance, if the client was violent, would probably admit that person either to an emergency department or they would admit them into the acute psychiatric unit. If it wasn't a crisis response that needed police or ambulance, then they might provide some mental health assessment about where their mental state is at and determine what type of service they would need from that point.

If the person didn't require admission and was suitable for home treatment, then the brief intervention or CAT team would then treat that person over a period of around two to four weeks. That would involve a multi-modal focus of possibly going into the person's home and seeing them there or getting the person to come into the clinic, depending on the need. One or two clinicians would be decided on, depending on the need of the person.

But ideally the role of the CAT team is to reduce risk, prevent hospital admission and to treat a person's mental illness in the least restrictive way possible. That would usually include medication. Sometimes it might include some crisis therapy, but not always. Once again, it depends on the education of the person who is providing the service. But ideally their aim is to reduce risk and get mental state under control, and sometimes if they have time they would attend to the psychosocial needs of the person, which would include family violence or financial problems or homelessness.

MS DAVIDSON: You say "if they have time"?

MR BISHOP: Yes.

MS DAVIDSON: Do they have enough time generally to be able to attend to psychosocial needs?

MR BISHOP: I think it depends on the time of the week and the time of the day. Definitely on weekends the service would be overrun on a Friday night or a Saturday night. There can be a bit of a bed pressure push from the inpatient units. So inpatient units will refer back out to the brief intervention team or the CAT team, and they would need to, I guess, clear up some space or some resources available to take some of these clients. So it does depend on the need, and it does ebb and flow during the week.

My experience in working with the CAT team is that they will prioritise certain interventions and then other interventions will get left aside depending on their need. So they may have time depending on the workload. But if they have a lot of clients that they are managing, then they might not have time to implement any psychosocial interventions.

MS DAVIDSON: What about how often do they go out into the family, into the home?

MR BISHOP: Again, it depends on the need of the client. They sometimes will go out daily, every second day and sometimes every third day. So it does depend on the need. The time that they spend in the family home is again dependent on what their board - we call it the board - what their workload is like for the day. They may have more time, so maybe 15 minutes, maybe half an hour to an hour to spend with someone. But often they might spend

15 minutes to half an hour just to interact. Again, it depends on the locale of the person, whether they are able to reach everyone in a particular time period because they are driving to the houses, and what they actually have on for the night. So they may have something like five to six to seven home visits to do in a shift, and they might not be able to provide everyone with the level of service that they would like to.

MS DAVIDSON: Professor McGorry talked about sort of forcing people to really come to the emergency department. Is that happening as a consequence of the availability of the CAT team?

MR BISHOP: It can do, again depending on the presentation of the person and depending on the resources that are available for that particular shift. There might be a move because of safety to move the person into an emergency department. There might be a transition phase between them being in the emergency department and getting an admission into an inpatient unit, which can be sometimes up to 24 hours. So it does really depend on the case.

I think that, like what Professor McGorry was talking about, with drugs and alcohol I think now we are seeing the level of violence has increased in the community, and the clinicians are probably more wary about going out and seeing people in the home and probably have a high reliance on police and ambulance and emergency services because their risk of being victims of violence themselves has actually increased because of substance abuse.

DEPUTY COMMISSIONER NICHOLSON: Could I just clarify. Do the

CAT team - are they first responders?

MR BISHOP: They can be first responders.

DEPUTY COMMISSIONER NICHOLSON: In what circumstances?

MR BISHOP: Usually when the person is presenting with acute presentation, like, they are expressing their psychotic delusions, they're being violent to the family or they are attempting self-harm or they have a suicide plan, the CAT team in that instance will be first responders. That is dependent on, like I said, the triage scale or the risk that has been assessed at that triage level.

DEPUTY COMMISSIONER NICHOLSON: So for a person that they haven't had contact with, what does a family do?

MR BISHOP: So a family - they may enter into the system in a number of different ways. They may go to their GP and their GP might refer them to the mental health service because the GP identifies some risk or need for specialisation. They may take the person to a private psychiatrist and the private psychiatrist may also refer the person through the gate and they will be seen maybe within a week or two weeks for an appointment, depending on need, or the family may ring emergency services and they will speak to 000 and the 000 operator would either issue the police or the ambulance, depending on their assessment, or the family - - -

DEPUTY COMMISSIONER NICHOLSON: 000 wouldn't connect them to a CAT team?

MR BISHOP: No, not usually. The family would only really get access to a CAT team, from my understanding, through accessing the central triage point of the mental health service. Often families will ring the triage service for an emergency response, and triage may facilitate that

emergency response for them by coordinating a police or ambulance response. But if the family rang 000 they might not necessarily get triage contact.

COMMISSIONER NEAVE: I have a follow-up. I have the impression, and this may be quite inaccurate, that there has been a reduction in the involvement of CAT teams and that police are doing the work - or some of the work that CAT teams formerly did. You have referred to an escalated risk, and that may be one reason for that. But are there other reasons? Is it because there's less funding available for CAT teams? Is it because there's a change in the philosophy of how these situations should be handled?

We have heard from - in our consultations, in our community consultations, of elderly people having to deal with children, adult children, in their families who are mentally ill and violent, and the great difficulties that they have had in getting a response to assist them, particularly in circumstances where they don't want to call the police.

MR BISHOP: Yes.

COMMISSIONER NEAVE: Because they don't want their child to end up in court or in gaol or whatever.

MR BISHOP: Of course.

COMMISSIONER NEAVE: So I would like to get some feeling as to what people should do in those circumstances and whether the CAT team responses are adequate.

MR BISHOP: I think one of the problems is that people may often get confused between the CAT teams being an emergency service versus being a responding service that deals with mental health problems. I guess all I can say

is anecdotally and from my experience in working in the public mental health field that perhaps there's an increase in mental health presentations that are overloading the system, perhaps there's expectations on both part that one will respond instead of the other. So there might be expectation from the police's view that they would expect the CAT team to respond, and the CAT team might feel that the police need to respond. So there can be, I guess, a mismatch of language, if you were, in terms of what needs to occur.

I feel that the resources that are available for the CAT teams in terms of being able to respond in a way that everyone would like is probably reduced. It is probably not large enough, and we probably need more clinicians, more mental health workers on shift to respond in a way that we would like to instead of being able to respond in what we would term to be a reactive crisis response way.

COMMISSIONER NEAVE: Has the funding in that area declined or not kept pace with the expansion of the population?

MR BISHOP: I will probably pass it over to Mark.

DR OAKLEY BROWNE: Commissioner, can I take that as a question on notice to confirm with my colleagues in the department. As I understand it, the funding hasn't reduced, and the rate of contacts hasn't reduced, but you need to be mindful that Victoria's population has increased substantially over the last decade, something like a million, I'm told.

COMMISSIONER NEAVE: I did have that in mind. So I was wondering whether it had kept pace with either the increase in population or, if mental health problems are

increasing, that increase.

DR OAKLEY BROWNE: Yes. I think it would be true to say the services haven't grown at a rate consistent with the growth in the population in the state. So the raw numbers that are presenting is greater, if that makes sense.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER NICHOLSON: Can I just clarify, then. Is it true, then, that the CAT teams no longer deal with crises, they are a brief intervention service, and the crises are dealt with through 000 with the police and ambulance service?

MR BISHOP: I think it's a coordinated response. So they want - - -

DEPUTY COMMISSIONER NICHOLSON: So if a family rings 000 you said, I think, that they are connected to the police or the ambulance, not to a psychiatric service?

MR BISHOP: That's right, yes. So if they ring 000 they go to police or ambulance.

DEPUTY COMMISSIONER NICHOLSON: Which is where most people would ring, I assume.

MR BISHOP: I think it depends on how the family feel, and what the Commissioner said before is very true, where families will be worried about contacting the police because they are afraid that their family member will be incarcerated or get criminal charges.

DEPUTY COMMISSIONER NICHOLSON: Who else would a normal member of the public know to contact?

MR BISHOP: They would probably contact our triage service.

DEPUTY COMMISSIONER NICHOLSON: How would they know that?

MR BISHOP: I hope through either accessing their GP or a private psychiatrist. I guess it's very dependent on

whether or not they have had interactions with the mental health system in the past, otherwise they probably would not.

DEPUTY COMMISSIONER NICHOLSON: They are probably not going to get it from a GP in a crisis, are they?

MR BISHOP: The GPs can ring the triage service, and they do often do that with the client in the room with them. However, they may be waiting on the phone for a while before they get a response. GPs, as we stated before, only might see people for 15 minutes or something and don't necessarily have the resources to wait with a client who is in an acute psychotic crisis for their crisis team to respond. Even then the CAT team may only respond within a period of two to eight hours before it gets shipped to an emergency service.

MS DAVIDSON: Were there any further questions from the Commission on that issue of CAT teams?

COMMISSIONER NEAVE: No.

MS DAVIDSON: Can we go back to the question of trauma informed care. You were present when the lay witness gave evidence. She identified really a range of different responses that she received from mental health professionals. In some cases she wasn't asked in relation to what was happening for her, and in other cases where she had disclosed the response didn't necessarily deal with what was happening for her. Are you able to perhaps comment on her experience and how you see the mental health profession should be responding and how you can improve that response?

PROFESSOR KULKARNI: I might start off by saying that unfortunately the description of the lay witness is not

one that's out of the blue. It's quite a common experience of patients. The difficulty is what I have said before, which is that a number of mental health clinicians and general practitioners in particular do not feel that they have had the training to be able to take a trauma history properly, and it's not as simple as saying, "Have you been abused? Are you being beaten up?" There's a lot more to it, and a lot of the practitioners of many disciplines do not feel that they have had and have not had enough training to be able to take that kind of history. So that is a problem, that we have a workforce that needs greater upskilling in how to do this, and there are some measures that are being taken at the moment to improve the education of the workforce.

The Royal College of General Practitioners have also undertaken various activities to improve the education and skilling of their practitioners - that's primary health care general practitioners - on this whole area as well. So both of those areas, mental health practitioners and primary care practitioners, need more training.

It needs to become embedded in the basic history taking and assessment before a management plan is developed so that situations like that don't arise, that no-one really knows the level or extent of the violence that the person is experiencing that has led to the symptoms that she's now describing.

I guess the other point that the lay witness touched on which is another significant one is what does the practitioner then do with that information, because as well as not feeling like they have had enough training the

other comment that comes back from the field is, "I don't know what to do if I do uncover violence. I really have no idea where I take that." That's another whole area that needs some attention, particularly with even providing more localised resource booklets. So if you are a GP practising in this area, you can send your patient to this particular counsellor or these services and so on.

So those kinds of informations need to be put together and be readily accessible for both mental health practitioners and primary care practitioners, otherwise we are going to keep seeing this missed information and missed opportunities and then greater suffering.

DR FERNBACHER: I think I have now forgotten your question, I'm sorry.

MS DAVIDSON: Firstly, how did you see the experience of the lay witness with respect to mental health professionals and how do you see that we could potentially improve the response that would be provided by mental health professionals in those circumstances, both in terms of ensuring that they ask but for those professionals who were made aware of what was happening to her, how do you see the way that they have dealt with that information and how can that be improved?

DR FERNBACHER: Thank you. I would agree with what Jayashri was saying, and it kind of links with what Mark was and what we were talking about before, a multi-layered approach overall. Also we must ensure a clinician is not left on their own to have to respond and have to know how to respond without the support of a system behind them.

I suppose within a greater focus on trauma informed care, for example, if somebody does not feel

equipped enough or knowledgeable enough to respond to someone like the lay witness, if a good relationship with a local family violence or a family violence service would exist, and/or secondary consultation would exist, it would be feasible to think that the mental health clinician would talk confidentially with the family violence service to either get a second opinion, get some support about, "How do I go about this?"

This is a specialist service who may have some ideas or support or - in fact, at one stage I know I assisted in a situation where we made sure that a family violence service worker came to an appointment with a psychiatrist with a woman who was experiencing something not too dissimilar to the lay witness and could support both the woman and the clinician and assist in thinking through some of the options, and that was really helpful to both, the woman who was the client as well as the clinician.

So I think there are a number of ways to think through those things, and what is really important is to know what we need to be able to and capable - what we could expect as skills and knowledge and knowing and how to respond as a baseline for hopefully most clinicians, no matter what their professional background is, when to maybe work or get a colleague involved who's more senior and more experienced in the work, like my colleague Drew here, and when to collaborate with a referral, so involve a specialist service. So again it's a multi-layered kind of approach.

MR BISHOP: I can just add to that. I think what Dr Fernbacher is saying is really important in relation to having

partnerships with service agencies and having good partnerships with the local family violence agencies, so we can do some, I guess, co-learning about each of our services and how to respond in sensitive ways towards mental health and to family violence, which would probably be dependent on one being able to form good relationships with the agencies in the area but also developing a training program that used both agencies' knowledge and then delivered that in a way that was suitable for both the family violence agencies, or mutually beneficial, if you will, to both the family violence agencies and to the mental health workers.

Then, on top of that, I think the supervision and mentoring for also the family violence workers but also the mental health clinicians is probably also important to make sure that the learning that is held between the two services, the education provided, is then carried on through the work into the practice, because I believe that a lot of the time we do what's called sort of didactic or teaching approach but the learning that is done there is not then consolidated into practice and not applied properly, so the learning is lost, and a lot of people just say, "I just went to a training. I can't remember a single thing about it," because it's not then carried on through the service and it's not championed by senior mental health professionals or family violence workers.

DEPUTY COMMISSIONER NICHOLSON: Perhaps, Mr Bishop, if I could take that issue up. In your statement you describe what I think is in effect the role that you play often with the family violence services is somewhat a bridge between the family violence service and the mental health system.

MR BISHOP: That's correct. Yes.

DEPUTY COMMISSIONER NICHOLSON: In a number of systems the most effective way of building on the training and ensuring that practice changes is by actually placing an advanced practitioner into, in this case, the family violence system. Is that something that you would consider?

MR BISHOP: Yes, I think that it's a very good way of working with the local agencies. We do that with a number of agencies in the team that I work with. It gives the workers, or in my case the family violence workers, direct access to me rather than needing to jump through a lot of hoops.

DEPUTY COMMISSIONER NICHOLSON: So you actually spend time in their service?

MR BISHOP: Yes. We used to have a worker that would go there fortnightly, weekly to fortnightly depending on need, and she would sit and do assessments at their service, and the clients that they would refer, had already been to the service, felt comfortable in coming in. The family violence workers could get consultation from her or, if she was unavailable, they could contact me and I could give them consultation over the phone. In her absence I could go to the service and provide whatever it was that they needed from a mental health perspective.

I do education with the family violence workers on a monthly basis around different mental health presentations, and they really actually enjoy that practice. They get a lot out of it, and it has actually raised their confidence in dealing with people who have complex mental health problems and have a history of family violence. So I believe that, yes, it's a very good

way of being able to integrate the two models.

COMMISSIONER NEAVE: Just as a follow-up, how do they educate the other way?

MR BISHOP: That's a good point. I actually went to a training with the Domestic Violence and Incest Resource Centre, or they were then called that, and I did some training on the CRAF, the tool that's used to assess risk in family violence. That was really useful for me to learn about the family violence system. I think one of the ways that there's learning back is that they are able to tell me about their experiences and some of the problems that they take, and then I take that back to my team and I run training for my team about not only what services are available and not only the experience of family violence but also I guess the experience of family violence workers as well.

MS DAVIDSON: Dr Oakley Browne has identified in his statement a partnerships project with some recommendations in 2006. Can you just outline where that project - what's happened since then?

DR OAKLEY BROWNE: Yes. The project was completed and the document was distributed to all health services with the expectation that the health services implement that in a way which reflected the local context. So each area would have different arrangements in terms of relationships with services, social services and so on, and they were felt to be in the best position to implement. Unfortunately there was no systematic follow-up by the department in evaluation. So we are unaware, other than from what we know from talking to colleagues, of how that's happened across the state. My sense is it's probably not been done

consistently across the state. There would be patches of excellence, and probably Sabin and Drew can talk about those, but there would be other areas where it hasn't been implemented in the way it was intended.

MS DAVIDSON: Dr Fernbacher, can you comment on the partnerships and the work that you have done and how you see those sorts of partnerships benefitting people with mental illness who also experience family violence?

DR FERNBACHER: Sure. The project or the report we are referring to is the project that looked at statewide levels of collaboration between mental health services, family violence and sexual assault services at the time. As Mark alluded, the report was put out. There were some great recommendations around the need for collaboration, reasons behind it, et cetera, but it was then left up to mental health services to implement that.

Locally where I work, having stepped out of that role at the department at the time, we took that as impetus to have more of a focus on those issues, and brought - and managed a project from about 2005 to 2013 where we brought local organisations from those three sectors together. It was an attempt at following the recommendations and looking at the - breaking down some of the silos that we often talk about, looking at how we can make it easier for people or for women from a family violence service to get - or family violence workers to get access to mental health services and vice versa.

We did a range of activities and smaller projects over the years, and one was the opposite of what Drew was talking about, a secondary consultation. We piloted secondary consultations by a family violence worker into

one of our community mental health centres. We modelled that on some work in New South Wales that was done over a number of years and evaluated, and showed some really hopeful results, and, similar to Drew's description, it was a very short-term project. It was associated with a Masters student, so it was time limited, therefore.

But the number of consultations that the family violence worker did over time showed up the level of need by mental health clinicians to get some support. When they had spoken to her it was not unusual for them to then have a further discussion or conversation with the client who had disclosed family violence, and then further disclosures of child abuse and childhood sexual abuse became evident, whereas some of those clients had been with the service for some time and nobody ever had spoken about it.

So the benefit that then flowed through to the client seemed very obvious, even though the family violence worker didn't do direct assessment or work with clients. But that sort of secondary consultation onsite, a bit like what counsel was saying earlier, the face-to-face, being as part of a team, even though part-time and short time, seemed to make a big difference. We couldn't extend that because there was no - family violence services, as we all know, struggle with demand as well and there was no funding attached to that. So that was a pilot project.

We did a number of other activities through that, some professional development, some reflective practice. But it never really - whilst there was a whole lot of energy for the project for a while - we also launched an

information poster that had information about the issues pretty much what we are talking about today, so some key issues around mental illness and family violence and sexual assault, with some information about local agencies, and there was great enthusiasm at the time - over time interest kind of diminished and some services said, "Look, mental services isn't on the top of our list to kind of work on." So eventually the work of that project folded due to lack of interest.

There was a project that came out of that that was funded by the Department of Human Services at the time that looked at the work of family violence services in the northern region and how they worked with women with a mental illness, mental health issues and their children, and that report was fed back to the department, with some recommendations again around some of the things we touched on, the structural changes that need to happen, professional development training policies, et cetera.

MS DAVIDSON: From that experience, Dr Fernbacher, what do you see as potential barriers to developing those partnerships?

DR FERNBACHER: Not all is about resources, but to manage a project you need someone in a position that has the endorsement by management, so a bit what Mark was saying, the high level - you know, that your organisation is actually taking this seriously, that this is part of core business, for example. So it is those kind of messages, on both or within all those sectors. You do need somebody who can manage or guide a project. In this case it was myself and our then area manager. But I did the bulk of work in a part-time role. But nevertheless we had that

resource, and not every area mental health service, or most don't, and a commitment to I suppose looking at those intersections and, furthermore, all those things that we talked about that could be development of policies local, as well as agreements between organisations, but those kind of things take time as well.

So some of it is resources. Some of it is allowing time for people to attend to some of those activities of a project. So some organisations had trouble getting workers there because they wouldn't allow them or they could not in their time, whereas others had that made available.

MS DAVIDSON: Dr Fernbacher, you have also identified the possibility of more multi-disciplinary hubs. Can you expand on that for the Commission?

DR FERNBACHER: So a little bit similar to what was raised in terms of connections are usually easier made when people are within a same building, and over the years in Victoria we have had many examples - I remember I think in the 80s there was something called the NOW Centre on Sydney Road. Some of us may remember that. There was Child Protection. I think there was a homeless service. There was a women's service and other services, and people would literally walk from one part of the building to the other one to talk to people in the other organisation. Whilst that might seem so simplistic, it is actually sometimes as simple as that, as co-location does make a change. People get to know each other, understand better how each other's services work. That person, if those relationships work, become often the friendly face of that service. We have heard that from Drew, for example, as well. We know from

the multi-disciplinary centres between sexual assault and police how well that interface also works.

Patrick McGorry was saying earlier on about Headspace, which is a different way to do that, which mostly has private practitioners. But there is opportunity for public mental health services, family violence services, sexual assault services potentially to be involved in co-located services, if it's primary or secondary or tertiary consultation.

MS DAVIDSON: I see you are all nodding. Is that something you all would endorse?

COMMISSIONER NEAVE: Can I just test that a little bit. I can see from the point of view of the client that it's an enormous advantage to walk in a single door and then to be able to go to different areas with different problems. Does it break down the professional and disciplinary boundaries, or do people still stay in their own little professional space? What's your experience, if you have had some, with the latter question?

DR OAKLEY BROWNE: I think it generally leads to breakdown in those boundaries. If you work alongside people and you get to know them in another way other than their professional role, I think you get a better understanding of their roles and tasks, and they of you. So I do think it can lead to an improvement in relationships and understanding.

I think Sabin, in her submission, refers to the fact that Mental Health speaks a different language from other services, and that can be a problem. We have different ways of thinking about things. The opportunity to talk around cases and do that over a period of time

leads to some merging of language and ideas. So I think generally it can lead to advantages. Other things are of importance too, but it is a useful way of proceeding.

DR FERNBACHER: I think the different languages is a very good point. I think early on in our partnership project someone said that we first need to work out that we all speak the same language, and my comment was we won't be doing anything for the next 10 years, I think. Maybe it is about being able to translate and understand each other, because each sector has such unique language. But by being co-located and working together I think that is possible, for professionals to at least understand each other and therefore hopefully for the client that to be better as well.

MS DAVIDSON: On the point of language, I think, Mr Bishop, you also identified that the different languages between the two sectors is a potential barrier, particularly for family violence workers getting access to services, but also you identified that as an issue for consideration in training mental health professionals on things like the CRAF. Can you explain what you see as being the differences in those languages?

MR BISHOP: I think family violence services and mental health services have different ideas about what constitutes mental health and what constitutes a mental health crisis, and what constitutes risk and what doesn't. I think that a family violence worker's assessment of risk when they are looking at a mental health presentation is different from how you would expect, say, a triage worker to assess risk. They would ask different questions around risk. They would have different screening, I guess, questions in

their head around things like psychosis and so on and so forth.

So I think that when a family violence worker interacts with the mental health system or with a mental health worker their expectations are not met because they are not often conveying the concerns that, say, a triage worker or a CAT clinician is expecting to then warrant - initiate the service that they would be after, such as a crisis response.

MS DAVIDSON: You have also identified the need to - if you are to have training and risk assessment for family violence for mental health workers, you would suggest some co-facilitated training?

MR BISHOP: I think that that would be useful. Again, we are talking about different languages and different styles of explaining the same problem. So I think that having co-facilitated training between family violence services and mental health services would be ideal because, again, it would lead to that breakdown and that barrier that seems to exist between systems.

MS DAVIDSON: Dr Oakley Browne, in terms of training in relation to the CRAF, the Common Risk Assessment Framework, for mental health professionals you have identified that some training has been done in Victoria?

DR OAKLEY BROWNE: That's correct, and we checked with the agency yesterday who's responsible for providing the training. They tell us that they have put through about 6,500 health professionals in their training and they have a regular program of training.

Having said that, that's a good number but the number of people employed by the public mental health

service is 10,000. They would be training people outside the public mental health service as well. So it's probably still a small minority of people who receive training. So it's not been as extensive as might be necessary.

Just while we are talking about the CRAF, I understand tomorrow there will be a session on addressing the issue of predictability and instruments like the CRAF will be discussed. The CRAF is a good starting point, I think, and provides a good framework for health professionals and social service workers. There have been some criticisms of it. One is, although 70 to 80 per cent of violence is male on female violence, there is 30 per cent of violence which relates to elder abuse, for instance, or sibling on sibling or female on male. The CRAF is a little bit light on those areas of violence. So it's good on male on female violence.

The assessment tools are a good starting point. They are a good aide memoire for a trained clinician to be thinking about the things that they should be engaged in in discussion with someone about. But they haven't been validated as screening tools as such. So further work would need to be done if they were to be used as a screening tool in health services.

But, having said that, I think it's a very good start. It provides a nice discussion for a health or social service worker and provides them with a framework which they can use as a reference point.

MS DAVIDSON: In terms of risk assessment from that perspective, do you see that as being part of a trauma informed care model, that if you are talking about trauma

informed care you are taking a full history, both past violence and also present violence; is that how they would interrelate?

DR OAKLEY BROWNE: Yes. I would place less emphasis on risk prediction because in fact the science is not very good at that and more on risk management. So in terms of family violence, yes, one of the things that an instrument like CRAF should be providing is a framework which health professionals can use for managing the risk. There is a difference between trying to predict the risk of this individual and also managing the risk to minimise the risk. We have perhaps overemphasised the risk prediction and underemphasised the risk management as to what actively should be done to make the situation safer for people.

MS DAVIDSON: Dr Oakley Browne, you have also identified a need potentially to improve intake and assessment processes and also improve discharge planning to ensure that there's a safe home to go to, and an integrated and supported recovery plan. Can you expand on what you'd identify as being possible improvements in those processes?

DR OAKLEY BROWNE: One of the key issues raised in both national documents and state documents and indeed service documents is the need to include family members and carers of persons with mental disorder in decisions about provision of care, management of risk and appropriate placement after discharge. Although I think we strive as health workers to address those issues, probably we could do better.

So as has already been pointed out by my colleagues on the panel, by Professor Kulkarni in

particular, if you did an audit of many case files and looked for evidence that a clear history had been taken, including the history of risk of harm to self or others, including family violence or the experience of abuse in childhood, you will find that's often overlooked.

If you look for evidence in files that people had taken a view - a trauma informed view about the presentation of this person and how they can assist that person, often that wouldn't be conveyed in the files. So that is a real problem and requires quite a shift in the thinking of the workforce, of all of us, and we have just begun on the pathway there.

Part of that shift is about being informed about how trauma impacts on people but also relates to how information is shared both within clinical teams and between teams and services and with carers and family members to minimise that risk. This will probably be subject to a different condition. We probably don't have as good a clarity about how information should be shared as we need to have to manage situations as well as should be done.

MS DAVIDSON: I will come back to the issue about information sharing shortly in relation to people with mental illness who are using violence. Before I do so, I wanted to just have your views, Ms Fernbacher, in relation to opportunities to improve family violence services and particularly refuge services. You have identified in your statement some of the difficulties that are associated for women with mental illness in accessing refuges. Can you outline those for the Commission?

DR FERNBACHER: Sure. I think there are some clear barriers or

situations or sometimes when women are really very unwell that a stay in a refuge may not be appropriate. However, I also know from practice and women talking about this over the years that - and some workers talking about - that, whilst it's also true that workers can feel underskilled in working with women with a mental illness or women and children with a mental illness or mental health problems, some of the barriers may also relate to the stigma around mental illness.

So in my statement I talked about one situation that was relayed to me where a woman had been referred to a family violence service, was going to a refuge, arrived there, and in the haste of packing up - she was leaving a crisis and just got out - didn't have her medication, psychiatric medication with her. The refuge refused to accommodate her and put her into a motel overnight, over several nights, until medication could be organised.

When I asked questions about it, because I was quite baffled by that, I have to say, it was alluded to that they couldn't guarantee the safety of the other residents in the house, which I think - I wasn't privy to the actual situation, but I think that kind of shows the lack of understanding, a lot of stigma and concerns about things that probably shouldn't be a concern. It's very - firstly, why would the woman be dangerous to anybody else? So that relates to the stigma around mental illness, I believe. But also if she misses one or two doses of her medication it's unlikely that her mental health will deteriorate that quickly. My psychiatry colleagues here can comment on that much better than I can, but usually medication takes some time to take

effect but also for it to wear off. So there really should not have been any problem.

If we juxtapose that with women, for example, who are on the methadone program, and I worked in the family violence sector some years ago when we had started then to ensure that when women needed to move out of their area, which they often need to do, that their methadone would be transferred to the chemist down the road and the family violence staff would support her to pick that up there.

So to me that example, that's just one example that raises a number of other issues. A little bit like what we were talking about earlier on, if the refuge or the family violence service has got a good relationship with their local mental health service, then they could maybe organise the transfer of the medication quicker. But, nevertheless, there was no real reason why the woman could not access the service.

I know anecdotally that often when a referral is made for a woman with mental illness, and having been on either side of the service system, that women are frequently asked, "But can she share with others?" I imagine all women are asked but women with a mental illness seem to be asked just that little bit more often, and I'm not sure what that relates to. Maybe it is again around the stigma. Women with a mental illness can share in the same way or cannot share in the same way with other people, and sharing a house with a number of other women and children at a point of crisis isn't probably great for anybody and isn't good for anyone's mental health other than peer support.

So there are a number of barriers, I think. Some

of them are quite legitimate. If a woman is really unwell, then a refuge may not be the right accommodation. But quite frequently it is difficult for women to access. I know that inpatient units, psychiatric inpatient units, have been asked for a written statement about a woman's mental state, that she's safe or well enough to go to a refuge, and that is problematic to obtain from an inpatient unit.

I know of a situation where a colleague assured the family violence service she was making that referral because the woman needed refuge and she was well enough, but she wouldn't be taken because a written statement wasn't given. At the same time, refuge workers did not feel well enough equipped to support the woman.

So there are a number of barriers, and I think some of the solutions, as we touched on earlier, you know, training is one of the things, reflective practice, secondary consultation, being more familiar with mental health services, not becoming a mental health specialist but knowing maybe a little bit more about mental illness and how it impacts and what is likely to be expected or how it may manifest or when to involve mental health services would all be helpful, I think things to do - for family violence services to feel more confident about working with women with mental illness.

DEPUTY COMMISSIONER NICHOLSON: Ms Fernbacher, would some of those problems you talked about associated with refuges be due to them being communal in nature? The Commission heard yesterday from a model of refuge accommodation in South Australia where a woman and her children have an independent living situation. Would that overcome some of

the problems that you have alluded to this afternoon?

DR FERNBACHER: Yes and no. I think it would in terms of having to share and refuges or family violence services being concerned about women being able to or not able to share with others. I think - I imagine overall it would be a great way to support women with children no matter if they have a mental illness or not.

However, if it was - and there are some examples in Victoria as well of kind of cluster, I think, living with a shared courtyard but separate units, which can go some way towards peer support, I imagine. But also separate units might allow easier access, for example, for a mental health service. So currently, and I know there are exceptions, some refuges would not have a mental health clinician attend at a refuge, whereas others may do that, because of the high security status of refuges, so nobody can know where they are. So a woman with a mental illness who receives mental health support who then has to move into a completely different area, for example, within Melbourne or Victoria loses her connection with the mental health clinician, which could potentially be a great source of support.

So if a model like the one you are describing from South Australia would allow for that, which I would imagine would be a little bit easier to do, that would probably solve or do away with some of those barriers, yes.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

MS DAVIDSON: You have also identified that the requirement to move away from the area in order to access a refuge service is - actually has a particular issue for those who

are receiving mental health treatment because of the way that the mental health service is structured. Can you explain that particular difficulty?

DR FERNBACHER: Sure. So clinical mental health services, as almost every sector, have their particular geographical boundaries. So, for example, the one I work in covers the cities of Darebin and Whittlesea, and many of the others have specific - a specific catchment area.

Given the high security model being the only refuge model being the only model in the State of Victoria, to my knowledge, women have to move usually a long way away from not only where they live, where their children go to school, where they see their mental health clinician and they have their supports, but also where family members and other people are known to them live. So they have to move out of their most immediate environment and their supports into a completely different area. Again, many women I know would find that stressful and distressing, including children, who then have to go to a different school, lose their local community support.

Now, obviously if lives are at risk that is a particular situation and it probably needs to override that disconnection. But, if it is not that precarious a situation, from my knowledge moving away from your support system, and that might include professionals, and in this case mental health professionals or your local GP or your mental health clinician, and having to then see someone completely new - sorry, so if a woman would move into a different area because the refuge is in a completely different geographical area, she would lose that connection with her clinical mental health service. It

would be too far to travel but also that service could no longer see her and would have to refer her to the local mental health service where she would stay in that refuge, but that would only be for the time that she's in that refuge. If she then moves again, she would have to potentially change again and she may well not go back into her own area. So potentially she would have two new mental health services working, and if she has to move again that occurs again at a time of high crisis.

COMMISSIONER NEAVE: I just wanted to understand that. Is that due to some rules about the funding of particular services? I can go to a GP anywhere in Melbourne if I want to. So is there some rule which requires you, if you move out of the area, not to access that service? Is that how it works?

DR FERNBACHER: Yes.

DR OAKLEY BROWNE: It is not quite as rigid as that, as I hope, but, yes, the services are organised around geographic boundaries. Typically, when you move into another area, then you would receive services from that other area . There are exceptions and the boundaries - - -

DEPUTY COMMISSIONER NICHOLSON: Even if that's temporary?

DR OAKLEY BROWNE: No, if it's temporary you might stay on, and there are agreements about how long you have to have been in the new area before the transition occurs. If it was just a temporary shift, you were staying with someone else or it was anticipated it would only be for a few weeks, then I would not think it would be good practice to change. It is recognised there is that flexibility.

DR FERNBACHER: I think there is probably two ways about that, that some services would adhere to that and others would

transfer the care. But also to have to travel back a long way to the mental health service - so someone could be from Bendigo and ends up in Frankston. That's a challenge. Or even within Melbourne you would then need to - if you don't have a car, how do you get - - -

COMMISSIONER NEAVE: I understand the practical problems. I was just wondering about what the principles were that governed the provision of services.

DR OAKLEY BROWNE: The broad principle is, if you shifted to a new geographic area and the shift is going to be permanent, however you define that, then there would be a change in the provision of care. But there is usually a transition period where you may continue with the old service, and the transition is meant to be done in an orderly, planned way rather than precipitously.

There can be practical issues. If the person needs ongoing access to out-of-hours services, then that may require a more immediate change, just for simple logistic reasons that the out-of-hours service wouldn't be able to be provided if you were at some distance away from it.

MS DAVIDSON: Mr Bishop, you have also identified the opportunities to provide mental health services within a refuge setting but also some issues about some potential barriers to doing that. Can you explain what you have previously investigated about providing a service within a refuge?

MR BISHOP: Sure. As I stated before, we had another worker who was working in our secondary consultation family violence outreach specialty, and we were devising a system of being able to provide some onsite group work or

consultation within refuge services. That model, we did not - I guess it didn't kick off because the resources that we had available to us had to be shifted. So we were unable to provide that model.

I guess some of the boundaries that I sort of see is - one of them is people not being there permanently, that that can be a barrier to people receiving good mental health services. So that's a barrier, that people stay there short term and then they move out. So trying to devise a mental health model that is treatment effective can be quite hard in those circumstances.

I think the other barrier that might be evident, and I can touch on this just from my personal experience, is being a male clinician and then some refuges having different policies around whether or not they let males into the refuge. The service that I work with, the Salvation Army Crossroads Family Violence Service, has a particular policy around males being I guess gender sensitivity trained, and they need to definitely understand the model of care and be very much trained in family violence practices.

In my experience, mental health workers are not traditionally trained in that, and that would include the male part of the workforce. So that may limit I guess a male's ability to be able to provide inreach services as I outlined into refuges, which can be difficult.

MS DAVIDSON: What is your view about or perhaps anyone's view about whether or not it would be a difficulty to have a male professional providing treatment to a woman in that kind of crisis situation? Is it a potential risk, or is it a beneficial thing?

MR BISHOP: I believe in some circumstances there can be a risk of re-traumatisation depending on what the women's and the children's exposure has been. From my practice perspective, afterwards, when I'm usually seeing women and/or children for psychotherapy, there hasn't been a problem with me being a male. I really think that it's important from definitely a therapy perspective and a therapeutic relationship perspective that women and children get exposure to positive relationships with male professionals and males in general. I think that it's really part of the therapeutic process and really important for them to recover from the trauma that they have experienced.

PROFESSOR KULKARNI: Again, it is interesting, in our clinic we started off with all-female staff, but over time in fact we now have male staff as well engaging in therapeutic interactions. It does work well, but you have to pick your cases. There will be - we always give the patient the option of having a female therapist. Sometimes people do ask for that and we go along with that. But it depends also on the training and sensitivity of the therapist. You can get some terribly insensitive and badly trained women therapists as well.

MS DAVIDSON: Another issue that was raised during the early days of the hearings was the possibility of child and adolescent mental health services providing services, particularly therapeutic services, for children. You heard from the lay witness the difficulties that she's had in terms of getting some sort of therapeutic services for her children. I think, Mr Bishop, you have identified a possible difficulty for child and adolescent mental health

services, or CAMHS, in relation to providing services in a refuge situation?

MR BISHOP: Yes. I should just preface this by saying that the team that I work in is an all-of-life service. So we are quite unique in the adult mental health field where we would see people from birth until death, essentially, which is unusual. Most adult mental health services see people from about 16 to 65, and sometimes 65 and over, or in Orygen's model I believe that it's 15. We have a cohort of clients who are under 15. So we are in a privileged position of being able to provide primarily psychotherapy services to kids who are under the age of 15.

The CAMHS model I think works very similarly to the adult mental health model about, one, they don't necessarily provide inreach or going into services to provide psychotherapy and, two, they work on a person-centred address model, where if the child was to move out of the refuge then they would have the same problems as the adult mental health service would. So their ability to be able to continually address the needs of children from a mental health perspective is I guess influenced by those barriers.

MS DAVIDSON: I think perhaps for the transcript people we might need to take a five-minute break, just until 25 past three.

(Short adjournment.)

MS DAVIDSON: Before I move on to the issue of mentally ill perpetrators of family violence, the lay witness raised an issue about the need for mandatory reporting of family violence. Perhaps if we were to break that down into

perhaps two issues that probably arose from her evidence, the first is the idea of mandatory reporting but perhaps the second would be whether or not there is a barrier to reporting, whether or not it's mandatory, in circumstances where in this case the lay witness had disclosed that information in the context of a professional relationship with potential confidentiality issues around that.

I would invite you each perhaps to think about that and perhaps give your views about, one, whether or not there needs to be some ability to at least permit a mental health professional or a health professional to disclose that kind of information or report it to someone and, two, whether or not it should be a mandatory reporting obligation.

PROFESSOR KULKARNI: Can I start, because it's an issue that I have been engaged with with the College of General Practitioners, who are debating this at the moment, and also the College of Physicians. The College of Psychiatrists hasn't got up to debating it yet, but I'm sure it's around the corner.

In listening to the lay witness's statement, I have been in exactly that same position with a number of patients that I have been involved with in the clinic, and the concept of some kind of reporting does allow the clinician to take some action. Sometimes the whole issue about the family violence can make you feel as the clinician quite powerless to do something because the woman who is suffering is suffering from several things. It's not just the abuse that clearly can be physical, sexual, mental that's going on, but it's also that over a period of time, as the witness said, she will have been

disempowered herself in a number of ways and also be sometimes not accepting of treatment or help.

So from many points of view there's a kind of stalemate in what can happen. As that witness said, it was through the mandatory reporting of the children and the child protection services that got involved that then unlocked a whole series of actions.

I have to say that it has been helpful to have some of the changes that have happened for Victoria Police, the police involvement in terms of the intervention orders and the sorts of more accessible service that the police have that allow some intervention to happen.

How do you negotiate that at the moment with the Mental Health Act or the confidentiality that's implicit in these interactions becomes an exercise in your own level of experience and your own level of capacity to work through this with your patient. That is fairly fraught because if you are more senior you will be able to negotiate it; if you are junior or you have even less time and autonomy, then chances are you will plead that you can't do anything because you are bound by confidentiality, and you can actually watch this person really go under and in fact with deathly consequences.

So in my view I think it would be very helpful for there to be some capacity for some reporting. The difficulties with mandatory reporting is: where do you draw the line? It may be very simple if there are significant bruises, fractures and physical evidence of physical assault or sexual assault. But with our field those signs are not there but in fact the damage can be

quite a whole lot greater and a whole lot more difficult to actually help. So I think we would have some problems with where do you draw that line, although with children we are to report emotional abuse or neglect or deprivation.

So I started some years back thinking, "We can't have mandatory because that's going to take away from the woman's own independence and her own volition and, if you like, the sort of things that we are trying to build up in this person - build up the confidence, build up the self-esteem. So if we jump in and take all that away, then we are going to be counter-therapeutic."

But, on the other hand, the more I have been involved in this field the more concerned I am about the level of harm that is happening to women who are in the situation of family violence and the harm that observing this violence is doing to their children. So it's almost a level of priority. We have to save some lives, we have to actually save the capacity for the children to have normal lives as much as possible. In that case we may need to intervene.

I think that every time we have had any change that's been effective - seatbelts, bicycle helmets, cigarette advertising - it hasn't been through medical education. It has been through the law. So I really do think we need something, and that's my personal view. I would agree with the lay witness, but perhaps not mandatory.

MS DAVIDSON: So if I can encapsulate what you are saying, you need an ability to breach the confidentiality?

PROFESSOR KULKARNI: That doesn't just depend on the

individual's clinician's seniority and skill base.

MR BISHOP: I would agree that there probably needs to be some level of being able to report or mandatory reporting that needs to be in place. But, again, I agree with Professor Kulkarni's statements about the difficulties that are within that. It is about balance, and it's about trying to balance the client's independence and empowerment versus you taking that away from them and doing something that they may not like.

So I think that negotiation with the client is very, very important, and sitting down with them and talking to them about the risk and giving them some family violence education is probably key to be able to get them on board. But, as we have previously stated, not all mental health clinicians are trained to do it in that way. In that field, how do we then know that everyone's getting the same level of education to deliver the same service versus should we just mandatory report irrespective of what the education level of the clinicians are? So it's hard to balance.

MS DAVIDSON: Does anyone else want to contribute a view?

DR OAKLEY BROWNE: Yes, it's an interesting problem. Certainly within the current laws and in common law, as I understand it, health professionals do have the discretion to break confidentiality if they think there is a serious and imminent risk to the person or there is a risk to the public good and wellbeing. So they can exercise their judgment in certain circumstances and choose to break confidence and disclose to another person. That's particularly the case when a person is a caregiver or a family member who may be at risk themselves.

But the situation where the person is continuing to be at risk and is saying, "No, please don't disclose this to anyone," is particularly problematic because you have to balance her autonomy versus the risk of exercising her autonomy poses to herself.

I understand there are different views about this, like the Australian Domestic and Family Violence Clearinghouse has said it is opposed to mandatory reporting. The National President of the Australian Association of Social Workers says this removes the power of the victim to decide when the police are notified and that makes the victim even more powerless. The Australian Law Reform Commission has also expressed concern. So I think there's quite a diversity of views.

If mandatory reporting is introduced, then my view is that staff have to have very clear and rigorous training around that, and their responsibilities need to be clearly delineated and done so in a way which is not ambiguous. They need appropriate support when making those decisions. There has to be an outcome which doesn't put the person at more risk. So there has to be an outcome which leads the person down a path where they are going to be safer as a consequence of the mandatory reporting. So those system things need to be in place.

Thinking of my own personal practice, I am of the view there would be circumstances in which I would disclose despite the person telling me not to disclose. That would be when I came to a view that the person's life was at serious risk, for instance, they had suffered serious assault and there was a strong indication that that was likely again, or they had suffered rape, or the

person had access to weapons or threatened to access weapons. So there would be scenarios like that which would cause me very serious concerns about the life and wellbeing of the person where I, in those circumstances, may disclose to other authorities like the police. But hopefully I would do so after discussion with the person and outlining my reasons for doing so, and also putting things in place to ensure that result of my disclosure wasn't her being placed at more risk.

MS DAVIDSON: Thank you. If we move on now to the question of people who are mentally ill and are using violence as a consequence of their mental illness. Perhaps, Dr Oakley Browne, can you first outline for the Commissioners the test that really is applied for compulsory treatment and detention of people with mental illness?

DR OAKLEY BROWNE: Yes. So essentially there's a number of criteria under the Mental Health Act which need to be met. First of all, the person has to have a mental disorder. That's defined in the Act as being a disturbance of feeling, cognition, perception - there's something else, but essentially it's a legal definition of a mental disorder. It doesn't necessarily coincide exactly with a medical definition of mental disorder.

On top of that, they need to pose a serious risk to themselves or other persons. What serious risk is is not defined in the Act. So that's left for judgment call.

Thirdly, you need to be convinced that provision of treatment cannot be done in any other less restrictive way other than placing them under an order, so it's not feasible to deliver the treatment that the person needs in some other manner. Particularly if you are placing them

in an inpatient unit you need to be of the view that that's necessary and that there is not a lesser restrictive option available to them.

Then the Act has a series of exclusion criteria defining what a mental disorder is not or what you can't place a person under an order for. That would be things like religious belief, use of drugs and alcohol just of itself aside from being a disorder. It would include things like antisocial behaviours. Antisocial behaviours of themselves wouldn't be sufficient to use the Mental Health Act.

So that's essentially it. So it is the presence of a mental disorder as defined in the Act; the presence of serious and imminent risk to self or others; that the treatment can't be provided in some other means; and that the behaviour of concern isn't one of these other ones which would be excluded by the Act.

MS DAVIDSON: That can result in both either detention or it can result in compulsory treatment; is that how it works?

DR OAKLEY BROWNE: Yes, both. Under the Victorian Act it can result in placement in an inpatient unit. There are designated area mental health services which have inpatient units within them. So if you need to detain a person they need to go to a designated area mental health service and be placed in the appropriate unit within that service. So that's to detain them.

Then if you need to initiate treatment there are temporary treatment orders which can be initiated so that you can use medication or other interventions to treat the person. It is also possible to treat the person under a community treatment order. So it's not necessary that

they go to an inpatient treatment facility. You could, if you felt that you could do it safely and appropriately, treat them in the community.

MS DAVIDSON: Does it mean under that test that it's a cumulative requirement?

DR OAKLEY BROWNE: Yes. All criteria need to be present, yes.

MS DAVIDSON: So a person can pose a serious risk of imminent harm to others but that wouldn't necessarily mean that they should be detained; they might be treated in the community on the basis that that would be a less restrictive way?

DR OAKLEY BROWNE: There would be some people who we would know would pose serious risk to others but don't have a mental disorder, for instance, or don't meet the criteria for the disorder. So there are people that we know who have a history of violence and maladaptive behaviours but don't have a mental disorder as defined in the Act. So that puts you in a very difficult predicament. You know there is a risk but you can't use the Act to detain them or treat them.

So that's the major scenario which causes problems for clinicians, particularly around persons who have antisocial behaviours and a history of antisocial behaviours and may meet the criteria for what we call antisocial personality disorder who can quite often present with aggression and violence, particularly if intoxicated, and then the issue will be do they truly meet the criteria for the Act and can you invoke it to compel them to have treatment.

MS DAVIDSON: So under the Act how does that incorporate the situation where you have a person who is posing a risk to

family members? How do you assess that?

DR OAKLEY BROWNE: Under the Act there is no assessment tool which is used across the state. There are a variety of assessment tools which can be used by front-line clinicians, and mostly services have developed their own. Typically they are a set of items which directs the clinician to enquire about these factors and come to a view about what the hazards are and then start planning to manage those hazards.

In specialist settings there are tools which have been developed and validated where their properties are well understood and which can be used to try to predict dangerousness. An example of such a tool which is widely used in forensic settings is the HCR-20, which is an instrument which we know depending on people's score what that means in terms of their potential dangerousness in the immediate and distant future. That tool requires a psychiatrist and another mental health professional, usually a psychologist or a psychiatric nurse, who are trained in the use of it. It's not a simple tool to use. It does require some degree of clinical sophistication.

Typically that tool is used in forensic settings and is a useful tool along with other information to inform decisions about disposition, leave, other issues about what should happen for the person. Unfortunately, it is probably not useful in the general psychiatric population, and there are not other tools which have been really shown to be able to guide decision making with any degree of reliability.

So essentially you come down to there are what are called actuarial items, so these are items which are

known from research to be associated with risk of violence - obvious things like a past history of violence, history of intoxication, male gender, youth and so on - and where people can go through a checklist on those things and identify people as meeting those criteria. But that of itself is a poor predictor for that individual of their likelihood of violence. I'm not sure if I'm explaining that well.

So essentially what we would want to emphasise with clinicians is, rather than becoming too focused on a checklist, really thinking clearly through how we should manage the risks in this situation. So if it is risk to other people, like risk to other family members, making decisions about should this person go home, what information should we be telling the family members that will guide their decisions about how to manage the situation; in extreme risk, should we be talking to the police and informing them about the situation. So those kind of risk management strategies.

If they have a mental health problem, a mental disorder, then the best risk management strategy is effective treatment of that mental disorder. So thinking through how you would manage their treatment.

MS DAVIDSON: In terms of the use of the Mental Health Act, any risk to a family member would be part of the - - -

DR OAKLEY BROWNE: Yes, risk to any person, so themselves, family members, members of the community, yes.

MS DAVIDSON: What we have heard through the consultations is often family members saying that their son or daughter or partner or other family member gets put into an inpatient unit for a very, very short time and is sent home, from

their perspective, before the risk really has completely abated. The suggestion has been that there's just not enough room in the inpatient facilities and that there is pressure to move people out. Does anyone have a view on that?

PROFESSOR KULKARNI: I can speak in terms of my role as a consultant psychiatrist. I do on-call work for the hospital that employs me. So, unfortunately, yes, that is true. There is considerable pressure on beds, and the idea is to try to stabilise somebody fairly quickly and get them out of the inpatient unit. That's not seen as a long-stay ward or somewhere that their continuing treatment should take place. The difficulty can be very much along the lines of if the information is not received from the family, and if the patient's information only is taken as the main primary source of information, then a whole lot of other things can be missed in terms of risk to other family members of violence and so on.

So it is a difficult time. It is a high-pressure system in the inpatient units. Of course, the more senior and the more well-supported the group that's managing the patient is, the more likely that then more information will come from somebody ringing the family or somebody ringing the general practitioner or somebody speaking with the community clinician that may have been managing this patient. But it is again going to depend on what is going on in that service, what is going on in that ward, what's going on in terms of the sort of level of seniority in the staff that are on at the time. They are all variable factors.

MS DAVIDSON: Does anyone else have a view about the pressure

on inpatient beds and the pressure to move people out potentially before the risk is fully abated?

MR BISHOP: Yes. We have an access policy which ensures that inpatient units act to try to discharge two people a day to free up resources for people who are deemed to be more unwell to come into the service and receive some treatment. So definitely there is pressure on beds, as Professor Kulkarni says.

The pressure is offset by relying on community mental health teams to maybe perhaps take people a little bit sooner than what they probably need to be. So there's a reliance on our CAT team to provide some home treatment to possibly people who are more acute than what you would necessarily expect, or for them to go back to their community case manager to provide ongoing community care.

Sometimes the person has to go back into the inpatient unit, they are not well enough to be out in the community, so they are referred back into the inpatient unit, and that cycle can happen, and I guess in that instance the family can be re-traumatised in that circumstance as well. Definitely, yes, there is an obvious pressure in the inpatient unit to get people out - or get them treated fast, get them out, which means that perhaps psychosocial issues are probably not attended to as well as what they should be.

MS DAVIDSON: I think it might be both Dr Fernbacher and Professor Kulkarni, you have identified the possibility of more step up and step down facilities that are able to potentially alleviate some of those issues in a slightly more cost-effective way than keeping people in inpatient units.

PROFESSOR KULKARNI: Certainly there are a number of really excellent step up and step down units across the state. I'm familiar with several of these. They do provide the option of longer stay and sort of more supervision and a better understanding of the patient's normal discharge environment or what would be ideal for that person to go back to. It allows more family engagement as well. So it's just less pressured in those kinds of units.

But of course again there are a limited number of those PARC - those sorts of units. There are some services that don't have those particular facilities in the number of beds that they would like to and that they need to have.

So I think it's saying that we need different levels of acute treatment, and we also need to be able to involve the other layers of treatment that are the non-acute, the sub-acute layers of treatment with being able to conduct more sort of family work and more involvement of family members to see if we can overcome some of the potential for violence if the patient who has the mental illness is not properly managed over a longer period of time.

COMMISSIONER NEAVE: Do we know how many people step up/step downs can accommodate across the state?

DR OAKLEY BROWNE: I have some bed figures, which is in 2009/2010 there were 90 PARC beds, and PARC stands for - I always get these acronyms wrong - prevention and recovery unit. So essentially they were a step up and step down unit as an alternative to acute admission. There were 90 then. In 2015/16 there are 210. So there has been a significant increase in the number of beds,

which is not to say there isn't room for more.

COMMISSIONER NEAVE: So 210 across the state?

DR OAKLEY BROWNE: Across the state, yes. In terms of SECU beds - SECU are secure extended care units, which provide longer term care, usually a matter of six months or even up to two years, particularly for people who pose ongoing and significant risk associated with their severe mental disorder - there has been a modest increase from 326 in 2009/10 to 358 in '15/16 - no, sorry, I quoted you the wrong figure. Sorry, that was for CCUs. For SECUs it is 103 in 2009/10, and it is 133, 2015/16.

COMMISSIONER NEAVE: Sorry, 103 and 133?

DR OAKLEY BROWNE: Yes, there was 103 in 2009/10, and this financial year it is 133. In SECUs there has been a small increase from 326 in 2009/10 to 358. So when we look at Victoria's spending and distribution of spending in terms of public mental health facilities, compared to other states our spending is low on inpatient units, on inpatient acute beds, but in terms of community care services it's high. It's higher. So Victoria has made the policy decision to put more spending into providing community supports and more recently has invested in subacute units to extend that.

DR FERNBACHER: Could I just add also to that that step up/step down, or subacute units, or PARC - we have three different names - the environment is quite different to an inpatient unit. So they are not part of a hospital. It doesn't have the atmosphere - certainly the ones that I know don't have the atmosphere of an acute unit, because they are obviously not. But they are much more a residential kind of place. Because they have just all been usually newly

built they don't have the feeling of the old institutions, and not the - I suppose not the level of maybe distress or not as many people also as an inpatient unit.

So, if we think about family violence and trauma, they also lend themselves in a different way to providing an environment that's less - maybe less disturbing or less anxiety provoking for people as well, and because they are longer term, as my colleagues were saying, some work can be done that is almost impossible to do in inpatient units.

MS DAVIDSON: Dr Fernbacher, you have also referred to residential mental health crisis facilities, I think, as an alternative to an inpatient - is that similar to a PARC? I think that's at paragraphs 97 and 98.

DR FERNBACHER: I think 97 is about RAMPs but 98 refers to a study that has come out of the UK about women's crisis houses; is that what you were referring to?

MS DAVIDSON: Yes.

DR FERNBACHER: There's a number of women's crisis houses across the UK which are - they remind me a little bit of our PARCs, except they are specifically for women with a mental illness who experience family violence. They can then also take their children with them. So it's an alternative to an inpatient unit stay.

The paper I referred to was that a colleague, Professor Louise Howard, and colleagues in London evaluated some of those women's crisis houses and talked about the benefits that women identified. So they found that environment a little bit like what I was just saying about PARC - more welcoming and less stigmatising. With some of them they can take their children, so they don't

have to be separated, so they don't have to make that decision about whether the child or children go.

Interestingly enough, they were mostly staffed by mental health workers who were also well trained in family violence. So different to our refuges. They sound quite promising, and the outcomes seem quite beneficial, similar to inpatient units. I think from memory they can also stay there a little bit longer. So it's just one other - I would not suggest that instead of refuges necessarily, but it could be something we could - that could be thought about as an alternative to be further explored.

DR OAKLEY BROWNE: Yes, I agree with Sabin, and it has already been alluded to by my panel colleagues that the level of acuity in inpatient units is quite high. The average length of stay now in Victoria is about 11 days, and the bed occupancy is about 95 per cent. Mental health is not special in that. If you go to any medical or surgical ward you will find a similar level of acuity, that there is very rapid turnover of patients across the acute service.

I spent a week in Peninsula Health on a secondment just about two or three weeks back, and I was struck even since I had walked the wards of hospitals how much busier it has got and how much more is being done. So there is that general increase in churn across inpatient units.

The consequence of that is really, I would say for myself and I would suggest to any consumer, hospitals are best avoided if you can. They are necessary when you have acute illness for investigation and for response to

that acute illness, but a lot of care can now be managed more safely and more appropriately in the community, and that includes mental health care. So the emphasis on acute mental health units is clarifying what the problems are, initiating an initial response, but then follow up mostly in the community.

In terms of concerns about managing risk, there are three ways you can think about that. One is risk can be managed in terms of the physical environment, the four walls; or it can be managed in terms of the relationship the care givers have with the person who is at risk or poses risk to others; and, thirdly, in terms of having a policy and procedure framework to oversight all that. The latter two, engagement with the person to get them involved in appropriate treatment and policies and procedures which provide a care pathway, are probably just as important, if not more important, than the physical environment in which the care is taking place.

So I think sometimes people construe that a person being in a place with four walls, that that conveys a degree of security. It does to some degree, but it's not sufficient. The other things have to be attended to, and they can be done on the community basis.

MS DAVIDSON: In terms of discharging people with a mental illness into the community where that mental illness has given rise previously to a risk of violence, to what extent are we relying upon and putting the burden on the family members who are the people at risk to manage the risk?

DR FERNBACHER: I think it would be fair to say that the mental health service overall relies heavily on family to support

their loved one who has a mental illness in all aspects. Mark might be able to talk about the level of risk, but I think it then goes also alongside that that families would carry a level of risk or a level of being exposed to violence for those people who have exhibited violent behaviour towards them prior to admission, because they have become unwell and they might only ever become violent when they are acutely unwell. But that may also be in the lead-up to an unwell episode. So I would say it is fair to say that families do carry a high burden in that area as well.

MR BISHOP: I would agree with that. I think that maybe there is an over-reliance on family members to be co-therapists or co-workers in working with someone with a mental illness. There can be an over-expectation that families are probably in better positions to report to the services or to the authorities when they are victims of violence. But often I hear stories about family members being threatened about calling the CAT team or calling the police and feeling like they are unable to do that. So sometimes the family, even though we have an expectation that they are going to manage the risk to an extent, they might not be in a position where they are able to. That can be a real conundrum when we are trying to work with issues around family violence and just violence in general.

DR OAKLEY BROWNE: The evidence suggests that with people who have a mental disorder who are violent - and I want to reiterate that's a minority - but when they are violent they are most likely to be violent towards people who they live with in their household.

PROFESSOR KULKARNI: Especially mothers.

DR OAKLEY BROWNE: Mothers, but not always. So it is people they have direct daily contact with who they are likely to be violent towards. So that does pose a problem. I think it is the responsibility of the treating team to be aware of that and planning and having ongoing discussions with the family or other care givers or people they live with so that they are aware of the person's illness, what are the manifestations of the illness, what might be the signs that they are becoming unwell again and that the risk of violence is escalating, and have a clear plan to manage those risks and to be providing appropriate levels of support to the family. But that requires very close cooperation. So the family has to be seen as an intrinsic part of the management of the person.

I think that requires a shift in our thinking. We do it better than we used to, but we used to take a very atomistic view of the individual, if you like. The individual was seen and treated without consideration of their social context . I think that is changing but needs to go further.

I have to say I'm really surprised - not surprised, it's very gratifying that most families take on the task very willingly and want to do it, knowing well what the risks are. I know that's not always the case and people sometimes don't have the information from their care providers to make informed decisions. But family really are often invested, and my concern is often their persistence with the task despite the hazards and warnings about the hazards.

PROFESSOR KULKARNI: I think another big factor in all of this,

though, is the use of illicit substances to exacerbate either an existing mental illness or to disinhibit the individual. Certainly with the substances that we have around now the change in the profile of the use of substances is definitely there. So we have the methamphetamine group and a whole lot of other designer amphetamine drugs that we can't even get pathology tests to show us what's in the person's system, has certainly become a bigger issue because of the activating disinhibiting effect of something like ice that 10 or 20 years ago it was cannabis, it was all very much cannabis, and that's a different substance. Yes, there are problems because it precipitates and perpetuates psychosis. But it doesn't have the same aggressive disinhibition that the methamphetamine group of drugs do.

In all of the Victorian emergency departments this is a problem. There are protocols for management of the patient with mental illness and amphetamine abuse. But one of the problems is that a lot of violence and damage has happened before that incident that brings the person to police attention and into the emergency department. So that's another whole issue in this family violence situation that I certainly see in the patients who come to my clinic, the women who have experienced family violence.

MS DAVIDSON: Are there ways that maybe the system could be improved to better support families to protect themselves in relation to when someone is discharged to go home when they have a mental illness and the people that they pose the greatest risk to are the family members?

PROFESSOR KULKARNI: If I could just jump in there. I think

that the follow-up appointments and the community teams that do the follow-ups again almost need to put the family as their primary focus and the patient as the second, which is a little bit sort of around the other way. But if we have greater involvement of family members in all of the ongoing interviews and also the sort of follow-up practice then we get information about what's going on on a regular basis with that.

Sometimes, unfortunately, that's not the focus. The focus is to see the patient and spend a relatively short period of time getting information from the patients, doing a mental state examination, "Is this person still hearing voices" et cetera, and then that's it. That is a difficulty when we don't have that other focus. That can be a resourcing issue, it can be a training issue, it can be a seniority issue, it can be a team issue. It fluctuates. Some places do it brilliantly; other places don't.

DR OAKLEY BROWNE: I think it would be true to say probably over the last decades we have placed undue emphasis on the use of medication to manage severe disorders and perhaps haven't placed the emphasis which is deserved on psychological and social interventions. There is quite a strong evidence base for the efficacy of psychological interventions and social interventions, such as family interventions, for the treatment of a disorder like schizophrenia.

But when people have done audits and looked at what interventions are widely used often those evidence based interventions are not. For instance, family interventions, intervening to look at the style of

communication within families particularly to address - it's getting a bit technical - a style called negative expressed emotion, can actually decrease the likelihood of relapse with the same level of success as medication. But when we look at the implementation of those strategies in mental health services they are very poorly used.

So I think we need as part of trauma informed care and other initiatives remind ourselves about the importance of psychological and social interventions, particularly actively working with families with people with severe mental disorder, and that effective treatment should go a long way to helping manage the risk.

MS DAVIDSON: When you are talking about family interventions, we haven't heard yet but there are some programs that run not necessarily for mental illness but adolescents who are using violence against the parent where the model is to work on the relationship between the adolescent and the parent where the parent is also taught conflict resolution. Is that similar to what you are talking about as a family intervention?

DR OAKLEY BROWNE: Yes, it's the same idea; looking at the styles of communication between the parties and how that may contribute to the likelihood of aggression or violence and how to manage it effective without resorting to coercive behaviours by one or other of the parties.

MS DAVIDSON: In relation to people who are discharged is there any priority given to families from the triage, the central - are they given any priority when they phone with an issue? Is there any sort of support around that?

MR BISHOP: Do you mean in respect of family violence or just

the mental health presentation in general?

MS DAVIDSON: The mental health presentation where they have been in an inpatient unit, they have only just been moved out back to their family. What sort of processes are in place for urgent crisis situations that arise? Are they expected to phone the police? Are they expected to phone - is it the CAT team or the central phone number that you have talked about?

MR BISHOP: I guess it depends on how the person moves out of the inpatient unit. They can move out in a number of ways. They can move out just generally into the community mental health team and then there would be an expectation that the community mental health team would then do the bulk of the work from there. There would be an expectation that the community mental health team would also do the family interventions, provide what we call psycho education, which is education about mental health, and then would do the mental state monitoring and provide any other interventions that would occur.

One of the other pathways out of the inpatient unit would be directly back to a GP or to a private psychiatrist. In that setting the person may not have any follow-up at all and the family members may not get any follow-up where family based interventions were actually occurring, unless the particular psychiatrist or GP was inclined to do that in whatever way, and then it comes down to the training of that person.

The third option would be that they would go back to the CAT team or the brief intervention team, whatever name the team is called, and they would do some in-home inreach our outreach type of a service for a short period

of time. During that time they would probably be well placed to be able to assess the family dynamics in the home and respond to any crises that may occur in that period of about, say, a month to three months after a person leaves hospital.

There's an expectation, I guess, that the staff in the inpatient unit do a level of family intervention or education for the family or provide some level of psychotherapy whilst the person was an inpatient, but there might not be any expectation that that would continue after they have left.

MS DAVIDSON: I was about to move on to the topic of information sharing with family. Were there any further questions of the Commissioners?

COMMISSIONER NEAVE: I just wanted to ask about the CRAF and the assessment that's done by a mental health professional. One of the things that's said, and anecdotally, is that the person who is best at assessing risk is the family member. Let's, for the sake of argument, say it is a woman. She has observed the behaviour over a period of time. She knows when it's likely to escalate and so on.

I wonder how much training there is of professionals in relation to taking account of those matters. I get a bit of a feeling that people rely on their professional expertise, which may or may not take account of the expertise learned on the job managing this particular person. I wonder if that's so and if anything's being done to change it.

DR OAKLEY BROWNE: I think my colleagues can also comment on this. You are correct. Actually I was speaking to

someone who I know will be appearing before the Commission, Professor Jim Ogloff, and we were talking about predictors of risk. One of the best predictors of risk is the woman or the victim's rating of her own risk. If she is able to describe that she feels her life is at threat or she is at serious risk, that is actually a very accurate predictor of risk. Unfortunately you are also right; we probably don't attend to that as well as we should do.

One of the things that might change so we become better at listening and responding to that information is the recovery oriented framework. That's a particular framework which puts the person's experience at the centre of their treatment and which acknowledges the person themselves is an expert in their own problems and management of their problems. So I think we need to be a lot more mindful than we have been in the past about the person's own rating of their risk and bring that very much into our consideration and response.

DR FERNBACHER: I think, similar to other issues that we have talked across the day about, there is great variation across the state if a family member's knowledge and opinion will be taken into account. So, other than specific family interventions that were discussed, there's also been a shift in some mental health services to work more family inclusive. Some time ago I think Mark alluded it would have been the person with the mental illness who's asked to come to an appointment. Now more and more services also invite family members or their closest partner or someone else who is their parent or carer to appointments and will in that process hopefully also

listen more to what family members say as well, including children of parents with mental illness; so some young people that we have worked with over the years who have said, "I was the one that sat with mum at 2 o'clock in the morning when she was so unwell and she was hearing voices, and I know how unwell she is and I know the signs, but I was never asked by mental health clinicians."

There are really good examples where that is shifting, where even young people, children of parents with mental illness, are asked for their opinions. Again it's not consistent, but there's certainly some work being done towards that.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: I wanted to come then to the topic of information sharing with family members. You have been provided with a case study which I'm not proposing to read out but just to draw out some issues that have arisen in that case study, particularly about sharing of information with family members who have been affected by violence that's been at the hands of the person with a mental illness.

In that case study we are concerned with a woman who, with a young baby, had experienced family violence brought on by an increase in drug use, with the background of her husband in relation to some sibling violence when he was a child, as well as an increase in drug use after the baby was born, including taking ice and then developing a form of psychosis and resulted in some family violence and a particularly nasty incident.

He was then admitted to an inpatient unit. By this stage this woman was reluctant to be involved at all in his care but was very concerned for her ongoing safety

because he potentially posed an ongoing risk to her.

Can I ask you first about the ability to share information generally with family members in the circumstance where they actually continue to be involved as a family member and, unlike this case, where you have an intervention order and there is some contact that's been cut off, but just generally in relation to the ability to share information with families, can you describe what the provisions are? Perhaps Dr Oakley Browne would be the best person to start.

DR OAKLEY BROWNE: There are a number of bits of legislation which cover this but I think, to summarise all of them, allow disclosure of information to a person when there is serious and imminent risk to that person. So the treating team do have a responsibility of confidentiality to the patient, but that is not absolute and there are clear circumstances in which the treating team have the discretion to breach confidentiality.

Under the Mental Health Act in Victoria it's more explicit than that. It requires that the treating team consult with family and carers, and consider issues to do with provision of care when it relates to children and adolescents; so children of the patient. When the person is under an order the treating team is expected to talk with the carer family members about their treatment and share information so that they can make informed decisions to exercise their caring function and in terms of their own safety.

When the person is not under an order the person's perspective on whether that information should be shared can and should be taken into account. But, as

I said, there are exceptions under the Health Privacy Act that when there is concern about serious and imminent risk confidentiality can be breached.

My view is in this case scenario, taking it on face value - clearly there's a lot of information I don't have - the treating team could have and should have disclosed information to the partner which would have informed her decision making about keeping herself and her child safe, and that would have included discussion of the diagnosis, likely outcome, likely risks into the future and what the treatment should be into the future. So I don't see that there's a problem there in terms of disclosing that information.

There were some aspects of information that she was seeking which is a little more problematic. She wanted a copy of the clinical file. That would not usually be disclosed, unless it was done under a formal process. So if there is a Family Court proceeding or some other thing where that information was being sought then it would be done usually under subpoena or some other mechanism, or if a mandatory report had been made to child and family protection services then the child and family protection services could ask for a report or a copy of the file to inform their decision making.

But it wouldn't be usual just to provide any family member with the whole clinical file. You would provide them with the information that they need to inform their decision making. You could do that in writing if you wished or verbally, or both.

There was one other area which was a bit more problematic because the patient had closed the bank

accounts. So she was under financial duress. This could be perceived as part of a pattern of coercive behaviour, along with other coercive behaviours. She had power of attorney, though it's not clear what the scope of that was, and wanted the service to write to the bank informing them that her partner was receiving treatment who had a particular diagnosis.

That is a little more problematic. I would actually seek advice from corporate counsel if I was the clinician involved and want to see what the order is and think through how that situation could be managed. I would certainly want to be talking with the patient, because as part of treatment we should be addressing his propensity for violence and other coercive behaviours and saying, "This is part of a pattern which is harmful for your family, and for yourself ultimately, and I think you need to seriously consider these decision makings and think about what other ways this could be done."

So that's my view about disclosure. I think there's a fair amount of latitude within the current Mental Health Act and other Acts to allow disclosure to ensure the safety of the person and other members in the family and ensure that they have enough information to make decisions to inform their care making responsibilities.

MS DAVIDSON: Does everyone else think that there's enough room within the law to be able to disclose the information that was necessary for this particular woman to, one, plan to feel safe, to plan to be actually safe, but also the issue that arises in the case study is her feeling of safety and perhaps what you get out of the case study is that she

felt she didn't have enough information, and information was being I suppose kept from her, actually making her feel more unsafe than she needed to feel?

DR FERNBACHER: Can I just say something to that. By reading through that and in answering your question I think from what I understand it's almost - because there was a lack of recognition of listening to her and her level of lack of safety for herself and her baby, because that seemed to be missed by a number of clinicians, including the psychiatrist, the confidentiality then was held up, "Well, you are not actually in a relationship anymore." There was a reason why they were not. But that was absolutely missed, and she was actually not heard in terms of the level of risk that she was in and her child was in. That's when confidentiality was kind of held up as almost like a shield, "I can't tell you. We cannot give you this information."

It also shows in the way that he was going to spend some time at home, that that absolutely negated or nobody seemed to understand the level of risk. So I think it almost demonstrates that mix of by not being skilled enough or not understanding the situation enough then confidentiality was kind of almost inadvertently used - I would hope not intentionally, but it's a conflicting of those two issues. I hope I have made that clear enough.

MR BISHOP: I agree. It appears in this circumstance that the family violence was not thoroughly assessed and it was missed. Their situation was seen through the lens of mental health and that he was only displaying this behaviour because he was unwell, and because of that

reason it appears the formula was, "If we treat his acute psychosis then he will no longer display this behaviour and the woman will be safe. So there's no reason to really disclose as much."

I probably agree with Dr Browne that in this circumstance, as it reads, I would disclose to the woman because her safety is definitely at risk. But it does appear to be in the way that Dr Fernbacher's stated.

DR OAKLEY BROWNE: It seems to be there's some confusion on behalf of the treating team as to the nature of the relationship because although they say, "You are in the process of separating and therefore we can't disclose," they also asked her to take him home when they were discharging, which seems contradictory. So I don't think that had been thought through clearly enough.

Even if they are in the process of separating, they still have a relationship. The relationship is changing in kind, but she will still exercise functions in terms of his wellbeing and also for a child's wellbeing. So I think there's a valid reason for incorporating her in decisions about his ongoing care.

MS DAVIDSON: Does the Commission have any additional questions in relation to that?

DEPUTY COMMISSIONER NICHOLSON: On that section?

MS DAVIDSON: On that section.

DEPUTY COMMISSIONER NICHOLSON: No.

MS DAVIDSON: There's a submission by the Royal Australian and New Zealand College of Psychiatrists which includes a number of recommendations. I wanted to just raise with you one of the recommendations. Number 7 was, "Adoption of the roundtable multi-disciplinary meeting agreed to set

up a multi-disciplinary working group that would facilitate liaison between Health, Justice and family violence services. The College, along with the community based organisations, such as WIRE, DVRC, CALD organisations, including the Australian Centre for Human Rights and Health and faith leaders," and suggested the Office of the Chief Psychiatrist and Office of Women need to be involved to influence policy settings.

Does anyone have a view on that recommendation and how it might fit? Professor Kulkarni?

PROFESSOR KULKARNI: Yes, I think the College of Psychiatrists needs to act more firmly, more definitively. There has been a push to try and get some more action happening in terms of the recognition of the problems of mental illness related to family violence. So, yes, it's a step in the right direction but it's all still a little too theoretical. There have been several meetings now of several working parties. I'm on one of the working parties looking at this. But we really do try and push for action to actually come out with some statements and policies on the management. Multi-disciplinary will necessarily have to be part of the outcomes. But it is going to be important that it is not setting up a committee to work on a subcommittee to have a working party. So I think that's one of the issues that I have with that recommendation.

Having said that, I have to say that the report that came out or the submission that came out from the College has got a lot further than the very preliminary discussions that were going on not so long ago. So it is heading in the right direction, but I would

urge that we push for more action quicker than seems to be happening there. The Victorian branch of the College, I must say, is possibly the most advanced of the other states of the College in this particular way, in this particular area.

DR OAKLEY BROWNE: I'm a College fellow. So I have a conflict of interest, as has Professor Kulkarni, and I'm one of those people who chairs one of the subcommittees of the subcommittees. But I understand College processes can seem somewhat laborious at times.

I think it's really important to involve the College because of its influence, particularly over the training of registrars, our future practitioners, and of continuing medical education of current fellows, that they be incorporated in whatever implementation process that happens. So they are one of the influential bodies and important stakeholders that does need to be involved in the conversation.

I think they are acknowledging, which is a good thing, that probably our training has been light on aspects of trauma informed care, light on aspects of understanding family violence and could be improved in terms of giving the trainees the skills to address those issues. So I think that needs to be acknowledged and reinforced and encouraged. Whether that's the particular structure for undertaking the conversation, I'm not sure. But they certainly need to be engaged along with the other stakeholder groups.

PROFESSOR KULKARNI: Was there a submission from the General Practitioners College, the ARCGP?

MS DAVIDSON: There was, I believe.

COMMISSIONER NEAVE: There was.

PROFESSOR KULKARNI: And the Physicians, because there is discussion going on in all the different areas and that's another - it's not multi-disciplinary in that they are all medical, but they are different branches of medicine and there was in fact a joint College position that was put out on another issue and again I wonder if that's the sort of thing that we can agitate to try and see if we can get a joint College position on some of this as well.

COMMISSIONER NEAVE: The General Practitioners College has actually got quite a lengthy submission in which it describes the sort of training that it has been doing on some of these issues. So I must say I would have to go back and look and compare, but it does seem to me that it is further advanced than the College of Psychiatrists. I don't recall whether there was a submission from the College of Physicians. But certainly - - -

PROFESSOR KULKARNI: It's still in the consideration process. They have the subsection of drug and alcohol and substance abuse. So that's also part of their brief. Just to add to that also, at Monash University the MBBS, that's the medical student teaching that I'm involved in, we are actually putting a lot more emphasis into trauma informed history taking so that we try and get them when they are very young in their medical profession.

MS DAVIDSON: Finally, just in relation to - we have previously talked about partnerships. One of the things that has come up in some of the consultations, particularly with services, is that there was previously funding - there are a number of family violence services or services that included a family violence service that also had a little

bit of funding for some mental health services but that was re-tendered and homelessness services, including many family violence services, lost the little bit of funding that they had for mental health services. Is anyone able to comment on that process and the impact that that might have had for the building of partnerships between family violence services, homelessness services and mental health?

MR BISHOP: My understanding is that the funding has actually been moved to centralise the support in one organisation rather than multiple organisations. In our area this service has been moved to the services of NEAMI, and there is an expectation of the clinical mental health services to work in partnership with them to provide, I guess, ongoing mental health support to those in the community.

I believe that there would still be a space to provide some partnership work using these services and the local family violence agencies. Perhaps that's again about having the knowledge and having someone who is well placed to be able to facilitate those partnerships. Definitely in our area there is a panel of people, local agencies, who discuss the issues of family violence. I know that the Moreland City Council used to have a family violence interest group. There are some platforms of where that style of partnership can be reinvigorated irrespective of whether the funding has been moved. It would just probably take a little bit more work on the ground.

DEPUTY COMMISSIONER NICHOLSON: In some of the consultations we heard that that reallocation or relocation of funds to a more centralised system is now so distant from where the

homeless family violence victims are located and where they receive services, it's so distant as to effectively deny them mental health services.

MR BISHOP: If I can speak again going back to the partnerships that we were talking about earlier about having mental health clinicians going out to the local family violence services and being able to provide that type of intervention, that would be a way that we would be able to bridge around the reduction in funding for the other areas. I think that that is a barrier, that moving all of the funding away and putting it in a central spot does increase isolation.

But I believe that, with careful consideration and good partnerships between the agencies, we should be able to work around it in a particular way. Whether that is about having mental health clinicians go out into the services to service the agencies or whether that is about devising other ways that mental health agencies can improve the community through running groups or through positioning mental health clinicians in other areas in the community, I'm not sure.

DEPUTY COMMISSIONER NICHOLSON: Given that the panel has talked at length today about multi-disciplinary, multi-agency, integrated service delivery, it does seem strange, as one person said to me, a provider of homeless services for family violence victims, to - reallocation of those mental health funds was like pulling one leg out of a four-legged stool. The ability of that organisation to deliver its suite of services was jeopardised.

PROFESSOR KULKARNI: Yes, I would agree. I have seen that happen with the end of some of the funding to a particular

group in the area that I work in, Prahran Mission. That has made a difference because there used to be a drop-in centre facility that was a sort of safety net for some of the homeless population as well as some of the victims of violence. So we have seen that happen, and it would be good to have a rethink about the PDRS, the psychiatric disability sector, to again have a decentralised process that does perhaps better respond to the local area needs.

MS DAVIDSON: I have no further questions for the panel.

COMMISSIONER NEAVE: Thank you very much indeed. You have spent a long day with us. It's been a very useful discussion, and we have a lot to reflect upon. So thank you. You are excused.

MS DAVIDSON: If we adjourn to 9.30 tomorrow morning.

COMMISSIONER NEAVE: Yes.

<(THE WITNESSES WITHDREW)

ADJOURNED UNTIL THURSDAY, 23 JULY 2015 AT 9.30 AM