PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Pandemic Orders

Melbourne—Friday, 29 April 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Josh Bull
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

Necessary corrections to be notified to executive officer of committee

WITNESSES

Dr Neil Coventry, Chief Psychiatrist, and

Ms Anna Love, Chief Mental Health Nurse, Department of Health.

The CHAIR: I declare open this hearing of the Pandemic Declaration Accountability and Oversight Committee. The pandemic accountability and oversight committee is a joint investigatory committee established under the *Parliamentary Committees Act 2003* and the *Public Health and Wellbeing Act 2008*. Its powers include the ability to review pandemic orders made under the *Public Health and Wellbeing Act* and report to each house of Parliament on these orders.

I would like to begin by acknowledging the traditional owners of the land on which we are meeting today. We pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today. I would ask that all phones be turned to silent.

Just by way of introduction, we have with us today me, as the Chair, and Mr Jeff Bourman, Deputy Chair. At this stage—we are waiting on a couple more to join with us—we have Ms Emma Kealy and Mr Kim Wells, and shortly Ms Vicki Ward and Mr Enver Erdogan will be joining us.

This is an important hearing today. I think we are all anxious to hear from senior people in our community about the impact of the pandemic on the community's mental health. Our first witness is Dr Neil Coventry, the Chief Psychiatrist, and we have Anna Love, Chief Mental Health Nurse, also. I understand, to commence with, you do have a short presentation to make.

Dr COVENTRY: Yes.

The CHAIR: I would ask you to try and limit it to about 10 minutes because we are all on limited time to ask questions and keen to do that as well. So I will hand over to you, and again, welcome and thank you for being here.

Dr COVENTRY: Fantastic. Thank you very much. Thanks for the opportunity. And could I also acknowledge the traditional owners of the lands on which we are meeting—we are currently on those of the Wurundjeri people of the Kulin nation—and pay our respects to elders past, present and emerging.

It is also very important to acknowledge the partnership we have with people with lived experience of mental health and wellbeing issues—individuals and consumers and their carers, family, loved ones—and also our very hard dedicated workforce, particularly our peer-led workforce with people with lived experience, and also our clinical and non-clinical workforce, who have done a great job under very challenging circumstances.

So thanks very much for the opportunity. I do not know, Matthew, if you are doing the slide show. We will, Chair, definitely keep it to under10 minutes.

Visual presentation.

Dr COVENTRY: Anna and I thought we would do this as a bit of a tag team and tell you a bit about what our role and function is—some of this you may be aware of—and then talk about a few specific things that we have done during the pandemic and also some of the learnings and what the data is showing. Then we are very happy to answer any questions, provide any advice. It is a great opportunity.

So I will start with myself. I am Neil Coventry, Chief Psychiatrist, and I have been in the role for about the last six years—prior to that I was deputy chief psychiatrist—and my subspecialty is children, families, and youth. Before that I was working in the clinical field. So both Anna and I have come from the clinical sector to work in the department.

So if I look at the next slide—thanks, Matthew—I will just explain a bit about my role and then I will hand over to Anna, who will talk about the role of the Chief Mental Health Nurse. And just to really clarify: my role is I suppose as an oversight regulator to monitor and support services, particularly on maintaining and improving quality and safety of care and also standards of treatment. And also, really importantly—which sometimes gets

forgotten about, and this is in the legislation—I also promote the rights of mental health consumers. I also provide clinical leadership across the sector and give advice back to the sector.

There are a wide range of activities that I undertake to fulfil those functions, and I will just talk about a couple of the most significant ones. You probably are aware of the term 'restrictive interventions', which is the term we use for interventions like seclusion, restraint, electroconvulsive treatment when that is not done with consent et cetera. So part of my role is monitoring and ensuring compliance with the *Mental Health Act* and the standards, responding to serious critical incidents and investigating—investigations are the way we learn if there has been a problem and we can drive improvements and change—and also helping to embed new practices. That is actually really important now. We have got a number of innovative approaches that we are doing, actually—during and since the pandemic.

And really central to this is, I really need to acknowledge, the partnership with lived experience. As you are aware, we had the royal commission, and one of the platforms of the recommendations from the royal commission was to embed safety and change with the people who actually use the services. So we very much, in everything we do, partner with people with lived experience. We also connect with Tandem, VMIAC and other peak bodies, so we have quite a lot of very robust partnership with people with lived experience both as consumers and carers. I will move on to the next slide. Thanks, Matt.

So my role is statutory; in other words, it is defined under the *Mental Health Act*. The advantage of this—I will stress this because you probably would not be aware that not every state is the same, and a lot of them have a chief psychiatrist; for example, the New South Wales chief psychiatrist is not a statutory role under their *Mental Health Act*. The significance of this in Victoria is that it gives me a power but also obligates me under the law to intervene whenever there are breaches of the *Mental Health Act* and to assist all services to comply with the principles and objectives of the Act. It also compels services to treat safety and quality as a top priority and collaborate with me to deliver the highest standards of care and treatment. It enshrines a responsibility to be providing clinical leadership and, even more importantly, consumer rights. I will move on to the next slide. Thanks, Matt.

The context of all of this is with, as you know, the royal commission and the huge number of reforms, so another important part of my role and Anna's role is our involvement in implementing the recommendations of the royal commission. We work very closely with our colleagues in the Victorian public service Department of Health, and we are very encouraged by the huge investment, which is really the most exciting thing that has happened in my career, in terms of the $3.8 billion in the last budget for mental health. It is very significant funding to start the implementation from the ground up.

I will just briefly mention a couple of key reforms; there are many that you would be aware of. Trying to provide more easy access to the front door with things like the local adult and older adult services that are being set up—there is going to be six of these that will be rolled out; the mental health and wellbeing hubs, which will be free and will offer access to Victorians of all ages, including children, adolescents and their families where there are mental health concerns, so it is trying to join up the sort of primary care tier 1 with the specialist services; and also, and we might get a chance to talk about this maybe a bit later on, the expansion of what we call HOPE, hospital outreach post-suicidal engagement, to now 21 Victorian locations, which is really important in terms of after care after self-harm and suicide attempts. Next slide. Thanks, Matt.

Really I guess during the pandemic it has been pretty unpredictable to try and work out what was the best way we needed to do this. We needed to be very quick and to learn on the job and to respond quickly. We have been involved in quite a number of areas. Some of these were translating the public health orders so that they were applicable to the Victorian mental health system, and helping services to change their clinical practices to comply with those orders, to understand the information that they were being given from the department and the protocols and guidance from the Chief Health Officer, to make sure that there were good standards of COVID-infection prevention and control because of the risk that we could end up having to close services and also getting a good collegiate sense of pooling of resources when we were in the pandemic crisis to minimise the impact of ward closures et cetera and staff being furloughed and really to keep our patients and our staff as safe as we possibly could. I will move on to the last slide. Thanks, Matt.

I just wanted to give you a high-level overview of some of what the data is saying. In particular we have focused on, during the pandemic, the presentations to emergency departments. As you know, people were

reluctant to come to emergency departments because of the risk of infection; however, there was an increased percentage of people presenting with mental health problems compared with physical health problems. But there are a couple of specific areas I want to focus on before I hand over to Anna. One was around self-harm and suicidal ideation presenting to the emergency department, and the sharpest rise was actually with young people, with teenagers, which was very concerning. I also need to say in the context there was a lot of concern 'Would we actually see an increase in the overall suicide rate?'. Thus far we have not. We have certainly been very concerned about suicide attempts, but the actual rate of completed suicide has not actually changed during the pandemic. But we certainly are watching that closely and work very collaboratively with the Coroners Court to look at that sort of data.

The other area I just want to flag that you may be interested in is the rise in presentations of eating disorders such as anorexia nervosa in young people. Again some of the concerns—were where these young people were presenting to the emergency department, often with very serious physical complications of their illness. Again, I can talk about this later if you are interested in more detail, but we are working with our partners to try and understand the various factors and what we can possibly do to mitigate against this. Obviously it is multifactorial, and the causes are really complex to try and understand that. It is interesting that when we have looked at this data—and I have liaised with my colleagues in other jurisdictions—we might think, naively, that the factor would be relating to lockdowns. It does not seem to be. In states where there have been many less restrictions than we had in Victoria they seem to also be showing the same trends, so there are clearly some other factors at work. I will stop there—sorry, that rambled on a bit—and hand over to my colleague Anna Love. Thanks, Chair.

The CHAIR: Thank you.

Ms LOVE: If you can go to the next slide. Thank you. So my name is Anna Love, and I am the Chief Mental Health Nurse here in Victoria. I have been in the role now just over six years. My experience is that I trained in the UK and came to Victoria in the late 80s, early 90s. The role of the Chief Mental Health Nurse is one of professional leadership—the professional leadership of the nursing workforce here in Victoria. But I just wanted to probably very quickly tell you about my role during the pandemic response, as Neil has started to outline, which was really the translator of the public health directions for the mental health and community sector—consumers and carers. This has included me hosting statewide forums in 2020–21 to help support the sector, including operational and sector leaders and peak bodies—VMIAC and Tandem—during this unprecedented time in Australia. I do that alongside my team, and my team actually consists of lived-experience advisers as well, so I have the consumers and carers who work alongside me to actually assist me with those forums. I intentionally also increased the number of meetings fortnightly with VMIAC and Tandem, the Mental Health Complaints Commissioner and the independent mental health advocates so as to have a forum for those bodies to discuss issues they were seeing in mental health services during 2020–21, a time when restrictions were at their peak. I also increased my support to the nursing leaders, at times increasing this also to weekly meetings as needed. This was to support practice changes that needed to arise in our acute inpatient settings predominantly. So the discussions were around workforce stressors and supports required.

As I said, the role of the Chief Mental Health Nurse is in that mental health nursing professional leadership, scope of practice and development of the profession of mental health nursing. I also have industrial engagement, and I do stakeholder engagement with industrial bodies, both HACSU and the ANMF predominantly. I support the mental health nursing workforce wellbeing. An example of that was during 2020: we actually funded sensory items for nursing staff and consumers in inpatient units that would actually help them during a time of stress. They were actually packs that were made particularly for individuals. I foster and sustain strong relationships with the mental health nurses, leaders and stakeholders, respond to workforce needs and develop practice guidance and models of care for mental health nursing. I also work, as I said, alongside lived-experience advisers. I also have endeavoured to liaise with researchers and academics, and at times I am involved in research that regards the nursing workforce and nursing practice.

Do you want to go to the next slide? Now, this slide actually is a way of really just demonstrating the why, how and what I do in my role. I actually moved to Safer Care Victoria in July 2021. Neil and I, we still work closely, but we worked even closer prior to July 2021, because we were actually sharing the same office and the same staff. But this really just demonstrates the mental health service practice issues that I look at through practice leadership. The service visits—one thing that I am renowned for doing is actually being out in the sector. So it is not about sitting in 50 Lonsdale Street, it is actually being out there in the sector and being with the staff and

understanding the stressors of the mental health system. We have also had things like the mental health nursing clinical supervision framework, which is in a five-year implementation. But in March 2021 the long-awaited Royal Commission into Victoria's Mental Health System's final report was released, and that report outlines the sector reform we have been asking for, including planned service and workforce reforms and more responsive services to support the mental health and wellbeing of our community.

Next slide, thank you. In line with the recommendations from the royal commission's report, as I said, on 1 July 2021 my office moved into Safer Care Victoria from the Department of Health. This move aligns with the quality improvement focus of the Chief Mental Health Nurse role with the other chiefs in Safer Care Victoria. The mental health improvement program of work focuses on the reduction of the use of seclusion, restraint and compulsory treatment and on tackling the unacceptable rates of gender-based violence and preventing suicides in healthcare settings.

In December 2021 the first large-scale improvement initiative, safety for all in acute mental health inpatient units, commenced with participation from 23 inpatient units across eight public mental health and wellbeing services, and this targeted the priorities of towards the elimination of restrictive practices, preventing gender-based violence and preventing suicides in mental healthcare settings. Expert working groups of clinicians, consumers and carers, supporters, families and others of expertise from participating services met over six workshops from December 2021 to February 2022. The expert working group was multidisciplinary and across age demographics, and the groups represented were regional and rural services. The workshops utilised evidence data in partnership with people with lived experience to identify the key areas requiring improvement against each priority, changes that can be made to achieve the priority improvement areas, local initiatives that can be shared across all services, key quality improvement capability building to start improvement in the local setting and experts that will maintain statewide engagement and provide expertise as faculty members for the initiative.

The output from these workshops will be used to commence improvement with teams in each inpatient unit. This will initially focus on the priority of towards elimination of restrictive practices, and currently the initiative is recruiting three leads for that work. Planning commenced in January 2022 on the final royal commission priority to reduce compulsory treatment, and as I said, that will now lead into a bigger program of work, which will be a collaboration with health services.

You can move on, thank you. The mental health workforce: a large part of the work that I do is to ensure that we actually have the workforce to do the work that we require in a mental health system now and into the future, and $269 million has been secured over the last two years for the workforce, creating approximately 938 new FTE across the system. There is a commitment to reform the system, including stabilising the workforce supply in the first instance and then transitioning towards a growth phase as the reform journey progresses. To that end, we have secured $269 million to support workforce reform over the past two years, and that includes $41 million in new initiatives for *Victoria's Mental Health and Wellbeing Workforce Strategy 2021–2024*, and this will provide 358 full-time equivalent positions across the mental health system. These new initiatives build on the $228 million previously invested through the 2020–21 and 2021–22 Victorian state budgets, which provided approximately 580 new entry-to-mental-health positions for nurses, lived-experience workers and allied health roles. We are already seeing the impacts of this funding across the system as new positions and placements are filled, and we are excited to see some more positions taken up over the coming years. Some of the highlights of that include the 575 junior medical officer positions to train in necessary mental health skills through psychiatric rotations, new social workers and OT graduates to be trained in 2022 so we have job-ready clinicians for services like our local mental health and wellbeing centres from 2023, up to 70 postgraduate scholarships for allied health and AOD clinicians to take advanced mental health training in 2022 and continued investment in our lived-experienced workforce—a clear learning from the royal commission.

We have focused on domestic workforce attraction during the pandemic. The pandemic significantly disrupted the international migration of healthcare workers, a critical component of Victoria's health workforce supply pipeline, and the closure of international borders was problematic for health services needing to address workforce shortages in psychiatry and nursing cohorts in mental health. Initially we believed that this supply would re-establish itself sooner than it has, so focus was given to international recruitment. However, due to the continuing COVID-19 environment, in mid-2021 the development and execution of the international recruitment campaign was delayed. In August last year funding was secured in the 2020–21 and 2021–22 state

budgets to support the development of a short-term domestic campaign targeting the public mental health sector and the undertaking of early planning for a larger scale attraction campaign for international and domestic markets—

The CHAIR: Ms Love, I am going to interrupt you because we have very limited time for questions—

Ms LOVE: Yes, that is fine.

The CHAIR: even with the number here, and your submission will of course be on the website and made available to all members of the committee. I think all of us will be keen to ask some more general questions.

Thank you very much, both, for the presentation. I will start with an opening question. There has certainly been a lot of discussion about the impact of the pandemic on mental health, whether we call it environmental trauma or give it some other name, and more and more studies are perhaps starting to emerge about the impacts, but I wonder, Dr Coventry, could you speak generally about the overall impact on Victorians in particular? And have there been any specific cohorts or more vulnerable groups that have been affected more significantly in that process?

Dr COVENTRY: Yes. Thank you, very good question. It has really impacted on everybody, and it is interesting that I think we have maybe overcome some of the stigma in talking about mental health and wellbeing. One of my concerns has been sometimes we separate this into sort of the specialty areas that Anna and I cover but then forget about general mental health and wellbeing, so I think there is much more robust discussion. It has impacted on everybody. Clearly that sense of uncertainty, the level of risk, the level of anxiety—everyone has really struggled with that. Certainly vulnerable groups, as you mention, are more susceptible to this sort of pressure when there are things that are out of everyone's control, when people are suffering problems with housing, unemployment, lack of school or tertiary opportunities, lack of socialising and losing contact with friends. We also need to remember that not every person and family and household is able to access the appropriate IT technology in a sophisticated way, including the internet. Certainly some pockets with disadvantage have really, really struggled.

In terms of who would be the most vulnerable group, I suppose my advice, being a child and adolescent psychiatrist, is obviously thinking about children and young people and the impact of the lack of socialising and their opportunities academically, and cognitive development at schools with school closure. Again I would say the results were variable. Some young people, particularly, interestingly, perhaps the group we would see who would have what we call developmental disorders like high-functioning autism spectrum disorder, some of those young people actually did better than you might have predicted, being able to access online learning without the pressures, because the socialising for them could be quite stressful. Other young people—the particular group I am very concerned about who already were perhaps only tenuously engaged with secondary education—really dropped off the edge; it was really too difficult.

So it has been really very concerning, and we have worked a lot with schools to look at how we can mitigate against this. You are probably aware of the enormous investment that has gone into schools both from the Department of Health and department of education to try and embed mental health commissioners within schools, both in secondary and now primary schools being rolled out across the state in rural and metro regions to try and help teachers be able to identify some of the young people, now they are returning back to school, who might have really been struggling because of their emotional, cognitive and developmental pathways being really blocked over that period of time.

So we are really very concerned, and it is part of, as I was saying, why we have developed these hubs to try and make access much easier. We did not want people to go through the enormous barriers of contacting the specialist mental health service but to try and provide something that is much more like a primary care model with multidisciplinary approaches and clinicians for, I guess, the less severe end of mental health problems that we know we need to intervene in as early as possible. That prevention and early intervention is the way to go. And we really need to see this as an investment, I think, with our children and young people, and our parents to be able to parent, because the children are often very sensitive to the parent anxieties so it is not just treating and supporting the child in isolation; often it is treating the parents because the children can be so sensitive to the parents' anxiety. So it is helping parents to have those conversations and particularly, as I was mentioning before,

the very vulnerable group where we are seeing increasing self-harm and suicidal ideation, helping parents and teachers and general practitioners to have those sorts of conversations to be trying to work it out.

It used to be a bit of a myth: 'Don't talk about feelings of self-harm and suicide because you might be encouraging young people to actually undertake that behaviour'. That is totally false. It is actually very reassuring for young people who are struggling if the people that they trust around them, the adults, can actually have that conversation. But we need to give people, particularly parents, the skills and competencies so that they feel they can actually have that conversation in different ways and not get too freaked out. So there is a lot of work still to do. I think we need to watch this very, very closely because it is still early days. We are in a different wave of the pandemic now with the high level of vaccination, but I think we still need to be very vigilant, to look at these signs and look at what might be some of the predictors of longer term problems.

The CHAIR: Thank you, Doctor. Given that I have a very limited time I want to launch into another question that relates particularly to my community of Shepparton, because it has been well known and publicised that there has been a significant rate of youth suicide, very tragically, and of course in a rural community that becomes widely known—and I know that you are aware of that situation. I just wonder whether you could speak to that in terms of whether we are facing a cluster, whether you would call it an epidemic, what the numbers mean, what can be and has been done to address the sorts of issues that are obviously concerning a local community about this.

Dr COVENTRY: Yes, I am happy to look at that. As you know, we did a lot of work with the Goulburn Valley community, and we have done it with other communities as well. Anna and I are very involved with this. We have a very good working relationship with the coroner, getting real-time data. The areas that I find out about are mental health patients who attempt suicide or complete suicide, but we need to understand that in the context of what is happening in the general community.

We know, as happened certainly in the Goulburn Valley, there are clusters of vulnerabilities, and particularly we are concerned about Indigenous young people, the LGBTI+ community, people with dual disabilities, alcohol and other drug use, people from linguistically diverse communities et cetera. We know there are pockets of people that are much more vulnerable to this, so what we do—as you are probably aware, Chair, with Goulburn Valley—is when we get that real-time data from the coroner we correlate that. So I get my reportable deaths, which are the mental health patients. We try and understand that in the context of what actually is going on. We also look at the longer term data because suicide is a reasonably rare event, so if you look at this statistically—and I do not want to say that is the way we need to do this, because every person is a terrible tragedy for not only their family but all the other people connected, but when we look at the sort of trend data sometimes we do see dips and increases. We need to still be vigilant about what might be the factors.

The best approach that I am aware of, and I think this was the approach, Chair, that was done in Goulburn, was getting all the experts in the community together—getting the Indigenous elders together, getting the schools together, getting the specialist mental health services, getting the primary care people together, getting people who are dealing with children in out-of-home care like child protection to try and workshop what might be some of the factors.

We have also been very concerned—and that was your question—about clusters. You probably know that sense of contagion, that when there has been a suicide in a community if there is a lot of media or a lot of awareness of that, there can be almost what we call copycat suicides where young people can be doing the same actual means of suicide, so we are very concerned. That is a well-known phenomenon around the world, so we have to be very vigilant about that. But it has really been the efforts generally of a local multisectorial group of experts coming together to try and understand all the factors that are relevant. Every community will be different, so Goulburn Valley is different to some other communities that we have worked with in terms of what the stressors might be, the arrangements with the local secondary school situation et cetera. So you need to understand that sort of local knowledge.

In terms of whether we call this a cluster, it probably would be a bit confusing to get into all these definitions; it probably does not help. But can I just say the approach we take is potentially they always could be a cluster, so it is like we want to prove that they are not. So the way we would regard this is two suicides would be sufficient for us to be putting the searchlight on and trying to understand what might be some of the factors going on

around that. As well as that, we also ensure that with the individual families that are being affected there is really, really important follow-up and support.

More importantly, I guess, we do not want to be dealing with the sort of tail end of this. You may be aware of an approach called HOPE. This is a well-recognised approach, and really Victoria has been the lead in Australia around this, which is looking at intervening with a vulnerable group, particularly of young people, who present with self-harm and suicidal ideation to the emergency department. Rather than in the traditional way in decades gone by where they would be referred to a service and no-one actually tracked whether they actually followed up, this is a much more robust, active tracking and support to the individual and their family with people with peer experience—so peer led—to ensure at a practical level that this person is actually linked in very, very shortly after they leave the emergency department, and that support continues for over three months. It is a fantastic approach, I think, to providing much more robust prevention and early intervention, because we do know that group that have already presented with self-harm and suicide are the high-risk group that could possibly go on to complete suicide, so the best bang for our buck is to really invest very heavily in that group. I think the great innovative approach is using peer workers with lived experience to help the clinicians. That has been very significant, and I am very pleased and proud that is now being rolled out to a number of sites, including many sites now in rural and regional Victoria where we know there are other vulnerabilities different to metropolitan areas.

The CHAIR: Thank you very much. My time has unfortunately run out. I will pass to our Deputy Chair, Mr Bourman.

Mr BOURMAN: Hi. Thanks for your presentation. Because of the short time I will just get into it. When the government is making an order do they at any point in time consult with you as to what the repercussions of that order might be from a mental health perspective?

Dr COVENTRY: Yes. Look, I am very confident that mental health and all the other relevant factors are being considered. As you know, the sort of principles are a bit like with the Mental Health Act: it is least restrictive and trying to balance the concerns particularly. I know one of the key concerns is community safety and level of risk versus mental health. Often it is not quite a seesaw; they go hand in hand. So I can say this very specifically, because I know your terms of reference are really looking at since Minister Foley has had the responsibility, Minister Foley—who used to be my mental health minister, so I know Minister Foley very well—has consulted with me about this.

But what happens in terms of the way the governance works in the department, we, both Anna and I, are getting very direct information almost on a daily basis, I would say—in fact it probably is still on a daily basis—from services about how they are managing the impact of COVID. We get the data—the data is collected through VAHI, the health information system. We help with the data analytics, and we provide reports. I manage this up to my executive in my division of the health department and my deputy secretary. I know that that gets discussed by the secretary and the board. We also have a weekly meeting with the Minister for Mental Health, where this data is analysed and we discuss what the trends might be.

So in terms of impact about what is happening COVID wise and also thinking about the impact of orders, what the restrictions would be and how those orders need to be interpreted within a mental health setting and again weighing up that seesaw about risk and benefits and how we can actually help to mitigate against some of the risk when we are trying to keep people safe, I am very confident that that data and all the other data is really being incorporated in making these very complex decisions about the impact of the order. And I am very confident that people take the approach of 'What is the least restrictive that will minimise the level of risk?', but with mental health being one of the many factors that have to be incorporated.

Mr BOURMAN: Thank you. I will get down to a couple of specific things. I have an emergency services background, and I still know a lot of people. Has there been an increase in cries for help, for want of a better term, from emergency services during this pandemic period? A lot of them are under extreme pressures. A lot of them are also copping it from both ends, having to implement the orders as well as being criticised. I have noticed a lot more people seem to be talking about it, but do the statistics show that or do you have the statistics?

Dr COVENTRY: Look, it is probably the field—it is often talking to those people. Anna and I, I think, have very good connections with colleagues in emergency medicine. We have got a number of directors of emergency services who are very mental health savvy, I would have to say. So one of their concerns was the increase in mental health presentations during the period of lockdowns. When people with physical health were not presenting, that was sometimes a concern too, because they were staying away because they were frightened of possibly getting infected and were presenting late with their physical illness. Emergency departments are not really the best place for providing mental health assessment or keeping people longer term. So that was certainly—

Mr BOURMAN: If I may interrupt, emergency services like ambulance and police and things like that as opposed to emergency departments.

Dr COVENTRY: Oh, yes.

Mr BOURMAN: Emergency departments—I mean, they did a fabulous job under the situations. But I am thinking more of: you have got ambulance out there trying to deal with people that think they have got COVID when all they really need is an aspirin. You have got the police there being forced to kick children off playground equipment when it is clearly not their idea. But I know a lot of people were struggling internally with that, and I do not know if it is actually starting to reflect in the people asking for help.

Dr COVENTRY: No. Look, I probably cannot. Sorry, I maybe misinterpreted what you were asking me. But maybe just a little anecdote might help to flesh this out. When we all had the lockdown orders and the curfews, and fortunately most people complied with that, there was a subgroup that I was quite worried about, which were very vulnerable young people where home was really not a pleasant place to be, so people coming from backgrounds where there might have been violence—domestic violence—sexual abuse or other complications. For some young people that was incredibly challenging for them because one of their escapes was actually to be out of home mixing with their peers at a very time when they were not able to do that. For other people it was not, it was a great time to sort of get much more attached with their family and do much more family-based activities and socialising.

When I talked to my colleagues in emergency services, particularly police, I think they were actually incredibly sensitive and sensible around that—they actually did understand the context of young people. It was only a very small number, but they were not being heavy-handed. I think they absolutely understood some of the issues for some young people where it was not sort of wilfully defying the order, it was actually a need to escape from a very toxic environment that they were in, and the curfew was making that extremely difficult. So I think generally the emergency services were very, very sensitive to that. I think they were very sensitive to the issues Anna and I were seeing with our mental health clientele, who might have been more unwell when they were needing to get that sort of help, and the sensitivity as well as sort of obviously managing the COVID safety and contagion risk.

The other area probably more concerning to emergency services, though, was the blockage when they get to an emergency department: to basically have some sort of continuum of care, to be then handing the responsibility for the patient over when emergency departments were really struggling prior to the pandemic with mental health presentations. So that was a concern: that it would tie up emergency services until they could actually hand over the person to health services. So that is something I think we need to improve on because we are very concerned about the sort of flow-on effect with emergency services if they are not doing their job because they are caught up in the emergency department,

Mr BOURMAN: I will make a statement: particularly ambulances have always been ramping, but the ramping just went absolutely nuts during COVID, just for timing out.

Ms LOVE: Anecdotally from our Ambulance Victoria colleagues who came to our huddles in the morning, about demand—they were actually were saying that the demand actually from a mental health perspective was low. It was much lower than they had expected it would be, and it times it was actually going back to prepandemic levels.

Mr BOURMAN: Okay. Interesting. One of the things I have always had a very big interest in is the role of the media in the increase in anxiety. What is your opinion? Is there any direct correlation between the sometimes hysteria that is coming out of the media and the increase in presentations?

Dr COVENTRY: I do not know of any hard research, but Anna and I can obviously talk anecdotally. I think when we say 'the media', we need to think not just the mainstream media—free-to-air TV and newspaper media that we might be accessing. Young people are accessing social media, and a lot of that is extremely concerning to me. Separate to the pandemic there are lots of very worrying sites around self-harm and suicide that young people are able to access, with very graphic information.

Regarding the pandemic, certainly there are many social media sites that young people are accessing with a lot of misinformation that actually aggravates the anxiety, so young people that are already struggling can then get more anxious than they need to be when they get an awful lot of misinformation. I know schools have done some great work to try and look at reliable information that young people can access. There are absolutely a number of online services, like Kids Helpline, Headspace et cetera, that provide fantastic information for young people, but there is a lot out there that is very worrying.

I think in general terms the mainstream media overall have been pretty sensitive and sensible, and they have certainly reached out to Anna and me to be able to get instruction. So some of what we have done is say to parents, 'These are some guidelines you can use to help people'. So they have tried to look at ways of minimising that level of anxiety. But the social media sites that we as adults might not be accessing are the ones that I am really much more concerned about. It is like giving young people some choices about appropriate information that is not alarmist—or even worse, some of it that is incredibly maladaptive, like instructions about suicide, for instance, are very concerning.

Mr BOURMAN: That is the sort of stuff we do not want our kids seeing. It is bad enough as it is.

Dr COVENTRY: Exactly.

Mr BOURMAN: I am pretty well out of time. Thank you for your presentation and for answering my questions.

The CHAIR: Thank you. Ms Shing, we will go to you for the next group of questions.

Ms SHING: Thank you very much, Dr Coventry and Ms Love. I hope that you can hear me all right. I am coming to you virtually from regional Victoria, and that is one of the things that I want to pick up on today. Before I go to my specific questions, though, which will relate to telehealth and to those early intervention matters that you have both spoken to, I want to get a better sense of the way in which lived experience has informed not just the pandemic response but also the everyday work that you are doing as part of what the royal commission has prioritised around that lived-experience framework and the fact that lived experience, as it relates to organisations but also to peer support, as it relates to the clinical and community workforce but also as it relates to co-design, is a part of the way in which the mental health response has been able to be dexterous, to be appropriate and to be tailored to the needs of clients, consumers and patients and also their support networks. So if you can bear that in mind as a lens through which I would like to get some answers to these questions, that would be really appreciated.

One of the things that you have both touched on is the role of telehealth and the way in which connectedness with services was an opportunity for people to seek assistance and tailored support perhaps where that was not necessarily something taken up before the pandemic and before there was a limitation on movement and access to services. One of the things I would like to get a sense of is the availability of telehealth as it increased and what that might then do to encourage more young people, particularly those digitally and technologically savvy young people, to access those services, an aid in early intervention, building on those hubs that exist already and the work associated with face-to-face service delivery in regional and rural Victoria in particular. Thank you.

Dr COVENTRY: Wow! That is a fantastic question and probably something that both Anna and I will tag team because both of us have been very passionate about co-production, collaboration and partnership with people with lived experience, particularly people with lived experience who are young people—young consumers and their families. Specifically regarding telehealth one of the interesting things that has come out of the pandemic is services having to be creative and innovative in ways that they never would have been forced to be, really, prior to the pandemic, telehealth being one of those. Probably there are some differences between rural-regional and metro. I think rural-regional services embrace that much more for a number of reasons. Obviously the geography and distance was one of the things. You might think intuitively that young people

would be very eager to do this and not to have face-to-face appointments. That certainly seemed to be the case more so in rural, regional Victoria. In metro part of perhaps the explanation with this increase in emergency department presentations is some young people not actually wanting to access this and actually wanting a face-to-face appointment. But the benefit I think out of this is that we will be able to give choices to people so that they can actually choose whether they want the face-to-face appointment or telehealth or a sort of hybrid model.

The other interesting part of what you are suggesting is how we have people with peer experience as part of that. Because for a number of young people, they are much more comfortable talking to someone who is a peer who understands where they come from. Particularly we know that is the case with eating disorders, but really across all of the presentations.

I might move to Anna, because Anna has done a lot of work, and our background is we have always had our colleagues with lived experience in the department. We have now got, thanks to the royal commission, a different governance structure, so it has actually embedded lived experience at the senior executive level.

But at a day-to-day level I would say probably in everything that we do, every meeting, every intervention, we are sitting with lived experience. And we have got good contacts, both with rural/regional and metro, with people with lived experience who are appropriate—so if we are talking about children and adolescents, someone from that sort of age range, or older age or whatever, so we can sort of match that using our peak bodies like Tandem and VMIAC. But I might hand over to Anna, because she has done a lot of innovative work.

Ms LOVE: So as Neil has already indicated, we work with lived-experience colleagues, so I actually have consumers and carers who work alongside me in my day-to-day work. Co-design is the way in which we do everything, from preparing for a meeting to, you know, designing a new service, to practice guidelines. And specifically for myself, whether it is a nursing practice, I will still have our lived-experience colleagues contributing and actually at times leading pieces of work which are to do with practice change which is in line with the journey that we are actually on.

The other thing I would say is about telehealth and just actually the use of technology, because at times in our inpatient settings during the pandemic it has been really difficult for people to have contact with loved ones. And whether that is because your family member is actually in a regional or rural service and area and you are in metro or because of visiting restrictions, people have not been able to get in to see their loved ones, the use of technology has been an amazing step forward. We never thought we would actually be here in mental health in Victoria at this time—if we think how quickly we pivoted and actually started to use technology in a way that we have never done before. So staff actually being able to have iPads, to be able to take someone into a room and put on a screen, just as you are on right now, and actually talk to their family members, to see their pets at home are being loved and looked after, which actually helps people settle and actually feel much more comfortable in their settings.

So we have made great leaps forward, and peer workers in our inpatient settings, who again could use that technology, but we are also continually there to support consumers during what is a very distressing time when they are actually in an inpatient setting. So co-design, co-production, working with our lived-experience colleagues is actually part and parcel of what we do. It is what we live and breathe.

Dr COVENTRY: Could I just—

Ms SHING: Thank you very much for that. Sorry, Dr Coventry.

Dr COVENTRY: I just wanted to add—

Ms SHING: Just quickly. I have got one more question.

Dr COVENTRY: Yes, very quickly. Just one of the things we had not anticipated: when we run the mental health tribunals—so people who are on involuntary orders—the foundation and expectation is that family members and carers are invited and can really contribute. Intriguingly, once we were doing this virtually using telehealth the percentage of families able to be involved increased dramatically, and many families preferred to actually be involved in that way, which was a great spin-off because that is really the ideal. And for many

families that was much more acceptable than actually having to come into hospital face to face and be part of that, which is terrific, that they could be there to support—

Ms SHING: Thanks, yes. That is a very useful insight to have as we consider the impacts of the pandemic on particularly the child and youth mental health space. I just want to touch on something that the Deputy Chair has raised around media and reporting. And I want to note also that for people who are watching or engaged in this broadcast or indeed this hearing there may well be issues that are raised for you, and there are support services available by telephony or in person. So I just want to put that on the record as well.

I would like to have an understanding, Dr Coventry, particularly in relation to your media and the work that you have done in talking about the impact of lockdowns on the mental health of Victorians. You have acknowledged that children, youth and families were particularly vulnerable and that early intervention plays a really significant role. I would like to get an understanding of the individual nature of supports and assistance that have innovated and have evolved during this time and also how we compare to other jurisdictions, given that we have got other states and territories who have also been through this and a commonwealth framework as well—just with the time we have left. Thank you.

Dr COVENTRY: Look, it is a complex question, but the sort of overall arching thing is giving people permission to talk about this, giving them the language to talk about it, and if we are talking about young people, children particularly, helping parents to be able to have that conversation and giving them principles, linking them in with—there are lots of services, as you know, online that are helpful to give people instruction, and letting them know that it is actually okay to have that sort of conversation and to try and look at this in the broadest context. Although Anna and I deal very much with the sort of tertiary specialist end, everybody is really struggling with some of these issues, so it is partly normalising that these are people's feelings and experience, trying to look at things like how we promote resilience, trying to look at the factors that we know mitigate against stress—so very basic things like having a regular routine et cetera, but particularly for parents with vulnerable children, having those conversations. This is something I talked about at the press conference I did last year, telling parents, 'Don't just have one go. Try and pick your opportunity with your child'. Also try and link in with the school, because the school might be seeing other behaviours of concern or academic struggling, so it is like piecing it together.

We have also done a lot of work with the college of general practitioners because they are often the first port of call that families will go to to try and access services. One of the great things, I think, is with the innovative reforms there are going to be a whole lot of other support services, what we would call tier one services, that people can go to that will not necessarily have the stigma of coming to a tertiary psychiatric service, so people with much less severe problems and earlier in the stage of development can get that sort of support and help. So there is a lot that people can do. The message we are trying to get out to people is support is available. We do not want people to think, 'Oh, we know there's a royal commission, everything's really in crisis and we will have long waiting lists'. With these sorts of innovative reforms people will be able to access the right service at the right level of intensity and hopefully be referred, if they need a specialist service, or be referred from the specialist service back to the primary care service. So there are many more alternatives, I think, to match what people actually might require.

Ms SHING: If you could take on notice the question about different jurisdictions and how they have worked together, I would be really grateful for that information to be provided to the committee.

Dr COVENTRY: Yes, sure. Absolutely I will get back to you with that. Thank you.

The CHAIR: Thank you. We will move now to Ms Kealy.

Ms KEALY: Thank you very much. Thank you both for presenting today. I just wanted to confirm, Dr Coventry—you just mentioned the press conference from last year. Can I just confirm that that was the one press conference that you have undertaken over the pandemic?

Dr COVENTRY: Yes.

Ms KEALY: Given the long-term mental health impacts, and we have gone over a lot of that today—you have gone over that in a very broad-ranging way, and it is good to hear your deep concern for the people who have been most significantly impacted by lockdowns and by restrictions. During that press conference I

understand that you confirmed you had not contributed to decisions about lockdowns and restrictions. Through the information you have given today you have spoken about analysing data and making sure the orders were implemented. Can you confirm: is that is still the case, that you have not provided input to any of the creation of the pandemic orders?

Dr COVENTRY: I think actually it might be a little bit different in terms of what I said. I think I was actually asked was I in the room when Professor Sutton, who was the Chief Health Officer, was making the decisions. That is not how it actually—

Ms KEALY: What input have you provided to creation of pandemic orders?

Dr COVENTRY: Well, I guess as I was saying before, in terms of what we do on a daily basis and then a weekly basis and a monthly basis, we are giving the sort of temperature of what is actually happening—

Ms KEALY: But that is the back end of it. That is the impact of the orders, of what is happening. It is the ambulance at the bottom of the cliff, isn't it, proverbially. Perhaps if you had provided the input that closures of schools—as you went through—would have significant social impacts on students and it would be hard for some students to catch up on their education, if you had been able to provide that input beforehand, perhaps it could have prevented harm.

Dr COVENTRY: I think we are providing that continuously. That is perhaps not quite correct, or maybe I was giving the wrong impression. We provide that sort of data, so that sort of information is really very well accessible.

Ms KEALY: But the data is only available after the orders have been created.

Dr COVENTRY: No, no. We are monitoring that constantly. This is part of what I do as my normal practice—and Anna as well—so it is not like we are only looking at this data now because there is a pandemic. We monitor this constantly. We also cut the data in very different ways depending on what actually might be happening. So certainly we cut it a bit differently because of the concerns with the pandemic, and once we got the data about emergency departments we tried to drill down and get different connection of data, but we are constantly looking at this. We also work very closely with our colleagues who might be outside of mental health—so, for instance, emergency departments, paediatrics et cetera—where they are getting a different dataset, and we try and match that. So I am very confident that the health department is doing that as part of their business as usual, which goes into—

Ms KEALY: Sorry, are you giving information to the health department or to the minister?

Dr COVENTRY: Well, both really.

Ms KEALY: On a weekly basis? So specifically in the weekly meetings that you have spoken about, you are providing data analysis to the minister, which you believe has an input to the outline of how pandemic—

Dr COVENTRY: Absolutely. We have weekly meetings with the Minister for Mental Health, very frequently where all that sort of data is presented—the issues about what is happening in mental health, the innovative reforms that are happening, any problems with implementation et cetera. So it is very much that sort of pulse check on what is happening.

Ms KEALY: Given that data, in your opinion, is being utilised to advise the creation of the pandemic orders, can I please ask for copies of the minutes from those meetings to be provided to the committee, including the recommendations that you have made around amendments to the orders?

Dr COVENTRY: I do not provide recommendations for amendments of the orders, but as long as I get approval, I can certainly provide you with minutes—

Ms KEALY: The data and the analysis. Given this committee has got a responsibility to look over the pandemic orders, you have said that this is the way that you provide input to the pandemic orders, this is basically the streamline that we have got of an understanding of 'This is how the mental health impacts in Victoria have input into what orders are created'. So given you are having these weekly meetings, I think it is very important the committee see that.

Dr COVENTRY: I certainly can provide that. I would not also want you to think that is the only way we do things either.

Ms KEALY: Oh, are there other meetings, yes?

Dr COVENTRY: Yes. Many. We can give you the whole suite of the various meetings and the governance structures and where information is going.

Ms KEALY: Well, it is the information that we would like to see as well.

Dr COVENTRY: Yes. Certainly we can take that on notice and provide that.

Ms KEALY: Thank you very much. Dr Coventry, I would also like to ask about the staffing. Perhaps it is better going to Ms Love actually. We have spoken about workforce. I guess, have you got the number of how many vacancies there are in the public mental health system at this point in time? That is through different levels—nursing, psychology, psychiatry—but also how it impacts on emergency departments.

Ms LOVE: Yes, recently there has been some scoping done with health services, so we could provide that. We will have to take that on notice to be able to provide you with that data. But we know, I do know, that in our health services there are vacancies right across all disciplines, and unfortunately in our mental health services we have been struggling probably with our workforce and developing our workforce and managing to have the right numbers for some time. But I think even prior to the pandemic the funding was actually given to health services to increase numbers. So we have increased graduate numbers and we have increased postgraduate numbers of nurses. We have now got new positions of community mental health engagement workers. We are creating new roles to actually bring people into health services.

Ms KEALY: Yes, I understand that, but creating a new role does not create a new skilled and qualified person to fill that role, and one of the challenges that we have gone through today is that people have not been able to access the mental health support that they need when they need it. And we found through the royal commission there were problems and shortages, the system was in crisis, but then the decisions made around lockdowns and restrictions have had such an impact on Victorians' mental health that it has compounded; it has put more pressure on the system.

Dr COVENTRY: Can I maybe sort of add another factor, which I am sure you are aware of too. We do recruit overseas staff for our workforce—nursing, allied health and medical. That was really one of the biggest problems for all jurisdictions in terms of many people being actually employed but they could not get to Australia to actually take up the positions, particularly in rural-regional Victoria, where we rely heavily on an overseas-trained workforce, particularly amongst our senior medical staff. So that was certainly one of the impacts. That was not due to lockdown, it was really due to people not being able to get to Australia.

Ms KEALY: The overall restrictions.

Dr COVENTRY: Yes, the overall restriction.

Ms KEALY: So would you say there are more vacancies in the mental health sector at this point in time than there were pre pandemic?

Dr COVENTRY: I do not really know.

Ms LOVE: We would have to look at the data with health services.

Dr COVENTRY: Yes.

Ms KEALY: If you can provide the data, and by region as well, it would be greatly appreciated, because it is a lot different, as you say, in rural and regional Victoria than in the city.

Dr COVENTRY: I mean, what we could say sort of anecdotally—I know that is not hard data—is: with the royal commission and the reforms, it really encouraged a lot of people to be considering mental health as part of a career pathway, because many people could actually go in different directions in terms of physical health or mental health training. I think a lot of people, encouragingly, saw that with the reforms this was really the best

opportunity to be considering a career in mental health, with the sort of innovations and the funding reforms et cetera. But we can certainly get more detail about the actual vacancies.

Ms LOVE: Yes, and probably just to say: our mental health services have not stopped functioning. They have actually been working, our public mental health system.

Ms KEALY: Absolutely, and they are all tired—

Ms LOVE: Yes.

Ms KEALY: and they want to see the light at the end of the tunnel and more people coming.

Ms LOVE: Absolutely.

Ms KEALY: They have done amazing job; I am not criticising them at all.

Ms LOVE: No, no.

Ms KEALY: But there are simply not enough of them, and they cannot hold that load forever.

Can I go to restrictive interventions, please? Dr Coventry, what changes and trends occurred in respect of the use of restrictive interventions over the pandemic period?

Dr COVENTRY: It is a good question. We monitored this very closely, partly because we were very concerned that we did not want restrictive interventions to be used for—how can I put it—infection control. That is a clinical decision. Our whole policy is the least restrictive approach, so that is what Anna and I endorse and that is what we train our staff to do. So we did not want any slippage where people might be using restrictive interventions as a way of infection control. So we monitored that very closely—looked at the data. We actually worked a lot with services.

Ms KEALY: What did the data say? Was there an increase in the use of restraint?

Dr COVENTRY: Again this waxes and wanes. Partly it is like you have got to keep your eye on that sort of data. We monitor that very, very closely on a monthly basis—

Ms KEALY: What does the data say, though, Professor? We need to get to the detail of why.

Dr COVENTRY: Yes. Well, I would say it varies, really. There is not a single trend that shows it is increasing or decreasing. We see some services might be using more than we think is appropriate, so we—

Ms KEALY: What services are they?

Dr COVENTRY: Oh, well, I would not want to name the services.

Ms KEALY: I would like it if you can, please.

Dr COVENTRY: But certainly I want to reassure you that if Anna and I see anything like that, we investigate. We look at the individual clients, we look at the trend data and we try to understand what might be the context of that. Certainly we would be very concerned if that was COVID driven as opposed to being based on clinical services. One of the things we do know, though, is there is certainly a factor when we have got staffing problems and we are using a lot of agency staff or there are not sufficient staff in a unit. That is always one of the risks, and you are probably aware—

Ms KEALY: Are you saying that the shortage of staffing leads to an increasing level of restraint?

Dr COVENTRY: Well, we know that was pre pandemic too—that that can be one of the factors that is involved. So you probably know about the work we have done, particularly Anna's team, around safe wards to try and help services to be looking at least restrictive approaches—how they can manage this. That involves having a cohesive team, and that is sometimes a challenge, particularly when you have got people who are having to be on furlough, which was part of our restrictions that we had to do.

Ms KEALY: Thank you. And just to close out, because I know we have run out of time: you referred to data around trends in restrictive practices. If you could provide that to the committee, by site, that would be appreciated.

Dr COVENTRY: Yes, we can certainly do that.

Ms KEALY: Thank you. And can I make one more comment: just in terms of the overall hearings today, we are not hearing from anyone with lived experience, and it has been mentioned quite prominently. I think at a future hearing we should prioritise it. I have put forward names in the past, but it would be great if we could do that.

The CHAIR: We will be doing that. Today is a day to hear from all our leaders in the field.

Ms KEALY: Thank you.

The CHAIR: Moving now to Ms Ward.

Ms WARD: Thank you, Chair. Hello. Sorry for being late. Thank you both for taking the time out of what I can imagine are very busy schedules to be here with us and thank you for all of the work that you have done over the last two years. I can only imagine how taxing that has been on your time and your time with your families. So thank you for all of the work that you have done and for all of the work that our mental health practitioners have done across the state. It has been a very big workload, and we thank them.

I do want to drill down a little bit though and go a little bit micro, I guess, and come back to some of the comments that have been made earlier. You were talking about self-harm but particularly eating disorders. I am sure that all of us here have probably had families in contact with us in our role who particularly have got children who have struggled with eating disorders, and they need to control their environment. Anecdotally it seems to be rising. It is terrific that there has been $2 million that has been committed to dealing with this particular issue. It is a difficult situation, and it is difficult when you have got families who—one of my families have got through one kid and now another kid is going on that journey, and it is really, really difficult. Can you talk to us around why you think—anecdotally we might just be becoming more aware of it, because people are talking a lot around how they are feeling. So I am interested in whether there has been an increase in eating disorders that we are seeing amongst young people and why you think that is—if that is the case.

Dr COVENTRY: That is a very good question. Some of it is data driven and some of it is anecdotal. Pre the pandemic there certainly seemed to be a progressive increase in people with eating disorders, particularly young people. There are probably lots of different possible explanations for that. Certainly with much more media attention people are probably much more aware of eating disorders and the sort of help that is available so that they can present—but certainly internationally that would be seen as a worldwide trend.

In terms of what we were seeing during the pandemic and now as we are coming out of this wave, there are probably a few different factors. One of the factors we might have intuitively thought was, 'This is just relating to lockdown'. It does not seem to be, because in states and other jurisdictions where there have not been the same lockdowns we have had in Victoria they are also seeing the same trend data. There seem to be possibly two cohorts. One cohort would be people who were known to mental health services who already had that diagnosis and for various reasons during the lockdown were not able to access the level of treatment that they required and the monitoring, and they were presenting quite late with physical illness. So that was very concerning, that that group who were presenting to emergency departments would often be admitted with physical complications of their eating disorder, like anorexia. But others were actually presenting for the first time, and this may be because they were not being picked up in the school setting or their families were not aware of it, so they were presenting quite late. That is very concerning to me because we know that early intervention is the way to go with eating disorders. What we have done to try and—

Ms WARD: Sorry. Can I just grab you with that thought?

Dr COVENTRY: Yes, sure.

Ms WARD: Could it be possible that we are actually able to diagnose more young people because they were spending time at home and parents were becoming aware of the fact that breakfast was getting skipped, that

lunch was not being eaten or that food portions were being controlled—which is often invisible. Particularly if you are working parents, you do not know that your kids may not have eaten breakfast or you do not know that lunch has ended up in the bin.

Dr COVENTRY: Yes. Look in some cases that was the case. It probably again was different for different situations. For some young people that sense of not having that control—people who were compulsively exercising and were not able to do that during the lockdowns and various factors that were quite different. I think I said this in one of my media appearances, that it was like the sort of perfect recipe for these sorts of pressures. But eating disorders generally are multifactorial; there is not one single cause.

One of the most important things in terms of our approach is to avoid a blaming approach. There has been in the past the blaming of the individual or the family. That is very unhelpful, so we try and work much more constructively with a family-based approach. So one of the things when you were mentioning about the investment is to skill up mental health services to have trained clinicians in these specialist child and youth mental health services to be able to diagnose and treat but also to work very collaboratively with their colleagues in paediatrics, because we need to remember we are talking about young people and there is another pathway where many of these young people present to paediatric services via their GPs with physical illness. But this is a physical and a psychiatric illness that needs both components of treatment. So, again, the message is early intervention. Certainly it is worth watching that data very closely because the international data does seem to be showing, irrespective of the pandemic, that we are seeing an increase in the incidence of eating disorders.

Ms WARD: Earlier you were talking about a sense of contagion when it comes to things like self-harm. Is this a similar situation with eating disorders and the likely connection to social media and again young people spending so much time on social media?

Dr COVENTRY: It certainly can be one component, and we know the social media about body image and body image distortion is one factor. That in itself is not enough, because we know many young people will diet, but not all that many, fortunately, go on to develop an illness such as anorexia. So there are multiple factors that are playing a part, but I would probably say the single most relevant factor when we think about the pandemic is that sense of control or not having control, and we all felt that during the pandemic with what was going on, so that was certainly, I think, psychologically a major contributor. But, as I said before, we knew that this was increasing anyway pre pandemic, which was very concerning.

Ms WARD: You were talking—and this would apply for both of you—around your conversations with other jurisdictions and seeing that there was a similar trend, regardless of what was happening in any given state.

Dr COVENTRY: Yes. We certainly saw this very early in the pandemic, and when we talked to our colleagues in other jurisdictions, particularly looking at the emergency department presentations, which was why we started to drill down in Victoria—hearing from New South Wales that they felt there was a subcohort of young people presenting with eating disorders, which was a surprise; we did not intuitively anticipate that—so we got that data and found that that was being confirmed.

Ms WARD: So the health measures themselves may not have necessarily then led to an increase in eating disorders, but the pandemic itself may have.

Dr COVENTRY: Well, that seems to be the case. Yes, you might intuitively think that just the lockdown restrictions were actually the factor. Probably the pandemic itself and the phenomena of the pandemic and what that means—

Ms WARD: So your own individual response to the fact that there is a pandemic around you and how you respond to that.

Dr COVENTRY: Yes. I think it would be more likely that and the psychological pressures of something that is unknown, that is creating anxiety, that is giving a lot of uncertainty for the future for young people who are already struggling with their internal sense of anxiety. So it is sort of a perfect recipe to add pressure.

Ms WARD: So how do we work through this then, considering we are still in a pandemic and health orders are diminishing anyway, so we are still going to see these eating disorders—how do we respond through the next part of the journey of this pandemic?

Dr COVENTRY: I think probably, again, it is part of the whole platform of what we are doing, that we are trying to join up the tiers, the tiered approach—with the base tier being level 1, level 2 the sort of middle area, and then level 3, the top tier, being the specialist area—to really try and pick people up at the base tier level. I am thinking about how we support primary care. While this is a specialist area, they often will be presenting to primary care, so skilling up GPs, skilling up schools, having mental health clinicians in schools who can be helping teachers and working with parents and letting people know there is a treatment that is available and working with our paediatric colleagues who might see the physical aspects of this. So it is sort of like joining up the dots but getting people as early as possible. And I think the way to go is with the approach and the platforms we have got now, particularly the child and youth and family hubs, where it is more a primary care approach within reach of the specialist services so there is not that stigma to actually access, but also letting people know what the symptoms and the criteria might be and getting early access, because that is really going to give the long-term best bang for the buck if we can try and intervene as early as possible.

Ms WARD: Sorry, Suzanna, you are looking at me—have I still got time?

The CHAIR: One more.

Ms WARD: Okay. Thank you. So how often are you sharing information with other jurisdictions and particularly the commonwealth, and what support, what overview, is the commonwealth having in this space? Because it is clearly something that is happening in every state, not just in Victoria.

Dr COVENTRY: Yes, look, absolutely it is. All this data gets shared, so at a commonwealth level Victoria, like other jurisdictions, contributes to the data. Anna and I discuss it constantly when we meet with our colleagues. It is probably a separate conversation, but we know the federal government has invested heavily into this as well and, with the mental health commissioner as well, is very interested in this area. So there is a lot happening in the commonwealth space as well as what is happening in the Victorian space to think about this subgroup and what we can do better, but I am more confident now that with this investment we have got the right platforms now to be able to roll out something much more intense for this group.

Ms WARD: Thank you.

The CHAIR: Thank you. We will move now to Mr Wells.

Mr WELLS: Thanks. Doctor, thank you for your time. One of the answers you gave before is that you gave that one press conference, and this morning you have raised an enormous number of issues regarding the impact of lockdowns on mental health. Why only one press conference?

Dr COVENTRY: That was the one I was invited to. I did not choose to do that.

Mr WELLS: So you were not invited to any others? You did not insist?

Dr COVENTRY: No, I was not invited to any others. That was the one I was invited to, which I attended, and as you probably recall, it was a specific focus, because I am a child psychiatrist, around impacts for children and what the messages could be with the children.

Mr WELLS: It is just because you have raised so many legitimate concerns about mental health I would have thought the opportunity for you, as the Chief Psychiatrist, to participate in more media events would have been important to be able to get that message out to the greater public in Victoria. Is that your view?

Dr COVENTRY: If I am invited, I will absolutely appear anywhere—very happy to do that.

Mr WELLS: All right. But you only were invited the once?

Dr COVENTRY: Only invited to that press conference once.

Mr WELLS: Just going back also to another answer you gave that Enver and the Deputy Chair asked. I am just wanting to try and pin down the advice that you give the minister and to the government. What is the status of that advice? You have spoken a lot about meetings and providing data, but if you give advice, is it advice that the minister, the Chief Health Officer or the government must accept, or how does that work in practice?

Dr COVENTRY: No. In practice, as you probably would be aware in terms of the governments, they are getting an enormous amount of information from many sources, which is what they need to do when they are having to make complex decisions. So mental health—my area of speciality and Anna's—is just one of many that is contributing to that. It is actually looking at the context, understanding what is happening with the mental health services. So it is giving that information, which is part of our job that we do on a regular basis; it is part of our absolute daily business as usual. So that advice or information gets incorporated by the people who have to make the tough decisions, with all the other speciality information and data that they are receiving constantly.

Mr WELLS: So with the pandemic orders that have been put in place, was there any time that you looked at them and said, 'That's not in the best interest of Victorian schoolchildren because it's going to impact on their mental health'? Did you go to the Chief Health Officer or the minister or the government and say, 'This is wrong. This pandemic order needs to change'?

Dr COVENTRY: No, I would not do that, and I would not see that I would have the expertise to do it. I am very confident that the people who make that decision weigh all of this up. They are qualified in public health. It is not perhaps as black and white as people might think. As an example: school closures. Because one of the concerns is the risk of infection—that children get infected; children bring home illness; if they do not have such a severe illness they infect their parents, who get sick, who have to go into hospital. So it is looking at that balance and complexity. So it is never something that I would feel I would have the expertise to be saying, 'This is the right order'. My concern or input is to make sure the people who make the orders are considering all the relevant factors that they need to consider in making that decision. It would not be appropriate for me to be actually saying, 'That's the right or wrong order' because I am not an expert in that field to be able to talk about that.

Mr WELLS: Okay. I am a bit confused then. If you are the state's Chief Psychiatrist, I would have thought that there is no-one in this state smarter than you or in a better position to advise the government on mental health. Have I got that wrong?

Dr COVENTRY: Yes, I think I am agreeing with you. I think that is what I was saying. I think you were asking me specifically do I criticise an order.

Mr WELLS: No, no. I did not say the word 'criticise'—to make an amendment because this is going to have a massive impact on the schoolkids in Victoria, that you did not go to the government or the minister and say, 'This is going to have a significant impact on the mental health of the schoolchildren. You need to make these changes'.

Dr COVENTRY: I would probably say in answer to that that all the restrictions would have significant impact. They did for all of us. But I was confident that they were considering in the balance of least restrictive what might be some of the impacts. I would not feel it would be appropriate for me to be saying, 'That order needs to be withdrawn because it's going to have significant impacts'. All the orders were part of my job of 'How do we manage that? How do we mitigate against that?' because it is a balance; it is a really delicate balance.

Mr WELLS: But if it is not you, then who would be giving that advice to the Chief Health Officer?

Dr COVENTRY: Well, I do not think it is a matter of giving that advice. It is actually how they take all of those factors into consideration. My job is then, given this is the order, how do we impose that, how do we mitigate against the risk? I am not qualified to be able to say, in terms of contagion, 'That's the right or wrong thing to do'. But certainly with every single order there would be impacts with people's mental health.

Mr WELLS: But that advice did not come from you.

Dr COVENTRY: Well, I am not sure. When you say 'advice', are you meaning was I actually giving advice about that order before the order was in place?

Mr WELLS: Yes, correct.

Dr COVENTRY: No. It would be making sure that people are aware of the context, the data and what the data is showing rather than specifically that I am going to be critiquing whether that advice will have mental health impacts, because I would have to say every single restriction has mental health impacts, but it is the balance.

Mr WELLS: Sure. So did you see the pandemic orders before they were released to the public?

Dr COVENTRY: No, I would not see the orders. I would be, as I said earlier—I think I have sort of covered that—contributing so that people have the context.

Mr WELLS: No, I understand that—

Dr COVENTRY: But they do not actually run the order—

Mr WELLS: but you are contributing to them.

Dr COVENTRY: No, they do not—

Mr WELLS: But you would not see the pandemic orders before they were made public.

Dr COVENTRY: No, it would not be appropriate because I am not actually, as I said, critiquing or saying this is a good thing or a bad thing. I am more providing a context and a background about mental health issues and then thinking about how we mitigate, but I am not the expert to be deciding on whether that is an appropriate order or not.

Mr WELLS: So who would be the expert then?

Dr COVENTRY: Well, at that time I think what you are talking about is the Chief Health Officer. Currently it is the Minister for Health.

Mr WELLS: And you would hope that the Chief Health Officer would then factor in all those mental health impacts but without your expertise to oversight that.

Dr COVENTRY: Well, I am doing that on a daily basis. That is part of what Anna and I do in terms of having that data, having the context, making sure that that is managed up in our governance structures so that all the various bureaucrats, the secretary, the ministers are aware of those sorts of contexts and the factors. So I am very confident that that happens.

Mr WELLS: Okay. And just to finalise, you also said that you provide a lot of data.

Dr COVENTRY: Yes.

Mr WELLS: Who do you provide that data to directly?

Dr COVENTRY: Well, I do not provide the data. The data is collected by VAHI in the department, so we provide assistance with them in terms of the analysis of the data, providing weekly and then monthly mental health data specifically. So we do the sort of interpretation. It is also assisted by the fact that Anna and I are very involved with the sector as well so that we can not just interpret the raw data, we actually know what is happening in the field and can put a context onto that.

Mr WELLS: Okay. But after you have looked at the data who do you then report your analysis to?

Dr COVENTRY: Well, as an example we provide a regular report that goes out to the sector. There is a—I am trying to think whether it is monthly—mental health analysis of the data that is a sort of high-level interpretation of the data that gets disseminated very widely in the department. Some of the data we also share with our colleagues with lived experience so that we get their input about what they are hearing from the sector. So all of that adds the richness to just the raw numbers to put a context in. So data is really one of the drivers, and it is shared fairly openly in lots of—I can certainly provide you with more details, take that on notice, but it is not just one single pathway at all; that would be ridiculous. It is actually disseminated very widely.

Mr WELLS: Who do you report to directly in the department?

Dr COVENTRY: I report to Katherine Whetton, who is the deputy secretary for mental health and wellbeing division.

Mr WELLS: Okay. Thanks. Have I got time for one more?

The CHAIR: Yes.

Mr WELLS: You mentioned there was no increase in suicide numbers but there was an increase in attempts.

Dr COVENTRY: Yes.

Mr WELLS: So why is that? Why the increase in attempts? I am trying to choose my words very carefully. Maybe if you could just answer: why was there an increase in attempted suicides?

Dr COVENTRY: Look, I do not think we know the answer to that, and I would probably say, anecdotally, every single situation has different factors. Sometimes, like I was saying to the Chair, there would be vulnerable groups. So we would be concerned if there was a theme around, for instance, Indigenous young people. Is there a theme around people who are dislocated who are in out-of-home care through child protection? Is there a theme around culturally and linguistically diverse groups who are sort of being stigmatised? So I would say there are some sort of trend factors we might see but for every individual probably a unique set of circumstances.

More my concern has been is that when we know that the data says that people who attempt suicide are certainly a high-risk group to go on and complete suicide, we need to be a lot more robust in the follow-up. We have got a window of opportunity in that first 24–48 hours and then up to three months to try and link people in with the appropriate service. I think we can do that much more robustly now. Again, this is hard data to show because of the time sequence that you need to look at, and you are talking about small numbers. But I think we have got the opportunity now when we are seeing that increase in self-harm, particularly with young people, to try and look at understanding some of the trends but look at each individual person and make sure we have linked them in with the appropriate service. I think one of the innovative approaches is using a peer-led approach so that young people talk to a young person rather than a professional for the clinical background, and that person has that responsibility to actually link them in with the professional services and guide them.

Mr WELLS: Thanks.

The CHAIR: Thank you, Dr Coventry and Ms Love, for appearing here today. All evidence taken by the committee is protected by parliamentary privilege. Comments repeated outside the hearing or on social media may not be protected by that privilege. All evidence today has been recorded by Hansard, and you will be provided with a proof of that to read through. And of course all verified transcripts, presentations, handouts and the like will be on the committee's website as soon as possible. We would ask you to leave, and we will move to the next witnesses. Thank you very much again for your attendance today.

Witnesses withdrew.