

Royal Commission into Victoria's Mental Health System

A submission from

[REDACTED]

Return address and contact details:

[REDACTED]

Ph: [REDACTED]

Mob: [REDACTED]

Email: [REDACTED]

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Introduction

We welcome the opportunity to prepare this submission and share our sons, and our subsequent experience with the Victorian Mental Health System. This submission is focused on the poor short term acute care our 18 year old son received which directly resulted in his unexpected, unnatural premature death, and the subsequent long term trauma our family has experienced at the hands of the Victorian Mental Health System.

In the following pages we have outlined details of our lived experience, and the systems shortcomings and addressed the questions posed by the Commissions.

Our lived experience

We are the parents of [REDACTED], an [REDACTED]-year-old student who suffered a psychiatric episode following a relationship breakdown. [REDACTED] actively sought professional psychiatric help at [REDACTED] Hospital and was referred to the [REDACTED] Crisis Assessment Triage (CAT) Team.

CAT Team members attended our home in the evening of the following day to make a preliminary assessment but failed to attend the pre-arranged follow-up appointment the following day choosing instead to contact our local GP.

In that telephone conversation the CAT Team Nurse stated that our son's condition was '*an idle threat and he would get over it*'. Similar remarks were made directly to our son in a telephone call to him by the same CAT Team nurse in a follow-up phone call an hour and a half after the meeting had been scheduled to take place.

Immediately thereafter our son overdosed on medication and was transferred by ambulance to [REDACTED] Hospital.

In a subsequent lengthy telephone conversation with our family the CAT Team nurse stated that he did not think that [REDACTED] would act on his ideation and that he, the CAT Team nurse had made an incorrect assessment. He then went on to state that there were no vacancies at the [REDACTED] Hospital Psychiatric Unit but there was one space remaining at [REDACTED] House.

When the nurse was questioned about treatment in an alternate private hospital, we were told that [REDACTED] House, which was part of the same hospital network operated by [REDACTED] Health in Melbourne, would deliver superior treatment, had better staff and facilities as well as powers to contain.

In addition to the above, we were assured that [REDACTED] would be monitored constantly, that even though he would be considered a 'voluntary' patient he would not be allowed to leave the facility unaccompanied, that if he attempted to leave on his own the staff he would be assessed by a Registered Medical Officer with a view to making him an involuntary patient. We were also informed that the staff had (legal) powers of restraint, there would be 15 minutely checks and that if his whereabouts could not be accounted for both we (his parents) and the Police would be notified.

Based on that advice we agreed to [REDACTED] transfer to [REDACTED] [REDACTED] in the expectation that he would receive the care and treatment he needed.

Following treatment in the Emergency Department and after the on-duty Registrar and two Registered Psychiatric Nurses determined that our son was '*at risk of completed suicide and could not be safely cared for in the community*' [REDACTED] was transferred and admitted to [REDACTED] [REDACTED]

(located well over an hour from his home), a purpose built adult psychiatric facility, as a voluntary inpatient.

In addition to a telephone handover by one of the psychiatric nurses to the nurse in charge at [REDACTED], a fax was sent outlining his condition, risk factors and documenting that there were recent suicide notes. On finding these notes a telephone call was also made from family to the nurse caring for [REDACTED] outlining their content and advising the staff of the need to closely monitor [REDACTED].

The notes were handed to the nursing staff at the facility the following day. Despite this there was no documentation in his Progress Notes. The Consultant Psychiatrist on the following day deemed our son to be at 'moderate' risk of suicide.

In his evidence to the Coroner that same Consultant stated that he never read the faxed notes and was not aware of the suicide notes until after our son's death and as such his prognosis was determined without having considered all of the available, relevant and vital information.

Despite the Consultant Psychiatrist documenting in the Clinical Notes that our son was displaying all the signs and symptoms of a Major Depressive Disorder he failed to make a definitive diagnosis and therefore our son did not receive any effective treatment.

During his time as a patient at the facility there were a number of documented concerns with our son's care and treatment including: Inadequate monitoring (changing of his observations without any medical input); communication failures between related health services, among psychiatric staff and nursing staff and between both psychiatric and nursing staff and with our son and our family; the prescription and provision of contra-indicated medication; reliance for a critical Medical Review on an inexperienced Resident Medical Officer with poor English language and comprehension skills and inadequate management of our son which did not correlate and was not commensurate with the facility's own staff risk assessment, including around unsupervised leave; poor, inaccurate or no documentation.

On several occasions both our son and members of our family advised the nursing staff of the adverse effects of the medication being administered to assist him sleeping and requested a review by the medical staff, which the nursing staff stated would be done.

This was not documented and the medical staff later stated that they were unaware there was a problem. The medication continued to be prescribed and administered.

We also requested that [REDACTED] mobile phone be held by staff unless he wanted to contact family members as we had observed had been done for another patient. This request was ignored and our son was subjected to extensive cyber-bullying the day before his death.

Our son was an inpatient at this facility for five days but was only seen by the Consultant Psychiatrist on one occasion.

Our son left the facility on the evening of the fifth day following his admission through the open, unlocked and unsupervised front door and committed suicide by stepping into the path of an oncoming train at the nearby [REDACTED] [REDACTED] overpass.

The staff were unaware that he was missing until the oncoming night staff did a head count on change of shift, some hour and a half after our son had left the facility and despite having a curfew an hour earlier where the front door should have been locked.

The staff failed to enact any aspect of the applicable [REDACTED] [REDACTED] Missing Patient/Person Policy and instead proceeded with their handover despite having ten staff members present at that time.

Having been alerted by one of [REDACTED] friends that he might not be in the facility our family immediately contacted [REDACTED]. We were told by the nurse that answered the telephone that *"we know he is missing, we are doing handover, if you think he is going to harm himself you call the police"*.

The police and ambulance were contacted by family and 16 family members and friends as well as security guards from the local shopping centre and metro trains carried out a search and all were present at the site when the emergency services recovered our son's body. The police told us that if they had been alerted earlier they could have triangulated our son's mobile phone and located his whereabouts within a short time frame.

The afternoon shift nurses responsible for our son's care did their handover and went home. Only when the Police attended the facility and advised the staff of our son's death did they then contact the relevant psychiatrist, the Clinical Director, the facility's managers and supervisors. We [REDACTED] parents) were not contacted at all that night.

As a Registered Nurse employed at the time by [REDACTED] Health at a public hospital, we trusted that our son would receive at least the pre-requisite level of care, treatment and monitoring as had been promised to us and that which applied in a public hospital setting. This did not occur.

During [REDACTED] admission, we had requested to speak to the medical staff on at least three occasions. At our insistence we engaged with the medical staff on one occasion and we were told that they only had 5 minutes to spare and that was on the day of his admission. We did not speak with the Consultant Psychiatrist until after our son's death. The nursing staff ignored or dismissed any concerns or requests made by the family.

Despite our son previously attempting suicide and that this (as well as the warning by previous clinicians in the progress notes, faxed material and telephone conversations) was a proven recognised risk factor along with the presence of suicide notes and the known fact that during this period there would be a much higher risk of completed suicide, the poor management at this facility allowed junior staff to make vital decisions without the pre-requisite senior clinician's input. The staff ignored written orders by the Consultant Psychiatrist with little or no oversight by senior staff or management ending in the worst possible outcome in our son's case which we believe occurred due to a lack of duty of care by the professionals entrusted to supervise, monitor, treat and care for him.

The facility appeared to be run to suit staff wants and routines.

Two days after our son's death we received a two lined letter of condolence from the Medico Legal Department of [REDACTED] Health signed by the [REDACTED] Director, [REDACTED] Professor [REDACTED] who did not even identify our son by his name. However, the [REDACTED] education/management status and contact details took up ten lines. At the same time we received an Invoice from [REDACTED] Health addressed to the 'Estate of the Late [REDACTED] [REDACTED] for \$10 for medication received after hours at [REDACTED] Hospital. We received one of these invoices every two weeks for six weeks and despite contacting the [REDACTED] [REDACTED] and [REDACTED] father paying the account a further invoice was sent. On Christmas Eve of that year we received a letter dated 23 December from [REDACTED] [REDACTED] – [REDACTED] Public [REDACTED] – [REDACTED] Hospital with a red smeared \$10 note enclosed stating that the account had been withdrawn and "from time to time these invoices are released". This letter caused our family great distress and in the New Year we returned a \$10 note with a letter stating that we did not accept their explanation.

After our son's death we requested documents under Freedom of Information which included our son's medical file and a copy of [REDACTED] Health's Absconding and Missing Patient/Person Policy and attached to that document (in error – we presume) was a draft copy of an [REDACTED] Health Mental Health Clinical Risk Review in which it stated in the introduction that ...*'an internal audit of suicides between July 2007 and September 2009 identified that of the 31 suicides, only 7 had a valid clinical risk assessment documented'* which indicated the large numbers of suicide deaths within [REDACTED] Health and the failure to provide valid risk assessments in a majority of those cases.

Almost 2 years after it was due to be enacted no new risk assessment criteria had been rolled out at [REDACTED] Health as stated by a witness under questioning by our Barrister at the Coroner's Inquest.

We tried on numerous occasions to speak with or engage with the [REDACTED] of [REDACTED] Health who was in charge at the time of our son's death and only when he was a speaker at a meeting in our home-town were we able to 'door stop' him. Unable to avoid us he agreed to a meeting at his offices at which he was to provide detail of the circumstances within [REDACTED] Health and [REDACTED] House that led to our son's death including the contents of the Root Cause Analysis (RCA).

Just prior to the said meeting we received a telephone call from the [REDACTED] Secretary to say that the venue was to be changed from his office to another campus. Upon arrival at the alternate venue we were told that the [REDACTED] [REDACTED] would not be attending and that the Head of Medical Services, Dr [REDACTED], would be attending in his place.

Also attending was [REDACTED] Health's [REDACTED]

At that meeting Dr [REDACTED] maintained that he had only limited knowledge of the contents of the Root Cause Analysis (RCA) and would require the [REDACTED] authorization to discuss or disclose that information to us, which was at odds with the reason that the meeting had been requested and agreed to in the first place.

We discovered some time later that in fact Dr [REDACTED] had been the [REDACTED] and as such would have been fully aware of all of the circumstances and the contents of the Report.

Further we do not accept that Ms [REDACTED] would not have been aware of that at the time, but she made no attempt to correct Dr [REDACTED] misrepresentation and as such is equally culpable. This fundamental dishonesty has further traumatised us and removed any faith we had in the System.

Although we further corresponded with Mr [REDACTED] he never provided any substantive information. Only after the intervention of the Minister for Mental Health, the Honourable [REDACTED] [REDACTED] was a heavily redacted copy of the RCA provided to the then Chief Psychiatrist who in turn forwarded what had been provided to him, to us.

From the limited information that we received we do not believe that the issues covered in the RCA addressed the failings that led to our son's preventable death.

With the appointment of the new [REDACTED] Mr [REDACTED], we further pursued this matter and subsequently met in his office where we presented him with a written list of questions and were provided with an assurance that each of these would be answered, in accordance with the 'Open Disclosure' requirements.

Questions relating to staff conduct and performance as well adherence to Policy and Procedural requirements have never been addressed.

When we sought answers and clarification to these matters, we were referred to the legal department at [REDACTED] Health, who were equally unco-operative and adversarial. We have never been provided with any detailed response.

We also note that at the time of [REDACTED] death Mr [REDACTED] was the [REDACTED] of [REDACTED] at [REDACTED] Health and therefore responsible for the performance of the nursing staff at [REDACTED] House.

Dissatisfied by the response provided by the CEOs' we attempted to engage the Board of Directors. Attempts to contact the Chairperson, [REDACTED], via [REDACTED] Health were directed to her Medical Rooms while telephone calls to the Medical Rooms were rebuked as being an issue for [REDACTED] Health.

None of the messages left at either [REDACTED] Health or Dr [REDACTED] Rooms were responded to. Subsequent to [REDACTED] death the [REDACTED] for our area, Ms [REDACTED], was appointed to the [REDACTED] of [REDACTED] Health as a Director. On two occasions we encountered Ms. [REDACTED] at our local shopping centre. On each occasion she was informed of the situation with [REDACTED] and Dr [REDACTED] refusal to engage with us and was given business cards with our contact particulars.

The promised contact with us that Ms [REDACTED] undertook to provide has never occurred.

Approximately two years ago at a Senate Inquiry in Canberra where we were providing evidence, Dr [REDACTED] was also in attendance in her capacity as [REDACTED]. When we approached her and introduced ourselves, she acknowledged that she knew who we were but refused point blank to engage with us.

More recently, contact was made with the most recently appointed [REDACTED] Health Board member who at first objected to being contacted through her place of work, but was not prepared to provide an alternate point of contact after it was explained to her that all previous attempts to contact Members of the [REDACTED] of [REDACTED] Health via the Hospital had been ignored, undertook to have the Medico Legal Department make contact directly with us.

As expected, this has not eventuated. We question why the Board Members are deflecting their responsibilities to the legal department.

It is our view that failure on the part of those Directors we have spoken to, to investigate the circumstances of our son's death are in breach of their statutory responsibilities as [REDACTED] of a Health Service. As set out in the Department of Health & Human Services (Victoria) – Health Organisation Board Director Position Description:

Role of the Board:

- Having ultimate accountability for the delivery of safe and quality care.

Role of the Directors:

- Commit to the delivery of safe, high quality, person-centred care...
- Having integrity and be accountable-dedication to fulfilling a director's duties and responsibilities...
- Provide constructive challenge and oversight...

Following our son's death in early September 2011 The Age Newspaper in Melbourne written by [REDACTED] Baker and [REDACTED] did a probing series of articles on the mental health system in Victoria in part detailing the huge numbers of unexpected, unnatural and violent deaths in state-run

and private mental health facilities. In one of the articles a Consultant Psychiatrist who chose to remain anonymous because he was still working in the system and who had worked at [REDACTED] [REDACTED] months prior to our son's death, stated that "[REDACTED] Health Adult Psychiatric Service has (among) the highest rate of unnatural deaths in the state, that unethical and illegal practices were resulting in such poor outcomes and that there had been over 22 resignations of senior medical staff since the commencement of management there". He also stated he had advised senior management at [REDACTED] Health and had also contacted the relevant Victorian Mental Health Minister with no response or action being taken other than being ostracised at his workplace.

The Coroner's Court:

Immediately following our son's death, we became aware of many of the failures in the management of our son's care and treatment and wrote to the then State [REDACTED] Judge [REDACTED] [REDACTED] outlining these concerns.

She was sufficiently concerned to direct the Inquest be brought forward and assigned Coroner [REDACTED] [REDACTED] to the case. Through his Registrar the Coroner requested our consent to have the Inquest heard 'In Chambers' which we declined.

At the Directions Hearing [REDACTED] [REDACTED] instructed us [REDACTED] (parents) that we had to redact our Statements or he would not proceed with the Inquest. There were elements of the case he would not hear, he limited the scope, timeline and number of witnesses that could be called and then proceeded to make, what we considered to be inappropriate and offensive comments.

It appeared to us that [REDACTED] [REDACTED] had taken exception to being directed to take-on this matter and our declining of his request to have the matter heard 'In Chambers' (or both) and it soon became evident to us that we would not get a fair and equitable hearing.

We immediately raised this issue with our legal representatives who stated that he [REDACTED] may not have been fully conversant with all the facts and that we should allow him to retain the matter and proceed with it. Our concerns were further reinforced when on the day the Inquest Findings were handed down [REDACTED] [REDACTED] attended the hearing in denim jeans and a casual open neck shirt.

At the two-day Inquest there were some twenty individuals from the Insurers of [REDACTED] Health their various Departments and other employees as well as the five witnesses and their respective legal teams most of which were funded by the public purse.

Notwithstanding that [REDACTED] [REDACTED] identified and commented on eighteen failings on the part of [REDACTED] [REDACTED] and its staff members he made no Recommendations. A number of the items identified in the Finding related to [REDACTED] [REDACTED] staff members failing to undertake basic required work practices prefacing those failures with the word 'ideally' (such and such should have occurred) in situations where those tasks had not even been attempted. He failed to make any comment on the fact that the staff did not in any way adhere to the relevant Policy and Procedure as is required by the organization and which is also a requirement to gain accreditation or the presence of suicide notes. Instead he commented on the requirement for a Visitor's Book which already existed (and had not been signed by anyone for months at the time of our son's admission) and the requirement to place a sign up to ask visitors to attend the Nurses Station.

The Coroner described the CAT Team nurse, who failed to assess our son correctly, attend the pre-arranged appointment and who down played and belittled our son's illness and situation, as a '*vastly experienced clinician and an impressive witness*' and not as unprofessional and inappropriate.

We were advised of the nurse's comments by the GP after our son's death in which he stated that he was disgusted by the comments and he had stated his concerns to that nurse of the seriousness of an 18-year-old with suicidal ideation following rejection.

The GP forwarded a letter to the Coroner outlining those concerns, but clearly the Coroner either did not read that letter or ignored its contents.

The Resident Medical Officer who carried out a vital review of our son on the day of his death and had never before done a review of a patient (in that it was supposed to be carried out by the Consultant Psychiatrist, Dr. [REDACTED] to assess the need for anti-depressants and who instead of carrying out the review instructed his unsupervised junior to do this review). Dr. [REDACTED] had only been registered with the Australian Health Practitioners Agency (AHPRA) two weeks prior to our son's admission. She was employed as a hospital medical officer to work under supervision. Her registration was conditional in that she was to work under the supervision of Professor [REDACTED] and he was the only Practitioner named. During the Inquest Dr. [REDACTED] was unable to comprehend even basic questions put to her. She was unable to explain what was in her Statement; stating that it had been done by the Legal Team at [REDACTED] Health. Times and dates were incorrect and the answers were not consistent with the questions being asked requiring the Coroner to intervene and say to Dr. [REDACTED] *"It's very important, if you don't understand the question you must – don't be ashamed, just say, 'Look, I can't understand it. I want to be clear about what you're asking. Okay?" To which she replied:- "Yes".*

In his Findings the Coroner stated:- *"At Inquest, I heard evidence from Dr. [REDACTED] Her assessment of the 4th October was appropriate within the parameters of her experience. The clinical observations were accurately conveyed to Dr. [REDACTED]* Given that the Inquest was held 14 months after [REDACTED] death and her role was primarily to communicate accurately with patients and staff (which she could not do at the Inquest even given the time lapse), we fail to see how the Coroner could determine that the clinical observations were accurately carried out or conveyed to the Consultant Psychiatrist, Dr. [REDACTED] and he failed to mention that she had never carried out a review and that she was registered to work only under supervision.

At the Coroner's Inquest in evidence the Consultant Psychiatrist, Dr. [REDACTED] stated that he did not prescribe anti-depressant medication to our son because there is a reported risk of anti-depressant medication increasing suicidal behaviour in the adolescent population.

The manufacturer of Temazepam (a benzodiazepam used to aid sleep) determine in their documentation and instructions for use that this drug is not to be prescribed or administered to adolescents and should not be used as primary therapy in psychosis or depression but while at [REDACTED] it was the only medication provided to our eighteen year old (adolescent) son.

Despite our son and his family complaining on three occasions that the drug was causing [REDACTED] to have hallucinations, vivid nightmares and difficulty sleeping and the promise from nursing staff that medical staff would be informed and it would be reviewed, this never occurred and it was continued to be prescribed and administered.

In his evidence at the Inquest the Clinical Director of Psychiatric Services at [REDACTED] [REDACTED], Professor [REDACTED] [REDACTED] confirmed that Temazepam was routinely prescribed by him and his medical staff and seemed oblivious to the fact that in our son's case (because of his age) it was contra-indicated. He also had no idea of the side effects of this medication

While at first dismissive of the information put to him in this regard when presented with supporting advice from MIM's (which was the required Pharmaceutical Reference Manual at [REDACTED] Health) he

stated that you don't take any notice of that information because they list all the side effects and contra-indications.

The Coroner's Finding made no mention of our son having been inappropriately medicated while in the care of [REDACTED] or the Clinical Director's (and his medical staff's) seeming ignorance of the danger they created by prescribing this contra-indicated drug. He also appeared to accept the statement of Dr. [REDACTED] that there is a reported risk of anti-depressants increasing suicidal behaviour in the adolescent population and that was why it was not prescribed but fails to acknowledge that the Temazepam which was prescribed and administered should not be given to adolescents and creates the same risk of suicidal behaviour if given to depressed patients.

In reply to a question from our legal representative at the Coronial Inquest the Clinical Director, Dr [REDACTED] was asked: What about [REDACTED] right to life? He certainly has a right to life ... I guess there's a right to death as well.

This statement in our opinion is not acceptable from the manager of taxpayer funded treating facility with regard to an adolescent boy with severe depression who sought help and treatment. The Coroner made no comment at the time of this statement or in his Findings.

The Coroner's Findings focused primarily on protecting the institution and the professions that worked within it rather than on the identified failings, acknowledgment of any accountability by the facility and its staff or achieving better outcomes in order to reduce the likelihood of similar occurrences in the future all of which are requirements under the Coroner's Act.

Following the handing down of the Coroner's Findings we prepared a document which identified some 50 errors in fact and conflicting evidence. The Victorian Coroners Act 2008 Section 76 (c) makes provision for the correction of errors and the appointment of an alternate Coroner under certain circumstances.

We have now submitted our request for correction of the Findings to three successive State Coroners each of which have referred the matter back to the offending Coroner who on every occasion has without explanation denied our request and referred us to the Supreme Court.

Whilst lodging a complaint with the [REDACTED] of the Coroners Court, Ms [REDACTED] [REDACTED] we were informed that any attempt to comment disparagingly of [REDACTED] [REDACTED] or his conduct would result in us being charged with Contempt of the Judiciary. When advised that we would welcome the attention that would bring we were advised by her ([REDACTED]) that the matter would be suppressed and that we would be fined or jailed or both and that *"no-one would ever know about it"*.

We then raised these issues with the [REDACTED] both maintained that they were unable to deal with the particulars of any specific case and said they were powerless to act about the threats made.

The Australian Health Practitioners Regulation Agency (AHPRA):

Prior to the formation of AHPRA individual State Boards were membership organizations responsible for registering practitioners. Only recently have the combined Boards under AHPRA been given regulatory powers.

Until the Coronial Findings had been handed down AHPRA would not accept any Notifications (their terminology for the lodging of a complaint against one of their members).

Following the issuing of the Findings from the Coroner's Court we submitted 15 Medical and Nursing Notifications. The four Notifications relating to medical practitioners were dismissed within weeks at the 'investigation stage' (at the direction of the Medical Board) without the doctors having to provide any response.

The nursing staff were required to respond to the Notifications, one (which was submitted electronically) was unable to be opened so was totally ignored. Some of the Nursing Notifications were dismissed within 3 months others extended to over 3 years.

Three of the Nursing Notifications related to nurses who could not be identified and ██████ Health refused to identify them. One Nursing Notification was lost. Every Notification had a different Case Manager and their communications and work practices appeared to be chaotic.

We made a written complaint to the ██████ of AHPRA who commissioned the Victorian Government Solicitor's Office (VGSO) to investigate and report on the handling of our Notifications.

The VGSO Report identified a 'lack of rigor', failure to comply with the Health Practitioner Regulation National Law Act 2009 (National Law), failure to address all aspects of a notification and requirement for a review, failure of its document management processes and practices by AHPRA', and made 13 recommendations for change.

Following the release of the VGSO Report, ██████ Health were required to identify the three nurses to comply with the National Law. Unfortunately, in one case the wrong person was identified by ██████ Health and AHPRA staff did not check that she was the correct person on the correct shift and investigated this individual, even when this error had been brought to the attention of AHPRA by us, they proceeded to place that practitioner before the Nursing and Midwifery Board to make a decision.

The previous decisions involving the four doctors made by the Medical Board were rescinded, reformatted in order to comply with the recommendation of the VGSO Report and shortly thereafter without requiring a response from those doctors or undertaking any further investigation were reinstated without any substantive change.

All Notifications were dismissed.

The Chief Psychiatrist:

We had several meetings with the then Chief Psychiatrist, Dr ██████, over an 18-month period seeking an investigation into the care and treatment of our son at ██████ House and the circumstances of our son's death as well as requesting a copy of the RCA.

He (██████) refused to investigate ██████ and its' staff, stating that the Coroner had already investigated the circumstances of our son's death.

Instead he noted that ██████ Health did not have the required Open Disclosure Policy (which in itself calls into question how this facility received it's accreditation) and to deflect away from our concerns he instigated an inquiry which required ██████ Health to formulate an Open Disclosure Policy and forwarded it to us. Despite this Policy being in place we have not received full 'open disclosure' to our written questions supplied to the CEO of ██████ Health.

As previously noted, we only received a heavily redacted copy of the RCA after we complained to the then Mental Health ██████ the Honourable ██████

The National Health Practitioner Ombudsman and Privacy Commissioner

The National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) is an independent Statutory Officer who we contacted following the rejection of all of the AHPRA Notifications. However this officer does not have the power to overturn a decision of AHPRA and the Boards and is only able to look at the documentation provided by the facility and its staff. If this documentation is non-existent, incorrect or limited as occurred in our son's case they are moot.

At every level of our son's care in the mental health system he was failed as was his family who entrusted him to the care of the staff at the facility on the promise of the required level of care, treatment and monitoring commensurate with his condition. None of which occurred.

Summary

Only after our son's death were we made aware of the poor outcomes within the facility and [REDACTED].

Clearly this model needs to change as it is a massive impost on the public purse and fails to deliver the required level of care, treatment or outcomes as well as lacking accountability or any form of effective oversight.

While the focus of funding for mental health services has been concentrated on acute clinical services, they do not achieve the required outcomes to the health and well-being of Australians with a mental illness.

When there are shortcomings resulting in failings or adverse outcomes in acute mental health services the 'fall-back position' from the clinical management or so called 'experts' is "lack of funding" and the number of patients presenting through their organization rather acknowledging the problem and their failures as well as their lack of competent management and delivery of the required, professional standards of adequate treatment and care.

These facilities quote deaths per 100,000 in their catchment areas and not the number of poor outcomes against admissions in their facilities.

This concentrates and perpetuates large funding allocations to the clinical health system. These small groups of clinical managers juggle legal professional witness work, research and education commitments instead of wholly concentrating on the management of their staff and their facilities and they seem more intent on 'empire building' and achieving kudos within their insular clinical community rather than those they are being paid to treat.

There is lack of communication or collaboration with other community services. In our son's case not one other community service including the General Practitioner or even the facility's own allied health staff such as a social worker were contacted. The patient is treated as a commodity and bed occupier rather than a person with a mental illness. Other impediments to the clinical mental health system are patients being labelled as 'voluntary' or 'involuntary' (which appears to be done for legal protection of the organization) rather than concentrating on the patient's condition, treatment, optimal care and environment, their wellbeing as well as their long term recovery.

The quality and commitment of many of the staff in these facilities also needs to be addressed. In our experience the staff primarily focused on the daily routines and their needs and wants and adopted a 'one size fits all approach'.

The nursing staff at [REDACTED] [REDACTED] ignored patient and family input and failed to document vital information. They did not appear to be dedicated or committed to patient care or outcomes and made decisions which required clinical input and when there was clinical input, they failed to follow those orders or the Policy and Procedures of the facility.

Many of the Clinicians were overseas trained and required a higher degree of supervision and oversight. This did not occur. Due to inexperience and poor English communication skills and the lack of management oversight these clinical staff members just accepted this situation.

The Consultant Clinician (by his own admission) failed to read all of the forwarded progress notes, faxed handover from the original affiliated treating facility and other vital information and based his decisions on his limited knowledge of the situation and the advice of an inexperienced Resident Medical Officer (with poor English communication skills) which was inaccurate and resulted in the worst possible outcome.

The complaint system fails because it is managed and adjudicated by the professions who have largely risen through the same system and are self-protective with no independent oversight. They appear to advocate for the professions in preference to providing objective critical assessment.

The Australian Health Practitioners Regulation Agency (AHPRA) supports 15 Boards which entails accrediting training and education (e.g. English language skills), register health practitioners, set national standards, auditing compliance and managing complaints, effectively overseeing all aspects of the system and so when there are complaints with any aspect of the process, they take on a protective role.

They (AHPRA) state that the main objective at the core of the scheme is public safety. That was not our experience.

We were failed on many levels by individuals and authorities who have a lot of power but for whom there is no effective oversight and where there is legislative requirement to provide oversight it is not carried out.

Commission Question Responses

Commission Question No. 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

It is our belief that unless you have suffered from a mental illness or have cared for a person with this illness your understanding of mental illness is often limited and may be moulded or influenced by peripheral sources.

The common terminology used to describe people with a mental illness such as 'nutter' or 'having a screw loose' undermines and dehumanises the person and the illness with little or no understanding of the facts.

Often the media in cases of violent crime describe the suspect as having mental health issues thereby blanketing anyone with mental illness from mild conditions to the most severe into the one category.

The social media platforms which many people (especially young people) use for communication allow for predators (trolls- often masquerading as friends) to prey on the vulnerable or those they perceive to have a weakness e.g. mental illness allowing them to torment the individual as well as to comment on and disseminate this information widely.

Mental illness has in the past been viewed in some circles as a weakness by those who have little understanding of the illness e.g. male peer group pressure espousing weakness in males if they cannot cope mentally.

All of the above create stigma, stifle open discussion and allow for discrimination to occur (in education, employment and healthcare) which in turn stops people from seeking help early in their illness and thereby allows the illness to manifest often with the individual only seeking help in a crisis situation in an Emergency Department or by self-harming/committing suicide.

Mental illness is an illness like any other although it often does not present with visible signs and symptoms but as a behavioural or mental pattern which causes distress or impairment of personal functioning and although it cannot be measured it is as relevant and debilitating as any illness and should be validated, taken seriously and treated as such. Our community still continues to undervalue and not take as seriously mental illness compared to medical illness.

By educating the community on what enhances good mental health there should also be education programs on the detrimental effect of labelling by individuals and the media. The social media platforms should be required to remove any demeaning or derogatory material before it is published or allowed to disseminate on their platforms and not as is required at present to remove it after it has already caused distress and harm. Individuals found to be targeting, harassing and tormenting other social media users should be prosecuted. With increased prevalence and transparency of mental illness and the willingness of high profile individuals such as sportsman to acknowledge their mental illness, seek treatment and return after recovery to their lives and sport aids in diminishing the stigma and sends a positive message to others in their situation. Whilst this speaking up is brave, it should not be seen and reinforced as a courageous act, but instead should be normalised.

Commission Question No. 2: What is already working well and what can be done better to prevent mental illness and support people to get early treatment and support?

With increased prevalence and with one in five Victorians suffering from mental health issues how do you evaluate what is working?

The current measures focused on hospital separations provide no indication of the quality of care and long term outcomes. KPI's centred around bed occupancy, and length of stay (alongside financial measures) distort outcomes and behaviour of those within the Mental Health System.

Many families want and need to be involved in the support and care of their loved ones but lack clear and transparent information on which to make decisions. Family input and pressure is often the only counter measure to KPI's which are not focused on long term recovery.

As such, providing agency and voice to both patients and families across all levels of the System is vital. Encouraging open discussions with friends and family is key, as is the continual reduction in the community stigma associated with mental illness.

Whilst campaigns raising the awareness of mental illness particularly across its most common and chronic forms (particularly depression and anxiety) have been welcomed, it is important that this moves to more specific and higher order investment in treatment and care; and importantly that the messages of these campaigns- that help is available if you ask- are realised with a system that actually responds and functions.

This should include:

- Encouraging open discussion with friends and family.
- Early screening in childhood and adolescence including mental health assessment and questions relating to mental health when doing the school medical assessment. Thereby flagging any problems found at an early stage.
- Extension of the Victorian schools curriculum to educate about mental health, avenues of support and general de-stigmatisation
- Education and awareness programs outlining the importance of a balanced healthy lifestyle and the need to discuss any problems.
- Community based services in the local community with 'drop in' areas.
- General practitioner's offices with visible posters on the signs and symptoms and how and where to seek help including brochures and online resources
- Workplace education and awareness programs.

This can only be achieved with regular improved monitoring and evaluation of the services provided against accurate mental health statistics, and earlier intervention to avoid the failing hospital based system.

Commission Question No. 3: What is already working well and what can be done better to prevent suicide?

Given the ever increasing suicide rate it is hard to evaluate what is working well, if anything. This can only be achieved by monitoring and assessing for positive and effective outcomes of suicide prevention strategies and programs on a regular basis. The problem seems to be that there is a plethora of these programs all operating independently.

Programs that have worked well overseas are the European Alliance Against Depression (EAAD)¹, which has been adopted from the Nuremberg Alliance Against Depression (NAAD) which resulted in a 24 percent drop in the suicide rate in 2 years in that city. It is a multi-faceted community based action programme with a 4-level approach around the treatment of anxiety and depression and the prevention of suicide. This approach has been adopted as world's best practice in many countries including Europe, Canada, South America and is being piloted in Australia by the Black Dog Institute to adapt to our conditions and requirements as well as the Western Australian Health Alliance (WAPHA) taking up its framework and acting as the national chapter. In Scotland, due to escalating suicide rates higher than comparable nations, the government set a 20% target and achieved an 18% reduction using a similar approach.

Our experience was that our son actively sought psychiatric treatment as is widely encouraged when he came to the realisation that he had a problem. The only available services were at that time over an hours travel away from our residence.

In our experience the only positive encounter within the system was with the Psychiatric Nurse at the Emergency Department at [REDACTED] Hospital who in a professional, caring and compassionate manner accurately assessed and documented our son's condition, treated his symptoms and referred him to the [REDACTED] CAT Team.

In contrast the [REDACTED] CAT Team failed to inform the family of vital information, were dismissive and downplayed our son's condition (making statements to our son and his General Practitioner that *"It's an idle threat and he will get over it"*) and failed to attend the pre-arranged follow up appointment. Our son's condition then escalated from mental illness to attempted suicide resulting in his admission to [REDACTED] Health's [REDACTED] House where the promised care and treatment never eventuated and despite documented warnings and risk assessments from [REDACTED] Hospital our son completed suicide.

The difference between the respective services was that the [REDACTED] Nurse was a caring professional who related to our son, reassured him and validated his condition whilst those that followed were neither caring nor professional. It should also be noted that the [REDACTED] Nurse attended our son's funeral as he was shocked at his sudden death. He documented in his progress notes that [REDACTED] was 'at risk of further deterioration' and 'at risk of completed suicide'.

Other than this one Nurse, our son did not think he was being taken seriously or treated and supported in the system.

Suicide Prevention and early intervention programs should be at the forefront of the mental health system and rolled out and funded on positive and effective outcomes accordingly.

¹ Website www.eaad.net

It is our belief that suicide prevention would be greatly enhanced with:

- Targeted evidence based education and awareness programs designed for specific gender and age groups which are regularly evaluated to determine their success e.g. school and social media programs for younger groups; work place, club and television awareness programs for older age groups e.g. similar to Cancer Council awareness advertising.
- School programs for mental health screening on all adolescent students as this is often when mental illness manifests.
- The use of Psychologists in schools in order to give students access to professional help at an early stage before illness manifests with an 'open door policy' to allow for open discussion of their issues or problems.
- Education Programs for General Practitioners and other health professionals to promote awareness of signs and symptoms of depression and to include mental health questions as part of any health evaluation when consulting with a patient so that it becomes a normal and integral part of a visit just like taking a blood pressure or blood sugar.
- Eliminating cyber-bullying by Government Legislation to stop Social Media Platforms from publishing or disseminating any derogatory, demeaning or denigrating content on their platforms.
- Listen and act on family and carer concerns as they know the person more intimately.
- Ensure that any encounter or experience within the system is positive, meets the person's requirements and is done in a timely manner. If the experience is negative the individual or family is far less likely to engage and develop a rapport and in turn creates mistrust of the system as a whole.
- If a person seeks and requires psychiatric treatment and care that it is of an equal standard as that required for medical and surgical patients; that the health professionals are highly trained, skilled committed individuals who relate to the needs of the individual and who validate the patient's symptoms and concerns and act appropriately on them.
- Continual monitoring of suicide/ self-harm outcomes of acute facilities, and intervention by an independent higher authority where continuous improvement cannot be demonstrated

In order to prevent suicide a cohesive committed approach is required with proven effective positive programs, robust targets and objectives and the will of both the community and Governments to commit to lowering the suicide rate.

Commission Question No. 4: What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with one another.

In our fast pace Western Society we are constantly subjected to an inordinate amount of stress. Whilst a small amount of stress is normal and healthy when we are subjected to constant and cumulative amounts of stress it becomes overwhelming resulting in poor mental health.

Young people are presented with negative views in the media and in daily life of 'Armageddon' with climate change, high cost of education, poor job prospects, inability to purchase a home in the future, news programs showing terrorism, violent crime, and road trauma. They are also confronted in the media and social media with how they should look and act and if they do not conform to these

unrealistic views they are often targeted. Bullying and cyber-bullying is ever present in young people's lives. They also have pressures from education and the workplace to succeed.

In the broader community financial, relationship, family, work and time pressures create unrealistic expectations on many in the community. Poverty and housing pressures also create issues.

In the elderly isolation, ill health, bereavement, loneliness and financial pressures all create issues.

In the emergency and armed services trauma from witnessing and attending road trauma, violent incidents and life and death situations as part of their employment creates stress and pressure on an individual's wellbeing.

Often it is the combination of several of these stresses that create the tipping point for serious mental health issues e.g. bereavement, relationship issues and financial pressures.

In general modern society place high expectations on people with limited support mechanisms.

In the case of young people the media should be more balanced and positive in their reporting of issues that will affect them in the future as well as presenting people of all ages, shapes, sizes and backgrounds to present programs and be on display in print media. Cyber-bullying should be outlawed by legislating against the publishing of demeaning, denigrating or derogatory material before it is published and when this occurs it should be pursued. Education and workplace programs should be in place with strategies on how to deal with stress and if required easy pathways for counselling and treatment. Encourage at all times open discussion with families, friends and colleagues. It should however be noted that many young people state that they do not want to burden or 'hurt' families with their problems.

Reducing stress by whatever means for the general population through sport, music etc. Increase pensions and social and affordable housing. Programs to visit the elderly and encourage social participation. Emergency service workers and members of the armed forces should receive timely support both emotionally and financially, validate and treat their symptoms and encourage peer group participation in clubs and sports. Put them in contact with peer support services such as Soldier On to provide support and aid in employment, psychological services etc.

Commission Question No. 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

In our experience living in a fringe rural town it was difficult to access mental health services. The nearest headspace mental health service was well over an hour from our home by car and much longer using the limited public transport available in our area. This makes it effectively unavailable to young people and those without significant financial resources. The nearest Emergency Department was forty minutes drive from our residence and well over an hour by public transport. Our local general practitioner was booked out and could not see our son for twenty four hours to arrange psychological care. All of the services appeared to be acting independently.

In 2016 the mental health organisation ConNetica and the University of Sydney carried out an audit of 28 federal electorates and found that our electorate of Casey, which stretches from Croydon to Yellingbo, had the highest suicide rate with almost one person a week taking their life. The audit

deemed Casey's suicide level – 184 people took their lives in four years – as “extreme” and the 16,344 cases of high psychological distress was “severe”.

Our electorate was covered wholly by [REDACTED] Health, there were no private medical or psychiatric hospitals or facilities in the electorate and no mental health services such as Headspace.

Some of the drivers behind some communities in Victoria experiencing poorer mental health outcomes we believe are:

- Lack of services
- Lack of knowledge of how to connect to services. If they are connected to a service because of the fragmentation of the system it is difficult to navigate
- Lack of willingness for skilled mental health professionals (psychiatrists and psychologists) to relocate to rural areas.
- In rural and isolated communities such as farms where farmers are working up to seven days a week on the land and are often faced with the stresses of extremes of weather (drought and floods); have financial pressures due to poor farm gate returns or mortgages and have a 'she'll be right mate attitude'.
- Stigma in seeking help or treatment.
- Cultural issues and barriers such as Indigenous Communities that find it difficult to engage with services other than 'on country'.
- Language barriers (including poor English skills of medical staff within the system)

Whilst there is a lack of services in rural and remote areas there are an inordinate amount of suburban based health services, an amalgamation of some of these services without reducing the number of operating locations could reduce administrative costs which could then be directed to the establishment of services in those rural and remote locations. In addition the following elements should be introduced:

- Enhanced online mental health services.
- Financial and housing incentives for mental health professionals to relocate to more rural and remote areas.
- Farming organizations (National Farmer's Federation and Country Womens' Association and rural media (Rural newspapers and Weekly Times) to promote the importance of good mental health and where and how to seek help early if you or a family member shows signs of poor mental health or depression.
- Rural area community based liaison or assessment officers or case managers. These officers can determine what programs are appropriate for individuals within the community and the community itself.
- Education and Awareness Programs specific to the cultural needs of indigenous communities and preferably with indigenous presenters and outlining how to achieve good mental health as well if experiencing signs and symptoms of poor mental health community information on how and where to seek help. In the remote [REDACTED] area in Western Australia, [REDACTED] [REDACTED] people, Engagement Officers oversee traineeship positions for teenagers and music and art programs for younger children with great participation rates². Equivalent programs for other rural and peri-urban communities should be also considered.
- Education and Awareness programs communicated in various languages to reach all communities and cultures.

² ABC 7.30 Report. 25 June 2019

Commission Question No. 6: What are the needs of family members and carers and what can be done better to support them?

Family members and carers bear the brunt of the person's mental health issues both physically and emotionally (and often financially). They are thrown into a situation usually with little or no knowledge of what they are dealing with and unsure where to turn for assistance.

When they do the system is so fragmented it is exceedingly hard to navigate. They are often trying to navigate the system whilst providing support and comfort to the patient and a wider family group.

In order to access the service they are relying on people within the system to give them accurate and professional information and assistance on where to get appropriate and high quality care for their loved one. Importantly, there is an expectation that those within the system will be honest and professional in their dealings. Unfortunately in our experience, we did not find this to be the case.

When the care and treatment is inadequate or there is concern about the patient's welfare, family members and carers have to invest significant time and energy in advocating for the patient. This is both inefficient and a poor reflection on the level of equity in the system – as those patients without suitable support networks do not have the advocacy and rely on the system working.

In our experience over 5 days as an inpatient over 8 hours was dedicated to chasing and seeking answers as to the care plan; even with this persistent follow up we were unable to get any effective answers. This in turn caused a high degree of anxiety both for our son and ourselves.

The current practice of quoting deaths per 100,000 in population of the catchment and not the number of poor outcomes and deaths in the throughput of the facility is misleading and problematic. This lack of transparency on patient outcomes means patients, families and carers lack real and timely information to evaluate the suitability of facilities, and when combined with no or ineffective communication on care plans this leaves families and patients in the dark.

The information asymmetry that exists in the system contributes to inefficient decision making, denies patients and families true choice in their care and is a significant factor in the lack of trust in the mental healthcare system.

Only after our son's death we were made aware that none of the safeguards, care or treatment which we were assured would be applied and given to our son ever eventuated and that this facility had amongst the highest rates of unnatural deaths in the State of Victoria. Had we been given this information (through honest answers to our enquiries) we would have sought alternative options of treatment and care.

In our case the negative effect of having to advocate and probe during our son's illness to gain answers which were never forthcoming and after his death to establish what had occurred and why as well as advocating for changes in the system has left us emotionally and physically drained. On every occasion that we have sought answers and changes this experience re-traumatises our family.

In order to support families:

- Family members need to have independent and informed information on how to access and navigate the system. This information should be made available and easily accessible.
- Families want and need safe, transparent and effective care for their loved ones in their local communities.
- Mental health facilities should have updated performance and outcome results readily available to the public preferably online in order for families and carers to make an informed and safe decision for their loved ones. This in turn would make the public and the Government aware of those under-performing facilities and require the Boards, management and staff to improve their performance and outcomes.
- Where a facility has been found to be dishonest or misleading in the provision of information about its services, outcomes or patient treatment, sanctions and improvement actions should be applied, and transparently shared with all patients and their families.
- Respite care available for those carers and families who care for those with long term illness.
- Support groups for families and carers in their local community.

Commission Question No. 7: What can be done to attract, retain and better support the mental health workforce, including peer support workers?

The mental health care system should be centred around safe, transparent, effective care by skilled, highly trained and suitably motivated staff with the required provision of a high level of senior clinical supervision.

In our experience the mental healthcare system was of poor quality and in most cases the quality of the staff reflected the quality of the system. They did not appear motivated or committed to patient care or outcomes but primarily focused on the daily routines and their needs and wants and adopted a 'one size fits all approach' and box ticking. Bureaucracy trumped patient care continually. The nursing staff at [REDACTED] ignored patient and family input and failed to document or communicate vital information and made decisions which required clinical input and when there was clinical input, they failed to follow those orders or the Policy and Procedures of the facility.

Many of the medical clinicians were overseas trained and required a higher degree of supervision and oversight. This did not occur. Due to inexperience and poor English communication skills and the lack of management oversight these clinical staff members just accepted this situation.

The Consultant Psychiatrist (by his own admission) failed to read all of the forwarded progress notes and other vital information and based his decisions on his limited knowledge of the situation and the advice of an inexperienced Resident Medical Officer (with poor English communication skills) which was inaccurate and resulted in the worst possible outcome.

There was a poor culture at the healthcare facility where our son was an inpatient because of unethical practices and numerous poor outcomes due to a lack of supervision by senior staff and management and if honest and dedicated staff spoke up about these poor practices and outcomes they were ostracised. This resulted in the resignation of 22 senior medical staff since the commencement of management.

In order to attract, retain and better support the mental health workforce, including peer support workers:

- Need a mental healthcare system that delivers timely, high quality care and therefore creates a positive culture
- Consistent high quality training with staff trained in Australia to ensure consistency
- Review of current credentialing and registration of mental health staff and training requirements within mental health services.
- Management that are approachable, with good people skills, focused wholly on the running of the facility, its' staff and patient care, treatment and positive outcomes
- Staff who are up to date in all areas of practice and treatments and who can communicate and relate to patients needs
- Right staffing mix. Highly educated and experienced staff to oversee and supervise junior staff at all times in order to maintain high quality of care and treatment in order for staff to feel supported
- Staffing ratios are upheld
- Flexible rosters
- Career pathways
- Continuous improvement training both on patient care and hospital policies and procedures
- Extra funding for education programs to incorporate new flexible and innovative models of care
- Vet all staff to ensure that they are suited to mental healthcare, have good communication skills and are committed to high quality care and positive patient outcomes thereby ensuring that they all have the same commitment and values
- A holistic approach incorporating all team members
- That all staff are able to fluently communicate with other staff members and especially the patients in their care to avoid conflict and poor outcomes
- Ensure Peer Workers are part of the team with valuable input

With highly trained, committed and motivated staff who all have the same goals and values for high quality care, treatment and good patient outcomes working as part of a team creates a positive culture in which people like to work and are more likely to stay. The consequence of this should be improved patient outcomes.

Commission Question No. 8: What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities ?

While good mental health enhances social participation and productivity to the Australian economy those with mental health issues are less likely or are unable to participate socially or be productive.

To enhance social and economic participation we believe the following needs to be done to realise these opportunities:

- Providing the required treatment and structural support in the early stages of an illness and as the patient's condition improves encourage resilience, social participation and self-help programs

- Access to community programs through partnerships with neighbourhood community houses, clubs or associations (eg: Computer, woodwork classes, Art and Cultural Centres and Sporting Clubs) as well as access to further education, employment programs leading to traineeships, apprenticeships and internships and housing assistance with access to subsidised housing or supported living
- Develop partnerships to provide work experience in different sectors; business, agriculture, horticulture
- Use of mentors, buddies or engagement officers to aid in participation of employment and social programs
- Animal diversion therapies, animal assistance, animal therapies and adoptions as well as equine therapy.
- Collaboration with the patient or carer as to their social needs and the requirement to encourage participation
- Advise the patient that in order to achieve their long term recovery social and economic participation is vital.

The focus on long term recovery has the ability to enhance the confidence of the patient and their carer's, limits isolation, builds resilience at both an individual and community level and avoids the loss of social welfare.

Commission Question No. 9: Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change ?

Victoria's mental health system should be a cohesive system centred around safe, transparent effective care by skilled adequately trained and suitably motivated staff with the required provision of senior clinical supervision.

We believe the following model would enhance the system:

- Community based mental health programs which treat the patient in their own local environment
- Patient centred care with the patient treated as an individual with a mental illness and specific needs (right care, right time, right patient)
- Input of those using the services and their carers into the management and delivery of the mental health services
- Holistic approach to their care involving GP's, mental health professionals, dieticians, social workers and peer group workers mostly contained within the one hub
- Evidence based care, with clinical supervision
- Flexible models to address diverse clinical needs
- Flexible funding (including consideration of the limit of 10 medicare supported sessions with a psychologist, if need is identified; individuals should not be denied treatment to support improved long term mental health outcomes due to lack of financial resources)

We also advocate for:

- Ongoing long-term consistent funding which is maintained with change of government
- Representation by a Carer and/or person with lived experience on the Board
- Fair, equitable, transparent and accessible complaint system with representation by a Carer and/or person with lived experience
- Regular independent audits of the service with regard to service provision, patient outcomes and financial management which should include patient/carers surveys
- Requirement of the mental health service to report on the outcomes annually and make it publicly available
- That staff and organisations are accredited and are vetted to ensure that they are dedicated and committed to youth mental health and positive outcomes
- That all staff are skilled to work with young people, are able to communicate effectively (no language barriers), are responsive to their needs, can identify individuals at risk of suicide and are able to respond quickly and effectively in an emergency situation
- High level of training for mental health professionals and high level of supervision by senior clinical consultants especially in the case of previous suicide attempt and ideation
- Regular updates to carer's and (where possible) the patient on diagnosis and treatment – what is being done and why. In other words Transparency of treatment and care.
- Electronic Health Record (A requirement whether it be an Electronic or written health record that the staff avail themselves to read the contents before and during treatment and care of the patient to ascertain all relevant information and facts)
- The pathway to long term recovery being the main goal

With targeted holistic care, treatment and support in a familiar community setting with patient and/or carer input and with the emphasis being placed on long term recovery, rather than in an expensive clinical setting with short term goals, the patient is better placed to recover.

Commission Question No. 10: What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Change in and of itself is highly challenging and disruptive to all organisations. Individuals and institutions often resist (sometimes passively) change, particularly where it creates uncertainty as to roles and accountability.

In our experience, the management, oversight and performance of [REDACTED] Health Psychiatric Services did not meet the current expectation. As such the priority should be on performance management and clear independent oversight until it can be demonstrated that this service is meeting its policy, procedural and performance obligations. Where it is determined that individuals directly do not adhere to or circumvent policies and procedures they should be disciplined and or removed from the service. Until this baseline level of performance is met and embedded, and patient safety and care is made central to operations it will be difficult to prepare for any future change without further undermining care outcomes.

Key to addressing the current shortcomings of [REDACTED] Health Psychiatric Services and their poor patient outcomes are a range of root and branch reforms, which will in turn establish a basis on which to make future change. These include:

Governance & Accountability: As outlined in Our Lived Experience (page 3) there is and has been a complete unwillingness for Senior Management, the Executive and Board (including individual directors) to respond to and address our enquiries with regard to our son's care, treatment and subsequent death and the circumstances as to how and why this occurred. This is in direct contradiction to the Priority Actions listed in Better Safe Care, Delivering a world-leading health care system (Oct 2016, Dept of Health, Vic) which states:

Safer Care Victoria will work with health services to monitor and improve the quality and safety of care delivered across our health system with the goal of achieving zero avoidable patient harm

AND

....a Duty of Candour where health services must apologise to any person harmed while receiving care, and explain what has gone wrong and what action will be taken;

This "closed shop" reinforces and protects poor performance and outcomes. To prepare for change the Governance and Accountability procedures need revision to include transparency and the provision of 'Open Disclosure' not just the setting up of a Policy that is not applied; term limits for Board Members, (including the removal of conflict of interest roles) and the Executive as well as Senior Management to allow for 'continuous improvement and innovation; Referral powers-independent body- answerable only to the Minister and Parliament.

Reporting and Transparency: Baseline data about quality not just quantity, real time reporting, transparency to the public of outcomes and quality of care by institution, monitoring of staff turnover; monitoring of staff complaints, monitoring of patient and carer surveys. Transparency of patient care and treatment plans to patients, families and carers outlining timeframes and targets.

Resourcing- Skills & Training: Recruitment and Retention Policy, establish and embed continuous improvement procedures, continuous professional development that includes both patient care, hospital policies and procedures and whistleblower protection and complaints procedures.

Connection to community care: communication protocols and adherence to them. Continuity of care between inpatient and community services

For the broader Victorian Community all of the above apply but there is also a requirement for:

- **Planning & Resourcing** for increased infrastructure – due to increased needs and population; planning and development of new systems and programs.
- **Workforce strategy** – Workforce planning and resourcing; improved skills training and staff skills mix to adapt to new systems and programs and broader casemix as well as provision for population growth and geographically specific issues. The provision of remote supervision and access to services (i.e. increasing technological capacities).
- **Set and articulate targets** for both infrastructure and workforce requirements.
- **Review Role and Function of CAT Teams-** strict governance and accountability procedures establishing role and powers in context of enhanced community care; performance manage against patient outcomes, valid complaints system (groups of people who have dealt with or been refused care describe the CAT Team not as the Crisis Assessment Triage Team but "Can't Attend Today or Tomorrow"); define unacceptable or high risk performance of CAT Teams (as previously described in our lived experience of broken promises and undermining).

Commission Question No. 11: Is there anything else you would like to share with the Royal Commission?

Coroners Court Reform

Coroners need to be competent, independent and impartial and be prepared to identify all the contributing factors relating to a death especially systemic management and staff failings in psychiatric facilities rather than being an apologist for them in order to improve the system and health outcomes. Any failings identified or commented on or failures to comply with the official Policy and Procedures of the organization should be subject to Recommendations for change in which there is a requirement by the institution to respond on how these failings occurred and will be addressed. Without such Recommendations the systemic and staff failings are not addressed and perpetuate throughout the organization and permeate through the system, with staff taking the position that poor conduct and performance is acceptable and has no consequences which results in further unnecessary poor outcomes and deaths. This also provides a level of protection for those under-performing managers and staff. The Coroner's should not be able to apply a 'no blame' approach if there is clear evidence of a failing or deficiency in the delivery of care or treatment in a health care facility. The Coroner's Findings should correlate with and reflect all of the evidence presented to the Coroner in either documented form prior to the Coronial Inquest as well as the evidence presented at the Inquest. The Findings should be based on all of the circumstances surrounding the person's death and not just limited to what the Coroner chooses to hear or to the limited time frame he has available to hear it. This should be a transparent process.

The Coronial process does not achieve the requirements defined under the Coroners Act in that it fails to effectively identify matters of public safety; it is not cost effective; it is not efficient; it appears to be a one sided process with health facilities able to state their case but families have no recourse to challenge untrue or distressing information regarding the deceased which remains on the public record and internet; the coronial process appears to favour big institutions and insurers who are cashed up with public funds and employ expensive barristers and their support staff; a Coroner can decide not to comment on witnesses (a 'no blame approach'); it is adversarial and re-traumatizes families; systemic failings are often not acknowledged; fails to deliver timely change; it requires expensive legal costs to participate in the process and if unable to afford legal representation families do not have a voice; diminishes value of deceased's life; negative experience of coronial process presents itself as 'unmet justice' to families and broader community; is self-protective with no oversight, if any complaints are made rather than dealing with the issue they direct you to a higher court – Supreme Court – with its associated massively prohibitive costs.

Our experience of the Coroners Court was that the Coroner was protective and an apologist for the failing system and the professions that work within and that the Findings did not reflect all of the evidence presented to the Coroner or the true circumstances of our son's death, the lack of treatment or care at the facility and his subsequent death whilst an inpatient. There was no requirement for meaningful change as was required under the Coroner's Act.

Due to the inconsistencies in the efficiency and efficacy of data collection processes after critical incidents occur a review of the role and function of the Coroner's Court in providing data and learnings related to the treatment of those with mental illness is required³.

The continued protection of the system as is, and the unwillingness of the justice system to suitably intervene and comment on poor performance reinforces poor outcomes and perpetuates fatalities as well as enhancing the emotional trauma and downstream costs to families and the community. Fundamentally the Coroners Court has shown an unwillingness to adequately identify the failings within the system or by the staff that work in them.

Removal of voluntary and involuntary status

Patients are told that they will only receive treatment in the public clinical mental health system if they agree to be a 'voluntary patient'. However families are reassured that they will receive strict monitoring and will be observed and if their condition deteriorates or they attempt to leave they will be reviewed by a Psychiatric Registered Medical Officer with a view to making the patient an involuntary patient and thereby invoking powers to restrain and contain the patient. This does not occur. In our case when staff were confronted with why this did not occur resulting in the sudden, unnatural premature death of our son we were told 'but he was a Voluntary Patient'. Thereby, absolving the staff and the facility of any accountability or legal responsibility. The Clinical Director stated that he makes all patients 'voluntary' as soon as possible. The use of the terminology 'voluntary' and 'involuntary' is being used by staff as a means to absolve their duty of care to the patient.

Purpose built buildings

██████ is a purpose built facility that has in its foyer a glass reception cubicle with automatic opening doors which creates an airlock, designed to provide a secure location for a staff member to observe and monitor patients and visitors coming and going. In our son's case this was not staffed or monitored. It was not staffed or monitored to maintain what the Clinical Director described as the 'open door policy'. The door was only locked, he said at the Coronial Inquest, when the acuity of the patients required it. He decided on the acuity but had no contact with our son or knowledge of his condition until after his death. He stated in evidence he did not know the configuration of the front of the building as he entered the building through the carpark entrance at the rear. What is the logic of having purpose built buildings if they are not utilized for the purpose they had been designed.

Improved Governance, Oversight and Management

Governance commences for mental healthcare and programs at the **Federal Government** level where they apportion and distribute vast sums of taxpayers money to the State and Territory Governments to implement programs and provide care. It is incumbent on them to ensure that these funds are being wisely, fairly and appropriately distributed and the funds are achieving positive patient outcomes and value for money.

³ <https://www.beyondblue.aug.au> Suicide figures are the tip of the iceberg: new research – Beyond Blue

At the **State** level through the **Mental Health Minister** that these funds are providing a high level of mental healthcare and the services required to the community as well as ensuring that these healthcare facilities through their Boards and management are complying with the requirements of their charter.

Medical Board of Australia: Role of the Board include: Registering medical practitioners and medical students; developing standards, codes and guidelines for the medical profession; investigating notifications and complaints about medical practitioners; assessing international medical graduates who wish to practice in Australia

Public Health Services Boards are appointed by the Minister for Health and are answerable to him/her. They comprise of ten Chairs of Hospital Boards. The Public Health Services Board of Victoria as part of their role requires: Quality and safety in healthcare; to promptly addresses any problems with service quality and effectiveness; strive to improve the quality of its' health service.

Hospital Board (as defined under the Health Services Act – 1988) are responsible for maintaining and monitoring the performance of systems to ensure that their services meet the needs of the community. Under the Department of Health & Human Services (Victoria) the role of the Board is having ultimate accountability for the delivery of safe and quality care. The role of the **Directors** is (a) To commit to the delivery of safe, high quality, person-centred care. (b) Having integrity and be accountable-dedication to fulfilling a Director's duties and responsibilities. (c) Provide constructive challenge and oversight.

The **Executive Management** oversee the day to day running of the hospital, the various departments and programs and its' staff.

The Clinical Directors and Nurse Unit Managers are responsible for the clinical, nursing and patient care in their units.

Accreditation is the responsibility of the **Department of Health and Human Services** requiring Four Standards: Management; Health and Personal Care; Care Recipient – Lifestyle; Physical Environment and Safe Systems.

It is our belief that in the past the Federal Government has provided large sums of taxpayer funds to the States and Territories to fund Mental Healthcare Facilities and Programs with the requirement of efficiency. The current measures focused on hospital separations do not provide any indication of the quality of care and long term outcomes. KPI's centred around bed occupancy, and length of stay (alongside financial measures) distort outcomes and behaviour of those within the Mental Health System.

The State through the Mental Health Minister have not fulfilled their role of ensuring that there is a high level of care and that the services meet the needs of the community or that there are adequate services provided throughout the State. In one case when the Minister was advised of high levels of poor outcomes, illegal practices and massive staff turnover at the facility where our son was an inpatient this information was ignored.

As stated in Our Experience (Page 3) we endeavoured on several occasions to communicate with the [REDACTED] of [REDACTED], but she refused to engage with us. At the time of our son's death Dr [REDACTED] was [REDACTED] which we believe was a conflict of interest as part of her role as Chairman encompassed registration medical practitioners and investigating notifications and complaints about medical practitioners, developing codes and guidelines and assessing international medical graduates who wish to practice in Australia.

Especially given that under the [REDACTED] of Dr [REDACTED] [REDACTED] staff failed to adhere to any of the codes, standards or guidelines set by the Medical Board and that the international medical graduate who reviewed our son on the day he died had such poor English language skills we do not believe that this is appropriate as her dual positions were in conflict with one another. The failure of the Chairman and the Board to act on the numerous poor outcomes under their Sentinel requirements or address the management problems in 2011 with 22 senior medical practitioners who had resigned since commencement of service at [REDACTED] House we do not believe the Chair or the Board is fulfilling its' role.

The management of [REDACTED] [REDACTED] was appalling with the Clinical Director not knowing the configuration of the front entrance, with numerous shortcomings evident from failure to supervise, communication failures, lack of documentation, the prescription and provision of contra-indicated medication and the failure to implement care plans or treatment or follow the required Policy and Procedures. The nursing staff were making decisions which should have had clinical input and failed on multiple occasions to communicate patient and family concerns. It was a free for all that in the end cost our son his life.

Not one of the Four Standards for Accreditation was met in our son's admission to [REDACTED] [REDACTED]. The facility had high levels of poor outcomes and low levels of compliant risk management. It did not have Policies and Procedures for Leave (granting leave, monitoring leave and responses to failure to return from leave) or Open Disclosure and yet they were accredited. The Accreditation process clearly does not meet community expectations. The Accreditation should involve a member of the Accreditation Team working in the unit for a given time frame of a week or more and which should encompass speaking with not only Nurse Unit Manager but all staff, patients and families and not just attending for one or two days to check the documentation or level of cleanliness but to observe the day to day running, levels of care and treatment and outcomes to give an accurate reflection of the management skills, staff performance and adherence to required standards and policies.

The Chief Psychiatrist is responsible for policy, procedural and performance requirements within the mental healthcare system however in our son's case he chose not to investigate the poor performance and procedural issues at [REDACTED]. His failure to act further perpetuates and reinforces poor performance and diminishes any respect or trust with the governance of the Mental Health System.

A review of the role and function of the Chief Psychiatrist into the efficiency and efficacy of policy, procedural or performance requirements as well as data collection and learnings related to those with mental illness including poor outcomes and critical incidents.

The Federal and Victorian Government needs robust and independent oversight of the mental health system with regular monitoring and reporting mechanisms to ensure the required standards and performance are being met especially with regard to patient outcomes, service provision and financial management.

At present none of the mandated authorities charged with overseeing the governance of Victoria's Mental Health System are fulfilling the roles they were established to deal with.

It is our belief that to achieve the required level of governance and accountability the Commission should consider the establishment of a single oversight committee who reports directly to the Minister for Mental Health as well as providing annual updates to the public to ensure compliance and accountability similar to the recently established Banking Code of Conduct.

Revision of the Least Restrictive Care Model and Open Door Philosophy

In our experience our son who had already attempted suicide and had been assessed by two medical staff and two psychiatric nurses at [REDACTED] Hospital as “that he was at risk of further deterioration” as well as “at risk of completed suicide” and “could not safely be nursed in the community”. However he was nursed as a Voluntary Patient (with the promise of strict observation and containment to his family) under the Least Restrictive Care Model with the Open Door Philosophy. The [REDACTED] of [REDACTED], Dr. [REDACTED] stated in reply to a question by Counsel at the Coroner’s Inquest that “the purpose of the [REDACTED] admission was to provide containment and safety”. This did not occur.

The relevant Victorian Mental Health Act 1986 (Section 4-2(a) States: “people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least intrusive manner consistent with the effective giving of that care and treatment’. He did not get any effective treatment other than contra-indicated medication that produced side effects and exacerbated his condition and the facility failed to provide safe containment.

To add to the issue the Facility did not have a ‘Leave Policy and Procedure’ only Guidelines issued by the Chief Psychiatrist which were not followed and Unescorted Leave was granted by the junior nurses (in contradiction to the Consultant Psychiatrist’s documented orders that he was only to be granted Leave if in the company of a responsible adult). Leave was written on a white board in the Nurses Station if there was anyone present. The nurses could not observe the front entrance from the Nurses Station. It was not a requirement to have written Leave Forms signed by the patient and those accompanying the patient as to where they were going with whom and the time of return as well as contact details which was a requirement in other [REDACTED] Health Hospitals.

The current Mental Health Act 2014 (Section 10(b) states: “to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity”. (Section 10(e) states: “to provide oversight and safeguards in relation to the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness”.

The Least Restrictive Care Model and Open Door Policy does not provide the required oversight and safeguards and is not consistent with the effective care and treatment where safe containment is essential. It does not provide the balance between risk management and safe and effective treatment. However, it provides the staff and management with an excuse to not effectively monitor the patient. Human rights and human dignity can co-exist with safe effective care as is seen in the public medical health system but it does not exist in the case of traumatic death.

We believe this model should be revised and new legislation introduced to protect these vulnerable people who seek care and treatment.

[https://www.abc.net.au/news/2015-11-18/\[REDACTED\]/6951452](https://www.abc.net.au/news/2015-11-18/[REDACTED]/6951452)

<https://www.abc.net.au/news/2015-12-17/mental-health-patient-sues-hospital-over-shock-therapy/7038740>

Complaints System:

In our experience there was no effective mechanism for complaints at ██████ Health. AHPRA were difficult to deal with. Our only method of complaint with AHPRA was via numerous single Case Managers who through staff, system and compliance failings could not compile or accurately assess our notifications (complaints). Each notification was looked at in isolation with no overarching consideration of the totality of the circumstances relating to any particular patient or event or inconsistencies in the evidence presented. Only when the Chief Executive Officer was made aware through extreme persistence of the incompetence of his staff and damning facts relating to the management and processing failures did he act to engage the VGSO to investigate and report on these failings, who in turn made thirteen recommendations for change.

The Nursing and Midwifery Board of Victoria and the Medical Board of Victoria consist of the professions who have largely progressed through the healthcare system as it stands. The public cannot engage with them and there is no transparency in how and why they determine their outcomes. They are protective and defensive of the professions that they represent. It took 3 years for all of the complaints to be processed and heard.

It is our belief that there is an entrenched conflict of interest for a membership/registration organisation (such as AHPRA) to also have any involvement in the assessment of regulatory adherence of its members.

The NHPOPC was quite supportive of us submitting a complaint, but the case manager who had come up through the mental health system was very condescending to us. Their only ability to investigate was through documentation provided through the facility and most of that was inaccurate or non-existent and they could not change the ruling of AHPRA or the Boards. They were moot.

All of the above were adversarial developing with a defend, protect and deflect attitude.

The complaint system should be fair, equitable and transparent and involve all of the stakeholders in face to face meetings not through closed door meetings where you cannot see or assess what has been presented.

Conclusion:

It is our sincere hope that the Royal Commission is a catalyst for targeted, effective, long term meaningful change and reform to a system which for too long has been fragmented and focused on volume over long term positive patient outcomes which has resulted in mismanagement of care and treatment in the pursuit of financial KPI's.

The system has been allowed to fester and decay under successive governments and the control of academics (the so called 'experts') with little or no governance or oversight or a fair and equitable, effective complaints system.

It should also be recognised that any failure to address poor performance within the system, at an institutional level or via the Coroner's Court, further exacerbates poor outcomes and perpetuates the emotional, economic and social cost to the effected families and the community.

The Victorian Mental Health System should be a cohesive, collaborative system which encompasses all of the stakeholders, targeted and holistic in its approach as well as being centred around safe, transparent, patient centred effective care by skilled staff with the required provision of a high level of senior clinical supervision. The pathway to long term recovery being the main goal.

With targeted holistic care, treatment and support in a familiar community setting with patient and/or carer input and with the emphasis being placed on long term recovery rather than in an expensive clinical setting with short term goals, the patient is better placed to recover.

With highly trained, committed and motivated staff who all have the same goals and values for high quality care, treatment and positive patient outcomes, working as part of a team, creates a positive culture in which people like to work and are more likely to stay. The consequence of this should be improved patient outcomes.

Accountability must be embedded through all levels of the service.

Families and carers should be acknowledged and at the forefront of care and treatment regimes and should be supported.

To limit mental illness there is a need for open discussion, family involvement, early screening, education and awareness programs as well as removing the triggers that create stigma. Whilst campaigns raising the awareness of mental illness particularly across its most common and chronic forms (particularly depression and anxiety) have been welcomed, it is important that this moves to more specific and higher order investment in treatment and care; and importantly the messages of these campaigns – that help is available if you ask – are realised with a system that actually responds and functions.

There is a need and requirement for more targeted services to rural and remote regions including enhanced online mental health services.

In general modern society place high expectations on people with limited support mechanisms which makes it hard for people to experience good mental health.

Suicide Prevention and early intervention programs should be at the forefront of the mental health system and rolled out and funded on positive and effective outcomes accordingly.

In order to prevent suicide a cohesive committed approach is required with proven effective positive programs, robust targets and objectives and the will of both the community and Governments to commit to lowering the suicide rate.

While accurate and timely collection of data is important it should be remembered that people are at the core of this system. Our son was a kind, gentle, socially conscious young man with a wide circle of friends who had not left school and had his whole life ahead of him. He suffered an acute mental health episode and unfortunately by entering the mental health system he is now regarded as a number and a statistic. A number in 100,000 of the population not the death of a loved person, and son in a failing system.

While it is evident that there are gaps in programs and services, there are many other deeply entrenched problems in the Mental Health System requiring timely innovative change and reform including service provision, management, patient outcomes, and staff culture, training and supervision. This also incorporates its governing bodies, the regulators and the Coroners Court.

With increased transparency and focus on the shortcomings within the Mental Health System the providers, management, governing bodies, regulators and the Coroners Court can no longer take the *'defend, protect and deflect'* approach and should be required to be honest, transparent and accountable for their actions.

With one in five Victorians experiencing mental health problems and the escalating suicide rate, which is described in many circles as a tragedy and an emergency, it is imperative that the taxpaying public have a system which is transparent, effective, efficient and accountable.

Attachments

[REDACTED]

[REDACTED]

[REDACTED]