Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF PETER LEONARD BURNETT

I, Peter Leonard Burnett, Associate Professor, of NorthWestern Mental Health (**NWMH**), Level 1 North, Main Block, Royal Melbourne Hospital, Parkville, in the State of Victoria, say as follows:

1 I am authorised by NWMH to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

Please outline your relevant background and experience and provide a copy of your current CV.

3 I have the following qualifications:

(a) Bachelor of Medicine and Bachelor of Surgery; and

(b) Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP).

4 I have worked in the mental health sector since 1979. I have held various clinical positions and leadership positions in both South Australia and Victoria, predominantly within the areas of adult and youth psychiatry.

5 I am currently the Director of Clinical Governance at NWMH and have been in this role since 2008. In addition to this role, I hold the following academic and government advisory positions:

(a) Clinical Associate Professor of the Department of Psychiatry at the University of Melbourne since 2007 (prior to which I held positions as a Clinical Tutor, Clinical Lecturer and Clinical Associate); and

(b) Member of the Chief Psychiatrist Morbidity and Mortality Committee (previously the Quality Assurance Committee) of the Victorian Department of Health and Human Services.

6 My formerly held positions within the mental health sector include:

(a) Acting Executive Director of NWMH from August 2011 to July 2012 and September 2012 to July 2013;

(b) Deputy Chief Psychiatrist of the Regions and Drugs Division of the Victorian Department of Health and Human Services (Mental Health) from March 2011 to July 2011; and

(c) Medical Director of Orygen Youth Health from 2001 to 2008.

7 Attached to this statement and marked **PB-1** is a copy of my Curriculum Vitae.

Please outline your current role and your responsibilities as Director of Clinical Governance at NorthWestern Mental Health.

8 I am currently employed as the Director of Clinical Governance at NWMH. In this role, I am responsible for quality, safety, medical engagement and administration for NWMH.

9 From 8 July 2019, following NWMH's restructure, my role will be more confined to the areas of quality and safety.

NWMH

10 NWMH is the mental health arm of Melbourne Health. NWMH provides publicly-funded hospital-based, community and specialist mental health services to youth, adults and aged people across northern and western Melbourne who are experiencing or are at risk of developing a serious mental illness.

Services

11 NWMH provides services across a catchment area with a population of over 1.5 million people. The catchments covered by NWMH services include four of the largest, and fastest growing corridors for metropolitan Melbourne, incorporating the cities of Moreland, Hume, Melton, Brimbank, Moonee Valley, Melbourne, Darebin and Whittlesea.

12 NWMH's services are delivered from a range of locations, including most major hospitals within the north and west of Melbourne, and various community-based mental health clinics based in Coburg, Broadmeadows, Preston, Epping, Sunshine, Melton, Mill Park, Wyndham and Moonee Ponds.

Workforce

13 NWMH has multidisciplinary teams in all areas of the service. NWMH employs 1344 equivalent full time staff and approximately 1900 people in total. The total headcount of clinical staff is 1370, primarily in the disciplines of medicine, nursing, occupational therapy, clinical psychology and social work. In addition, there is a lived experience workforce of approximately 38 staff, comprised of consumer and carer advisors, consultants and peer support workers.

Partners

14 NWMH works closely in partnership with a range of external services to ensure that the individual needs of people accessing its services are met. NWMH's partners are summarised as follows:

(a) Primary Care partners including general practitioners (**GPs**), primary health networks (specifically Eastern Melbourne and North Western Melbourne) and private psychiatrists;

(b) Community Care partners including community health services, drug and alcohol services, mental health community support services, family violence services, Aboriginal and Torres Strait Islander community controlled health services (such as VAHS and VACCA), refugee support services and community pharmacies; and

(c) Other partners including acute hospitals and health services, universities and training institutions, consumer and carer peak bodies and organisations, housing services, Victoria Police and Child Protection services.

ASSESSING THE RISK OF SUICIDE

In your experience, how common is it for individuals experiencing suicidal thoughts to give some indication of their intention – presenting opportunities for intervention?

15 In my experience, it is very common for individuals experiencing suicidal thoughts to give some indication of their intention to end their life and accordingly presenting opportunities for intervention. Suicidal thoughts are very common in the general population: 40% of people report having had troublesome suicidal thoughts at some point in their life, and 4% report having such thoughts within the past 12 months.[1]

16 There is a significant number of people who tell or at least hint to somebody that they are having suicidal thoughts. UK studies show that 47% of patients with a history of mental illness who suicided were in contact with their GP in the previous month, and 16% in the previous week, but suicidal intent was communicated in less than a fifth of the final consultations.[2] Another study reported that 43% of such patients had attended an emergency department (**ED**) prior to their suicide.[3] Similarly, a US study found that

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1 JA Chiles, KD Strosahl and LW Roberts, *Clinical manual for assessment and treatment of suicidal patients* (APA Publishing, 2nd ed, 2019) 3-4.

2 A Pearson, P Saini, D Da Cruz et al, 'Primary care contact prior to suicide in individuals with mental illness' (2009) 59(568) *British Journal of General Practice* 825-832.

3 D Da Cruz, A Pearson, P Saini et al, 'Emergency department contact prior to suicide in mental health patients' (2011) 28(6) *Emergency Medicine Journal* 467-471.

45% had contact with primary care services before suicide, but less than 20% had contact with mental health services.[4]

When is a person considered to be at risk of suicide?

17 Generally, a person is considered to be at risk of suicide when what they say, their behaviour or information obtained from other sources indicate that they are considering or have performed an act of self-harm or suicide.

What criteria or assessment tools are used by health service staff (including emergency department and mental health service triage staff)?

18 Mental health service staff are well trained in assessing the severity of a person's mental illness. In Victoria, different services have developed their own assessment tools, which are generally variations on the standard psychiatric assessment supplemented by a form of risk assessment. Other jurisdictions, such as New South Wales, have a standard assessment form which is used by all services. Within NWMH, we have a detailed assessment form used for assessments of new consumers and risk assessment forms tailored for the different settings in which they are used (that is, ED, inpatient unit, community etc). Risk assessment forms must be tailored to the specific setting because the risk issues arising in an acute ward are often very different compared to, for example, a community clinic. Attached to this statement and marked **PB-2** and **PB-3** are copies of NWMH's standard psychiatric assessment form and Clinical Risk Assessment And Management (CRAAM) form respectively.

How effective are the current criteria or assessment tools in determining whether a person is at risk of suicide?

19 There are currently no reliable assessment tools which have been found to accurately predict the risk of suicidal behaviour in the short term. The reason for this is that suicidal ideation is common, up to 4% of the general population in a year,[5] but suicide is rare, in the order of 1 in 10,000 or 0.0001%.[6] Similarly, the vast majority of people who attempt suicide do not go on to end their lives.[7] This is the statistical problem of events with low base rates. For example, consider a service which achieved 80% accuracy in predicting which persons attempting suicide would go on to end their lives. If they assessed 1000 persons attempting suicide, they would correctly identify 8 of the 10 who

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4 JB Luoma, CE Martin and JL Pearson, 'Contact with mental health and primary care providers before suicide: a review of the evidence' (2002) 159(6) *American Journal of Psychiatry* 909-916.

5 Chiles, Strosahl and Roberts, above n 1, 4.

6 SC Curtin, MA Warner and H Hedegaard, 'Increase in suicide in the United States, 1999-2014', *NCHS Data Brief No. 241*, Hyattsville, MD: National Center for Health Statistics (April 2016) <www.cdc.gov/nchs/products/databriefs/db241.htm>.

7 Chiles, Strosahl and Roberts, above n 1, 3.

would have gone on to end their lives. However, they would have also identified 192 as being the same high risk, but who would not have gone on to end their lives.

20 While there is unfortunately no magic tool to identify suicide risk, there is evidence that a good psychiatric examination undertaken by skilled clinicians with attention to risk issues performs better than most specific suicide interviews.[8] There are known risk factors, such as major psychiatric or physical illness, substance abuse, and the presence of a psychosocial crisis which overwhelms the person's coping capacities.

Controlled setting vs open setting

21 It is certainly possible to reduce the risk of suicidal behaviour in a controlled setting such as an inpatient unit, however it is difficult to prevent it totally. In the United States, 5% of suicides occur in inpatient units, and the suicide rate in gaols is also high. In the United Kingdom, the rates of inpatient suicide fell significantly from the late 1990s, possibly due to improved safety measures through attention to environmental factors such as ligature points. However, this has not extended to the post-discharge period.

22 There may be sudden changes in a person's mental state, which can limit the usefulness of any kind of assessment tool. For example, one consumer showed excellent recovery following treatment at another mental health service. Nearing discharge, the consumer went to the hospital cafeteria and was found to have attempted suicide by hanging. It was later learned that the patient was feeling so positive that he called his sister to whom he had not spoken in 10 years. After she refused to speak to him, his condition deteriorated. This type of situation outlines the difficulty in assessing the risk of suicide. Had this particular consumer not survived his suicide attempt, the service would not have known about the phone call and would have concluded that the patient's treatment plan had failed.

Predisposition of risk

23 There is good evidence of risk factors which predispose people to the risk of suicidal behaviour. For example, the presence of trait factors such as a mental illness, drug or alcohol problems, severe physical illness, previous history of suicide attempts or family history of suicide may predispose a person to the risk of suicidal behaviour.

24 People with complex mental illnesses (such as schizophrenia, affective disorder or personality disorders) have a particularly elevated risk of suicidal behaviour. When the presence of one or more of the above trait factors act in concert with intersocial personal crises (such as the loss of a significant relation or loss of a job), these combinations can further exacerbate the risk of suicidal behaviour.

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[8] M Large, 'The role of prediction in suicide prevention' (2018) 20(3) *Dialogues in Clinical Neuroscience* 197-205; Communication with RD Goldney (Peter Leonard Burnett, 2019).

25 While there are actuarial type tools which may indicate who is at a higher risk based on a sample population, these tools do not inform us whether or when that person will attempt suicide. The data available is usually a 'lifetime risk', which simply informs us that, for example, one in eight people will attempt suicide during their lifetime. In a sense, this is not terribly useful. Knowing that someone is at risk of suicidal behaviour is important, however it does not inform us as to what course to take in relation to treatment or support.

Broadly, what is the optimal approach to assessment by health service staff (including emergency department and mental health service triage staff)?

26 In 2017, NWMH conducted a half day workshop specifically focused on the assessment and management of suicidal intent. The workshop was compulsory for all NWMH staff and was introduced in response to an increasing rate of suicide during the 2017-18 Financial Year.

27 The optimal approach to assessment involves being meticulous and asking patients more detailed questions in order to obtain a clearer picture of the person's behaviour and thoughts. These questions not only provide clinicians with the necessary information in order to assess the magnitude of risk, but also allows the consumer to engage with the clinician and feel more understood.

28 The optimal approach to assessment requires consideration of nuances that may inform the outcome and whether hospital admission or community support may be more appropriate for the patient. For people with chronic high risk of suicidal behaviour, clinicians should consider whether there has been a *change* in that risk. Risk should also be weighed up in conjunction with the level of support the particular consumer has around them.

MENTAL HEALTH SYSTEM

In your experience, what are the pressures on the mental health system's ability to meet demand?

29 There are enormous pressures on the mental health system's ability to meet demand. One example arises from the three EDs in the NWMH catchment. The number of mental health presentations in these EDs has risen by 55% over the past five years compared to the state average of 10-11%. This is largely due to significant population growth.

30 Notably, Victoria was previously the national leader in mental health (according to the amount of funding spent on mental health), however it is now the lowest with the exception of the Northern Territory. Like many other Victorian mental health services, NWMH has received an effective reduction in real terms in core funding despite major

population growth. The combination of greater demand and fewer resources places enormous pressures on mental health services.

31 The mental health sector is generally less attractive to prospective employees than other parts of health. An additional consequence of the inability of the mental health system to meet demand is that work becomes stressful for health service staff, many of whom leave to work in other sectors. NWMH routinely recruits people from overseas (both nurses and doctors) due to the difficulty in filling these positions locally.

Do pressures on the mental health system impact on suicide rates? If so, in what ways?

32 It is difficult to draw a causal assumption between the pressures on the mental health system and rates of suicide. Rates of suicide fluctuate according to a whole range of social phenomena and have been increasing at a national level.

33 Theories explaining the fluctuation in rates of suicide may include the following:

(a) Rates of suicide are not directly related to factors such as times of great social stress. The theory is that people are more likely to commit the individual act of suicide when they feel that their own unhappiness is disproportionate to the unhappiness of others. Traditionally, rates of suicide actually decline during times of war or during the Great Depression, as a person's own unhappiness may feel 'less immediate' during these times.

(b) Suicidal behaviour may be triggered by a sense of loss of cohesion, feeling a loss of support or feeling alienated from the people around them.

34 However, as discussed previously, many people who have ended their lives have attended an ED, GP or mental health service. Ensuring that these services have the capacity to respond to these consumers in a timely and effective manner is likely to improve outcomes.

In your experience, in relation to people who present at the emergency department or mental health triage services stating they are at risk of suicide, what are the criteria or considerations for admission to an inpatient bed?

35 The decision as to who is admitted to an inpatient bed is a clinical decision. Criteria or considerations for admission to an inpatient bed are essentially based on parameters such as the degree of risk, the quality of a person's support in the community, the presence of active mental illness and the person's wishes (noting, however, that the person's wishes may not override the other three parameters). Inpatient admission is often useful in containing a suicidal crisis, but there is no evidence that it is an effective treatment of suicidal behaviour in the longer term.

36 This means that it is often more effective to support those who are assessed as having chronic risk in the community rather than admitting them to hospital, other than for brief containment of crises. Hospitalisation can also have adverse effects on a person's sense of autonomy and hopefulness.

In what ways are finite resources or demand pressures taken into consideration in making the decision to admit a patient? How are those factors balanced against clinical need? What are the criteria or considerations for admission to an inpatient bed?

37 The decision to admit is always based on clinical need, and is not dependent on bed availability. Rather, if a bed is needed, one will be found in one of our units. A twice-daily bed conference call triages the urgency of those waiting. If necessary, planned discharges may be brought forward if this is safe and possible. If no bed can be obtained within NWMH, a bed is requested from other services.

Where people present to emergency departments or mental health triage services as being at risk of suicide and, from a clinical perspective, require admission to hospital, how often would a bed be unavailable either in that hospital or throughout the system more broadly?

38 A bed may not be available at that hospital, but will usually be found in another NWMH unit. Failing that, a bed will be requested at another health service. Usually, it is possible to find a bed somewhere, although this often requires considerable effort and may entail delay which is less than desirable. Ultimately, if a person's clinical presentation indicates that they are at such a high risk of suicide that they require admission to hospital, and no bed is available, that person would be kept in the ED or short-stay unit until a bed is found.

Are there enough beds to service demand for acute need? If not, why not?

39 There are insufficient acute beds in Victoria, and particularly within NWMH's catchment areas. The MidWest Area Mental Health Service has only 1.1 beds per 10,000 population, and in our view, a ratio of 3 beds per 10,000 population is necessary for effective and timely service to consumers. The bed numbers are low partly due to a service model which prioritises care in the community, partly due to the rapid growth in population and also due to demand coupled with a reduction of funding in real terms.

If there is unmet need, what are the key drivers of unmet need?

40 The key drivers of unmet need are population growth, insufficient resources and a steady increase in substance abuse in the community.

What treatment is available for people who are in "crisis" but who do not meet the criteria for admission? In your experience, to what extent is immediate support available?

41 Treatment is available through the crisis services of community mental health. In NWMH, these services are integrated with the community continuing care teams, while in some other services they stand alone as Crisis Assessment and Treatment Teams.

What are the barriers to people who are at risk of suicide receiving appropriate treatment, from a systems perspective?

Lack of inpatient beds

42 At a systemic level, inpatient units are not attractive places for treatment and are not as therapeutic as they once were. Due to very high demand and limited funding, inpatient units have a complex mix of consumers which may not always present an optimal context for treatment of particular consumers. In addition, the available facilities and infrastructure have aged and investment would be required to make them more welcoming, which is likely to be more conducive to therapeutic outcomes. Finally, due to the lack of beds available, people typically have to be quite unwell before being admitted to an inpatient unit.

43 NWMH operates a total of 502 beds, 203 of which are acute mental health beds. This provides NWMH with 1.41 adult beds per 10,000 adult population. It is generally accepted that to be able to efficiently manage unexpected peaks and troughs in demand and acuity, an occupancy rate of 85% of hospital beds is best practice. For the last five financial years, NWMH acute beds have been operating above the 95% capacity.

Lack of community support

44 Another barrier to people who are at risk of suicide receiving appropriate treatment is the lack of support within both the community and the mental health system. The capacity to provide adequate community support is diminished as funds are diverted towards inpatient services and beds.

In relation to the obligation under section 348 of the Mental Health Act 2014 (Vic), are suicides by people who presented to an emergency department located in the catchment area serviced by North West Area Mental Health or NWMH triage services but who were not admitted as an inpatient, reported to the Chief Psychiatrist? If so, in what circumstances?

45 The obligation under section 348 of the *Mental Health Act 2014* (Vic) arises when a person contacts NWMH. This refers not only to presentations to NWMH, but any

contact with the service whether on the phone or in person. If a person contacts the service and later dies in suspicious circumstances, this falls within the reportable deaths obligation.

46 NWMH may not always be aware that a person who previously contacted the service has died. There may be situations where we are notified of a death by a family member of the person, the police, the Coroner or through a published death notice. Other times, we may find out by chance or may never become aware of a death (such as where the person has moved interstate).

MORTALITY BENCHMARKING GROUP

What is the Mortality Benchmarking Group and what is its purpose? Why was the group established? Who are the members of the group? What does the group do?

47 The Mortality Benchmarking Group (**MBG**) was set up in 2007 to examine reportable deaths occurring across the eight health services (including three regional services and five services in Melbourne) who are members of the MBG. The MBG does not geographically cover the entire State of Victoria.

Purpose

48 The purpose of the MBG is to allow each health service to benchmark their data on reportable deaths against the other health services and the MBG as a whole. Each of the eight health services collects data according to agreed definitions and forwards this data to NWMH for analysis and reporting.

Interpretation of data

49 Each health service may use the data as it sees fit and is able to refer to the benchmark partners anonymously. This data permits the health service to make comparisons and explore, for example, whether a high number of unexpected deaths maintained over several years is unique to that health service or common across Victoria.

50 The MBG previously held meetings on a quarterly basis however now meets on an annual basis to review the results for the particular year. A de-identified running sheet is analysed at the MBG meetings, which compares data in relation to deaths of people aged 18 to 65 years within each area mental health service. The MBG does not consider smaller age group brackets as not all health services divide their services based on age or do so in the same way. The data considered includes the total number of reportable deaths, the number of reportable deaths due to suicide, the number of inpatient deaths, as well as the gender of the person who has died, the means of death and the number of days since the last face-to face contact with the health service.

51 Where a health service records a disproportionate number of deaths in a particular year, which decreases the following year, this may be within the bounds of natural variation. This is especially the case where there is a low base number. In addition, it is not always clear whether a reportable death can be classified as a suicide. If, for example, the cause of the death was an overdose of heroin, it is difficult to conclude whether there was a suicide or whether the person was a habitual heroin user but did not intend to end their life. In such cases, accurate comparisons cannot be made without considering the Coroner's report, which may not be available for several years. While uncertainties exist in categorising reportable deaths, the impact of these uncertainties reduces as the base number increases, allowing reasonable comparisons to be made using the data collected by the MBG.

52 The MBG has also been useful for ensuring that each participating health service is recording and analysing the data in a consistent way. In the early stages, some variations in results across health services were found to be due to differences in recording and analysing the data. The Chief Psychiatrist and the Department more generally have recognised the value of the MBG in contributing to the comparability of data.

53 The principal findings have been that no health service is an outlier in terms of the number of reportable deaths, and that there is often considerable variation in the annual number of deaths in any particular health service.

Expansion of the MBG

54 Preliminary discussions have indicated that the Chief Psychiatrist may be interested in taking over the MBG and requiring other services to participate in the MBG or, alternatively, setting up their own version of the MBG. In addition, two interstate services have asked to join the MBG.

55 The Chief Psychiatrist has also liaised with the Coroner's office to explore the possibility of merging data from the MBG with data from the Coroner's office. The MBG had previously sought to merge this data and analyse the rates of deaths and suicides within particular catchment areas, however this was not possible due to the stringent privacy and confidentiality obligations surrounding the Coroners' files.

Does the Mortality Benchmarking Group have targets? If so, what are they?

56 The MBG does not have targets, rather it provides individual services with comparative data to help them assess their own outcomes.

REFORM

What do you think are the most significant challenges facing the mental health system in meeting the needs of people at risk of suicide?

57 The main challenges are the high levels of demand in EDs, the lack of appropriate interview places and the need for a greater range of treatment options.

What changes do you think would bring about lasting improvements to help people at risk of suicide in relation to:

- ***access treatment and services; and***
- ***getting help to people earlier?***

58 There are various changes that may be implemented to bring about lasting improvements to help people at risk of suicide. Potential changes may include:

(a) Improving the accessibility of primary care – For example, permitting longer consultations with GPs, implementing better pathways from primary to specialist care and re-establishing mental health nurses in general practice;

(b) Setting up EDs in a way which accommodates the needs of mental health patients – Modern EDs can be quite noisy, busy and lack the sense of privacy appropriate for psychiatric consultations with mental health patients;

(c) Consideration of a dedicated section of the ED for consultations with mental health patients; and

(d) Expanding the range of treatment options for mental health patients – There are currently options for standard hospital admissions or referrals to community care teams, however there is no appropriate treatment option for the portion of patients who do not require hospital admission but require intensive support. These patients may benefit from a more integrated treatment option (such as a hospital outpatient service where the consumer is seen in an ED on a Saturday and then attends a follow up appointment on the Monday). Ideally the outpatient service would be structured to maximise continuity of care, so that the consumer would generally see the same clinician.

sign here ▶ 

print name Peter Leonard Burnett

date 11 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PB-1

This is the attachment marked 'PB-1' referred to in the witness statement of Peter Leonard Burnett dated 11 July 2019.

PETER L. BURNETT

CURRICULUM VITAE

September 2017

CURRICULUM VITAE

September 2017

PERSONAL DETAILS

Name: Peter Leonard Burnett.

Work Address: NorthWestern Mental Health
Level 1 North, Main Block
Royal Melbourne Hospital,
Parkville, Victoria 3050

QUALIFICATIONS

1978	Bachelor of Medicine, Bachelor of Surgery, University of Adelaide.
1984	Member of the Royal Australian and New Zealand College of Psychiatrists. (MRANZCP)
1986	Fellow of the Royal Australian and New Zealand College of Psychiatrists. (FRANZCP)

PRIZES

1983	David Maddison Medallion, RANZCP

CURRENT POSITION

Director of Clinical Governance, NorthWestern Mental Health, Melbourne Health

POSITIONS HELD

Aug. 2011-July2012	Acting Executive Director, NorthWestern Mental Health
Sep 2012-July 2013	Acting Executive Director, NorthWestern Mental Health
March-July 2011	Deputy Chief Psychiatrist, Victorian Dept. of Health, Mental health, Regions and Drugs Division (0.5 FTE secondment position)
2008-present	Director of Clinical Governance. NorthWestern Mental Health
2001-8	Medical Director, Orygen Youth Health
1996-2001	Senior Psychiatrist, EPPIC/MH-SKY,(now Orygen Youth Health)
1993- Dec 1995	Chair, S.A. Psychiatry Training Committee and Senior Visiting Psychiatrist, S.A. Mental Health Service.

1992-Nov. 1993	Acting Director, Northern Area Team, Hillcrest Hospital.
1989-1991	Director of Training, Chairman, Senior Medical Staff, Senior Psychiatrist, Hillcrest Hospital.
1986-1989	Psychiatrist/Senior Psychiatrist, Hillcrest Hospital.
1984-1986	Psychiatrist, Carramar Clinic, South Australia.
1978-1984	Intern, Psychiatry Registrar, Royal Adelaide Hospital.

ACADEMIC POSITIONS

2007-present	Clinical Associate Professor, Dept. of Psychiatry, University of Melbourne
1996-2007	Clinical Associate, Department of Psychiatry, University of Melbourne.
1984-Dec 1995	Clinical Lecturer, Department of Psychiatry, University of Adelaide.
1983-1984	Clinical Tutor, Department of Psychiatry, University of Adelaide.

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS POSITIONS

2004-2008	Chair, Committee for Exemptions (renamed Committee for Specialist International Medical Graduate Education in 2007)
2003-2008	Member, Fellowships Board. (reconstituted as Board of Education in 2007)
2000-2004	Member, Fellowships Board Exemptions Sub-committee
1997-2001	Member, Victorian Psychiatric Training Committee
1996-1997	Secretary, Victorian Psychiatric Training Committee
1994-1999	Secretary, RANZCP. Committee for Training Member, Fellowships Board.
1990-Dec 1995	Member, (ex-officio) S.A. Branch Committee
1990-Oct 1994	Member, RANZCP Committee for Training.

GOVERNMENT ADVISORY POSITIONS

2011-2013	National Mental Health Service Planning Framework(COAG) member, Modelling Group, Deputy Chair, Inpatient and Hospital-based Services Working Group
2009	Member, Technical Expert Reference Group, Suicide Guidelines Project, Dept. of Health, Victoria
2008-pesent	Member, Quality Assurance Committee, now renamed Chief Psychiatrist Morbidity and Mortality Committee, Dept of Health, Victoria
1998	Member, Australian Medical Workforce Advisory Committee Psychiatry Working Party
1997-2000	RANZCP representative on Medical Training Review Panel (Commonwealth Govt.)

REVIEWS FOR EXTERNAL ORGANISATIONS

2017	Member, SA Mental Health Inpatient Review Team
2015-16	Co-Chair, QLD. Sentinel Event Review Committee
2013-current	AHPRA Performance Assessments
2010-11	Service Reviews for Chief Psychiatrist of Victoria
2008	Sentinel Event Review, Gold Coast Mental Health Service, QLD.

The course of schizophrenia, the role of family factors in its outcome and the efficacy of low-dose antipsychotic medications

PUBLICATIONS

12 journal articles and 7 invited papers or chapters

Royal Commission into Victoria's Mental Health System

ATTACHMENT PB-2

This is the attachment marked 'PB-2' referred to in the witness statement of Peter Leonard Burnett dated 11 July 2019.

NWMH288

NorthWestern Mental Health

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

ASSESSMENT DETAILS

Preferred name / Alias		Language *(if interpreter required)*	
Date of Assessment		Time of Assessment	
Assessing AMHS		Assessing Unit / Team	
Referred by		Referrer's relationship to the person	
MHA Status		Other legal status *(e.g.- NCSO, IVO, Admin Order)*	
Current Advance Statement (Yes/No)		Nominated Person	
GP Details		Carer Details	

REASON FOR REFERRAL

Presenting difficulties and strengths

CURRENT SITUATION

Living situation (ADLs/Functional status), Family/significant relationships, Community engagement, Support services, Guardianship, Family & domestic violence issues, Financial situation incl. current application for public housing, Pets

ASSESSMENT

4926

January 2017
Version 3.0.
iPolicy print on demand NWMH.04926Fb

NorthWestern Mental Health

NWMH288

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

Details of dependents including current family related/ protective orders or other orders affecting care of dependents

HISTORY

Mental Health, Medical, Forensic, Alcohol & Other Drugs, Personal, Trauma, Family & Cultural, LGBTI, Eating disorders, Education, Employment

Collateral Information

TREATMENT

Current Medication

Name (use generic)	Dose	Frequency	Route	Prescribed by (or over counter)	Comments (including Clozapine number)

NWMH288

NorthWestern Mental Health

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

Current Psychosocial Interventions/Therapies

Known adverse drug reactions or allergies

IMPORTANT: Any known adverse drug reactions or allergies must be recorded on the relevant hospital alerts form according to local hospital policy and procedure

PHYSICAL HEALTH SUMMARY (General Physical State)

PHYSICAL EXAMINATION

(Complete if med/nursing staff member is undertaking assessment. Otherwise complete at 1st med review & document in progress notes)

Vital Signs, Weight & Height

Other Physical Examination Findings (medical staff)

ASSESSMENT

4926

January 2017
Version 3.0.
iPolicy print on demand NWMH.04926Fb

NorthWestern Mental Health

NWMH288

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

MENTAL STATE EXAMINATION

Include: Appearance & general behaviour, speech, affect & mood, disorders of perception, stream, form & content of thought, cognitive function, judgement, insight

NorthWestern Mental Health

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

FORMULATION (Including Risk Factors)

PROVISIONAL DIAGNOSES

		ICD-10
Provisional diagnosis		
Dual Diagnosis/ Psychosocial / contextual factors		

SHORT TERM PLAN (Including Risk Management)

Include: Compulsory treatment, Person's identified needs, Family / Carer's identified needs, Assessor's perspective, Initial recovery & Risk management plan, Recommended specialist/targeted assessments and/or investigations

RIGHTS OF THE PERSON

Rights and responsibilities
Have rights and responsibilities been discussed with the person? If yes, how have they confirmed an understanding of their rights and responsibilities?

OTHER PEOPLE & SERVICES INVOLVED IN THIS ASSESSMENT

Name	Relationship/Service *(eg- GP, Carer, other AMHS etc…)*	How has this person been involved in the assessment? *(please indicate if those providing collateral/additional information have stated they would like to remain anonymous)*

NWMH288

NorthWestern Mental Health

Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS					
LOCAL UR		MH UR			
NAME					
ADDRESS					
PHONE		DOB		SEX	

MANDATORY SCREENING (inpatient & community)

ALCOHOL & OTHER DRUG SCREEN

PRE-SCREENING QUESTION	Yes/No
Does this person have an alcohol and/or other drug issue?	
Does this person smoke?	

If YES has been responded to either question above, please complete the *Substance Use Brief Assessment*

MANDATORY ASSESSMENTS

✓ done	Form/ Documentation The following forms must also be completed	Inpatient	Community/ Residential	EMH/ PACER
	Clinical Risk Assessment & Management (CRAAM, CRAaP, Aged Inpatient Risk Assessment)	•	•	•
	Outcome measures (HoNOSCA/ HoNOS/ HoNOS+65)	•	•	

MANDATORY SCREENING (inpatient only)

NUTRITION RISK SCREEN	Yes/No
Does the consumer have newly diagnosed or unstable diabetes?	
Has the consumer had limited or no nutrition for >5 days and have a recent history of alcohol or drug abuse?	
Has the consumer recently lost weight in the last 3 months without trying?	
Is the BMI < 20 kg/m^2 ?	

If 'yes' to any of above, consumer is considered 'high' nutrition risk. Complete the *NWMH Nutrition Risk Assessment*

FALLS RISK SCREEN	Yes/No
History of falling in the past 6 months	
Sensory impairment (sight impaired / hearing impaired etc…)	
Ambulation / transfer with assistance required	

If 'yes' to any of above, consumer is considered 'high' falls risk. Complete the *NWMH Falls Risk Assessment*

SKIN INTEGRITY SCREEN	Yes/No
Have you any issues of skin integrity (pressure ulcers, wounds)?	
Have you any issues with mobility that could result in shearing or friction?	

If 'yes' to any of above, consumer is considered a skin integrity risk. Complete the *NWMH Pressure Injury Prevention & Assessment (PIPA).*

Assessment completed by

Clinician Name *(print)*	Designation	Signature	Date	Time

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PB-3

This is the attachment marked 'PB-3' referred to in the witness statement of Peter Leonard Burnett dated 11 July 2019.

NWMH264

NorthWestern Mental Health

Adult & Youth Inpatient Clinical Risk Assessment And Management (CRAAM)

Initial Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS MEH.0017.0001.0014

LOCAL UR	MH UR
NAME	
ADDRESS	
TELEPHONE	DOB / SEX M/F

Name of Inpatient Unit

Initial Assessment

SUICIDE				AGGRESSION				GENERAL VULNERABILITY			
Suicide Static (Background)	Y	N	U	**Aggression Static**	Y	N	U	**General Vulnerability Static**	Y	N	U
Previous Attempts				Previous incidents of violence				Intellectual disability			
Family history of suicide				Previous use of weapons				Previous diagnosis of mental illness			
Major psychiatric diagnosis				Male				History of absconding			
Serious Medical condition				Criminal history				History of sexual vulnerability			
Separated/widowed/divorced				Previous dangerous/violent ideation				History of predatory behaviour			
Loss of job/retired/role loss				Childhood abuse/maladjustment				Medical History			
Recorded Alerts				Role instability				**General Vulnerability Dynamic**	Y	N	U
Suicide Dynamic (current)	Y	N	U	History of drug/alcohol use				Cognitive deficit			
Expressing suicidal ideas				**Aggression Dynamic**	Y	N	U	Self-neglect eating/drinking/self-care			
Has plan/intent				Expressing intent to harm others				Non-compliant with medications			
Expressing high levels of distress				Access to available means				Current delusional beliefs			
Hopelessness inability to cope				Paranoid ideation about others				Intrusive behaviour			
Substance abuse				Command hallucinations				Physical Risk Screening Completed			
Recent significant life events				Anger, frustration or agitation				Poor orientation/memory			
Perceived lack of resources to deal with current difficulties				Recent/current violence				Falls			
								Nutrition			
				Substance use				Disorganisation			
				Reduced ability to control behaviour				Pre-occupation with being in hospital			
SELF HARM								Absconding risk			
Self Harm Static	Y	N	U	**Self Harm Dynamic**	Y	N	U	Agitation			
History of self harm				Actual or thoughts of self harm				Disinhibition			

Overall level of risk and engagement ☐ Medium ☐ High

Action Plan from initial assessment and rationale for management

Please consider protective factors, collateral and corroborating information *(factors that reduce the likelihood of a negative outcome, eg. supports, familial factors; information from other sources i.e family, Police or significant others)*

Admitting Doctor (print)	Designation	Signature	Date	Time
Admitting Nurse (print)	**Designation**	**Signature**	**Date**	**Time**

Consultant Revised Risk

Date of review		Time		Bed location	☐ LDU ☐ ICA

Description	L	M	H	Description	L	M	H
Suicidality				Inappropriate Sexual Behaviour			
Self Harm				Medical Condition			
Substance Use				Level of Non-compliance			
Aggression				Disorganised			
Cognitive Impairment				Absconding			
Falls				Agitation			
Nutrition							
Other:							

Action Plan from assessment and rational for management *(Include conditions for all leave, protective factors & collateral)*

Assessed level of risk and engagement ☐ Low ☐ Medium ☐ High

Leave Arrangements ☐ Nil ☐ Escorted ☐ Unescorted

Consultant Psychiatrist (print)	Signature	Date	Time

CRAAM Initial Assessment

4922

August 2016
Version 2.6
FMIS 41704. iPolicy print on demand NWMH.04922F

NWMH264

NorthWestern Mental Health

Adult & Youth Inpatient Clinical Risk Assessment And Management (CRAAM)

Initial Assessment

ATTACH LABEL OR RECORD PATIENT DETAILS		
LOCAL UR	MH UR	
NAME		
ADDRESS		
TELEPHONE	DOB	SEX M/F

Clinical Risk Assessment And Management (CRAAM) Instructions for Use

North Western Mental Health (NWMH) believes that risk assessments and management plans are an integral part of the care provided in an acute inpatient unit and are best done collaboratively with the consumer, family/ carer/ nominated person / advocate, and the treating team. Risk assessments are recorded on the NWMH Inpatient Unit Clinical Risk Assessment Form by any member of the treating team.

Risk assessments are completed to allow a decision to be made about the level of risk management that the consumer requires. There are three levels of risk with corresponding risk management strategies:

- Low
- Medium
- High

The initial risk assessment should be comprehensive and include static and dynamic risk factors/history of risk AND be informed by relevant collateral and corroborative information. Collateral & corroborative information should be sought from family/ carers/ nominated person or advocates. Where this type of information is not available the level of assessment confidence needs to be considered.

PROCEDURE:

Initial Risk Assessment

- The admitting medical officer and/or nursing staff will complete an initial risk assessment with the consumer at the time of admission or on arrival to the inpatient unit. If the medical officer is not available the admitting nurse will review all relevant pre admission information (including risk assessments completed by the referrer) and discuss with the ANUM.
- The consumer should be involved in the Clinical Risk Assessment, and the process explained during the admission procedure and throughout their stay in hospital.
- No leave will be given until the consumer has had a review with a consultant psychiatrist.
- All consumers are managed on medium or high risk until reviewed by a consultant psychiatrist. In the first 24 hours the Risk Level can only be reduced by a consultant psychiatrist or after adequate collateral history is obtained.

Action prompts for the various risk screening components include but are not exclusive to the following:
Suicide – explore thoughts and feelings, review suicide plan, emotional distress and resources, contract safe plan, check environment and consider level of risk.
Self-harm – explore thoughts and feelings, contract safe plan, assess environment and engagement levels.
Aggression – develop safety plan, check the environment, assess safety of staff, consumers and visitors, review engagement level required, i.e. is specialling or restraint indicated, review mental state and medication, consider duty of care to others at risk.
General vulnerability – mental status assessment, MMSE, medication review, carer stress, environmental review and bio-psychosocial assessment.
Assessment Confidence – refers to the level of confidence a clinician has in the information obtained at the point of assessment. Factors which may influence this level of confidence include but are not limited to the following:

- Drug & alcohol abuse or present intoxication
- Inability to engage or collaboration in care planning
- Isolation
- Impending court case
- Incomplete assessment or inability to obtain collateral information
- The level of the consumers changeability
- Non psychotic distress

Revised Risk Assessment

To be carried out:

- At the 24-hour consultant psychiatrist review.
- Daily review in the Intensive Care Area (ICA)
- At clinical ward round.
- At any time risk factors are perceived to have changed.
- Whenever an absconded patient returns to the unit.
- Whenever a patient is transferred to the ward, at the time of arrival.
- On transfer to the ICA or LDU
- Any change to leave conditions
- Pre Discharge

Documentation

All risk assessments must be accompanied by a clinical note within the clinical file, addressing the rationale for the risk level set and any changes. Special instructions for individual clients may be stipulated in the appropriate section of the Clinical Risk Assessment Form.

Safety Plan

A safety plan is required for all patients.

Leave

Nil – No Leave. Escorted leave should note type of escort required. Unescorted leave and should specify time and frequency.

Management of Risk

Refer to iPolicy *NWMH19.01.03G Adult & Youth Inpatient Clinical Risk Assessment and Management (CRAAM) - Guideline* and *NWMH02.07.03G Intensive Care Area - Guideline*