Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR NEIL COVENTRY

I, Dr Neil Coventry, Chief Psychiatrist of the Office of the Chief Psychiatrist, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne, say as follows:

Professional background

1 I am the Victorian Chief Psychiatrist appointed under the *Mental Health Act 2014* (Vic) (**the MHA**). I have held this position since September 2016. Prior to my appointment, I acted in this role from September 2015 to August 2016, and was the Deputy Chief Psychiatrist for Children and Youth from December 2011 to August 2016.

2 I have held a variety of roles in public and private clinical settings. I have over 40 years of practice in public psychiatry, including almost 22 years as the Clinical Director of the Child and Adolescent Mental Health Services at Austin Health, as well as periods as Acting Medical Director, Mental Health Division at Austin Health. I also worked part-time in private practice from 1987 to 1994 at the Pathway Centre (the forerunner of Albert Road Centre for Health), a private psychiatric facility, including periods as Acting Medical Director.

3 I have also held positions as Honorary Senior Lecturer with La Trobe University, University of Melbourne and Monash University where I lectured in undergraduate and postgraduate courses in medicine, psychiatry, psychology and related fields and training positions from 1993 to 2014. I was statewide Director of Postgraduate Training in Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (RANZCP) from 2006 to 2008; Director of the Mindful Centre for Training and Research in Developmental Psychiatry, which provides postgraduate training for psychiatrists and allied disciplines, in 1996, 2004 and from 2006 to 2008; and was a Victorian Committee member of the RANZCP Faculty of Child and Adolescent Psychiatry from 1990 to 2005.

4 I hold a Bachelor of Medicine and Bachelor of Surgery from the University of Melbourne (MBBS 1977), and I am a consultant psychiatrist and Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP, 1985). I hold a Certificate of Advanced Training in Child and Adolescent Psychiatry (RANZCP, 1985) and in 1986 was a foundational member of the Faculty of Child and Adolescent Psychiatry, RANZCP. I have also completed training as a family therapist (Williams Road Family Therapy Centre, 1990).

5 I was a board director of Berry Street Victoria, a not-for-profit organisation providing out-of-home care for vulnerable children and youth, from 2003 to 2010, and since 2014 have been a

member of the board subcommittee on safety and quality for Berry Street Victoria. From 2003 to 2014 I was also a member of the Take Two consortium, a trauma service for children in out-of-home care who are child protection clients, auspiced by Berry Street Victoria and funded by the Department of Health and Human Services.

6 This statement is my second to the Royal Commission into Victoria's Mental Health System. Throughout this document, I refer to my statement of 28 June 2019 (statement identifier WIT.0003.0004.0001) as my 'previous statement to the Royal Commission'.

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

8 All opinions expressed in this statement are my own. My opinions are informed by my own clinical experience, my observations from site visits to services, and the regular contact I have as part of my role as Chief Psychiatrist with leaders in my field in Victoria, and also Chief Psychiatrists in other Australian states and territories.

9 This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my own knowledge, and documents and records of the Office of the Chief Psychiatrist (Victoria) (the OCP) which I have reviewed. I have also used and relied upon data and information produced or provided to me by officers within the OCP.

10 This statement has been prepared with the assistance of lawyers and the OCP.

Note on terminology

11 In this statement I refer to people who receive treatment in the specialist mental health system as 'consumers', with the exception of 'forensic and security patients', which are terms that have a defined meaning in the MHA. I also use the term 'people living with mental illness' depending on the context of comment. I acknowledge that many people identify with and prefer a number of different terms that for reasons of consistency I have not used in this statement.

Opening comments

12 The COVID-19 pandemic, along with the Victorian bushfires, have been defining features of 2020 to this point. A mental health response has been central to both events, and social distancing requirements associated with COVID-19 have precipitated changes in service delivery which may result in longer term impacts on the way mental health treatment is delivered.

13 Throughout this statement, I highlight:

(a) factors critical to the performance of my role, which are not replicated elsewhere, and which will be crucial to future work to strengthen the quality and safety of Victorian mental health services

(b) the variety and multitude of quality and safety issues dealt with by the OCP, which require me and my office to balance immediate clinical responses with a longer-term strategic perspective

(c) safety risks impacting on consumers, carers and families and the mental health workforce, and recent work addressing specific risks

(d) the importance of service environment and setting, and acknowledgement that the needs of some cohorts are not met by existing options

(e) how critical it is to provide safe and appropriate care for children and young people, with age separation the accepted standard internationally

(f) that consumers and their rights must be central to any decision making within the compulsory treatment framework, and that treatment must be provided in the least restrictive manner possible

(g) that compulsory treatment is an essential element of the mental health system, yet should never be provided in custodial settings as this gives rise to concerns about the potential for human rights violations

(h) my aim to eliminate restrictive interventions, which are never therapeutic, through a long-term program of work building on extensive efforts over a number of years

(i) challenges for the current secure extended care model to meet the needs of consumers with very complex treatment and support needs

(j) the challenges in responding to consumers with complex needs, and work that is underway to enhance support and improve outcomes for this cohort

(k) the lack of appropriate and supported accommodation, which restricts 'step down' and discharge options.

14 The engagement of consumers and carers is fundamental to any mental health policy and practice change. Working collaboratively and in partnership with consumers and carers is

critical to the work carried out by the OCP and the broader Mental Health and Drugs Branch in the Department of Health and Human Services.

15 Consumers and carers are central to identifying safety, quality and human rights issues in mental health services, as well as possible solutions. In preparing this statement, I have had the benefit of input and advice from lived experience advisers within the OCP.

16 To give full and meaningful consideration to each of the issues canvassed in the witness questions posed by the Royal Commission into Victoria's Mental Health System, it is imperative that the lived experience perspective be sought, that engagement be supported, and that consumers' and carers' voices are heard.

The role of the Chief Psychiatrist in ensuring high quality and safe mental health services

Question 1: What is the role of the Chief Psychiatrist in ensuring high quality and safe mental health services?

17 As Chief Psychiatrist, my role is to:

(a) provide clinical leadership and expert clinical advice to mental health service providers in Victoria

(b) promote continuous improvement in the quality and safety of mental health services provided by mental health service providers

(c) promote the rights of persons receiving mental health services from mental health service providers

(d) provide advice to the Minister for Mental Health and the Secretary of the Department of Health and Human Services about the provision of mental health services by mental health service providers.[1]

18 The role of the Chief Psychiatrist is primarily to intervene at a system-level through promotion of clinical practice improvement. The OCP operates as a resource to drive continuous improvement and embed the principles in the MHA.

[1] Mental Health Act 2014, s. 120.

19 My statutory functions enable me to provide leadership to the sector and intervene when quality and safety issues arise. These functions are:

(a) to develop standards, guidelines and practice directions for providing mental health services and publish or otherwise make available those standards, guidelines and practice directions

(b) to assist mental health service providers to comply with the standards, guidelines and practice directions developed by the Chief Psychiatrist

(c) to develop and provide information, training and education to promote improved quality and safety in the provision of mental health services

(d) to monitor the provision of mental health services in order to improve the quality and safety of mental health services

(e) to assist mental health service providers to comply with the MHA, regulations made under the MHA and any codes of practice

(f) to conduct clinical practice audits and clinical reviews of mental health service providers

(g) to analyse data, undertake research and publish information about the provision of mental health services and treatment

(h) to publish an annual report

(i) to conduct investigations in relation to the provision of mental health services by mental health service providers

(j) to give directions to mental health service providers in respect of the provision of mental health services

(k) to promote cooperation and coordination between mental health service providers and providers of other health, disability and community support services.[2]

20 I discuss my roles in relation to regulation, monitoring and supporting quality and safety in greater detail at paragraphs 101 to 113 below.

[2] Mental Health Act 2014, s. 121.

21 As part of my role as Chief Psychiatrist, I am the Victorian member of the National Safety and Quality Partnerships Standing Committee, which is a subcommittee of the national Mental Health Principal Committee, with a particular focus on eliminating restrictive interventions. The role of the Mental Health Principal Committee is to develop and implement a shared National Mental Health and Suicide Plan, and to advise the Australian Health Ministers' Advisory Council on mental health and drug service issues of national significance.[3]

Changes to the role following introduction of the Mental Health Act 2014

Question 1(a): How has this role changed since the Mental Health Act 2014 came into force?

22 The role of the Chief Psychiatrist was originally established in the *Mental Health Act 1986* (the 1986 Act). Under the 1986 Act, the Chief Psychiatrist was directly accountable for the 'medical care and welfare' of persons receiving treatment or care for a mental illness and for overseeing and monitoring standards of mental health services.[4]

23 The introduction of the MHA significantly changed the Chief Psychiatrist's role, with Victoria leading the nation in having an expert clinician with broad powers to lead best clinical practice and promote continuous improvement and human rights.

24 The purpose, powers and functions of the Chief Psychiatrist were refocussed, with the role shifting from responding to individual client complaints and service issues to a strategic, system-wide role with responsibilities for clinical leadership and system-wide quality assurance and improvement. Responsibility for managing individual client and service complaint issues became the purview of a new role - the Mental Health Complaints Commissioner.

25 Under the 1986 Act, the Chief Psychiatrist had powers relating to public and private hospitals admitting or caring for persons with a mental disorder. Under the MHA, the Chief Psychiatrist does not have jurisdiction over private mental health services.

26 The Chief Psychiatrist's responsibilities under the MHA focus on public mental health service providers. They are publicly funded designated mental health services that auspice or provide clinical mental health services, including compulsory assessment and treatment and publicly funded mental health community support services (MHCSS).[5] The nature of my statutory powers and functions means that most of the activities of the OCP relate to the clinical services

[3] COAG Health Council, 'Principal Committees' <https:www.coaghealthcouncil.gov.au/ahmac/principal-committees> [accessed 28 June 2020]/
[4] Mental Health Act 1986, s. 105.
[5] Mental Health Act 2014, s. 3.

provided by designated mental health services. The Chief Psychiatrist's responsibilities under the MHA include a power, on application, to review the treatment of a consumer where the authorised psychiatrist of a mental health service provider does not adopt the changes recommended in a second psychiatric opinion report.[6]

27 As a result of the introduction of the National Disability and Insurance Scheme (NDIS), the MHA has been amended to clarify that the Chief Psychiatrist's jurisdiction does not extend to mental health services funded by the NDIS.[7] Oversight of these services is provided by the NDIS Quality and Safeguards Commission.

Factors critical to fulfilling my role as Chief Psychiatrist

Question 1(b): What factors have been critical to fulfilling your role as Chief Psychiatrist?

28 During my tenure as Chief Psychiatrist, the following factors have been critical to fulfilling my role.

Centrality of lived experience of consumers and carers

29 Strong engagement of people with lived experience is critical to fulfilling my role and ensures that the consumer and carer voice is central to all of our work. My office models the systemic way in which we expect services to work with consumers and carers. This approach is articulated through guidelines and clinical frameworks, and modelled in our contacts with services (including forums, meetings, service visits, and formalised activities such as reviews and investigations).

30 My office has strong engagement with consumers and carers, taking the approach that consumers and carers are to be represented in all of the OCP's activities. This is demonstrated through:

(a) lived experience consumer and carer advisers within the OCP, who are also able to draw on their consumer and carer networks and leadership groups across the state as resources

[6] Mental Health Act 2014, s. 87.
[7] The Chief Psychiatrist's role, functions and powers, set out in Division 2 Part 7 of the Mental Health Act 2014, relate specifically to mental health service providers, defined in section 3 as a designated mental health service, or a publicly funded mental health community support service, to the extent that it provides services not funded by the National Disability Insurance Scheme. Transitional provisions empower the Chief Psychiatrist to investigate the provision of mental health services by a mental health service provider providing services funded by the National Disability Insurance Scheme where the investigation predates transition to NDIS or relates to provision of services prior to transition.

(b) participation of consumers and carers in investigation panels and audit teams

(c) engagement with people with lived experience through methods including consultation, engagement, co-design and co-production, which may be consumer or carer led and consumer or carer owned

(d) regular meetings with peak bodies and advocacy services, and a senior OCP representative on the Lived Experience Advisory Group, a reference group to the Mental Health Ministerial Advisory Committee

(e) representation of consumers and carers on all committees and reference groups

(f) the OCP working closely with consumer and carer advisers and peak bodies to develop robust approaches to supporting consumer and carer input, collaboration and co-design

(g) development of processes for reviewing opportunities for input, best approaches, liaison with peak bodies and other stakeholder groups, induction and orientation resources, debriefing and support mechanisms.

Interprofessional approach within my office

31 The varied nature of the work of the OCP requires a mix of skills and staff, including consumer and carer advisers, data analytics capabilities, policy and governance expertise, and clinical staff with specialist qualifications, including in medical, nursing and allied health disciplines.

32 The Chief Mental Health Nurse and Office of the Chief Mental Health Nurse (OCMHN) provide nursing leadership and support broader mental health workforce development through planning, education and training, and promotion of best practice for the mental health system.

33 Embedding the Chief Mental Health Nurse position and functions within the OCP has been critical for the effective and practical implementation of the OCP's work with policy, procedures and workforce development initiatives. For example, the statewide implementation of the Safewards initiative, discussed below at paragraphs 519 to 531, has been led by the OCMHN.

34 This structure has also enabled the use of interprofessional teams in service reviews and investigations.

35 The structure has broadened the expertise base on which the Chief Mental Health Nurse and I are able to draw. This has enabled combined reviews of legislative compliance and data, and

an interprofessional approach in work to develop strategies, policies, guidelines and Chief Psychiatrist Directives.

Engagement and collaboration with the sector

36 As outlined in my previous statement to the Royal Commission, the OCP fosters strong engagement with the sector and seeks to build robust relationships with services through frequent contact, and through engagement when we become aware of a quality and safety issue, enabling clarity and understanding regarding the significance of the issue and the appropriate response.

37 Depending on the severity of the risk identified, the OCP can mount an immediate response or undertake a watching brief approach and spend time gathering additional intelligence to inform my understanding of the issues arising.

38 Services actively approach my office to seek assistance and participate in investigations and reviews. As an example, in late 2019 my office was invited by a service to formally investigate identified quality and safety issues, with the result that I did not have to rely on my statutory powers to initiate the investigation.

39 I take a collaborative approach throughout both formal investigations and less formal engagements, and will partner with services to address systemic issues, improve the quality of treatment, and ensure that consumers' rights are promoted. In my experience, while my statutory powers enable me to carry out formal investigations and give directions to mental health services, they are most effective when coupled with a partnership approach, as described at paragraphs 29 to 31 of my previous statement to the Royal Commission.

40 Engagement with the sector through education and professional forums has also been a critical part of fulfilling my role as Chief Psychiatrist. Forums include:

(a) quality and safety forums with interstate and international guest speakers to address priority quality and safety issues within mental health services (for example, a forum on risk assessment in June 2018 and a forum on sexual safety in December 2018)

(b) annual electroconvulsive treatment (ECT) forums which are attended by psychiatrists, psychiatry trainees, nurses, educators, consumer and carer representatives and peer support workers from both the public and private systems. These educational initiatives address emerging clinical, practice and legal issues associated with ECT. Private practitioners are also represented on my Chief Psychiatrist ECT Statutory Committee to promote consistency in training and practice across both sectors

(c) specialist sector forums (such as forums for Child and Adolescent Mental Health Services, Secure Extended Care Units (SECUs), and Autism Coordinators from Child and Adolescent Mental Health Services).

41 Educational sessions facilitated by the OCP and the OCMHN are highly valued. They are often oversubscribed, and attendees provide positive feedback.

42 Sector engagement through education is a resource intensive activity. It is nevertheless valuable, as it helps to improve safety and quality across the system, reinforces the activities of the OCP, and provides further opportunities for services to engage with my office.

Integration of the role within the Mental Health and Drugs Branch

43 The Chief Psychiatrist is appointed and employed by the Secretary to the Department of Health and Human Services and is embedded within the Department of Health and Human Services, holding an executive role, formally designated as a Senior Medical Adviser. The position of Chief Psychiatrist is not an independent statutory role.

44 The role and office of the Chief Psychiatrist currently sit within the Mental Health and Drugs Branch, which has responsibility for funding and performance monitoring of mental health services, and my office and I report to the Director, Mental Health and Drugs.

45 Integration in the Mental Health and Drugs Branch is essential for the performance of my statutory roles and functions, including those relating to quality and safety. The diversity of my functions, and the understanding and expertise required to oversee quality and safety in the mental health system, require a specialist approach and visibility that cannot be achieved within a general quality and safety function. Importantly, the structure facilitates my input into policy development and design and performance discussions with services, and enables my office to work with the broader branch to identify and address quality and safety issues.

46 As the Secretary's appointee, it is important that I provide the Secretary with frequent advice in order to effectively discharge my roles and functions. I brief the Secretary via a formal written briefing process on matters of importance, such as major investigations, clinical reviews and clinical audits, and arrangements have been put in place for me to meet with the Secretary twice yearly.

47 The events of 2020, and the centrality of mental health in the Victorian response to both the bushfires and COVID-19 pandemic, have highlighted the importance of specialist mental health advice at these senior levels. Consistent with best practice in other Australian jurisdictions, a

fully embedded quality and safety framework would have an ongoing and direct reporting arrangement with the Secretary.

Challenges to achieving the objectives of the role

Question 1(c): What factors have made it challenging to achieve the objectives of your role?

Scope of the role

48 The role of Chief Psychiatrist requires a strategic focus and longer-term planning, particularly for those aspects that relate to providing clinical leadership and promoting continuous improvement.

49 This strategic function informs the clinical aspects of my role. Regulatory and compliance tasks, and my involvement in managing the complex cases and crisis situations which may be escalated to me, are unarguably important functions which safeguard and promote the rights of consumers and ensure that consumers are able to access the care they need.

50 It can be challenging to balance the need for an immediate crisis response with a strategic and systemic continuous improvement program. The volume of acute crisis clinical demands impacts on the capacity of the OCP to devote time to the strategic part of my role. However, individual incidents are often linked to broader system gaps – for example, service gaps relating to inadequate packages under the NDIS, the lack of step-down options for people with dual disability, and the treatment of children with autism spectrum disorder in acute inpatient units rather than community settings – and my role gives me leverage to resolve complex clinical issues for consumers.

Resourcing

51 In order to resource the volume and nature of work undertaken by the OCP, it is necessary to second clinicians from the field into the Department of Health and Human Services. This practice has enabled my office to be responsive when demand from consumers, carers and services is high.

52 The ability of the OCP to use and interpret the rich, extensive data it collects has been limited in the past, which posed a challenge when fulfilling my functions.

(a) A data analyst position has sat within the office since October 2019. This position has improved the capability of the OCP to use data to identify patterns, clarify issues, and consider and plan new ways to understand aspects of care relating to quality and safety, and has enabled my office to consider data in more flexible ways than previously.

(b) The data analyst position has also maximised the OCP's ability to make use of the Victorian Agency for Health Information's (VAHI) data collections. It has also enhanced the relationship with VAHI, the Coroners Court and other agencies that hold data of interest to my office.

(c) This position, and the enhanced capabilities it provides the OCP, has been and continues to be valuable to our work on quality and safety, and I would strongly support continued resourcing for this function. Recent work has focused on data on restrictive interventions within inpatient units and general hospital settings, sexual safety data, data sharing with the Coroners Court, and enhancing the collection of data relating to my statutory functions.

53 As outlined in paragraphs 36 to 42 above, my office engages proactively and frequently with the sector.

(a) This conscious approach to engagement was a deliberate shift in the way we work with services. It has meant that my role and the OCP are now very visible, and we receive consistently positive feedback from the field for our work.

(b) However, resourcing constraints make it challenging for the OCP to maintain this level of engagement and visit all services across the state, with the result that sector visits are often reactive, rather than planned and periodic. Inevitably, this means that some services have more exposure than others to the OCP and OCMHN.

(c) Current resourcing also places constraints on the educational sessions that the OCP is able to provide. As noted previously, these sessions are extremely valuable yet are resource intensive. There is both an appetite and need within the sector for further activities of this nature.

Mix of disciplines within the OCP

54 While senior doctors and nurses are represented through my role, the Deputy Chief Psychiatrists and the Chief Mental Health Nurse, and whilst at any one time there are persons with diverse clinical backgrounds within the Mental Health and Drugs Branch, there are currently no senior positions in the Department of Health and Human Services for a psychologist, occupational therapist, social worker, speech pathologist, or senior lived experience adviser.

55 This gap in multidisciplinary representation limits our ability to obtain advice from allied health experts in the field, and does not model a best practice approach for the sector. To address this

need, we seek assistance from clinicians in the field to undertake reviews and investigations, contribute to policy development, or carry out specific tasks (such as COVID-19 planning). This approach ensures that a wider range of views and people are represented and involved in the work. However, the lack of dedicated allied health positions in the OCP likely results in a less focussed approach or strategy to supporting the role of the Chief Psychiatrist in areas such as psychology and social work.

56 In addition, progress on specific pieces of work could potentially be enhanced by an allied health lead. For example:

(a) a lead with expertise in psychology could contribute to the personality disorder program, and would have some input into specialist programs such as eating disorder and parent-infant programs

(b) a lead occupational therapist could make a significant contribution to the interface between NDIS and clinical services

(c) the social work discipline could further promote family sensitive practice, as well as enhance discussions relating to homelessness, family violence, housing and child protection work and the interface with external agencies

(d) a speech pathology lead could make considerable contributions to work on child and youth services, and on communication issues and barriers relating to autism spectrum disorder and intellectual disability.

Timely access to a broad range of data

57 Expanded capture and reporting of data, and more timely access to this, would enhance my ability to respond quickly to emerging trends and risks. I discuss this further below in relation to restrictive interventions.

Similar roles in other Australian jurisdictions

Question 3: Are there examples of roles similar to yours in other jurisdictions? (a) What are your views on the advantages and disadvantages of different models?

58 Every Australian jurisdiction has a Chief Psychiatrist whose principal role is to ensure that its mental health legislation is applied correctly and appropriately.

59 Other specified domains of activity vary between jurisdictions. In New South Wales, for example, the Chief Psychiatrist does not have statutory authority conferred by the New South

Wales *Mental Health Act 2007* but is nevertheless required to provide high level advice to government on the mental health needs of the state's population, offer leadership to mental health clinicians, and give '[c]linical input to policy development and implementation to improve the mental health status of target groups.'[8] In Queensland, the *Mental Health Act 2016* speaks of its Chief Psychiatrist protecting patients' rights, writing policies and practice guidelines for implementation by mental health service providers and having power to investigate matters pertaining to the Act. In South Australia and Western Australia, the *Mental Health Act 2009* (SA) and *Mental Health Act 2014* (WA) place an emphasis on setting standards of care and treatment and overseeing compliance with these standards.

60 The Victorian MHA sets out a much more detailed list of the Chief Psychiatrist's roles and responsibilities than applies elsewhere. While I know that other Chief Psychiatrists provide leadership in a variety of ways – legislatively, administratively and clinically – only in Victoria is there an explicit expectation that the Chief Psychiatrist should:

(a) promote continuous improvement in the quality and safety of mental health services

(b) assist mental health service providers to comply with standards, guidelines and practice directions

(c) provide training and education to promote improved quality and safety

(d) monitor the provision of mental health services in order to improve the quality and safety of mental health services

(e) conduct clinical audits and reviews of mental health service providers

(f) analyse data, undertake research and publish information about the provision of mental health services and treatment

(g) promote cooperation and coordination between mental health service providers and providers of other health, disability and community support services.

61 This list of responsibilities, with its focus on promoting the quality and safety of mental health services, is much broader than that of other Chief Psychiatrists. The fact that these responsibilities are enshrined in legislation makes my position unique in Australia.

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[8] NSW Health, 'Mental Health Branch' <https://www.health.nsw.gov.au/mentalhealth/Pages/mhdao.aspx> [accessed 28 June 2020].

62 There is no consistent policy, commissioning and oversight model for mental health in Australia. There is a National Mental Health Commission which is working to establish a national mental health agenda and the Australian Minister for Health has recently created the role of Deputy Chief Medical Officer, Mental Health. Other jurisdictions have Mental Health Commissions that, broadly speaking, work together with communities to build resilience in vulnerable populations; identify opportunities to prevent the onset of mental illness and its consequences (for example, suicide); support the recovery of people with mental illness; advocate for carers; reduce stigma and discrimination; make representations to state and Commonwealth governments; host conferences; and other related tasks. The Commission in Western Australia has the additional role of planning, commissioning and funding the state's mental health services.

63 In Victoria, these various functions are undertaken by a range of bodies including the Mental Health and Drugs Branch and other sections of the Department of Health and Human Services, consumer and carer peak bodies (the Victorian Mental Illness Advisory Council (VMIAC) and Tandem) and community mental health support services.

64 The role of Chief Psychiatrist, which relates directly to protecting consumers' rights and improving the quality and safety of mental health service quality, is quite distinct and requires a strong, trusting relationship with the psychiatrist leaders in the field. My senior, clinically-focussed and outward-looking position allows me to call for assistance from an array of other regulators and providers within and without the Department of Health and Human Services to resolve issues, including the disability senior practitioner, child protection services, the multiple and complex needs initiative (MACNI), the National Disability Insurance Agency (NDIA) and major disability service providers.

65 My position within the Department of Health and Human Services' Mental Health and Drugs Branch gives me ready access to specialist advice on and capacity to provide input into mental health legislation and funding, health and social policy and health service data. In twice-yearly meetings with the chief executives of every mental health service, the Director of Mental Health and Alcohol and Drugs and I raise concerns about service quality and safety at the highest level with confidence that our concerns will be addressed.

66 The inclusion of consumer and carer policy advisors within the OCP means that my advice is strengthened by their perspectives on clinical and service issues.

67 In summary, I believe that my role as Chief Psychiatrist combines clinical expertise with statutory authority, proximity to departmental commissioning and funding bodies, access to data and data analysts, a trusting relationship with service leaders, and a lived experience viewpoint. This particular combination of strengths and assets is not replicated elsewhere and

offers a springboard for further opportunities to strengthen the quality and safety of Victorian mental health services.

68 It is critical to ensure that the role of Chief Psychiatrist remains discrete and has clearly delineated lines of responsibility, but also remains attached and integrated with policy makers and service commissioners.

69 My office's role overlaps to some extent with that of Safer Care Victoria (SCV) whose stated mission is to identify and implement targeted improvement projects across Victoria's general hospitals and health services. To this end, SCV disseminates clinical guidelines, analyses and promulgates health service data, supports and trains quality and safety leaders, monitors sentinel events, and responds to emerging safety issues.

70 I collaborate with SCV in several important respects. I sit with the Chief Mental Health Nurse as an ex officio member on the SCV Mental Health Clinical Network; we attend inter-jurisdictional quality and safety meetings coordinated by SCV; a member of SCV has attended some of our site visits; we conduct joint reviews of mental health sentinel events; and members of the OCP have engaged with SCV in joint training activities.

71 I believe, however, that my role has a number of special features that SCV cannot replicate. While both offices focus on quality and safety, SCV must attend to the broad needs of Victoria's general hospitals and health services. By contrast, there are just eighteen designated mental health services including Forensicare identified within the MHA. As noted already, this narrower field of operation confers a level of access and trust on the OCP that would be difficult to replicate otherwise.

72 Unlike the Chief Executive Officer of SCV, I have statutory powers that allow me to conduct investigations, reviews and audits to assure myself that services, individually and severally, meet current legal, clinical and ethical standards. I can issue directives to services and require improvements in practice within specified time periods.

73 I am keen to work with SCV to identify further opportunities to harness our two agencies' strengths.

Technological advances in service delivery and consumer engagement

Question 4: How are technological advances in service delivery and consumer engagement impacting on your role? (a) How do you expect this to change in the future?

74 Technology in healthcare is a rapidly evolving field, with a great deal of variation depending on location, socioeconomic demographics, and individual capacity and interest. The availability and cost of new technologies, and access to devices such as smartphones, will continue to shape the way health professionals interact with each other and with consumers, carers and other agencies involved in care.

75 In my role as Chief Psychiatrist, it is essential that I understand and keep abreast of the rapidly changing landscape of technological advances, and I welcome innovations in service delivery and consumer engagement that enhance consumers' care and experiences and improve service quality and safety.

76 Digitisation of data has precipitated a new era of accountability and transparency in relation to the delivery of government services. This is true for mental health services, and as consumers and carers are able to access more and more information about services and treatments, it will be important to assist people to understand the information which is published. Education will form a key platform of the OCP's quality and safety function into the future.

Online service provision

77 Online service provision is not limited to clinical consultations (either direct consultations with consumers or secondary consultations with clinicians), but also encompasses online support tools and information platforms.

78 Mental health services are increasingly using technology and telehealth options for assessment, treatment and adherence monitoring. As a fundamental principle, service providers should adhere to the same principles when using technology as for face-to-face consultations. They must also assess whether the mode of delivery is safe and clinically appropriate for the consumer.[9] Whatever the mode of service provision, it needs to sit within the service's broader quality and safety framework and be integrated in its governance practices.

79 Changes to mental health service delivery as a result of COVID-19 have seen the rapid uptake of telehealth use, particularly in clinical community health settings, which I discuss in greater detail at paragraphs 614 to 628 below. This uptake has highlighted the need for the development of guidelines on governance, privacy, treatment models and models of care that online service provision is best suited to, and my office will be able to make valuable

[9] Australian Health Practitioner Regulation Agency 2020, *Telehealth guidance for practitioners* <https://www.ahpra.gov.au/News/COVID-19/Workforce-resources/Telehealth-guidance-for-practitioners.aspx>.

contributions to this work. Further consideration will need to be given to the consumer perspective, which I discuss further below.

80 Additional training is also needed for clinicians on the use of telehealth and online services as a treatment modality, and their place in the model of care. The Centre for Mental Health Learning (CMHL), a Department of Health and Human Services funded initiative established in 2018, is a key agency that can support access to training and development, including for online service provision and new models, through a variety of platforms and formats.

81 In addition, the Mental Health Professional Online Development (MHPOD) Learning Portal is a valuable national and Victorian resource for members of the public mental health workforce. It provides access to content developed within the context of the National Standards for the Mental Health Workforce to establish a nationally consistent approach in developing Australia's mental health workforce. Funded by all jurisdictions, Victoria manages this work on behalf of the National Safety and Quality Partnership Standing Committee through the OCMHN. Through Victoria's management of the portal, which has grown from 14,780 to 25,439 members over the past 12 months, the Department of Health and Human Services has developed expertise in engaging and collaborating with Victorian and interjurisdictional stakeholders to identify needs regarding psychoeducation and the development of online training; understanding how users engage with a platform in order to facilitate better registration, growth and engagement; and developing strategic plans with funders, key stakeholders such as the CMHL, and across jurisdictions to build efficiencies and avoid duplication of effort.

82 Online support tools and information platforms include Orygen's Moderated Online Social Therapy (MOST) platform, and app-based therapies and information platforms such as Smiling Mind and Moodgym. Some tools are designed and managed by services themselves, in which case they would be expected to be integrated in the service's quality and safety framework. Issues may arise, however, with the use or promotion of tools and platforms offered by other providers, and how the quality and appropriateness of these can be formally validated. The National Safety and Quality Digital Mental Health Standards, discussed below, may address this in part, but without an external approval process or standard evaluation and adoption guidelines, there may be both inconsistent approaches and duplication of effort at a service level.

Development of standards for digital mental health services

83 The Australian Commission on Safety and Quality in Health Care is currently developing new National Safety and Quality Digital Mental Health Standards.[10]

84 I understand that compliance with the standards will initially be voluntary, and that subsequent consultation will occur if they become mandatory. Learnings for both services and the Department of Health and Human Services as a result of this year's rapid shift to online service provision will provide a clearer perspective of the likely impact of the standards on services. The standards will nevertheless guide both the Department of Health and Human Services and services in the approach to emerging digital technologies, and will inform quality and safety activities undertaken by the OCP and the broader Mental Health and Drugs Branch.

Use of electronic devices in mental health services

85 Mobile devices are increasingly carried and used by consumers, carers and staff in acute inpatient, community and residential settings. Use of devices can promote recovery, and can be an important way for individuals to stay connected with their support networks, to access their legal rights, and to meet their day-to-day needs and maintain a sense of normalcy. However, the use of electronic devices in these settings poses risks, such as where recording is carried out without consent.

86 Similarly, the use of CCTV within mental health services is problematic. I am of the firm view that the use of CCTV in areas such as seclusion rooms and high dependency and intensive care units is not consistent with privacy and human rights, and have been working with some services to have devices removed, focusing instead on processes and strategies that decrease reliance on CCTV.

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[10] Australian Commission on Safety and Quality in Health Care 2020, *National Safety and Quality Digital Mental Health Standards – Consultation Draft* <https://www.safetyandquality.gov.au/sites/default/files/2020-02/national_safety_and_quality_digital_mental_health_standards_-_consultation_draft_-_feb_2020_0.pdf>.

87 Given the importance of these matters, I issued two guidelines for services in September 2018: *Electronic communication and privacy in designated mental health services*[11] and *Surveillance and privacy in designated mental health services.*[12]

Neurostimulation treatments

88 The range of treatments available in the private hospital sector is currently broader than in public mental health services. Advances and research in new neurostimulation techniques such as Transcranial Magnetic Stimulation (TMS) and transcranial Direct Current Stimulation (tDCS) are leading to increased availability of these treatments in mental health, neurology and geriatric medicine settings, and are showing some positive results for a range of psychiatric and neurological conditions.

89 Techniques such as TMS can be helpful for and acceptable to people with milder conditions, yet public services have generally withdrawn from this area, focusing instead on meeting the needs of people with more severe conditions. This limits the choices available to consumers treated in public services, and also younger clinicians' exposure to and experience with the full range of treatments.

Electronic clinical databases

90 The mental health Client Management Interface and Operational Data Store (CMI/ODS) was deployed across Victoria in 2000. During the first decade, it gained international recognition for its capability to support the provision of integrated, safe and effective client-centred mental health care. The CMI/ODS has undergone numerous version updates over the past twenty years to meet legislative, statutory and policy changes.

91 However, underinvestment in the information architecture and technologies underpinning the system have resulted in it reaching legacy status, and aspects of the system are hampering the implementation of modern digital clinical systems by health services. The age and complexity of the system, and dependence on aligning statewide health service information technology for deployments, mean that release management requires significant lead time, planning and resourcing. The current release schedule is restricted to two or three updates per year at best,

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[11] Department of Health and Human Services 2018, *Chief Psychiatrist's Guideline: Electronic communication and privacy in designated mental health services* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/electronic-communication-privacy-designated-mental-health-services>, Melbourne.
[12] Department of Health and Human Services 2018, *Chief Psychiatrist's guideline: Surveillance and privacy in designated mental health services* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/surveillance-privacy-designated-mental-health-services>, Melbourne.

and the system lacks the agility required to promptly correct defects or respond to rapidly changing policy initiatives from the OCP and the Mental Health and Drugs Branch. In particular, it is the main repository for collecting information regarding restrictive interventions and ECT, and could be more efficient for the reportable deaths function. In addition, the ODS does not support data exchange with applications other than the CMI, which compromises the delivery of integrated health care by excluding mental health care from the digital clinical information strategies of health services.

92 Data recorded in the ODS is used by the OCP to support system monitoring functions, by the Mental Health Tribunal for scheduling hearings, and by the Department of Health and Human Services for performance monitoring, funding acquittal and national data reporting. Further, CMI/ODS enables area mental health services – including mental health clinicians integrated with emergency departments and police and ambulance response teams – to obtain critical information about a consumer's current and past interactions with mental health services across Victoria. Staff outside the mental health system do not have access to this database, however, and there is considerable local data on brief interactions with consumers that is not shared centrally. This includes data on contacts with unregistered consumers occurring in emergency departments, short stay units and general medical settings, and there is a risk that crucial information could be missed if a consumer presents to a different health service.

Consumer engagement

93 The use of technology in the service system provides opportunities to engage with consumers in different ways, particularly in relation to education and prevention activities.

94 A co-production approach is essential to ensure that the service is relevant to both consumers and carers.

95 Technology can allow consumers to engage in real time in their own comfort, rather than having to attend clinical appointments in person, and can provide opportunities for those who find it difficult to physically attend appointments to seek advice and assistance when they need it. Ideally, a mixture of face-to-face appointments and the use of technology would be available.

96 Advances in online service provision have been described above. From a consumer perspective, some consumers who appreciate the social contact of clinic visits may prefer not to use these platforms; others may have difficulty using the technology or not have access to an appropriate device or bandwidth.

97 Some consumers do not have access to technology due to low income or financial hardship, loss of access due to COVID-19 related closures of public facilities, or lack of knowledge and skill. The OCMHN recently assisted implementation of a program to provide phone and data plans for vulnerable and high-risk clients of public clinical mental health services and Alcohol and Other Drug (AOD) services as part of its response to the COVID-19 crisis. The initiative aims to support consumers to stay engaged in treatment, with assistance also available for families and carers.

98 The Your Experience of Service (YES) survey, available both in paper and online formats in Victoria, is used by the OCP to inform its quality and safety initiatives and has provided useful learnings. There are currently very few online responses to the survey, and discussions have occurred with other jurisdictions to identify best practice options for increasing accessibility and survey response rates through electronic means. While there have been trials using tablets, and a tablet-based application providing the respondent with immediate feedback on how their response compares with that of other service users, most surveys continue to be returned in paper format. Instead, higher response rates appear to be more closely linked to a culture within services than to access to technology. This can occur, for example, through services supporting and actively engaging with consumers to complete the survey, creating visibility of the data within the service setting, and demonstrating use of the data to develop improvements – using co-design approaches – in a visible way to build interest and engagement with the survey.

99 Use of YES survey data could be supported by improved reporting technology. Some improvements are being implemented, including incorporating the data into consumer/patient experience reporting through the Victorian Experience of Health Survey (VEHS) portal. In addition, public visibility of the YES survey data in Victoria is currently limited to six data items, published in the annual report. Visibility of the results for consumers, carers and families is therefore dependent on individual health services making these available.

Common quality and safety issues in the Victorian mental health system

Question 2: Over the last five years, what are the most common quality and safety issues that you have identified?

100 The OCP deals with a multitude of issues related to the quality and safety of mental health services. Some are clinical in nature and have an immediate impact on the lives of consumers and carers. Others concern the system of care and require a longer-term, strategic perspective. My office must be capable therefore of holding both perspectives in balance and calling upon a wide array of responses. For the purposes of discussion, I have categorised the most frequently encountered quality and safety issues under six broad themes.

(a) *Difficulties experienced by consumers and carers negotiating the mental health system:*

(i) The issues reported to my office by consumers and carers relate principally to *accessing* care; *transitioning* within the mental health care system, and *exiting* a service in a safe, well-coordinated manner.

(ii) In recent years, much of my time has needed to be directed to facilitating *entry to services* by consumers with unusually complex needs because of a developmental disability compounded by mental illness, an admixed mental health and substance use disorder; or a condition that requires highly specialised interventions (e.g. eating disorders).

(iii) Carers' (and sometimes consumers') efforts to access care are sometimes rebuffed by providers on the grounds that the person's symptoms are 'behavioural' (i.e. not the result of a mental health condition) or the result of substance abuse which is therefore the province of an AOD service, or beyond the scope of a public service. As a result, people requesting a service, sometimes in hugely stressful and even hazardous situations, find themselves pushed backwards and forwards between agencies.

(iv) For people engaged with a service, one particularly difficult *transition point* concerns moving from an acute inpatient unit to a SECU for longer-term rehabilitation. At present, some of those in need of rehabilitation in a secure setting remain on inpatient wards for months at a time waiting for a bed to become available. This delays their recovery and limits access to acute beds by others.

(v) As an example of the difficulties that arise with discharge planning, *exiting* from services presents a particular challenge for people whose combinations of developmental disability and mental illness result in behavioural symptoms that require one-on-one care in custom-built accommodation. Some of the young people in this situation have remained on inpatient units for 18 months waiting for the NDIS and community support service to make the necessary arrangements.

(vi) To give a measure of the volume of these sorts of activities, between 2015-16 and 2018-19 the number of clinically-related contacts with the

OCP increased 99 per cent; contacts by carers increased 94 per cent, and requests by other parts of the Department of Health and Human Services for help in coordinating care for people with complex, multiple needs increased 850 per cent.[13]

(b) *Care practices that fall short of standards:*

(i) Standards of care that fall short of contemporary standards come to my attention through approaches to the OCP by consumers and carers. The concerns often raised with my clinical advisers include poor communication, insufficient regard to the needs of carers and insufficient liaison with general practitioners and other care providers.

(ii) I learn of other concerning care practices through the visits the Chief Mental Health Nurse and I pay to services in response to issues that come to our attention or as part of structured audits of particular care practices (for example, the ongoing audit of ECT services). As part of these visits, many of which last for a day or more, we engage with clinical leaders, quality and safety managers and staff members from a range of disciplines including consumer and carer consultants and peer support workers. We inspect facilities, check clinical records and review policy and procedure documents. This allows us to comment in detail on standards of care and make recommendations for improvement.

(c) *Adverse care outcomes,* including sexual safety violations which I discuss at paragraphs 241 to 244 below, and deaths from unnatural or unexpected causes, which I discuss at paragraphs 310 to 343 below.

(d) *Unexplained variations in clinical practices:* examples of unexplained variations in practice between service providers that warrant further enquiry include differences in the rates of falls, ECT and restrictive interventions in inpatient units. Information of this kind comes to my attention through scrutiny of CMI/ODS and is now the basis of the *Inspire Mental Health* benchmarking report. I discuss this report, and how I use this data to drive change in clinical practice, at paragraphs 125 and 179 to 182 below.

[13] Chief Psychiatrist's Annual Reports, 2015-16 and 2018-19.

(e) *Staff safety:* Issues relating to staff safety, usually as a result of occupational violence, are communicated to me by service providers, clinicians and industrial bodies, and are discussed in more detail at paragraphs 227 to 238 below.

(f) *Stigma resulting from mental illness:* I am alerted to issues resulting from the marginalisation and discrimination associated with mental illness through a variety of sources. To list just a few examples, I know through my contacts with consumers of their problems in finding suitable, affordable accommodation and the problems that accrue from homelessness; I learn with other Chief Psychiatrists of work from the National Mental Health Commission on the poor health outcomes of people with mental illness; and VMIAC keeps me updated on its efforts to promote the human rights of people with experience of mental illness. My responses to these and other issues are described throughout this statement.

Regulation, monitoring and support of quality and safety in the Victorian mental health system

Question 5: How is quality and safety regulated, monitored and supported in the Victorian mental health system?

101 As Chief Psychiatrist, I play a key and wide-ranging role in regulating, monitoring and supporting the quality and safety of the care provided to mental health consumers in Victoria, and I discuss this in detail from paragraph 107 below.

102 Within health services, health service boards are accountable to the Ministers for Health and Mental Health for the safety and quality of care provided by their organisation, and are responsible for ensuring that appropriate clinical governance structures support the delivery of high-quality and safe care.

103 Quality and safety is also regulated, monitored and supported in the Victorian mental health system through:

(a) the National Safety and Quality Health Service Standards set by the Australian Commission on Safety and Quality in Health Care (ACSQHC)[14]

(b) standards set by the Australian Aged Care Quality and Safety Commission (for twelve health services identified as designated mental health services in the MHA

[14] Australian Commission on Safety and Quality in Health Care 2019, *The National Safety and Quality Health Service Standards* <https://www.safetyandquality.gov.au/standards/nsqhs-standards>, Sydney

that provide specialist residential care services to older people with mental illness or dementia)

(c) the Australian Health Practitioner Regulation Agency (AHPRA) in accordance with the Health Practitioner Regulation National Law

(d) Worksafe Victoria in accordance with the *Occupational Health and Safety Act 2004*, in relation to workplace safety.

104 As mentioned above, SCV is the state's peak authority for quality and safety improvement in general health care services including private and non-government services. It oversees and supports health care services to provide safe, high-quality care using a quality and safety, as opposed to regulatory, framework.

105 VAHI monitors and reports on public and private services that impact on health, wellbeing, quality and safety in order to stimulate and inform improvements, to increase transparency and accountability and to inform the community.

106 In addition, there are a number of bodies that provide independent oversight of the mental health system, and I discuss these mechanisms and the scope of these bodies' responsibilities from paragraph 158 below. Independent oversight bodies include:

(a) The Mental Health Complaints Commissioner, which is an independent, specialised body established under the MHA to safeguard rights, resolve complaints about Victoria's public mental health services, and recommend improvements.

(b) Other complaints bodies, including the Health Complaints Commissioner, NDIS Quality and Safeguards Commission and the Victorian Ombudsman.

(c) The Mental Health Tribunal which is an independent statutory tribunal which makes and reviews compulsory orders and determines some treatment applications (ECT and neurosurgery for mental illness).[15]

(d) The Office of the Public Advocate which provides guardianship and advocacy for people with disability, including mental illness and brain injury.[16]

[15] Mental Health Act 2014, Part 8.
[16] Guardianship and Administration Act 1986, Part 3.

(e) Community Visitors who monitor services provided at prescribed premises and can assist people receiving services.[17] Community Visitors are appointed on the recommendation of the Public Advocate, and are empowered by law to make unannounced visits to mental health facilities (including sub-acute and residential facilities) to speak with consumers and residents about their experiences and needs, observe their interactions with members of staff, and check the environment. Community Visitors can speak privately with consumers and residents, make enquiries about their rights and wellbeing and inspect documents. If they have concerns, they can raise issues with clinicians, service providers, the Department of Health and Human Services and the Public Advocate. The scheme reports annually to the Minister for Mental Health.

(f) The Forensic Leave Panel, which is an independent statutory tribunal responsible for considering applications for leave of absence from forensic residents and patients on custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

(g) The Independent Mental Health Advocacy (IMHA) service supports people who are receiving compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment and recovery. Although IMHA is not a statutory body, it is recognised in the MHA as a body to which communication cannot be limited.

Role of the Chief Psychiatrist in regulating, monitoring and supporting quality and safety

Regulating actions

107 Services must have regard in their work to the principles of the MHA. These principles direct that mental health treatments be provided in the least restrictive way possible with the goal of promoting recovery and a full participation in community life; that people receiving mental health services have their rights and dignity promoted; that they be able to make decisions about their assessment, treatment and recovery that entail a degree of risk; that their individual, cultural and medical needs be responded to; and that carers be included in decision-making.[18]

108 The MHA includes provisions that touch directly on the quality and safety of consumers' and carers' experiences of mental health services. Examples include an insistence that consumers'

[17] Mental Health Act 2014, Part 9.
[18] Mental Health Act 2014, Part II.

rights be supported by means of a statement of rights, an advance statement that sets out their treatment preferences, and access to a nominated person and second opinion giver.[19]

109 If I form the opinion that the health, safety or wellbeing of a person is or was endangered as a result of mental health services provided by a service provider, I have the authority to investigate the quality and safety of the mental health services and if the provider had acted in accordance with the MHA and my various standards, guidelines and practice directions. Services must allow me access to their premises, records and personnel and must comply with my recommendations.[20] Except in emergencies, I must give reasonable notice of my intention to mount the investigation. In return, providers must grant me access to their premises, personnel and records and anything else that is reasonably necessary for my purposes. At the conclusion of my investigation, I make recommendations or give directions to the provider to which the provider must respond in writing within 30 business days. If it is in the public interest, my findings and the provider's response may be published.

110 If I wish to identify those processes and practices that need to be addressed to improve the quality and safety of the services offered by one or more mental health service providers, I have the authority to conduct a clinical review.[21] Similarly, if I wish to identify systemic issues or trends that need to be addressed to improve the quality and safety of the services provided by one or more mental health service providers, I have the authority to conduct a clinical practice audit.[22] As with investigations, I have powers under the MHA to gather whatever information I reasonably need to exercise my functions.

111 Investigations, reviews and audits are major undertakings that typically involve members of my office including consumer and carer policy advisors, together with clinicians and consumer and carer consultants from other services. I provide written feedback in accordance with the MHA to service executives with remedial actions and timelines for response.

Monitoring actions

112 As Chief Psychiatrist, I work with the Mental Health and Drugs Branch, VAHI and SCV to monitor the quality and safety of mental health services in the following ways:

[19] Mental Health Act 2014, Part III.
[20] Mental Health Act 2014, ss. 122, 126 and 129.
[21] Mental Health Act 2014, ss. 130-133.
[22] Mental Health Act 2014, ss. 134-140.

(a) As noted above, consumers, carers, clinicians, clinical leaders and the Mental Health Complaints Commissioner tell me of incidents that suggest non-compliance with legislation or health care standards.

(b) Visits made to services by the Chief Mental Health Nurse or me in response to news of an incident and some system-wide concerns give first-hand insights into the treatment and care offered within a service or services.

(c) My office is supported by VAHI to collect and collate data supplied by mental health services concerning their use of restrictive interventions and ECT (in addition to other activities including sexual safety incidents).

(d) Mental health services notify me of inpatient deaths and the deaths of community consumers from unnatural or unexpected causes, which I cross-reference with information from the Coroner's Office.

(e) I receive data through the Mental Health and Drugs Branch of services' performance against funding requirements.

(f) I learn of particular issues at the interface of mental health services with disability services, the NDIA, child protection services and the justice system from colleagues within the Department of Health and Human Services, other government departments and other services.

(g) SCV shares information with me about sentinel events in mental health services. These are defined by SCV as inpatient suicides and 'other catastrophic events' (that is, potentially preventable incidents that result in death or serious, enduring illness or disability), which must be reported to SCV as described in the *Victorian sentinel event guide: Essential information for health services about managing sentinel events in Victoria*. Attached to this statement and marked '**NC-2**' is a copy of the *Victorian Sentinel event guide*.

Supporting actions

113 The Chief Mental Nurse and I support the improvement of quality and safety in mental health services in a number of ways.

(a) We communicate a vision of the standard of care we expect in particular clinical situations by engaging directly with service providers to resolve issues raised by consumers, carers and advocates. In particularly complex cases, we chair case

conferences of mental health clinicians and representatives of disability, child protection and emergency services.

(b) We provide guidance about quality and safety standards through the development and promulgation of clinical guidelines, mental health care frameworks and clinical practice advisory notices.

(c) We meet with the authorised psychiatrists, senior nurses and managers of mental health services and with leaders of clinical programs (child and adolescent, aged, SECUs etc.) to develop a shared vision of standards of care.

(d) We host forums on matters of special or ongoing concern to consolidate standards of care across Victoria.

(e) We work with VAHI to analyse mental health service data collected through CMI (for example, concerning restrictive interventions and ECT) to understand trends and practice variations. We communicate these learnings through the *Inspire Mental Health* report, described further at paragraph 125 below.

Standards, guidelines and policies that apply across the system

Question 6: What standards, guidelines and policies apply across the system?
- (a) How are these mandated, monitored and enforced?
- (b) How are they updated?
  - (i) Have the standards changed in recent years?
  - (ii) What generally triggers a review?
- (c) How are services accredited and/or assessed against the relevant standards, guidelines and policies that are in place?
  - (i) How is this monitored and reported?
  - (ii) How is non-compliance responded to?
  - (iii) How has this process changed since the Mental Health Act 2014?

114 As described at paragraph 103 above, health services are required to meet standards imposed by external bodies such as the ACSQHC and the Australian Aged Care Quality and Safety Commission.

115 In addition to these national standards, I publish guidelines, frameworks and clinical practice advisory notices pursuant to sections 121(a) and (b), 133 and 139 of the MHA, and I will focus

on these in my discussion of guidelines and policies that apply across the Victorian system. These documents can be found on the Department of Health and Human Services' website.[23]

116 Some guidelines and notices address specific clinical practices (such as treatment and discharge planning) while others address administrative requirements (for example, reporting notifiable deaths). Guidelines and frameworks with an educational focus (such as responding to family violence and improving consumers' physical health) tend to be lengthy and have a descriptive, aspirational tone. Some others are briefer and more prescriptive.

117 In recent years, guidelines have been written over a period of months using a co-production model with input from consumer and carer consultants, clinical leaders and the Interprofessional Leadership Network, a community of practice comprising leaders from the nursing, allied health, medical and lived experience workforces.

118 Critical steps in the production pathway include:

(a) a forum with input by experts, clinical leaders and other stakeholders including people with lived experience

(b) a drafting process with feedback from clinical leaders and people with lived experience

(c) a pilot phase in selected services

(d) a formal launch with post-implementation follow-up through meetings with authorised psychiatrists, senior nurses, consumer and carer advocates and others.

Mandating, monitoring and enforcing standards, guidelines and policies

119 As articulated in the Policy and Funding Guidelines and Statements of Priorities, service providers are expected to comply with my guidelines and practice notices and to develop local implementation plans, ongoing educational activities and policy and procedure documents. Attached to this statement and marked '**NC-3**' is a copy of the *Policy and Funding Guidelines 2019-20.*

120 Systematic monitoring is difficult in the case of guidelines that focus on building capacity across the whole of the service network. In the case of my guideline on family violence, for example,

[23] Department of Health and Human Services 2020, *Chief psychiatrist guidelines* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>, Melbourne.

my goal was to extend clinicians' knowledge and skills in recognising family violence and responding to it sensitively and proactively. This project will extend over many years.

121 I monitor the degree to which guidelines are implemented in practice in a variety of ways using all the information sources and data tools available to me, including through formal mechanisms of investigations, clinical reviews and clinical practice audits, as well as through my other monitoring functions and informal engagement with providers, consumers and carers.

122 When the consumers and carers who contact the OCP describe experiences that seem not to align with the MHA or the standards articulated in my guidelines, I engage in discussion with the service provider to understand what happened. Where care practices were deficient, I use this opportunity to reinforce those standards of practice.

123 Having a trusting, open relationship with clinical leaders is critical in my view to the success of this style of communication. It works best when leaders feel able to speak openly with the Chief Mental Health Nurse and me about their issues and concerns in a way that points directly to a shared view of whatever steps are needed to lift standards.

124 I monitor clinical practices regulated under the MHA (restrictive interventions and ECT) using data supplied by providers. I now provide feedback to providers about their use of these interventions and treatments for the purposes of benchmarking with the goal of provoking critical enquiry within and between services to uncover the reasons for variations in practice.

125 As an example, I collaborate with VAHI on the six-monthly *Inspire Mental Health* report that is distributed on a confidential basis to services and clinical leaders. The report benchmarks services' performance against a rotating suite of indicators including their use of restrictive interventions and choice of ECT modalities. As discussed further at paragraphs 179 to 182 below, where providers' use of restrictive interventions and ECT exceeds the statewide average, I engage in correspondence with clinical leaders to understand what systemic, environmental, staff-related and clinical issues might have contributed to this variation and, where indicated, to develop a remediation plan.

126 In another initiative, I have developed an approach to auditing adherence to guidelines (in this case, the recently revised ECT guideline) that combines clinical peer review with lived experience input. Each of the public services that deliver ECT in Victoria has been or will be visited for a day by a team comprised of a deputy chief psychiatrist, a clinical advisor, a director of ECT and ECT nurse coordinator from other services, and consumer and carer representatives. The team inspects the treatment facilities and equipment, interviews senior

clinicians and checks clinical records. Written feedback to the provider specifies remedial activities with a timeline for response.

127 If I have reason to believe – based on reports from consumers, carers, the Mental Health Complaints Commissioner, providers themselves or any other source including benchmarking data – that practices have breached the MHA or fall short of the standards articulated in my guidelines, I or the Chief Mental Health Nurse may visit the service to meet managers, clinical leaders, consumer and carer consultants and peer support workers to form an understanding of its care policies and procedures, governance and staffing arrangements, and educational supports that impact on clinical standards. This is an informal mechanism that does not rely on my specific powers at section 122 of the MHA. Rather, we arrive at an agreement with the service about the steps to be taken to improve care standards. If required, we will engage in a series of visits, extending sometimes over months, to check that improvements have become embedded in everyday practice.

128 Where evidence points to a major breach of standards, or an event creates widespread concern that practice standards were deficient, I have the option of conducting a formal investigation of the service, including any of its practices, procedures, restrictive interventions or treatments, as described in paragraph 109 above. In other circumstances, I may conduct a clinical review or clinical practice audit as described in paragraph 110.

Development of updates to standards, guidelines and policies

129 It is my intention to review and update all my guidelines on a rolling basis and a number are due for updating at present (see the Department of Health and Human Services website for the list).[24]

130 This process has been slowed by the imperative to develop new guidelines and frameworks (for example, the framework on consumers' physical wellbeing) and by my wish to engage more actively with service providers, people with lived experience and other key stakeholders in the development of new documents.

131 The current process is significantly more complex and time-consuming but will, I believe, result in guidelines and frameworks that align better with the principles articulated in the MHA to promote consumers' recovery, respect their choices and engage with carers.

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[24] Department of Health and Human Services 2020, *Chief psychiatrist guidelines* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>, Melbourne.

132 In the last five years, I have published new or updated guidelines on discharge planning, ECT, family violence, leave of absence from inpatient units, privacy, reporting sexual safety incidents and treatment plans. A new guideline on risk assessment and safety planning for inpatient units is under development.

133 Within the same period, I have published practice advisory notes on ECT consent pathways, psychiatric assessment processes and preparing for heatwaves as well as a large framework document on consumers' physical health.

134 The decision to update guidelines is driven also by the need to align with changes in legislation and government policy. This prompted the revision of multiple guidelines in the time leading to the promulgation of the new MHA in 2014 and the development of a guideline and resource package on family violence in response to recommendations made in 2018 by the Victorian Royal Commission into Family Violence.

135 Other updates have been prompted by the need for guidelines to reflect changes in evidence-based practice. As an example, the guideline on ECT was revised last year to reflect a preference for treatment modalities that limit cognitive side-effects. This change in practice is now widespread throughout Victoria.

136 The new framework on consumers' physical health which alerts service providers to evidence of consumers' much greater risk of physical illness and reduced life expectancy, together with tools to improve awareness, screening and access to physical health treatments, followed from our collaboration with the National Mental Health Commission's Equally Well project.

137 The *Mental Health Intensive Care Framework*, released in late 2019 and in the process of being implemented, provides clear direction on the role of mental health intensive care within mental health inpatient units, and sets out a framework for providing care in a way that responds to an individual's needs. The framework was developed in response to a 2016 project on high dependency units, the Chief Psychiatrist's audit of inpatient deaths from 2011-2014, the Mental Health Complaint's Commissioner's *The right to be safe* report, and the 10-year review of restraint practices in Victoria.

138 The principal change since 2014 results from my wish when developing and monitoring standards to include the viewpoints of consumers and carers from the outset. I am supported in this by my consumer and carer policy advisors, the leaders of VMIAC and Tandem, and the consumer and carer representatives and peer support workers who have participated in my forums, working parties and audit teams.

139 Another change is my increased determination to engage actively with providers through clinical leaders' meetings, site visits, clinical audits and benchmarking activities. These activities consume a large proportion of my time.

Adherence to standards, guidelines and policies

140 Services are not formally accredited against my own standards, guidelines and policies, which is the same position as under the *Mental Health Act 1986*, which made no provision for accreditation apart from the licensing of ECT.

141 I monitor providers' adherence as described above and gather evidence through multiple sources: calls from consumers, carers, clinicians and service providers, the Mental Health Complaints Commissioner, the data supplied by providers through VAHI, evidence gleaned through visits to services by the Chief Mental Health Nurse and me, and through the exercise of my formal powers of investigation, review and audit under the MHA.

142 As described already, my preference is to work with providers in a constructive and collegial manner to achieve adherence to policies and guidelines. Since a lapse within a single service might point to more widespread difficulties, the Chief Mental Health Nurse and I see such instances as an opportunity to reinforce our standards in regular meetings with authorised psychiatrists, senior nurses, operational managers and sub-speciality groups (child and adolescent, aged, forensic etc.).

143 In addition, I make frequent contact with providers to resolve particularly serious clinical issues. A key element of the resolution process is to bring together senior representatives of other agencies (disability, NDIA, child protection, justice, housing etc.) to arrive at a solution that best meets the needs of consumers and carers.

144 Learnings from adverse incidents and Coroners' findings are disseminated to providers through the Quality and Safety Bulletins I re-instated in 2017.[25]

145 I have the option, when responding to evidence of serious non-compliance, of initiating a clinical review, audit or investigation as described previously.

[25] Department of Health and Human Services 2020, *Chief Psychiatrist Quality and Safety Bulletins* <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/chief-psychiatrist-quality-and-safety-bulletin>, Melbourne.

Complaints processes

Question 7: How do consumers make complaints in the Victorian mental health system and to which body(ies)?
Question 8: Are consumers able to contact your or your office, to discuss their treatment in Victoria's mental health system and lodge a complaint?
Question 9: What processes and procedures are in place in your office in relation to these complaints?

146 There are a number of avenues for consumers to make complaints in the Victorian mental health system. In the first instance, consumers are encouraged to make a complaint with the service itself. If unresolved, they can complain to a range of independent complaints bodies, depending on the nature of the complaint:

(a) Complaints about mental health services provided by mental health service providers (designated mental health services and publicly funded mental health community support services) can be made to the Mental Health Complaints Commissioner.

(b) Complaints about NDIS funded services provided by a mental health service provider can be made to the NDIS Quality and Safeguards Commission.

(c) Complaints about private mental health services can be made to the Health Complaints Commissioner.

(d) Complaints about any registered health practitioners, including nurses, psychologists and psychiatrists, can be made to the service that they work for or the Australian Health Practitioner Regulation Agency.

Consumer contact with the OCP

147 The MHA does not confer a formal complaint handling function to the Chief Psychiatrist. My office provides information regarding informal and formal complaint procedures and assistance with referrals as requested by consumers and carers.

148 Consumers and carers do contact the OCP to discuss treatment and care. The majority of these consumers and carers first come in contact with my office through contacts with the Minister for Mental Health's Office. These contacts often relate to access to the system and are not appropriate to be escalated to a formal complaints process with the Mental Health Complaints Commissioner.

149 My office applies a stepped approach to managing these contacts. In all cases, the approach taken is driven by the consumer and is dependent on context. If a matter is raised by a carer, consent of the consumer is an essential prerequisite for engagement of the OCP.

150 When a contact is made, clinical advisers based in the OCP assist in supporting the person to make contact with the relevant service and may facilitate this if the consumer gives consent.

151 In instances where serious and immediate risks to quality and safety are indicated, clinical advisers will consult and collaborate with the consumer or carer and the mental health service to explore the issues raised. Where the matter is characterised by a high degree of complexity, the associated issues are discussed in an OCP clinical meeting to ensure all options are considered. Clinical advisers provide comprehensive and timely feedback on progress and outcomes to consumers.

152 Clinical advisers may also provide consumers and carers with details of independent advocacy organisations, both legal and non-legal. These include IMHA, Victoria Legal Aid, VMIAC, Tandem, and Carers Victoria.

153 Clinical advisers also provide information about the consumer's right to make an official complaint to the Mental Health Complaints Commissioner.

154 In the event that the matter is unable to be resolved through these mechanisms, or if the Mental Health Complaints Commissioner does not have jurisdiction over the health service associated with the complaint, consumers can make a complaint to the Health Complaints Commissioner and/or the Victorian Ombudsman.

155 Contact from consumers and carers is an important source of data and is used to triangulate other data sources and reports received by my office, including restrictive interventions and sexual safety notifications. Matters raised by consumers and carers also assist by adding context to trends in data and may raise additional flags or concerns, resulting in further review or investigation.

156 In addition to direct contact with consumers, my office also regularly receives calls from IMHA advocates requesting input and liaison with consumers and mental health services. Consumers often complain to the IMHA advocate in an informal capacity, and my office regularly meets with IMHA to hear about issues from a quality and safety perspective. The frequency of these meetings has recently been increased to fortnightly to ensure timely responses to the challenges emerging during the COVID-19 pandemic.

157 Consumers may also contact my office to apply to me for a review of their treatment under the Second Psychiatric Opinions provisions at sections 84-88 of the MHA. These provisions, which apply to consumers who are subject to a Temporary Treatment Order or Treatment Order and to security patients or forensic patients, allow the consumer (and other persons specified in the Act) to seek a second psychiatric opinion in specific circumstances. In rare instances where the first and second opinions are conflicting (in that the authorised psychiatrist does not adopt any or all the recommendations contained in the second psychiatric opinion report), I may be asked to review the case.

Independent oversight mechanisms

Question 10: What independent oversight mechanisms are in place across the mental health system?

158 I have described the bodies that provide independent oversight of the Victorian mental health system at paragraph 106 above. In addition, I provide independent oversight through my statutory functions in conducting formal investigations, clinical reviews or clinical audits, and issuing directions to mental health service providers as outlined above.

159 There are also statutory requirements in place to ensure I can monitor the use of restrictive interventions, such as seclusion and bodily restraints,[26] and reportable deaths of persons receiving mental health services from a mental health service provider or the death of a security patient or forensic patient.[27] Attached to this statement and marked '**NC-4**' is a copy of the *Reportable Deaths: Chief Psychiatrist's Guideline (Summary Version)*, which articulates the notification requirements.

160 Sentinel events are described at paragraph 112(g) above. Reports of these incidents, and their associated recommendations, are reviewed jointly by SCV and members of the Chief Psychiatrist's Morbidity and Mortality Committee, including consumer and carer advocates.

Question 10(a): How have these changed since the reform of the Mental Health Act in 2014?

161 As indicated above, the role of the Chief Psychiatrist in overseeing Victoria's mental health system has changed with the commencement of the 2014 MHA. Namely, the Chief Psychiatrist's responsibilities are limited to public mental health service providers and

[26] Mental Health Act 2014, s. 108.
[27] Under section 348 of the Mental Health Act 2014, services are required to notify me of the death of any person receiving mental health services from the mental health service provider that is a reportable death within the meaning of section 4 of the Coroners Act 2008.

responsibility for managing individual client and service complaint issues is now the purview of the Mental Health Complaints Commissioner.

162 The introduction of the MHA established the Mental Health Tribunal, to replace the Mental Health Review Board and the Psychosurgery Review Board. The Mental Health Tribunal is an independent body which is responsible for making compulsory treatment orders. Under the 1986 Act, involuntary treatment orders were made by the authorised psychiatrist, with review from the Mental Health Review Board.

163 As explained above, with the introduction of the NDIS, the MHA has recently been amended to make it clear that oversight of NDIS funded mental health services is the responsibility of the NDIS Quality and Safeguards Commission.[28]

Scope of responsibilities of oversight bodies

Question 11: Please consider the responsibilities of the Chief Psychiatrist and the responsibilities of other bodies with oversight of the Victorian mental health system: (a) is there any overlap or duplication?

164 The range of complaints bodies with oversight of the Victorian mental health system means that consumers may need to approach multiple complaints bodies in relation to different aspects of their care. The distinction between a complaint and an issue that raises serious quality and safety concerns can be unclear. This complexity can create duplication of effort and a level of confusion around accountability. Progression of matters can require ongoing and in-depth collaboration between multiple partners including the OCP, the Public Advocate, Community Visitors and the Mental Health Complaints Commissioner. Although involving a variety of viewpoints can add depth and richness to the solution, it can also create barriers and delays to resolution of matters.

165 For example, a mental health consumer may be at a health service that provides both general health and mental health services, and the responsibility for a complaint differs depending on the type of care. A person seeking mental health services during a presentation to an emergency department might raise complaints about the interaction and coordination of services between emergency departments and mental health clinicians, such as the use of restraint in emergency departments on a person subject to compulsory treatment under the

[28] 'Mental health service providers' are defined in section 3 of the Mental Health Act as a designated mental health service, or a publicly funded mental health community support service, to the extent that it provides services not funded by the National Disability Insurance Scheme.

MHA. In this instance both the Mental Health Complaints Commissioner and the Health Complaints Commissioner could have jurisdiction over different aspects of the complaint.

166 I note that while the Mental Health Complaints Commissioner and the Health Complaints Commissioner seek to cooperate in the resolution of complaints, they operate within different statutory frameworks and have different policies and procedures, which can lead to parallel approaches to the resolution of complaints and different experiences for consumers.

167 Similarly, oversight of mental health service providers differs based on whether the service being provided is funded by the NDIS or not.[29] Some mental health service providers will provide both NDIS and non NDIS services, meaning that both the Mental Health Complaints Commissioner and the NDIS Quality and Safeguards Commission will have jurisdiction in those facilities in respect of different services.

168 The Mental Health Complaints Commissioner has a function to identify, analyse and review quality, safety and other issues arising out of complaints.[30] The Commissioner has used this function to conduct statewide reviews of mental health service providers, for example the sexual safety project *The Right to be Safe - Ensuring sexual safety in acute mental health inpatient units* (2018).[31]

169 While this review made a welcome contribution to the development of policy and a strategic framework for the promotion of sexual safety in inpatient units, this work overlapped with the jurisdiction of the Chief Psychiatrist with respect to my obligation to promote continuous improvement in the quality and safety of mental health services provided by mental health service providers and my powers to conduct formal investigations, clinical reviews or clinical audits.

170 The overarching recommendation of the project was for the Department of Health and Human Services to develop a comprehensive sexual safety strategy that plans, coordinates and monitors action to prevent and respond to breaches of sexual safety in Victorian acute mental health inpatient units. The development of the strategy was assigned to me as the Chief Psychiatrist and required significant diversion of resources within the OCP and the OCMHN. Again, I emphasise that this was important work which has led to improved outcomes for

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[29] A 'mental health service provider' under the Mental Health Act 2014 is defined in section 3 as a designated mental health service, or a publicly funded mental health community support service, to the extent that it provides services not funded by the NDIS.
[30] Mental Health Act 2014, s. 228(j).
[31] Mental Health Complaints Commissioner 2018, *The right to be safe – Ensuring sexual safety in acute mental health inpatient units: sexual safety project* <www.mhcc.vic.gov.au/resources/publications>, Melbourne.

consumers, however it did mean that the review by the Commissioner directed the priorities and the allocation of resources within my office for a period of over 12 months.

Strengthening existing mechanisms to improve quality and safety

Question 12: How could existing mechanisms be strengthened to improve the quality and safety of mental health services? Please consider existing regulatory, non-regulatory and independent oversight arrangements.

Mental health services

171 Whereas SCV has a broader quality and safety remit in health services that includes areas such as maternity, emergency departments and surgery, it is important in my view to bolster the quality and safety of mental health services 'from the ground up' using the powers and resources of the OCP.

172 Larger services have the resources to dedicate to mapping, monitoring and improving the calibre of their work, but this is not uniform. The clinical directors and operations managers of services, especially smaller ones, are naturally occupied with day-to-day matters, making it difficult to respond assertively and consistently to 'big picture' issues. To counter their understandable focus on compliance with national, state and local standards and indicators, it will be helpful to:

(a) Expect services' own quality and safety programs to be sufficiently resourced to promote an understanding across the whole of the organisation of strategies to lift standards beyond compliance levels. It will be helpful for quality and safety leaders to occupy senior roles within their services and for them to have access to ongoing training in contemporary quality and safety principles and methodologies.

(b) Include consumer and carer consultant and peer support workers in quality and safety activities, with representation on services' quality and safety committees to ensure that a lived experience perspective is represented when developing new initiatives, monitoring progress and embedding improvements in everyday practice. To assist with this, it will important that the lived experience workforce receives training and ongoing support to facilitate this new role.

Chief Psychiatrist

173 I envisage a greater role for my own office in augmenting 'on the ground' improvements in quality and safety in a range of ways including:

(a) Offering services' quality and safety leaders secondments to my office and SCV to work on jointly-managed projects that will enhance their knowledge and skills in promoting and embedding improvements in clinical practice on return to their service.

(b) Boosting my office's capabilities to analyse, interpret and disseminate data specific to mental health service delivery. As noted at paragraph 52 above, I recently appointed a data analyst who has already improved my capability to collect better quality data at lower cost to services and my office. It will be important for data analysts and researchers to have explicit links with VAHI and SCV to ensure consistent messaging to services.

(c) Monitoring in 'real time' the data supplied by services to my office and through CMI and the Victorian Health Incident Management System (VHIMS) concerning restrictive interventions, sexual safety incidents, deaths, critical incidents and sentinel events. My greater awareness of trends within and between services will allow me to respond more quickly to emerging trends.

(d) Adding depth to my own strategic capacity by adopting one new major quality and safety project each year. Such projects might focus on one of the existing national safety and quality standards (for example, clinical governance, harm reduction, partnership with consumers). This will build on services' need to meet these standards and add depth to the national accreditation process which, by its nature, is time-limited and cross-sectional in focus.

SCV

174 Consistent with the MHA, I retain oversight and clinical leadership of the quality and safety of public mental health services. As described previously, I have powers in excess of those available to SCV to conduct investigations, audits and reviews and can direct services to take remedial action. Equally, SCV has resources far in excess of mine to support training, develop guidelines and host clinical networks. Both my office and SCV could benefit immensely from mandated access to information such as accreditation reports from accreditation bodies such as the Australian Council on Healthcare Standards.

175 The way in which I work together with SCV has evolved more in response to circumstances than a broader strategic framework. As noted above, clinical advisers and policy advisers in my office have benefitted from some of SCV's training sessions; we conduct joint reviews of mental health related sentinel events; and the Chief Mental Health Nurse and I sit on SCV's mental

health clinical network. Members of SCV have also contributed to some of my site visits and investigations.

176 Given the large size of Victoria's public mental health service system and the challenging nature of its work, I welcome the opportunity to develop a shared framework that allows SCV to benefit from my office's expertise in mental health while sharing SCV's educational and other capabilities with mental health service providers. This may also provide benefits to health services who need to work with multiple oversight bodies and within multiple frameworks.

177 It would be helpful, for example, to work with SCV to build the capacity of consumer and carer mental health consultants and peer support workers to apply quality and safety principles and methodologies within their own workplace.

178 In addition, SCV's mental health clinical network could contribute to selecting major shared projects, implementing them and helping embed improvements in clinical practice. This will build on their proven capability to scale up successful interventions across service networks (for example, the Safe Haven mental health diversion project piloted within the Better Care Victoria Innovation program at St Vincent's Hospital Melbourne).

VAHI

179 VAHI collects and collates all the data submitted to the Department of Health and Human Services by health services, including mental health services. I have worked with VAHI very successfully to develop indicators based on data submitted through CMI on the YES survey, restrictive interventions, ECT, treatment orders and the like. The findings are communicated in confidence to providers through the *Inspire Mental Health* report.

180 I add value to the report by engaging in dialogue with services that show as an 'outlier' on indicators (for example, where rates of ECT or treatment orders exceed the state average by more than one standard deviation). The point is not to attribute blame but to encourage services to question why their rates of a practice are higher than in other similar services. I encourage exploration of the data by asking larger services to check if rates differ between their own community teams or inpatient units and engage in discussions with services.

181 Where it emerges that differences have no obvious reason (such as a specialty clinical program or expanded catchment population) I request clinical leaders to work with their teams to review the particular practice and take remedial action. Some of the responses to date have been very impressive. The *Inspire Mental Health* report format makes it possible to track changes in practice over time to ensure that changes are enduring.

182 I am aware that VAHI is collaborating with services to ensure the content and format of its reports meet their needs. I am keen to collaborate with them to assist in this endeavour.

Mental Health Complaints Commissioner

183 I meet with the Mental Health Complaints Commissioner on a regular basis to discuss matters of mutual concern. The Commissioner provides me with information about particularly serious complaints, worrying trends and aspects of complaints that might warrant action on my part (such as possible breaches of the MHA). We are writing a memorandum of understanding at present that describes more clearly our relative roles and responsibilities to minimise duplication of effort and facilitate shared activities. However, the areas of duplication and overlap may be better addressed through future structural reform or legislative change.

184 It is my intention, where possible, to use the Commissioner's insights into key aspects of the care delivery system – consumers' access to care, the appropriateness and adequacy of care, and respect for consumers' and carers' rights – to assist in my choice of major quality and safety improvement projects.

The Public Advocate

185 Community Visitors, appointed on the recommendation of the Public Advocate, provide independent oversight of the public mental health sector at a 'grass roots' level. While the Department of Health and Human Services published a code of practice in 2016 detailing service providers' obligations to support Community Visitors, I am aware of inconsistencies in providers' responses to visitors' queries and concerns and I shall take action to remind providers of their need to observe the code.[32] This will ensure that visitors can exercise their responsibilities with good effect. At the same time, it is important to have a clearly documented understanding of the role of the Community Visitors to ensure that it does not suffer from scope creep into areas for which the visitors are not sufficiently qualified.

Addressing potential oversight gaps

Question 11(b): Please consider the responsibilities of the Chief Psychiatrist and the responsibilities of other bodies with oversight of the Victorian mental health system. Are there any gaps? If yes, what are the implications of these for mental health service providers and your role as Chief Psychiatrist?

186 I have highlighted gaps between my roles and those of SCV and the Mental Health Complaints Commissioner, together with strategies to address them, above. Some other potential gaps are

[32] Department of Health and Human Services 2016, *Mental Health Act 2014: Community visitors: Code of practice* <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/oversight-and-service-improvement/community-visitors>, Melbourne.

described below, although this list is not exhaustive. I also highlight some potential gaps in oversight, accountability, safety and quality mechanisms and governance as part of my discussion of changes in practice and service delivery at paragraphs 193 to 206 below.

Clinical registration notifications

187 I regulate mental health service providers, and not individual clinicians who are accountable for their work to their clinical and operational supervisors and for their professional registration to AHPRA. If I conclude after an investigation that a clinician's standard of care or behaviour presents an unacceptable risk to consumers or the public, I may recommend that the provider makes a notification to APHRA. If some aspect of the matter was the subject of a complaint to the Mental Health Complaints Commissioner, the Commissioner might also make a notification. Clear communication between providers, the Commissioner and my office will prevent confusion about our various roles.

Albury Wodonga mental health service

188 All mental health service providers are located in Victoria apart from Albury Wodonga Health (AWH) which delivers services in both New South Wales and Victoria. This gives rise to some complexity because of the two states' different legal and regulatory frameworks. In response to these concerns, my office initiated a process to clarify the arrangements that would underpin safety and quality for AWH's mental health services. This included extensive consultation with AWH, the NSW Chief Psychiatrist and NSW Health and culminated in January 2019 in the signing of a memorandum of understanding (MOU) between the Secretary of the Victorian Department of Health and Human Services and the Secretary of New South Wales Health.

189 The MOU clarifies a number of issues related to safety and quality at AWH, including the legislative requirements for AWH mental health services, applicable policies and guidelines, my oversight of AWH and complaints handling policies.

190 The MOU defines AWH as a Victorian-governed entity responsive to the Victorian Chief Psychiatrist, Chief Mental Health Nurse and authorised staff within the OCP. My office holds oversight of the safety and quality of care of all AWH mental health services and may conduct clinical reviews if warranted. The MOU is due to be reviewed this year to ensure that it remains current and relevant.

Aged persons' mental health residential care facilities

191 There has been a trend in recent years for management of Victoria's aged persons' mental health residential care facilities to move from mental health programs to health services' aged

care, sub-acute or residential programs. This makes sense at an operational level. Aged persons' mental health residential facilities have much in common with services' other aged care facilities with respect to accreditation requirements, funding streams and hotel services.

192 I retain oversight of these facilities because they continue to be delivered by health services that have been prescribed as designated mental health services and they have a specific mental health focus. It emerged, however, in my recent review of the standards of care in these facilities, that while old age psychiatrists attend on a regular basis to supervise treatment, the nursing and allied health workforce within the facilities usually receive no specialist mental health education or supervision. I am working with health services to ensure that staff members have in-reach by mental health service educators to ensure that levels of knowledge and skills remain contemporary.

Responding to changes in practice and service delivery

Question 13: In a reformed system there may be a greater diversity of professionals and providers, increased community based services, and more online service provision. What would need to be re-examined in relation to existing quality and safety mechanisms to respond to such changes in practice and service delivery?

193 In a reformed system there may be a greater diversity of professionals and providers, increased community based services, and more online service provision. Responding to such changes in practice and service delivery will require many elements of the existing quality and safety mechanisms to be re-examined, including what the quality and safety framework would need to be for new entrants to the publicly-funded provider market; what elements of the current quality and safety frameworks would be retained or amended; who is responsible for the clinical governance mechanisms; and what the reporting processes might be.

194 Online provision of mental health services has been addressed at paragraphs 77 to 82 above. I will focus here on quality and safety mechanisms as they relate to: peer support workers, the newest professional group to enter the mental health workforce; private psychiatric hospitals whose role in accommodating public mental health consumers will expand further; and community mental health support services whose role in offering residential recovery services is relatively new.

Peer support workers

195 Consumer peer support workers use their own lived experience of mental illness and recovery to support other consumers. Carer peer support workers use their experience of supporting a family member or friend who has experienced mental illness to support consumers' family

members and friends. Their 'hands on' clinical role differs from the more systemic approach taken by consumer and carer consultants.

196 Peer support work focusses on building mutual and reciprocal relationships with consumers (in the case of consumer support workers) and carers (in the case of carer support workers) with the goal of encouraging and sustaining recovery and well-being. This skilled, specialised work which extends now from inpatient units to emergency departments and the community requires ongoing support and supervision. Strategies to achieve this were canvassed in a recent research report and are the subject of an ongoing co-designed and co-produced action project.[33,34]

Private mental health providers

197 In recent years a number of public designated mental health service providers have contracted with private providers to accommodate public inpatients in private hospital beds. These inpatients, all of whom receive care on a voluntary basis, are selected through the public triage process on the basis of a favourable risk profile and their likelihood of benefitting from the kind of therapeutic programs offered in the private sector. The people accommodated in this way remain registered consumers of their area mental health service and most will return to the service for continuing care after discharge.

198 There is no agreed model, however, of oversight by public services of the quality and safety of the care offered to the consumers they refer to private inpatient facilities. At present, some services have clearly defined lines of accountability: others do not.

199 There is also no shared understanding of my role as Chief Psychiatrist in monitoring these public-in-private arrangements and my capacity to intervene in the event of a serious untoward incident.

200 To address this gap, it will be necessary to develop a uniform model of governance in collaboration with public and private providers that specifies oversight accountabilities and processes, including oversight by my office. This will ensure my access through public reporting

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[33] Department of Health and Human Services 2019, *"You get what I'm going through" research report: Expanding the post-discharge support initiative* <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/expanding-post-discharge-support-initiative-report>, Melbourne.

[34] Centre for Mental Health Learning 2019, *Strategy for the consumer mental health workforce in Victoria* <https://cmhl.org.au/sites/default/files/resources-pdfs/Consumer-Workforce-Strategy-web.pdf>, Melbourne.

pathways including CMI and VHIMS to the information I need to monitor the quality and safety of the care provided to public consumers regardless of setting.

Subcontracted subacute services

201 Prevention and recovery care (PARC) centres offer short-term, community-based mental health care to people in need of multi-disciplinary treatment and support within a residential setting. The centres function as an alternative to an acute inpatient admission (step up) or following discharge from an inpatient unit (step down).

202 The majority of PARCs have functions subcontracted to community-based mental health support services by clinical mental health service providers. Typically, the community-based mental health support service will manage staffing, therapeutic programs and hotel services. Staff members come from a variety of backgrounds including community services, allied health and lived experience. There is a strong focus on personal recovery. Interventions are tailored to consumers' needs and include counselling, creative activity, help with relationships and family, and linkages to promote physical wellbeing, ongoing community support and appropriate accommodation.

203 Clinical mental health service providers manage clinical in-reach in the form of a mental health nurse and/or allied health clinician (typically in working hours, with some PARCs extending cover into evenings and across seven days) and a visiting consultant psychiatrist and registrar.

204 Formal agreements between the subcontracted subacute service and clinical service provider stipulate requirements for escalation pathways within the respective organisations and appropriate quality and safety review mechanisms.

205 Given the rapid escalation in the acuity of illness of PARC residents in recent years, and a commensurate increase in levels of clinical risk, it would be timely for the Department of Health and Human Services to review guidelines to services for use in subcontracting negotiations to ensure that the community providers' incident review mechanisms are in accord with those required for clinical and inpatient program areas.

206 Clinical governance mechanisms are key here to the delivery of quality and safe mental health treatment. The Department of Health and Human Services should also have assurance that subcontracted subacute services have adequate systems in place to monitor the safety and quality of their own care systems and to intervene in the event of serious incidents. Going forward, an oversight mechanism for mental health community support services in a stepped care model will need to be considered.

Service safety and minimising the occurrence of harmful incidents

Question 14: Overall, across the system, what arrangements do services have in place to: (a) minimise the occurrence of harmful incidents?, and (b) respond to the needs of consumers and staff when they do occur?

207 As noted at paragraph 103(a) above, all health services including clinical mental health services must be accredited against the current edition of the National Safety and Quality Health Service Standards published by the ACSQHC. These standards touch directly on services' harm minimisation strategies and responses to consumers and carers involved in harmful incidents.[35] Each individual service is therefore responsible for having frameworks, systems and leadership structures in place. Mental health service providers are assessed by accreditation agencies for adherence to these standards and must take action to remediate any findings of non-compliance. Failure to meet the national standards jeopardises services' ability to operate.

208 Smaller service providers will struggle more than larger ones to meet all of the required standards to an exemplary degree. To provide them with specialist, targeted support, I propose working with SCV to undertake visits to services, with a focus initially on smaller regional ones, to review their quality and safety systems and processes. These support teams will include quality and safety leaders from other services and consumer and carer representatives.

209 A review of our findings and recommendations will prompt the development of interventions at a statewide level to address wide-spread gaps in practice standards. These interventions might include new frameworks, guidelines or advisory notices, training programs and leadership enhancement opportunities.

Responding to the needs of consumers and staff when harmful incidents occur

210 The National Safety and Quality Health Service Standards require that services have a charter of consumers' rights that is consistent with the Australian Charter of Healthcare Rights (Standard 2.3). This charter stipulates among other things that consumers and carers are told if something goes wrong during health care, how this may affect them and what is being done to make care safe.[36] A copy of the charter must be readily available to consumers and carers.

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[35] Australian Commission on Safety and Quality in Health Care 2019, The National Safety and Quality Health Service Standards <https://www.safetyandquality.gov.au/standards/nsqhs-standards>, Sydney
[36] Australian Commission on Safety And Quality in Health Care 2019, *Australian Charter of Healthcare Rights* <https://www.safetyandquality.gov.au/australian-charter-healthcare-rights>, Sydney.

211 When unexpected incidents cause harm to consumers, the service must comply with the Australian Open Disclosure Framework and monitor and act to improve the effectiveness of its open disclosure processes (Standard 1.12).

212 At a minimum, the open disclosure process entails an apology or expression of regret; a factual explanation of what occurred, including actual consequences; an opportunity for the consumer to relate their experience; and an account of the steps taken to manage the event and prevent its recurrence.[37]

213 The Safewards program, which is described in detail at paragraphs 519 to 532 below, sets out a style of relating to consumers that reduces the likelihood of incidents that harm consumers and also members of staff. In a local evaluation project, inpatients and staff reported better communication, reduced conflict and a greater sense of safety.[38]

214 In the event that an unexpected incident results in death or very serious, enduring harm to a mental health consumer or member of staff, it is reported to SCV as a sentinel event, as described at paragraph 112(g) above. Unlike other jurisdictions which restrict the reporting requirement to strictly limited circumstances, Victoria applies much broader inclusion criteria.[39]

215 Service providers must conduct a detailed analysis of the event using an agreed methodology with input from independent reviewers. Their report, which specifies learnings and remedial actions, is reviewed jointly by SCV and members of my Morbidity and Mortality Committee. The provider is given feedback about the adequacy of its analysis and recommendations and may be asked to undertake further actions to prevent a recurrence.

Reporting on safety incidents

Question 15: Are mental health services required to report on safety incidents and their responses to safety incidents? (a) To whom and when are mental health services required to report safety incidents and their responses to safety incidents? (b) How adequate are these arrangements in preventing and responding to harmful incidents? (c) How can these arrangements be improved to better ensure consumer and staff safety?

[37] Department of Health and Human Services 2008, *Open disclosure for Victorian health services – a guidebook* <https://www2.health.vic.gov.au/about/publications/researchandreports/Open-disclosure-for-Victorian-health-services---A-guidebook>, Melbourne.
[38] Centre for Psychiatric Nursing 2016, *Safewards Victorian Trial Final Evaluation Report* <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/evaluation>, Melbourne.
[39] Safer Care Victoria 2019, *Victorian sentinel event guide: Essential information about managing sentinel events in Victoria* <https://www.bettersafercare.vic.gov.au/resources/tools/victorian-sentinel-events-guide>, Melbourne.

216 Mental health services (like health services generally) report safety incidents, and their responses to incidents, via VHIMS, a standardised dataset that will eventually store records of incidents and hazards from all Victorian public health services. The *Policy and Funding Guidelines 2019-20*, attached to this statement and marked '**NC-3**', set out these reporting requirements for health services.

217 VHIMS has been hindered by services' multiplicity of internal reporting definitions and systems and by difficulties distinguishing one part of a service from another.

218 It has not been possible therefore for VAHI, which collects and collates VHIMS data, to provide me with meaningful data about clinical and occupational incidents on a service-by-service basis or to track patterns in incidents over time.

219 Attached to this statement and marked '**NC-5**' is a copy of the *Victorian Health Incident Management System Minimum Dataset*. All services will provide VAHI with the VHIMS standardised minimum data set by July 2021. From 2022, VAHI will be able to provide mental health service providers with regular reports (much like the *Inspire Mental Health* reports) showing incident categories, numbers and trends. I will have access to these reports too.

220 I will also be able to request reports, on a regular or occasional basis, of incidents of particular relevance to the mental health field (for example, occupational violence, sexual safety incidents and suicide attempts on mental health inpatient units) within a particular service or program stream, cross-sectionally and over time.

221 This will allow the Chief Mental Health Nurse and me to map patterns and trends in incidents and to target interventions (site visits, investigations etc.) more strategically. This will represent a major advance in my capabilities.

222 In developing its new application, VAHI consulted with numerous bodies including SCV, the Mental Health Complaints Commissioner, the Victorian Managed Insurance Agency, WorkSafe and my office.

Adequacy of existing arrangements in preventing and responding to harmful incidents

223 Services' own incident reporting standards are governed nationally and subject to accreditation. Mental health service providers are required under the national health care standards to use incident reporting systems to generate timely reports on quality and safety systems and performance to the governing body, the workforce, consumers, the local community and other relevant health service organisations (standard 1.9), and to use clinical and other data collections to support risk assessments; act to reduce risks; review and improve the

effectiveness of the risk management system; and report on risks to the workforce and consumers with plans to manage internal and external emergencies and disasters (standard 1.10).

224 As noted in paragraph 219 above, I shall have much better information available to me from 2022 to track differences in patterns of selected types of incidents within and between services and over time.

225 These improvements in the detail and consistency of incident and near miss data will greatly improve incident oversight within and between services and at a statewide level.

Safety risks within Victorian mental health services

Question 16: Within Victorian mental health services: (a) What factors contribute to safety risks? (b) What factors contribute to occupational violence and other safety issues being encountered by the mental health workforce? (c) What factors are protective and support: (i) consumer safety and wellbeing? (ii) carer and family safety and wellbeing?

226 Issues relating to suicide risk will be addressed in paragraphs 310 to 343. I will focus here on three other important risks facing mental health consumers, namely physical aggression and violence, sexual safety incidents, and physical illness and incapacity. I shall also consider risks where indicated to the mental health workforce, carers and families. I shall conclude each of the three sections with a discussion of current responses to these areas of risk to identify the factors that are protective and support consumer, carer and family safety and wellbeing.

Physical aggression and violence

227 In the community generally, people with mental illness are more often the victims of violence than the perpetrators. [40]Aggression is a significant issue however in emergency departments and mental health inpatient units.

228 Once the standardised VHIMS data platform becomes operational in 2022, it will be possible to map the prevalence of aggressive episodes across services, facilities and time. There are no meaningful statewide data available at present but proxy markers give some insight into the occurrence of the behaviours on wards that prompt staff to take inpatients into seclusion. There

[40] Galletly C, Castle D, Dark F et al. 2016, 'Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders', *Australian and New Zealand Journal of Psychiatry*, vol. 50, pp. 410-72.

are many reasons for inpatients to be secluded but aggressive behaviours, or the threat of aggressive behaviours, are a leading cause.

229 In 2018-19, there were 3,178 episodes of seclusion across all of Victoria's mental health inpatient units, giving a rate in adult wards of 9.2 episodes per 1,000 occupied bed days. This represents a drop of 11 per cent over a five-year period despite a steady increase in admissions over the same period.[41] The number is troubling nonetheless.

230 Aggression on inpatient units poses multiple hazards. For those inpatients who behave aggressively, the consequences may include physical restraint, injected medications and seclusion, sometimes for lengthy periods. The consumer and staff members involved in the incident may be injured and the other consumers who witness it are likely to experience great anxiety. Repeated episodes of aggression are likely to result in feelings of mistrust and resentment by consumers toward staff and, for staff members, high levels of absenteeism and burnout. These sequelae make it difficult to provide a hope-filled, therapeutic environment for those admitted to the unit and a congenial, rewarding workplace for clinicians.[42]

231 Multiple, complex factors contribute to aggression in mental health units. Clinical and socio-demographic correlates include diagnoses of psychosis, substance abuse and antisocial personality traits coupled with male gender, youth, compulsory legal status, multiple previous admissions and unemployment. Staff characteristics and behaviour play a part too; trigger factors may include inexperience, fatigue, burnout, negative attitudes towards consumers and a lack of engagement with them, an emphasis on rule-keeping and inflexibility. Poor design, over-crowding and high turnover also contribute, as do unsupportive managers who fail to address staff members' concerns.[43]

Current responses

232 To provide context, I note that occupational violence and aggression are issues across the whole of the health care sector, and the Department of Health and Human Services has established a framework for preventing and managing occupational violence and aggression

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[41] Department of Health and Human Services 2019, *Chief Psychiatrist's annual report 2018-19* <https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2018-19>, Melbourne.
[42] Renwick L, Stewart D, Richardson M et al 2016, 'Aggression on inpatient units: clinical characteristics and consequences', *International Journal of Mental Health Nursing*, vol. 25, pp. 308-18.
[43] Slazmann-Erikson M and Yifter L 2019, 'Risk factors and triggers that may result in patient-initiated violence on inpatient psychiatric units: an integrative review', *Clinical Nursing Research*, 1, pp. 1-38.

that covers the six domains of governance, prevention, training, response, reporting and investigation.[44]

233 The framework specifies that service providers will develop site-specific policies and procedures to prevent aggression and manage it safely when it occurs; make training relevant to staff members' roles; support staff members appropriately after incidents; and classify and report incidents for the purposes of benchmarking, staff feedback and prevention.

234 The Department of Health and Human Services has also invested in enhancing the skills of frontline employees including receptionists and allied health workers, implementing programs to address employee wellbeing, and progressing capital works to reduce environmental risks. Because of the link between aggression and use of amphetamines, the Department of Health and Human Services embarked in 2015 on an Ice Action Plan to support front line workers to manage and treat people using stimulants.[45]

235 More recently, six new mental health and AOD hubs in emergency departments are being developed to provide more timely and appropriate treatment for people with mental health and AOD issues and reduce their levels of distress and agitation.

236 With respect to mental health services, a number of initiatives will strengthen workforce capacity and make inpatient units more therapeutic: 31 clinical nurse specialist appointments as discussed at paragraph 239 below, 140 postgraduate nurse scholarships, and a clinical supervision program for nurses run in conjunction with the Australian Catholic University.

237 One key development in my view is the appointment of peer support workers in inpatient units. Their insight into the experience of inpatients and their ability to think creatively of ways to address people's needs should engender a more consumer-focused and recovery-oriented unit milieu. This will, I hope, reduce aggression and the use of restrictive interventions.

238 The Safewards program, which supports staff to think and behave more flexibly, empathically and positively, has now been implemented in all Victorian mental health inpatient units, and is discussed in detail at paragraphs 519 to 531 below. In the UK, its use was associated with a

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[44] Department of Health and Human Services 2017, *Framework for preventing and managing occupational violence and aggression* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/occupational-violence-aggression-healthcare-framework-2017>, Melbourne.
[45] Victorian Government 2015, *Ice Action Plan* <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/ice-action-plan>, Melbourne.

15 per cent reduction in conflict on inpatient wards and a 26 per cent reduction in containment events.[46]

239 In a recent initiative, 31 Clinical Nurse Consultant (CNC) full time equivalent positions were funded for allocation to inpatient units across the state. These ongoing positions are supernumerary to current staffing numbers on inpatient units. CNCs are senior level nursing positions – they provide mentorship and clinical experience to address priority issues such as consumer and staff safety. The intention of the CNC role is to reduce and where possible eliminate restrictive interventions and lead work through therapeutic engagement frameworks such as Safewards, the Mental Health Intensive Care Framework and the Clinical Supervision Framework for the workforce. The roles will be a crucial resource and will provide leadership for staff teams to support vulnerable consumers presenting with high level needs.

240 An additional 25 full time equivalent positions would ensure that the rest of the acute inpatient units and SECUs across the state are allocated the CNC role.

Sexual safety

241 The Mental Health Complaints Commissioner published an analysis in 2018 of 90 complaints of sexual activity, harassment, intimidation or assault made to the Commissioner or to service providers by, or on behalf of, mental health inpatients between 2014 and 2017.[47] Notably, none of the eight complaints that met criteria for sexual assault had been reported to me. The report prompted a forum attended by consumer and carer representatives, service providers, Victoria Police and members of my office.

242 I have implemented a reporting tool and am collecting data on sexual safety incidents. I have also established a Sexual Safety Committee with consumer and carer representatives, a transgender spokesperson, clinicians and an academic nurse to provide advice on ongoing reforms including a revision of the inpatient sexual safety guideline.

243 The guideline will give direction to clinicians about communicating expectations of behaviour to new inpatients, clarifying definitions of safety incidents, and responding promptly and

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[46] Bowers L, James K, Quirk A et al. 2015, 'Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial', *International Journal of Nursing Studies* vol. 52, pp. 1412-22.

[47] Mental *Health Complaints Commissioner 2018, The right to be safe – Ensuring sexual safety in acute mental health inpatient units: sexual safety project* <www.mhcc.vic.gov.au/resources/publications>, Melbourne.

appropriately to the needs of victims, perpetrators (most of whom are very unwell) and members of staff.

244 The guideline, and the program to launch and implement it, will help change a culture within services of minimising the effects on consumers of unwanted sexual comments and suggestions and attributing reports of harassment and assault to the complainants' mental condition. This culture must change if reports are to be taken seriously and investigated properly.

Physical illness and disability

245 People with mental illness are significantly more vulnerable to physical illness, physical disability and premature mortality. Rates of serious, chronic health conditions like cardiovascular disease, respiratory disease, diabetes, metabolic syndrome and osteoporosis are roughly double those found in the general population. Rates of cancer are higher by a factor of 50 per cent. Hepatitis C is about ten times more frequent. Taken overall, life expectancy is reduced on average by about 20 years.[48]

246 The reasons for these discrepancies include a multiplicity of factors including life-time trauma, unemployment and inadequate housing, limited dietary options, smoking and substance use, poor access to services, social exclusion and stigmatisation resulting in delayed diagnosis and treatment.

247 To help overcome these barriers, it is imperative that mental health clinicians are mindful of consumers' physical well-being and take action to encourage screening, testing and treatment of physical health conditions where indicated. It is no longer acceptable to expect physical and mental health to be addressed by different health providers in different places at different times. Where consumers have limited access to health care, mental health clinicians must take an assertive role to help consumers overcome barriers to good health.

Current responses

248 After the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) stipulated that Australian governments will commit to improving the physical health and wellbeing of people living with mental illness (Priority 5), the Chief Mental Health Nurse took the lead in

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[48] Department of Health 2017, *The Fifth National Mental Health and Suicide Prevention Plan* <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf> Canberra.

publishing *Equally well in Victoria: Physical health framework for specialist mental health services.*[49]

249 This comprehensive document describes the elements that must be in place, both organisationally and clinically, to allow consumers to advance their goals for health, health care and community participation.

250 For each of the framework's priority areas (smoking, alcohol and substance use, metabolic and dental health, physical activity, falls, medicine optimisation, sexual and reproductive health and blood borne viruses), it describes strategies to understand consumers' physical health risk profiles, identify opportunities for partnering with consumers and carers to identify acceptable and appropriate physical health interventions, build interprofessional workforce capabilities, and engage consumers and carers to gather feedback and improve health care practices.

251 As an example, the metabolic health domain addresses the consumer's perspective (for example, the relationship between weight and recovery goals), health assessments in routine practice (such as regular checks of weight and circumference), links between physical and mental health (such as the relationship between psychotropic medications and weight), developing realistic goals, and engaging other professionals (such as dieticians). It lists workforce considerations, suggests health promotion strategies and gives tips for younger and older age groups.

252 Under the National Safety and Quality Health Service Standards, providers must also take steps to protect the physical health of inpatients, many of whom have complex combinations of mental and physical health conditions. Services are required to have organisation-wide systems in place to support and promote the detection and recognition of acute physiological deterioration including delirium (Standard 8). Inpatients must therefore have medical checks, their wellbeing must be monitored regularly and there must be clear escalation pathways in the event of physical deterioration.

253 Finally, mental health services attached to general hospitals provide in-reach to other parts of the hospital to support the diagnosis and care of individuals whose medical or surgical treatments are complicated by new or pre-existing psychological or psychiatric conditions. There is no agreed framework for these consultation-liaison services and provision varies significantly between one mental health service and another.

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[49] Department of Health and Human Services 2019, *Equally well in Victoria: Physical health framework for specialist mental health services* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/equally-well-in-victoria>, Melbourne.

Family and carer wellbeing

254 Families and carers play such a major and ongoing role in providing support and care to people with mental illness that mental health service providers must engage with them constructively to produce the best outcomes for consumers.

255 I know through the calls to my office that carers do not always feel included in assessments and treatment plans. Services are under great pressure, but this in itself is not a reason to exclude from consideration people with invaluable information to share about the consumer's recent trajectory and whose contribution is sometimes critical to the consumer's continued safety and wellbeing in the community.

256 For this reason, I have appointed a carers' senior policy advisor to my team to ensure that my colleagues and I have ready access to contemporary, high quality advice on issues pertaining to carers and that all my site visits, committees and investigations include a carer's perspective.

257 I expect mental health service providers to engage carer consultants and I look forward to consumer and carer consultants contributing to services' quality and safety activities.

258 To reinforce this message, I published two guidelines in 2018: one on working with families and carers and one on family violence.

259 The guideline on working with families and carers provides a policy framework and guidance to service providers on recognising carers' central role as partners in consumers' recovery. It speaks of the need to engage carers in the assessment and treatment pathway while ensuring consumers' rights to privacy and confidentiality (for example, by revisiting consent to sharing information if the consumer refuses this initially). It addresses carers' own needs for information, understanding, practical support and safety and the needs of dependent children. Finally, it acknowledges that some consumers do not want their families involved in their care and some families choose not to be involved.[50]

260 The guideline on family violence was written in response to the Victorian Royal Commission into Family Violence. It describes the complex connections between mental illness and family

[50] Department of Health and Human Services 2018, *Working together with families and carers: Chief Psychiatrist's guideline* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers>, Melbourne.

violence (most notably that exposure to family violence can cause or exacerbate mental health problems and mental illness).[51]

261 The guideline states that the clinical leaders of mental health services have a responsibility to ensure training and supervision on family violence is available to all clinicians; develop policies and procedures for identifying and responding to family violence; and ensure that the service meets its legal obligations to share information with other prescribed providers. Perpetrators of family violence must be held accountable for their actions while receiving appropriate, respectful support and treatment for their own mental health condition.

262 Finally, my clinical advisors advocate constantly in their interactions with service providers and clinicians for family members and carers to be heard, included and respected. I acknowledge that we have a long way to go, especially in times of service constraint, but I am hopeful that the growing presence of carer policy advisers within the Department of Health and Human Services, and the presence of carer consultants and peer support workers within services, will make life better for carers and consumers throughout Victoria.

Approaches to separating consumer cohorts in mental health facilities

Question 17: Are there approaches to separating patient groups in mental health facilities that: (i) Improve consumer experiences and safety? (ii) Improve worker experiences and safety?

263 Separating consumer cohorts is a necessary part of delivering specialised and safe healthcare. In the general medical setting, diverse settings such as intensive care, high dependency and critical care units, and geriatric, rehabilitation and oncology wards allow for specialist input for the patient's medical condition, and an appropriate level of nursing and medical care.

264 Similarly, in mental health facilities – including acute and subacute settings, and standalone residential style buildings in the community – the separation of consumer cohorts can improve both consumer and worker experiences and safety.

265 For a range of cohorts, the need for separation is clearly established. For example, children must be separated from adults (as I discuss in detail at paragraphs 297 to 309 below) and consumers with acute care needs should be separated from those approaching discharge or transition to step-down settings.

[51] Department of Health and Human Services 2018, *Chief Psychiatrist's guideline and practice resource: family violence* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/family-violence-guideline-practice-resource>, Melbourne.

266 Design of spaces that emphasises safety and flexibility to meet consumer needs is paramount to engendering trust for vulnerable consumers. This is not solely a matter of creating gender sensitive areas, but also ensuring the use of spaces can be adapted for individual needs while ensuring safety and quality treatment.

267 Within acute settings, it is imperative to give consideration to the service environment, compatibility, and the most appropriate setting for a person's needs. The Mental Health Intensive Care Framework, described at paragraph 137 above, draws attention to issues that can arise when people are grouped into treatment environments according to risk severity and support needs, resulting in clustering people whose needs are incompatible. Any decision on care settings should take into account the potential risks and impacts of both the treatment environment and the communal environment.

268 Over time, new sub-areas have evolved within adult acute mental health settings that provide options for separating consumer cohorts. Seclusion rooms and anterooms provide a quiet and safe environment with very low stimulation, whereas high dependency units and intensive care areas operate with increased staffing support and a smaller number of consumers compared with the general inpatient setting.

269 Innovative programs and quality and safety interventions have also been introduced over time, with gender sensitive corridors, Safewards and other quality and safety activities now widely practiced in acute inpatient settings. The Mental Health Intensive Care Framework was released in late 2019 and is in the process of being implemented.

270 The available settings, however, are not always able to meet consumers' needs, and I address this further at paragraphs 272 to 285 below.

Separation of cohorts in existing facilities

271 Within the existing public system, there are a range of settings – both state and federally funded – that facilitate the separation of specific cohorts. For instance:

(a) Acute inpatient units, which cater to different age groups (child, adolescent, youth, adult and aged) and acuity.

(b) Psychiatric Assessment and Planning Units (PAPU) designed as short stay units (24-72 hours admissions) that provide timely access to short-term care with a view to discharge to the community. The design and location of these units varies according to resource availability and new build planning, with some located

adjacent to emergency departments and generic short stay units, and others within and adjacent to acute adult inpatient units.

(c) SECUs, which provide medium to long-term inpatient treatment and rehabilitation in a secure environment, and are discussed in detail at paragraphs 541 to 567 below. The design, number of beds, location and cohort of consumers significantly vary. For instance, one large metropolitan unit is separated into three distinct subunits which allow streaming of male, female and a mixed cohort of consumers.

(d) Thomas Embling Hospital (Forensicare) which provides secure acute, residential and rehabilitation options for people from the criminal justice system who need specialist psychiatric assessment and treatment, and a small number of consumers from the public mental health system who require specialised management.

(e) Specialist units for eating disorder services established in several area mental health services. Models of care delivery have evolved locally depending on resource availability, and vary between services. One model sees the eating disorder service situated in a general medical setting with significant co-delivery of care with general health; in another model, eating disorder beds are situated with another specialist mental health service and sharing a unit; a third model has eating disorder beds which are separated but sited within adult acute inpatient units. These settings offer very different environments and experiences of care. In addition, there are residential and day programs and outpatient programs for consumers with eating disorders which complement these acute care models.

(f) Parent and infant mental health services, which have evolved according to funding, resource availability and clinical demands. Outreach and virtual beds have been added to the models of care to meet the demands and needs of the consumer cohort.

(g) Transition Support Units (TSUs) have recently been developed to address the needs of consumers with dual disabilities. One unit, located on an acute health site, has SECU-like design features; the other has features similar to a PARC and is located in the community. These statewide services, their models of care and their roles within the mental health system are still evolving.

(h) Community based residential rehabilitation services, including community care units (CCUs) providing medium to long-term care and rehabilitation, and PARC services (including three specialised youth PARCs for young people aged 16-25 years, a

women's PARC, and an additional youth PARC and women's PARC in development) providing short-term treatment.

(i) Mental health community support services (MHCSSs), which provide adult and youth residential rehabilitation services.

(j) Aged acute mental health services, which vary from standalone units on acute and subacute health campuses to integrated services within adult acute mental health wards. Depending on the setting, the care delivered may differ due to shared staff expertise, as well as the overflow of adult demand into aged beds, and can impact on consumer experiences and safety. For example, in a regional hybrid unit, an elderly consumer was assaulted when an agitated adult consumer gained access to the aged mental health subunit on the ward.

(k) Mental health residential aged care units, which are distributed across most area mental health services and regions. They are frequently collocated with non-mental health residential aged care, with a governance structure falling either under mental health programs or subacute medicine programs. The provision of specialist aged mental health services is influenced by funding, staff experience, and facility design and age. Some regions have significant new private residential bed stock with associated aged mental health and geriatric medicine in-reach. This can result in lower demand for public residential mental health beds, and can challenge the viability of some units, with some services in metropolitan Melbourne closing due to these issues.

(l) ECT suites, which receive both inpatients and outpatients, and are usually situated either adjacent to acute inpatient units or within theatre recovery or day procedure areas. There is a range of issues associated with each setting. Suites shared with day procedure services mean there may be limited session times and caps on the number of consumers who can receive ECT. If the suite is not located close to the inpatient unit, or is located at another campus, an acutely unwell person must sometimes travel some distance which may be challenging for someone with severe symptoms. Waiting areas also may be inappropriately situated, providing less than adequate privacy. In contrast, ECT suites collocated with acute inpatient units have greater flexibility with time and space, although do not have the full range of staff and resources that theatre suites have.

(m) Other specialist statewide and regional services that stream consumers to provide specialist treatments include a statewide neuropsychiatry unit at Melbourne Health

specialising in mental illnesses associated with disorders of the nervous system; the Alfred Psychiatry Intensive Care Statewide Service, caring for inpatients of area mental health services who present with significant behavioural or treatment difficulties in those settings; a statewide brain disorder service at Austin Health for people with acquired brain injury or neurodegenerative conditions with associated psychiatric conditions; and the statewide trauma service provided by Foundation House.

272 There are particular groups where both consumers and staff would benefit from alternative options to these. I describe some of the most pressing challenges below.

Challenges for young people

273 Young people with conditions such as autism spectrum disorder, emergent personality disorder, intellectual disability or eating disorders can face particular challenges. Child protection, the NDIS, and paediatric specialists may be involved in their care, however there are few services with accommodation options specialising in these consumers' specific needs.

274 In addition, there is a significant care interface between paediatric units and mental health units, as well as outpatient services provided by each discipline. Often, conditions such as eating disorders are primarily managed in paediatric units with consultation liaison input from mental health clinicians. To provide coordinated and effective care, in-reach between departments is needed. Similar to the discussion below regarding aged consumers, improved consultation and liaison services could address some of the issues in the paediatric and child and youth space.

Aged mental health consumers

275 For ageing consumers with cognitive impairments and psychiatric symptoms, there is a significant care interface between aged mental health (bed-based and community) and geriatric medicine.

276 In bed-based services, consumers with cognitive impairments and low acuity psychiatric symptoms (such as behavioural and psychological symptoms of dementia (BPSD)) are managed in the geriatric setting, with consultation liaison in-reach provided by local aged mental health clinicians. When acuity of psychiatric symptoms increases, transfer to aged mental health wards may occur, with corresponding in-reach by geriatric medicine clinicians. These arrangements, and thresholds for transfer between programs, are locally driven. Along with access to aged residential beds, this may result in significant variation between services in the proportion of aged mental health inpatients with cognitive or organic disorders.

277 Specialist dementia units in residential aged care homes provide specialised care to people with very severe behavioural and psychological symptoms of dementia, and aim to reduce or stabilise symptoms so that consumers can move into less intensive care settings. Three units in Victoria have been funded by the Commonwealth government – one which has recently opened, and a further two which are in the planning phase of commissioning – and are intended to enhance the existing health and aged care service systems for people with BPSD and complement State and Commonwealth government services and supports.

278 Additional consultation liaison resources will likely enable improved care for aged persons in specific settings, and may reduce the frequency of transitions between acute hospital units.[52] In addition, extending the community consultation liaison services provided by aged mental health community teams to residential aged care settings would match existing acute health geriatric in-reach services,[53] reducing the likelihood of hospital readmissions and enabling earlier discharge for ageing consumers with cognitive impairment and psychiatric symptoms.

Options for consumers with eating disorders

279 There are opportunities to improve service delivery for consumers with eating disorders. At present, care is delivered in a range of settings including general hospital, mental health inpatient units and the community, however consumers can experience access issues in rural and regional areas. In addition, the needs of some individuals are not necessarily met by the available aged-based programs (for example, consumers who would benefit from family-based programs but fall outside the age range for Child and Adolescent Mental Health Services (CAMHS)). Transitions between CAMHS and adult service streams and from inpatient to community settings can also impact on the treatment options that are available and compromise continuity of care.

280 Options for consumers with eating disorders could be improved through:

(a) building the expertise and capability of the workforce through a model similar to the Personality Disorder Initiative, which provides senior clinicians across six health services with intensive training, active clinical supervision and oversight from the statewide specialist service

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[52] Crotty, M and Ratcliffe, J 2011, 'If Mohammed won't come to the mountain, the mountain must go to Mohammed', *Age and ageing*, vol 40(3), pp. 290–292.
[53] Refer to the Department of Health and Human Services' Health Independence Program webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/specialist-hip-clinics>.

(b) enhancing the existing consultation liaison model for mental health intervention, which would improve the level of engagement with acute and subacute medical services and consumers and carers during non-mental health bed-based and community episodes of care

(c) stronger links between services and the Victorian Centre of Excellence in Eating Disorders, and with private and primary care resources and services.

Inadequate secure care options

281 The inadequacy of existing secure care options is highlighted at various points throughout this statement. This inadequacy means that a growing cohort of consumers with complex forensic mental health treatment needs is accommodated in acute inpatient units with limited rehabilitation opportunities. Some members of this group may be awaiting transfer to a SECU, however neither the acute inpatient unit nor the SECU setting is appropriately designed or staffed to provide optimal care for this group.

282 The current SECU model does not meet consumers' needs. As detailed at paragraphs 541 to 567 below, the relatively small bed stock limits access to beds, and the models of care and staffing formula – designed to support consumers with subacute needs – pose challenges for providing care to consumers with very high complexity and acuity of illness. Incidents of interpersonal violence have occurred against other vulnerable consumers, visitors and staff. In addition, some consumers require ongoing care for extended periods, which may not accord with rehabilitation programs (generally six to 12 months) or the trajectories of other consumers.

283 The demand for beds at Thomas Embling Hospital, discussed at paragraphs 152 to 157 of my previous statement to the Royal Commission, impacts not only on service access for forensic and security patients, but also on options for civil consumers (often former security patients) who cannot safely be accommodated in an adult acute or SECU setting. Access to medium secure beds outside of Thomas Embling Hospital, or alternative options to acute inpatient units that are appropriately constructed, designed and staffed, would assist this cohort.

Consumers with dual disability

284 There are also significant challenges relating to consumers with dual disability, some of whom are not well-served by current options. People with intellectual disability have a higher risk of co-occurring mental illness in comparison to the general population, with studies estimating that between 30 and 40 per cent of people with intellectual disability will experience a mental illness

at some point in their lives.[54] This group does not have homogenous characteristics: while some people with relatively mild levels of intellectual disability can manage relatively well in mainstream services, others will have very different support needs. Challenges for this group include:

(a) barriers that prevent people with both a disability and mental illness from accessing an informed diagnostic process, as their presentation may be misconstrued as behavioural in origin.

(b) a lack of capability within area mental health services to adequately assess, treat and manage consumers with complex disabilities. There is a shortage of trained professionals with relevant experience and qualifications, and existing inpatient environments are often inappropriate. The Mental Health and Intellectual Disability Initiative (MHIDI) program is are currently only available in two services, which report increasing referrals, and the Victorian Dual Disability Service – the statewide service located at St Vincent's Hospital Melbourne which works with specialist mental health services across Victoria to assess, treat and support people with a dual disability – has limited capacity to provide support.

(c) there is limited governance coordination across the system, with many resources (such as the Victorian Dual Disability Service, TSUs, the Brain Disorders Unit and the Mental Health and Intellectual Disability Initiative for adult and youth) managed locally by area mental health services, and therefore unable to harness their combined potential in the same way as forensic or personality disorder specialist service systems which have strong connections between the central statewide hub and local area mental health service spokes.

(d) the need for improved links and collaboration with NDIS providers. In addition, the consistency of NDIS staff and their skill level has been identified as an increasing challenge in maintaining behaviour support interventions and mental health.

(e) the lack of, or delay in acquiring, appropriate discharge accommodation for people with high and complex support needs. I discuss this further at paragraphs 572 to 575 below.

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[54] Department of Human Services 2010, *Disability, mental health and medication: implications for practice and policy* <https://providers.dhhs.vic.gov.au/disability-mental-health-and-medication-implications-practice-word>, Melbourne.

285 Consumers with dual disability require a supportive environment that is responsive to individual needs, whether or not the setting is separate from other consumer cohorts in mental health facilities. Core components for service provision for people with dual disability include the provision of high quality assessment and treatment and continuing care; access to inpatient services; crisis intervention; specially trained staff and a level of skill within the service system to meet support needs; interprofessional service provision; and strong and collaborative relationships between service providers.[55] Building skills and capability through learning and development opportunities across the broader mental health sector may lead to improved and more systematic responses to meet the needs of this population.

Physical environments most conducive to the care, treatment and support of people with complex needs or behaviours of concern

Question 18: What physical environments are most conducive to the care, treatment and support of people with complex needs or behaviours of concern?

286 Environmental design plays an important role in mental health care. Across all mental health settings, there are common elements that support the provision of safe and quality care, treatment and support.

287 Different clinical settings are required to meet the needs of diverse groups of consumers. For example, the setting appropriate in a child family unit will be vastly different from that in an acute forensic unit or acute brain injury assessment unit. The building fabric, inclusion and exclusion criteria, and staff skill sets – particularly the need for staff who are well-versed in trauma informed care and a recovery care approach, as well as a holistic understanding of the consumer, their families and carers, cultural background and connection to the land, and developmental stage of life – are all essential elements.

288 Regardless of the physical environment, services can be delivered within a culture of care and support, and with an interdisciplinary workforce that includes the lived experience and peer workforce to support people in periods of recovery. The Mental Health Intensive Care Framework, lived experience workforce models, Safewards, and work towards elimination of restrictive interventions all support a transformation in the way services are delivered and experienced.

[55] Department of Human Services 2013, *Senior Practitioner – Disability: Building capacity to assist adult dual disability clients access effective mental health services*, State Government of Victoria, Melbourne.

289 The clinical setting and experience of staff significantly influences the care for consumers with very complex needs. Members of this group often require a unified and organised interprofessional approach, and the setting needs to support a recovery focus. For example:

(a) sensory rooms and programs, which should form part of a universal approach to mental health care, provide significant benefit to those with experiences of trauma, and for consumers with developmental disorders or neurodegenerative conditions[56]

(b) some consumers with very challenging behaviours are cared for in Thomas Embling Hospital, which provides a high secure facility in which behaviours can be managed humanely, openly and with significant expertise in order to maximise safety for all

(c) there are increasing numbers of consumers with significant mental health issues and intellectual disabilities whose needs place them in a vulnerable position within adult acute unites and SECUs, and which the TSUs at Austin Health and Monash Health were intended to address

(d) consumers with very complex needs can benefit from a stepped care approach to physical environments with options for independent, family and group living and an appropriate level of care and support.

290 The *Australasian Health Facility Guidelines* set out generic planning and design requirements for mental health inpatient units, which all new builds and refurbishments are required to comply with.[57] The guidelines support recovery-oriented models of service delivery, and aim to create a physical environment that is welcoming and supportive, supports therapeutic relationships, maintains meaningful engagement with family and friends, provides a range of spaces and resources to assist with self-management, allows the holistic management of consumers' health, and provides a safe environment. Among other matters, the guidelines outline requirements for anti-ligature fittings and fixtures, access control, high dependency units and seclusion rooms, facilitating observation and communication, and providing easy access to facilities such as the emergency department, other mental health units, and areas such as ECT suites.

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[56] Chalmers A, Harrison S, Mollison K et al. 2012, 'Establishing sensory-based approaches in mental health inpatient care: a multidisciplinary approach', *Australasian Psychiatry*, vol. 20, pp. 35-9.
[57] See Australasian Health Facility Guidelines, <https://www.healthfacilityguidelines.com.au/> [accessed 28 June 2020].

291 In addition to these guidelines, the Department of Health and Human Services and the Victorian Health and Human Services Building Authority (VHHSBA) also provide guidance to services and impose requirements that reflect and influence contemporary practice, including in relation to single bedrooms, single gender areas, vulnerable consumers, and anti-ligature safety.[58]

292 Existing settings do not always provide an appropriate environment for providing safe and therapeutic care and one that is consistent with the principle of least restriction. While the design guidelines apply to new builds and renovations, they do not address existing infrastructure, and so a broader approach to respond to distress needs to be addressed through workforce cultures, therapeutic engagement and workforce capability.

293 The Mental Health Intensive Care Framework conceptualises the care setting not only in terms of its environmental design and construction, but also the community it supports and influences within it. The care setting should be based on the person's needs and preferences, and the setting that is least restrictive and best supports the person's safety needs to be chosen.

294 The physical environment should be designed and built to enhance the physical and mental wellbeing of consumers, carers, staff and visitors, with consideration given to matters such as universal access, wayfinding, sensory modulation, low stimulation, care areas based on treatment needs, and the proximity of security staff.

295 In terms of process, major capital builds are led by VHHSBA, which works closely with the Mental Health and Drugs Branch and relevant services to ensure that the work aligns with the Department of Health and Human Services' guidelines and policy directives. For smaller remodelling projects, the relevant health service is responsible for adhering to guidelines and contemporary practice, but there is an expectation that services keep the Mental Health and Drugs Branch informed.

296 A co-design process that ensures consumers and carers are involved from the beginning of the project is essential. The Department of Health and Human Services has worked with VMIAC, Tandem and services in this area, and consumers and carers participate in the development of all capital projects.

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[58] These include the Chief Psychiatrist's guidelines *Appropriate locations for the use of seclusion in designated mental health services and High dependency unit guidelines* (due to be updated), and my advice on ligature point audits in the *Chief Psychiatrist's Quality and Safety Bulletin 2018/1*. Other guidelines include the VHHSBA's *Planning and development guidelines*, and the Department of Health and Human Services *Guidelines for behavioural assessment rooms in emergency departments* and the *Mental health prevention and recovery care unit – Part B: health facility briefing and planning*.

Age-based streaming for children, adolescents and youth

Question 19: Could services for children, adolescents and youth be streamed by age, and why? (a) What are the challenges associated with age-based streaming? (b) Could the aims of aged based streaming be met through alternative means? For example, by streaming based on different criteria. (c) Are there examples of high-quality systems and services that don't use age-based streaming?

297 Specialist mental health services are currently streamed on the basis of age, with separate services for infants, children under 13 years, adolescents (from 13 to 18 years old) and young adults (from 18 to 25 years old), and mother-infant streams for those with postpartum mental illnesses. In addition, there are two statewide child inpatient units; some CAMHS that have been redesigned as Child and Youth Mental Health Services (CYMHS) and provide services up to age 25; Orygen Youth Services for ages 15 to 25; and a headspace youth model for those aged 12 to 25.

298 The models of care are very different for each age cohort, requiring diverse approaches, training requirements for staff, and linkages to support agencies. Each area is regarded as a sub-specialty area in mental health, requiring further training and advanced qualifications to take on this work.[59]

299 All streams use a broad biopsychosocial model set within a developmental framework, with both an individual and family context. Separation by age – children under five, ages five to 12, ages 13 to 17, and ages 18 to 25 – is a sensible framework given the involvement of key agencies: kindergartens, maternal child health and early childhood services; primary and secondary schools; and post-secondary higher education or vocational training.

300 Within the existing mental health system, specialist services for each age group tailor their models of care. The two statewide child inpatient units have complementary models, with Monash Children's Hospital's Oasis unit focusing on acute admissions and assessment, and Austin Health on longer-term admissions and a systemic family-based approach to treatment. A further example is the infant and preschool service provided by Alfred Health's CYMHS, which provides direct clinical support to families and caregivers of infants and young children who are

[59] For example, a RANZCP qualified child and adolescent psychiatrist requires a further two years of comprehensive and rigorous advanced training in child, adolescent and family developmental psychiatry, with one day per week of lectures and clinical supervision at Mindful Centre for Training and Research in Developmental Health, two years of clinical placements in accredited CAMHS with college accredited supervisors, followed by RANZCP accreditation if all requirements are met. Many staff in this area have also undertaken further advanced qualifications, such as a three-year masters in Family Therapy through the Bouverie Family Therapy Centre, Masters in Child Psychotherapy through Monash University, and Graduate Diploma in Infant Psychiatry through the University of Melbourne.

yet to start primary school and who have difficulties in emotional, social and development areas, as well as providing consultation to professionals in maternal and child health services and kindergartens. Parent and infant programs employ different models of care again, with services across the state such as Austin Health providing specialised inpatient and ambulatory care for parents experiencing severe mental illness in the postnatal period.

Challenges associated with age-based streaming

301 A key challenge associated with age-based streaming is the adult paradigm generally used by mental health services. This can be challenging for CAMHS, CYMHS and aged mental health services, as there can sometimes be a lack of understanding of the different models of care and the central role of families in assessment and treatment.

302 Further challenges include:

(a) workforce training: there are insufficient clinical placements for senior registrars wishing to become child and adolescent psychiatrists, and a significant financial disincentive to undertaking advanced training, as senior registrars continue to be paid at this level for a further two years while their colleagues are paid as qualified consultant psychiatrists. Clinical psychologists in child and adolescent mental health are also highly qualified – usually at university doctoral level – requiring additional years of study and clinical placements. Clinical placements are generally required by all disciplines in addition to formal education and training, with clinicians undertaking a supervised clinical placement (effectively an apprenticeship model) in child and adolescent mental health facilities, which is a considerable investment of time and resources.

(b) providing a variety of clinical services: this requires a critical mass of qualified clinicians for training, clinical supervision commensurate with level of experience, and service provision. Providing an appropriate level of discipline-specific, clinical supervision can be a particular challenge in rural and regional services, especially with regard to consultant child and adolescent psychiatrists and various other disciplines.

(c) providing an interprofessional approach and a variety of interventions when there is a shortage of disciplines such as occupational therapy, speech pathology, psychology and neuropsychology, and still less access to creative therapy disciplines such as art therapy and music.

(d) generalisation of service provision, with some services and subspecialty programs for children and young people subsumed by the functions of generic child and adolescent services such as Intensive Mobile Youth Outreach Service (IMYOS) teams, CAMHS mental health promotion officers and CAMHS and Schools Early Intervention and Assessment (CASEA) teams.

(e) a focus by services on cohorts with highest risk and acuity, particularly adolescents, leading to fewer contacts with pre-school and primary school aged children. The 2016-17 State Budget acknowledged the importance of providing mental health early intervention, assessment and treatment for children aged up to 12. Funding was provided for a number of initiatives, including the Clinical Specialist Child Initiative, which aims to improve the leadership and responsiveness of services in engaging, assessing and treating children in that age group, and focuses on building workforce capability and developing stronger and sustainable partnerships with relevant agencies. These investments have been reflected in increased service contacts for children.[60]

(f) provision of autism services: CAMHS and CYMHS all have multidisciplinary teams for assessments of children with developmental disorders such as autism spectrum disorder. A diagnosis is required for these children to access other supports including schooling and financial assistance, yet these teams have waiting lists from 12 months to up to two years, and teams mainly provide assessment (and not ongoing treatment) due to the workload.

(g) provision of eating disorder services: this is a specialist sub-area within CAMHS and CYMHS, with most services providing further training to their staff through the Victorian Centre of Excellence in Eating Disorders, and using evidence-based treatments such as family based therapy, which is the accepted best practice approach for this age cohort. However, there are issues when adolescents transition to adult public mental health services and eating disorders are not seen as 'core business', but are instead managed by private practitioners in the community.

(h) use of the MHA for minors: the MHA is rarely invoked for children, with parent/guardian consent sought for assessment and treatment, just as it would be for treatment of a physical illness. The parent/guardian role must always be

[60] Department of Health and Human Services 2019, *Victoria's Mental Health Services Annual Report 2018-19* <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report> Melbourne, p. 58.

considered, and it is imperative that services do not misuse the MHA in the absence of clarity on guardianship arrangements for minors. Challenges can arise in the middle teen years, where adolescents would be seen as having capacity to make informed decisions which may be in conflict with parents/guardians, yet there is no clear age-based criterion. It is important that a developmental perspective is taken, and that clinicians take a flexible approach.

Safe and appropriate care for children and adolescents

303 Age separation is the accepted standard internationally, and there is agreement across all developed countries that vulnerable children and adolescents must not ever be treated with adults in mental health services, and particularly not in adult acute inpatient units. The American Academy of Child and Adolescent Psychiatry maintains the importance of separate programs for children and adolescents under 14, and the need for programs for both children and adolescents to be specifically designed for patients of that age.[61] In Australia, the Royal Australasian College of Physicians confirms that children and adolescents must be cared for on wards that are appropriate for their age and stage of development and must be physically separated from adults,[62] and the MHA confirms that children and young people should receive services separately from adults, whenever this is possible.[63] In my opinion, any attempt to stream based on criteria other than age, such as diagnosis or acuity, would be fraught and dangerous. As in the physical health setting, where minors are treated by paediatricians rather than adult physicians, children are not merely 'little adults', and a different approach to their treatment and care is needed.

304 Children and adolescents require a developmental perspective, and there can be serious consequences when this is absent. In my practice as a child psychiatrist, I have seen children misdiagnosed by adult psychiatrists as having psychosis, and others misdiagnosed and given large doses of psychotropic medication. Children, however, need a multimodal approach that is family-focussed and that uses psychological and behavioural interventions within a family systems framework. Medication has less of a role in comparison to adult psychiatry, and there may not be an evidence base for its use in a paediatric age group.

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[61] American Academy of Child and Adolescent Psychiatry 1989, *Inpatient Hospital Treatment of Children and Adolescents* <https://www.aacap.org/AACAP/Policy_Statements/1989/Inpatient_Hospital_Treatment_of_Children_and_Adolescents.aspx>, Washington D.C.

[62] Royal Australasian College of Physicians 2008, *Standards for the care of children and adolescents in health services* <https://www.racp.edu.au/docs/default-source/advocacy-library/standards-for-the-care-of-children-and-adolescents-in-health-service.pdf>, Sydney.

[63] Mental Health Act 2014, s. 1(i)

305 A different model of care and approach is needed: by way of example, the approach needed with a pre-pubertal child experiencing an eating disorder in the context of family and school will be very different from that used with an adult living independently from their family.

306 Children and adolescents are vulnerable, and it is risky and traumatising to treat them within an adult framework. This risk is even further heightened in an inpatient setting.

307 In my own experience, there are considerable risks in placing children and adolescents in an adult setting. In my early years practising child psychiatry, there was only one adolescent inpatient unit – Travancore Centre in Flemington – servicing the whole state. At that time, the upper age threshold for CAMHS was 16 years. Without rural CAMHS services or options for regional autism assessments, families had to travel to Melbourne, and adolescents were transferred to adult facilities on reaching the age of 16. This approach did not make sense for vulnerable adolescents, some of whom were still at secondary school and living at home with their families, and it was traumatic to impose an adult individual model on both the adolescents and their families. It also resulted in vulnerable teenagers being placed in acute adult facilities, and posed substantial risks of sexual exploitation, violence and drug use.

308 I am unaware of any services in the developed world where it would be seen as acceptable not to stream children and adolescents separately from adults, in the same way that children and youth justice clients are not placed in adult prisons. Likewise, I am unaware of any programs of excellence that do not stream children and adolescents separately from adults.

309 I consider that aged-based streaming for children, adolescents and young people is essential to providing safe and appropriate care. Within this framework, however, there needs to be flexibility to determine how a consumer's needs can best be met, as rigid criteria for age, diagnosis or acuity may not result in an appropriate outcome for an individual. In my view, it is worth considering:

(a) streaming for intensity of service provision within each age cohort – for example, through IMYOS teams for adolescents with challenging behaviours whose needs span different service systems (such as child protection or out of home care) and who would benefit from an outreach service.

(b) the most appropriate model for youth between 12 and 25, noting that there is not consensus on the suitability of this model which covers a diverse age range. The youth model has less of a developmental focus and is less family-based than other models, however a person under 18 living at home – or indeed a person over 18

with vulnerabilities and still living at home – may need a more family-based approach.

(c) the level of intensive involvement that is needed: not all referrals to CYMHS require long term intensive involvement with the specialist CYMHS service. The Brief Intervention Model is used at a number of CYMHS and originated from systemic family therapy. It takes a family systems approach which looks at family strengths and resilience and utilises a solution focus. There is a strong evidence base for this model, and its strengths-based approach accords with contemporary best practice models that promote recovery.[64] It is individualised for each family, and can divert families from a more traditional resource intense assessment, which may not actually be indicated nor required clinically. Many families can be helped after only a few clinical sessions. It enables children and families with high needs and acuity to receive the resources they need, while allowing those in less need to use the families' coping strengths and preserve family autonomy.

Reducing risks of suicide: inpatient wards, community mental health services and triage and emergency departments

Question 20: How can mental health services reduce the risks of suicide for: (a) people admitted to inpatient units, or recently discharged from them? (b) consumers of community-based mental health services? (c) people who come into contact with mental health services (for example, through triage or emergency department services) but who are assessed as not requiring specialist intervention?

Inpatient units

310 Deaths on inpatient units must all be notified to my office, as set out in the *Reportable Deaths: Chief Psychiatrist's Guideline (Summary Version)* attached to my statement and marked '**NC-4**'.

311 In 2018-19, there were 26,682 admissions to Victoria's acute mental health inpatient units including child and adolescent, youth, adult, aged and SECU wards.[65] Within this period, there were six inpatient suicides. Three of the six deaths occurred on a unit; one followed transfer to another unit; one occurred during a period of approved leave from a unit, and one occurred

[64] Talmon, Moshe, 'When less is more: lessons from 25 years of attempting to maximise the effects of each (and often only) therapeutic encounter', *Australian and New Zealand Journal of Family Therapy*, vol. 33, pp. 6-14.
[65] Department of Health and Human Services 2019, *Victoria's Mental Health Services Annual Report 2018-19* <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report> Melbourne.

within 24 hours of discharge.[66] This total of six deaths in 2018-19 compares with 11 in 2016-17 and 12 in 2017-18.[67,68]

312 SCV classifies all mental health inpatient suicides (as defined above) as 'sentinel events'.[69] Its sentinel event program stipulates that providers must conduct a detailed analysis of the circumstances surrounding the death - the person's mental and physical health, the treatment plan, the inpatient environment, staffing issues and anything else that might have contributed to the incident or impacted on the service's response to it - to ensure that providers learn as much as possible from these tragic incidents and take action to prevent a recurrence.

313 The investigation team includes a member from another service and at least one member must have training in root cause analysis. Providers are encouraged to have consumer and carer consultants as part of the team and to consult carers of the deceased person to ensure that their voice is represented.

314 My office convenes panels of psychiatrists, mental health nurses, quality and safety managers and consumer and carer advocates to review the analyses of inpatient suicides submitted to SCV. The panel gives written feedback to each service commenting on the comprehensiveness of its analysis, learnings and remedial actions. If indicated, services are asked to extend the investigation to gain a better understanding of the factors associated with the death or to craft more pertinent and practicable recommendations.

315 Because of their gravity, my office has conducted two audits of inpatient deaths for the periods 2008 to 2010 and 2011 to mid-2014. In the more recent audit, members of the audit panels

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[66] Department of Health and Human Services 2019, *Chief Psychiatrist's annual report 2018-19* <https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2018-19>, Melbourne.
[67] Department of Health and Human Services 2017, *Chief Psychiatrist's annual report 2016-17* <https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2016-17>, Melbourne.
[68] Department of Health and Human Services 2018, *Chief Psychiatrist's annual report 2017-18* <https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2017-18>, Melbourne.
[69] Safer Care Victoria 2019, *Victorian sentinel event guide: Essential information about managing sentinel events in Victoria* <https://www.bettersafercare.vic.gov.au/resources/tools/victorian-sentinel-events-guide>, Melbourne.

included clinicians, quality and safety managers, consumer and carer policy advisors and consumer and carer representatives. Both audit reports are in the public domain.[70,71]

316 Most suicides on inpatient wards result from hangings in bedrooms and bathrooms from ligatures attached to doors, rails and other fixtures. Since the first of the two audits, service providers have conducted formal checks at least annually of all inpatient facilities, looking for fittings and fixtures that present an unacceptable safety risk. These checks are conducted by a team working from a structured template with at least one member of the team coming from outside the ward.

317 After the first of the Chief Psychiatrist's inpatient death audits, funding was allocated to remediate risks notified to the Department of Health and Human Services. Since then, all new or significantly renovated inpatient units are built with safety in mind. As examples, door hinges are concealed, cupboard rails are replaced by shelves and shower heads are flush with the wall. The units are made as spacious and light-filled as possible with excellent preservation of consumers' privacy and dignity.

318 What matters more than physical design, however, and as described at paragraph 288 above, is the quality of care provided by clinicians to the people admitted to hospital. Clinicians must respond empathically to people's distress, hear their fears and concerns, and meet their practical, social, psychological and physical needs. These demands are onerous in a stressed, busy system, but recent initiatives are likely to prove helpful.

319 The Safewards program, which aims to build an empathic, supportive style of care, is described at paragraphs 519 to 531 below. In addition, new clinical nurse consultants will provide leadership to less experienced nurses and the recently released Mental Health Intensive Care Framework sets a new standard for the care of distressed, vulnerable inpatients.

320 My office is currently developing a new guideline on risk assessment and safety planning in inpatient units. Its goal is to replace the now customary checklist of perceived risks for every inpatient on every nursing shift with a more considered, multi-disciplinary assessment of risks

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[70] Department of Health and Human Services 2012, *Chief Psychiatrist's investigation of inpatient deaths 2008-2010* <https://www2.health.vic.gov.au/about/publications/researchandreports/Chief-Psychiatrists-investigation-of-inpatient-deaths-2008-2010>, Melbourne.
[71] Department of Health and Human Services 2017, *Chief Psychiatrist's audit of inpatient deaths 2011-2014* <https://www2.health.vic.gov.au/about/publications/researchandreports/ocp-inpatient-death-audit-2011-14>, Melbourne.

that is updated on an individual basis and links to therapeutically-minded responses to inpatients' physical, mental, social and practical needs.

321 Finally, there has been an expansion of the peer support post-discharge initiative in which members of the peer workforce remain in contact with people recently discharged from hospital to mitigate risks in this vulnerable period by promoting recovery and resilience, facilitating a return to the community and reducing the risk of re-admission. The program will be fine-tuned following a positive external review in 2019.[72]

Clinical community mental health services

322 Again, obligations for clinical community mental health services to report deaths are set out in the guideline attached to this statement and marked '**NC-4**'.

323 In 2018-19, I was notified by community teams of the deaths of 403 clients, representing about a half of one per cent of the 74,794 individuals registered with the state's mental health services in that year. The causes of many of these deaths have yet to be established by the coroner.

324 To better inform myself of the circumstances leading to people's deaths, I conducted an analysis of all the deaths of community-resident consumers in 2015. This time period was selected deliberately to ensure that virtually all coroners' reports were available.[73]

325 Over the course of the year, nearly half (48 per cent) of deaths were due to suicide, a third (33 per cent) to natural causes and 14 per cent to accidental overdose.

326 Men accounted for two-thirds (68 per cent) of deaths due to suicide with a peak in age-group 30-39 years. By far the majority of consumers who died by suicide had been enrolled with an adult mental health service. Child and adolescent programs, and aged persons' programs, accounted for 7 per cent each.

327 Taken overall, the most common primary diagnoses were depressive disorder (42 per cent), schizophrenia and other psychoses (30 per cent), personality disorder (11 per cent) and anxiety and adjustment disorders (10 per cent). Within the three months prior to death, rates of harmful

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[72] Department of Health and Human Services 2019, *"You get what I'm going through" research report: Expanding the post-discharge support initiative* <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/expanding-post-discharge-support-initiative-report>, Melbourne.

[73] Department of Health and Human Services 2017, *An analysis of deaths in 2015 of community-resident consumers of Victoria's mental health services* <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/ocp-community-deaths-report-2015>, Melbourne.

use of substances were recorded for alcohol (29 per cent), stimulants (18 per cent), cannabis (19 per cent), opiates (14 per cent) and benzodiazepines (6 per cent). Use of multiple substances was common.

328 With respect to their social circumstances, most (70 per cent) were single, separated or divorced, and nearly half (48 per cent) were unemployed or on a disability pension. Small proportions of people had identified as belonging to Aboriginal or Torres Strait Islander (1 per cent) or LGBTI (4 per cent) communities.

329 Social stressors in the three months prior to death were common, especially for those with depressive or anxiety disorders. The most frequently cited difficulties were separation from a spouse or partner (21 per cent), other interpersonal conflict (16 per cent), finances (12 per cent), work (12 per cent) and physical ill-health (11 per cent). A fifth (20 per cent) were known to have inflicted some sort physical self-harm within this time-frame.

330 Just over half (56 per cent) of those who died by suicide had been in contact with a mental health service for more than a year. A few (2 per cent) had spoken just with a triage service though this is likely to be an under-estimate as services are sometimes not told of their deaths.

331 Most people (71 per cent) had been admitted at least once to a mental health facility. Some (13 per cent) had been admitted more than five times. For those with recent inpatient experience, there was a peak in death by suicide in the two weeks following discharge.

332 The majority of people who died while still registered as consumers (some had been discharged by the service) had been seen within the week prior to their death.

333 Causes of consumers' deaths can be complex and multifactorial. There can be factors outside the domain of the treating service that contribute to an individual's death. I have taken steps over the last year to improve the quality of the information I receive about consumers' deaths and to use this information constructively to help providers improve the quality and safety of their work.

334 The notification form has been made more structured to help capture detailed information about the individual, their circumstances and the type of care they had received. Once received by my office, they are reviewed by one of my deputies who contacts the notifying clinician to clarify details if necessary and raises questions for the clinical team to consider in its own internal review. These reviews must then considered by the service's own risk review committee to ensure that learnings are fed back to clinical programs to reduce the likelihood of a recurrence.

335 A data linkage program was established recently with the Coroner's Office to alert me to recent probable suicides. By matching this data to the notifications received by my office, I ensure that services learn of all the deaths of people who had been discharged from mental health services in the previous three months. Records are now much more accurate.

336 I am working with VAHI to provide regular feedback to services about the suicides of consumers and people recently discharged from their service, corrected for catchment population. Because suicide rates are likely to vary from one part of Victoria to another, (with higher rates anticipated in areas at greater socio-economic disadvantage), this feedback will be set in the context of the suicide rate of each service's catchment population.

337 The purpose of this benchmarking exercise is not to attribute blame to services with higher than average suicide rates but rather to inform services' boards and executives (as well as the Department of Health and Human Services) of services' greater than average need.

338 As part of an effort to maximise the impact of learnings from deaths, I publish quality and safety bulletins to inform clinicians of recommendations made by coroners and to provide commentary on the lessons to be drawn from them.[74] The bulletins, which are in the public domain, recount in a de-identified format particularly difficult clinical situations, or situations in which care systems or communication pathways have proved inadequate, to encourage reflection across the sector on strategies to prevent these situations arising again.

339 To ensure that clusters of suicides are recognised quickly, I liaise with the policy officers who manage the new place-based suicide prevention trial delivered by primary health networks in 12 locations across Victoria. Each network brings together local community leaders, health care providers and emergency services to build awareness of mental health, build capacity to respond to mental health issues and develop coordinate responses to suicides. While clusters of suicides are uncommon, there is now a mechanism for de-identified alerts to move from my office to local communities and vice versa.

Triage and emergency departments

340 People who present to an emergency department after an episode of self-harm are at substantially increased risk of suicide in coming weeks or months.[75] Previously, clinicians focused on the need for admission to a mental health inpatient unit or follow-up by a crisis

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[74] Department of Health and Human Services 2020, *Chief Psychiatrist's Quality and Safety Bulletins* <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/ocp-community-deaths-report-2015>, Melbourne.

[75] Miller IW, Camargo CA, Arias SA et al. 2017, 'Suicide prevention in an emergency department population: the ED-SAFE study', *JAMA Psychiatry*, vol. 74, pp. 563-70.

mental health team. If these specialised interventions were judged not to be warranted, people were returned to the care of their general practitioner.

341 To remedy this gap in care, Victoria embarked in 2016-17 on a six-site pilot of the Hospital Outreach Post-suicidal Engagement (HOPE) program, the initial roll-out of which was led by the OCMHN. The HOPE program offers individuals who present to hospital after attempting suicide intensive, comprehensive, individually-tailored support for a period of three months by clinicians from a range of backgrounds to address stressors in their life including difficulties with relationships, family, education, training, work, Centrelink or drug and alcohol use. Clinicians also support carers, family members and friends to bolster their ability to protect the person and build resilience.

342 An additional $18.7 million recurrently was provided in the 2018-19 State Budget to expand HOPE to a further six sites across Victoria giving 12 in total, to ensure an equitable spread across metropolitan and regional centres. The 12 sites are: Albury Wodonga Health, Alfred Health, Ballarat Health, Barwon Health, Bendigo Health, Monash Health's Casey Hospital, Latrobe Regional Hospital, Eastern Health's Maroondah Hospital, Peninsula Health, St Vincent's Hospital Melbourne, Western Health's Sunshine Hospital (operated by Melbourne Health) and Mercy Health's Werribee Hospital. The Commonwealth is contributing to costs at three of these sites as part of its bilateral Aftercare suicide prevention program.

343 The Royal Commission has made an interim recommendation that HOPE be expanded to all adult area mental health services, including establishing a regional and sub-regional health service approach and broadening referrals to include consumers of community-based mental health teams. In addition, the Royal Commission has recommended developing a model specific for children and young people. It looks forward also to collaboration between HOPE and local Aboriginal social and emotional wellbeing teams to help reduce barriers to engagement with mental health services. The Mental Health and Drugs Branch is working closely with Mental Health Reform Victoria to deliver these recommendations.

Challenges facing the mental health workforce

Question 21: From the pattern and nature of issues you see in your role, what do you think are the most significant issues facing the mental health workforce?

344 There are significant challenges facing the mental health workforce, many of which are experienced in every jurisdiction in Australia as well as other jurisdictions internationally.

345 In my experience, the most significant issues facing the mental health workforce in the current system are workforce supply (specifically supply of nurses and psychiatrists), retention and

capability. These issues will need to be considered in the development of any future model recommended by the Royal Commission, to ensure there will be the capacity and capability to staff such a model.

346 Going forward, there would also be value in reconsidering the conventional definition of mental health workforce, and expanding this to encompass carers and consumers, security staff (noting that some are embedded in acute inpatient units), staff providing NDIS in-reach, private psychiatry and psychology, allied health practitioners, and all members of a clinical team, including contractors and clinical visitors.

Workforce supply

347 In the current medical-focused model of care, health services experience difficulties with recruiting nurses and psychiatrists. Supply challenges can be specific to each discipline, service and geographical location.

348 The specialist mental health workforce is unevenly distributed across Victoria. There are severe shortages of psychiatrists in some rural services, and 93 per cent of psychiatrists and psychiatry trainees are based in metropolitan Melbourne.[76] Bed-based nursing vacancies are also between ten and 30 per cent across mental health services in Victoria, again with rural service more impacted by vacancies.[77]

349 For allied health disciplines, supply is not the primary issue: rather, it is the availability of discipline-specific positions. Limited career pathways are a major concern for social work, occupational therapy and psychology. These disciplines are mental health work-ready, but they have few opportunities to enter clinical mental health services or to advance their career within them.

350 Lived experience workers also experience career pathway issues and challenges with culture, practice supports and access to other resources to assist them in their work. There are currently limited career pathways for members of this workforce, as well as limited lived experience workers who can provide appropriate supervision, meaning that it is likely that an employed lived experience worker may not receive any supervision. Current levels of support are not sufficient to sustain the lived experience workforce. To foster leadership in this

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[76] Royal Australian and New Zealand College of Psychiatrists 2017, *Psychiatry Attraction, Recruitment and Retention Needs Analysis Project* <https://www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx>

[77] Royal Commission into Victoria's Mental Health System 2019, *Interim Report*, State of Victoria, Melbourne, page 124.

discipline, more lived experience workers need ongoing training, as well as options to progress their careers.

351 There is a heavy reliance on an international workforce, particularly psychiatrists, with mental health services increasingly dependent on sourcing qualified workers from abroad.

352 The ageing workforce also contributes to these challenges, with 62.7 per cent of the mental health nursing workforce aged 40 or above, and 30.4 per cent of the psychiatry workforce aged 60 years or older.[78]

353 Accurate and timely data to describe the current situation for the mental health workforce is a challenge, as there is no consolidated source of this data held by the state at a sufficiently detailed level.

354 Supply shortages in nursing and psychiatry place pressure on the mental health workforce, which in turn leads to retention issues.

Retention

355 In my role, I also observe the difficulties experienced by mental health services in retaining their workforces. Recruitment and retention difficulties result in a less experienced clinician group in acute mental health units, and less effective management of consumer distress. This in turn contributes to higher rates of staff attrition.

356 For psychiatry in particular, workforce retention can pose more of an issue than supply, with clinicians leaving the public system for the private system. In addition to differences in remuneration, psychiatrists express that they are not able to provide psychotherapeutic supports within the public system, limiting their scope of practice.

357 The work environment, particularly in demand-pressured inpatient units, has an impact on workforce wellbeing, and staff report their dislike for working in an environment which is not conducive to providing therapeutic care.

358 Occupational violence is a further issue that contributes to workforce wellbeing, which then has an impact on workforce retention. Research indicates that up to 95 per cent of healthcare

[78] Department of Health, National Health Workforce Dataset, Table .02 (Total number of registered medical practitioners and FTEs employed in Victoria by specialty) and Table .07a (Total number of registered nurses employed in Victoria by nurse main job areas).

workers have experienced occupational violence and aggression,[79] and a 2014 study of workers in mental health services, carried out by the Health and Community Services Union in conjunction with the University of Melbourne's Centre for Psychiatric Nursing, identified that more than one in three mental health workers had been physically assaulted in the past 12 months, and that 83 per cent had been a victim of abuse or violence,[80]

359 The limited availability of senior positions in allied health and lived experience workforces has a trickle-down effect, constraining capacity to provide supervision and support student placement and other workforce development activity.

Capability

360 Currently, there is limited mental health education in most undergraduate or entry level masters courses. The CMHL has been established to ensure that Victoria is able to provide training and development in a coordinated, strategic way. This will improve access to quality, contemporary learning and development for the mental health workforce.

361 There is also a lack of specialist expertise and capability in forensic mental health settings. Services can experience difficulties recruiting qualified forensic mental health workers, and this was demonstrated recently when the opening of new beds at Thomas Embling Hospital experienced a range of delays due to recruitment issues. Forensic youth mental health programs also experience difficulties when recruiting, and note that many candidates have a background in youth mental health but lack forensic expertise.

362 In addition, the existing generic case management model has an impact on clinicians' ability to maintain discipline specific skills, and can lead to staff attrition. Many clinicians report that administrative functions, such as scheduling appointments and chasing information, reduce time available for therapeutic engagement with consumers, families and carers, and afford clinicians less opportunity to deliver specialist evidence-based interventions related to their specific disciplines and qualifications. While this model, established in the 1990s, aimed to provide a holistic and multidisciplinary approach to mental healthcare, some mental health services have begun to transition away from case management to models that better use and maintain clinical expertise.

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[79] Griffiths, D, Morphet, J, & Innes, K, 2015, *Occupational violence in health care: Final Report*, Institute for Safety, Compensation and Recovery Research, Victoria, p. 1.
[80] Victorian Auditor General 2015, *Occupational violence against healthcare workers*, <https://www.audit.vic.gov.au/report/occupational-violence-against-healthcare-workers?section=>, Melbourne, p. 11.

Workforce enablers

363 Addressing the issues outlined above would require:

(a) greater workforce planning capability and access to timely, relevant workforce data

(b) reconsidering the current medical model of care, where the majority of the mental health workforce comprises nursing staff, yet there has not been a needs or costs analysis to determine whether the workforce composition is appropriate

(c) improvements to infrastructure, and in particular changes to inpatient unit environments which are not conducive to providing therapeutic care

(d) greater respect for consumers' autonomy and self-determination, noting the effect a locked unit can have on both consumers and staff

(e) research and funding into supportive therapeutic techniques and modern medications, noting the impact on morale and retention when staff perceive that available treatments make little difference to the consumer.

Challenges to achieving collaborative, cross-disciplinary professional practice across different service settings

Question 22: Are there particular challenges to achieving collaborative, cross-disciplinary professional practice? (a) If so what are they across: (i) different service settings? (ii) different workforce professions and disciplines? How could greater collaboration be fostered?

364 The Victorian model of devolved governance results in area mental health services offering different services. The composition of the workforce by discipline will therefore differ from one service to another, resulting in different levels of knowledge.

365 The different governance, funding and operating models of Commonwealth, state and privately operated services can result in broken care pathways and poor collaboration between services. There can be a culture of services 'competing' with one another, creating barriers to cross-disciplinary practice. In addition, hospital-specific health records can compromise continuity of care when a consumer is referred to another provider.

366 Several workforce challenges have been illustrated in the Victorian place-based suicide prevention trials, including barriers to effective cross-sectoral coordination and integration.

(a) A key component of the trials' activities is building workforce capability through training: gatekeeper training, including general practitioners, teachers and pharmacists who are in a position to identify early warning signs of suicidality, and frontline training, including emergency services. There are challenges within and between these workforces and sectors.

(b) Quarterly and annual reports indicate challenges to service linkages in several sites. Workforce capability is particularly variable and limited in the effective identification, assessment and appropriate and timely referral of consumers with elevated risk factors for self-harm and suicidality. Trial coordinators report that this is commonly found in primary healthcare, including general practice, but also in a range of allied health services. Awareness of referral pathways is also limited, particularly between the health, education, and social service sectors.

(c) Services and the workforce do not necessarily have the capacity or the capability to meet the increased demand resulting from increased awareness of mental health issues, self-harm and suicidality in the community. Capacity is further limited in rural and regional communities due to less services and greater distance to access them. General practice as a medical home in a person-centred model is compromised in rural and regional communities because of an under-supply of general practitioners in these areas. A lack of a medical home limits accessibility to a range of other services and sectors.

Challenges across workforce professions and disciplines

367 Across the different mental health workforce professions and disciplines, feedback from the sector suggests that individual disciplines are not fully cognisant of the role and purposes of other disciplines. Individual disciplines can be protective of their scope and reluctant to 'dilute' their specialty where there are competing disciplines or a perceived lack of respect. Workplace hierarchies and cultures – for example, doctors' willingness to listen to nurses – can also act as barriers to cross-disciplinary collaboration and communication.

368 In addition, the current medical model of care prioritises doctors and nurses in consumers' care, resulting in the perception of allied health and other disciplines as less valuable. Current structures within the Department of Health and Human Services do not challenge this perception: as noted at paragraph 54 above, while doctors and nurses are represented through me and my deputies and the Chief Mental Health Nurse, there are currently no senior practitioners representing allied health within the Department of Health and Human Services.

369 In relation to the lived experience workforce – including consumers and carers who provide direct support to other consumers and carers, and consumer and carer consultants who are funded to develop lived experience policy at a local service level – it is my view that this group is not sufficiently included in treatment planning, service design or evaluations and reviews. Currently, the lived experience workforce lacks sufficient recognition as a discipline. While work is occurring within the Department of Health and Human Services to address this, a shift in understanding is required by clinicians and providers of the critical importance of peer-based programs, and the value of shaping services in partnership with the people who use them.

370 Conferences that are discipline-specific prevent those in other parts of the workforce from learning about the value, ongoing work and research among other disciplines.

Fostering greater collaboration and cross-disciplinary practice

371 To foster greater collaboration and cross-disciplinary practice, it is essential that each discipline understands what others within the team offer that is specific to them.

372 Models of care which rely on generic case management positions limit cross-disciplinary professional practice. Rather, research into effective interdisciplinary teamwork in the mental health context suggests that differentiated disciplinary roles must be retained and shared core tasks developed. This requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices, with no one profession holding a monopoly on leadership.[81]

373 At a local level, greater collaboration and more effective interdisciplinary teamwork can be fostered through positive leadership and management attributes; communication strategies and structures; personal rewards, training and development; appropriate resources and procedures; appropriate skill mix; supportive team climate; individual characteristics that support interdisciplinary team work; clarity of vision; quality and outcomes of care; and respecting and understanding roles.[82]

374 In terms of collaboration across different services, factors that could promote collaboration include an increase to multidisciplinary conferences and opportunities for disciplines to network and collaborate with other disciplines. In addition, junior staff could be trained early in their

[81] Alan Rosen & Tom Callaly 2005, 'Interdisciplinary teamwork and leadership: issues for psychiatrists', *Australasian Psychiatry*, vol. 13:3, pp. 234-240.
[82] Nancarrow, S.A., Booth, A., Ariss, S. et al. 2013, 'Ten principles of good interdisciplinary team work', *Human Resources for Health*, vol. 11, 19.

careers on the roles, purpose and scope of other disciplines, and their value to mental health consumers.

375 By way of example, the Victorian Reducing Restrictive Interventions Sensory Modulation and Trauma Informed Care Trainer Program used multidisciplinary and collaborative approaches to training.[83] Learnings from this program suggest that:

(a) a multidisciplinary trainer approach supports collaboration between disciplines through interprofessional learning; role models strong, positive and connected leadership; and strengthens education as a valuable strategy to help gain buy-in from multiple disciplines

(b) a collaborative approach to training is particularly relevant for rural and remote services where there can be limited access to specialty or allied health staff. It can also improve the availability, quantity and depth of content, in contrast to when single-discipline trainers are used. This is ultimately of benefit to consumers.

Compulsory treatment

376 The MHA provides for people with a mental illness to receive compulsory treatment, subject to strict criteria being met. A compulsory treatment order may be made where a person needs immediate treatment to prevent serious deterioration in their mental or physical health, or to prevent serious harm to the individual or any other person.

377 Compulsory treatment is an essential element of the mental health system. It can allow people with a mental illness to receive treatment in a timely manner and in a setting of reduced risk, as some vulnerable consumers do not seek or receive treatment voluntarily when experiencing severe symptoms of illness.

378 However, compulsory treatment places real and tangible limits on a person's human rights. Compulsory treatment should never be used without significant consideration, and the consumer and their legally protected rights must always be central to any decision making.

379 The MHA seeks to minimise the use and duration of compulsory treatment to ensure that treatment is provided in the least restrictive and least intrusive manner possible. Aspects of the

[83] McEvedy S, Maguire T, Furness T, McKenna B, 2017, 'Sensory modulation and trauma-informed care knowledge transfer and translation in mental health services in Victoria: evaluation of a statewide train-the-trainer intervention', *Nursing Education in Practice*, vol. 25, pp. 36-42.

MHA framework allow care to be delivered in ways that maximise levels of autonomy and choice, even where compulsory treatment is necessary. For example, the MHA:

(a) allows compulsory treatment to be provided both in inpatient and in community settings

(b) includes leave of absence provisions for people on inpatient treatment orders

(c) includes provisions that enable and support consumers receiving compulsory treatment to make or participate in decisions about their treatment, including advance statements and second psychiatric opinions, which I consider further in my discussion of safeguards at paragraphs 401 to 414 below.

380 The challenge for service systems, clinicians, consumers and carers, as well as others involved in care, is that mental health and risks to self and others are not fixed states. These states are fluid and can change over time, location, setting, and a multitude of known and unknown factors specific to the individual, their environment and their support systems, such as homelessness, relationship breakdown and traumatisation.

The role of compulsory treatment

Question 24: From your perspective, in what ways, if any, does compulsory treatment provide benefit to: (a) people living with mental illness, including children and young people (b) a consumer's family and carers (c) the community (d) diverting demand for more acute mental health services, such as admission to an acute mental health inpatient unit?

381 Compulsory treatment can allow a health service to intervene and deliver optimal care for the stage of illness experienced by the consumer at a specific time. It plays an important role in enabling treatment planning to occur and can be appropriate when a person's mental illness poses a risk to self, carers, family members or the wider community.

382 The severity of a person's illness, and the likelihood of the use of compulsory treatment in their care, is influenced by a person's symptoms, their pattern of illness expression and their response to treatment and recovery. Biopsychosocial factors, including culture, developmental issues, the supports in place, and conditions and situations which complicate treatment and care – such as acute and chronic health conditions, substance use disorders, forensic and criminal justice orders and associated risks, personality disorders and conditions, and homelessness and limited accommodation options – also play an important role. Factors such

as these pose challenges for service provision and are often cited by area mental health services seeking advice on treatment planning and care options from my office.

383 Compulsory treatment can allow for some of these factors to be managed in a way that reduces risks, provides additional support, and can enable existing supports – including family, work and community connections – to be preserved, which can have a significant impact on the person's mental health and the course of their recovery. For example, community treatment orders allow for compulsory treatment to be provided in a less restrictive environment and can reduce the need for consumers to receive mental health care in emergency departments and general medical settings. Community treatment orders have been associated with improved access to physical health care in acute settings[84] and lower mortality risk,[85] and for some groups have been found to improve treatment compliance, thus contributing to symptom reduction, shorter hospital stays and improved functioning.[86]

384 For adolescents, compulsory treatment can provide stability of care and time to coordinate resources to support the young person and their family or carers. For this group, the evaluation, care and decision to seek an order for compulsory treatment may also be influenced by additional factors such as mental illnesses that are not fully differentiated, changing family dynamics and structures, underlying physical illness (either separate from or as a result of mental illness), and the impact of social media and influential peer groups on the individual. Compulsory treatment can also provide an opportunity to address these factors in a therapeutic environment with specialist expertise.

385 For children, treatment must always be considered within a developmental framework. Consent to mental health treatment will generally be sought from parents and guardians, as it would for any medical care provided to children. The compulsory treatment provisions in the MHA are rarely invoked, and it is inappropriate to use this framework instead of parent/guardian consent for treatment.

386 The situation is less clear for adolescents. The individual's competency and decision-making capacity must be assessed and considered within a cognitive and developmental framework:

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[84] Segal, S.P, Hayes, S.L. and Rimes, L, 2018, 'The utility of outpatient commitment: acute medical care access and protecting health', *Social Psychiatry and Psychiatric Epidemiology*, vol. 53, pp. 597–606.

[85] Segal, Steven & Hayes, Stephania & Rimes, Lachlan, 2017, 'The Utility of Outpatient Commitment: I. A Need for Treatment and a Least Restrictive Alternative to Psychiatric Hospitalization', *Psychiatric Services*, vol 68, pp. 1247-1254.

[86] Levy E, Mustafa S, Naveed K, Joober R, 2018, 'Effectiveness of Community Treatment Order in Patients with a First Episode of Psychosis: A Mirror-Image Study', *Canadian Journal of Psychiatry*, vol. 63, pp. 766-773.

as a general rule, a 14- or 15-year-old could be considered to have capacity to make decisions regarding their medical treatment. Their wishes for privacy also need to be respected. As a result, it may not be appropriate to rely on parent/guardian consent as one would for younger children. In some cases, the MHA may need to be used for community and inpatient treatment, especially if restrictive interventions such as seclusion and restraint are to be used. In my opinion it is inappropriate to use parental/guardian consent to apply restrictive interventions.

387 Families and carers always play a significant and complementary role in recognition, care, support, and enhancement of treatment. Compulsory treatment should always support the ability of families and carers to participate and perhaps play a more significant role in a consumer's care, and their involvement can provide a foundation for the consumer's ongoing engagement with mental health services. In addition, we know that families and carers are often left to manage the significant impacts that mental illness can have on the family and the home, which can include violence, disturbing or threatening behaviour, or episodes of self-harm. Compulsory treatment in these situations can provide a protective space and period for care, allowing for stabilising of symptoms and identification of necessary support needs.

388 However, compulsory treatment can disempower families and carers who would normally be at the forefront of care and management. Even when a person is voluntarily accessing treatment, there is an inherent power imbalance that treating teams need to be cognisant of. For people subject to compulsory treatment orders, it is vital that a balance be struck so that families and carers are included during acute episodes of care, as the family will often be essential to supporting the person's care and recovery over the longer term.

The legal framework for compulsory treatment

Question 23: How and why does the approach to compulsory treatment for mental illness, differ to other areas of healthcare where greater agency is provided to the individual?

389 Compulsory treatment for mental illness differs from physical health care due to the different legal frameworks that apply to each. The differences in those frameworks are a consequence of the requirement to include safeguards around compulsory mental health treatment that recognise that persons with mental illness will sometimes lack capacity to give informed consent.

390 The threshold requirement for physical health care is the person's informed consent to treatment. The only exceptions to this are emergency treatment, public health control orders and special arrangements for persons under legal disabilities. The *Medical Treatment Planning and Decisions Act 2018* establishes a single framework for medical treatment decision making

for people without decision making capacity that ensures that people receive medical treatment that is consistent with their preferences and values.

391 It is assumed that every person has the capacity to provide informed consent to medical treatment, unless there is evidence to rebut this presumption. At the outset this means the person (albeit relying on the advice of their clinician) decides whether to have treatment and which treatment to have. Once medical treatment is commenced, the person is entitled to withdraw consent at any time and stop the treatment.

392 By contrast, the primary threshold requirement for compulsory mental health treatment is not consent but risk: risk of a serious deterioration in the person's health or a risk of serious harm to self or others.

393 Compulsory treatment is a significant interference with an individual's rights and the MHA sets out the criteria for compulsory treatment (which include the 'risk' criterion). Having a mental illness by itself is not enough to justify compulsory treatment. All the criteria in section 5 of the MHA must apply.[87]

394 Once a compulsory treatment order has been made there is a statutory obligation to seek the individual's informed consent to treatment under the order.[88] The MHA introduced a statutory presumption that a consumer subject to a compulsory treatment order has the capacity to provide informed consent to mental health treatment, unless there is evidence to rebut this presumption (this is no different to other areas of healthcare). The MHA requires consent to be sought for each episode of treatment under the order and requires persons receiving treatment to be supported to be involved in all decisions about their assessment, treatment and recovery. The MHA seeks to preserve as much of the consumer's rights and autonomy as possible with respect to treatment while they are subject to an order. This means a consumer subject to a compulsory treatment order will provide informed consent to their treatment or participate in treatment decisions, depending on their capacity to give informed consent to treatment at a given point in time under the order. In the event an individual is unable to provide informed consent or does not give informed consent, the MHA allows the authorised psychiatrist to make a treatment decision if they are satisfied there is no less restrictive way for the person to be

[87] The treatment criteria in section 5 of the MHA require that: (a) the person has mental illness; (b) because the person has mental illness, the person needs immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to another person; (c) immediate treatment will be provided if the person is subject to an order; and (d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.
[88] Mental Health Act 2014, s. 70.

treated.[89] The MHA provides that a person must be given treatment for their mental illness.[90] This reflects the principle of reciprocity, so that where a decision is made to impose compulsory treatment order on an individual (and therefore limit human rights), there is a parallel obligation on the mental health service provider to provide safe and appropriate treatment and services.

395 Before making such a decision the authorised psychiatrist must have regard to the consumer's views and preferences and those views expressed in any advance statement. They must also have regard to the views of others such as the nominated person or a carer.[91]

396 Although the individual cannot terminate the order, they can apply to the Mental Health Tribunal at any time to stop the order.[92] Both the authorised psychiatrist and the Tribunal must end the order if they are satisfied the criteria no longer apply to the person.[93] Orders are of a fixed duration and expire unless an application for a further order is made to the Tribunal.[94] The Tribunal is required to regularly review all orders to determine if the criteria continue to apply.[95]

Application in practice

Question 26: In Victoria, the Mental Health 2014 (Vic) states that the compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or to another person. (a) Are there other factors that influence how people may seek to use compulsory treatment? Please consider the impacts, if any, of resource constraints within the current mental health system.

397 An assessment order or treatment order cannot be made unless the MHA criteria for compulsory mental health treatment apply. However, the complexity of the mental health system, and the broad range of settings, support services, consumers and carers, means that the use of compulsory treatment may differ depending on the person's presentation, setting of assessment, and even the time of day or day of week. From the perspective of consumers and carers, these variations may appear arbitrary and inconsistent.

398 Within the current system, there is also a spectrum of people whose needs are complex. This can include individuals with disability, eating disorders or physical conditions, personality disorders, experiences of trauma, those experiencing homelessness, domestic violence or child

[89] Mental Health Act 2014, ss. 75-76.
[90] Mental Health Act 2014, s. 72.
[91] Mental Health Act 2014, s. 46.
[92] Mental Health Act 2014, s. 60.
[93] Mental Health Act 2014, ss. 55(b) and 61.
[94] Mental Health Act 2014, ss. 51, 57 and 54.
[95] A number of sections in the Mental Health Act 2014 give rise to an obligation for the Mental Health Tribunal to consider if the criteria for a Temporary Treatment Order or Treatment Order apply, including section 50(2)(a), 53, 54(5), 58(5) and 59.

protection issues, as well as those who display challenging behaviours at various points in time. These factors frequently contribute to the level of risk, and the possibility that the threshold for compulsory mental health treatment will apply to an individual. As described in my previous statement to the Royal Commission, resource constraints significantly hinder smooth pathways of care for some consumers, particularly those with complex needs. Factors such as limited access to secure extended care beds, the absence of medium secure beds outside of Thomas Embling Hospital, and limitations on access to beds at Thomas Embling Hospital for prisoners with acute mental health conditions can lead to higher acuity illness prior to presentation and delayed transfer to appropriate specialist settings. Limited or delayed access to specialist treatment, along with the frustration experienced by the consumer, contribute to an increased level of risk.

399 Some of these individuals are likely to meet the criteria for compulsory mental health treatment, however it can still be challenging to engage, provide and link them in with appropriate services across different systems. Challenges can include:

(a) service delivery for people with dual disability, which often requires the involvement of mental health, housing and youth justice systems

(b) treatment options for individuals with autism spectrum or eating disorders, where compulsory treatment may be considered for the person's protection, but could be counterproductive because of the corresponding loss of autonomy

(c) limited options for consumers requiring secure care, noting the difficulties in accessing SECUs, the lack of medium secure options, and the environmental robustness and staffing levels that are required

(d) the lack of supported accommodation and "step down" options for individuals with complex needs, noting that these may require specialist construction and design and appropriate staffing

(e) insufficient housing or out of home residential care for minors. There are currently insufficient residential care options for minors under child protection orders, and it is almost impossible to find out of home residential care for those not involved with child protection. Some minors are not able to be managed safely within the residential care options currently available, and it is very concerning to my office when I am informed about a minor inappropriately remaining in an acute inpatient unit due to the lack of supported accommodation in the community.

400 My office devotes significant effort to addressing challenges for individual consumers and works with the sector and across the Department of Health and Human Services to ensure access and appropriate support, advocate for consumers, and ensure that compulsory treatment is being used appropriately.

Safeguards

Question 27: To what extent are the existing safeguards contained in the Mental Health Act (including advance statements, nominated persons and the second opinion scheme) as well as current non-legal advocacy and legal representation arrangements: (a) reflective of contemporary practice and evidence? (b) compatible with international conventions on human rights? (c) operating as intended? (d) currently taken up by consumers? (e) currently taken up by families and carers? (f) currently considered in practice by clinicians when determining assessment and temporary treatment orders? (g) currently considered by the Mental Health Tribunal when determining treatment orders?

401 The MHA was developed to promote recovery-oriented practice and create additional safeguards to protect the rights and dignity of people with mental illness.

402 Central to recovery-oriented practice was the establishment of a supported decision-making model (SDM) in the legislation. This model includes a statutory presumption that consumers have capacity to make decisions about their treatment, that informed consent be sought for treatment, having non-legal advocates and nominated persons to assist consumers to participate in treatment decisions and advance statements to enable consumers to record their treatment preferences. SDM seeks to maximise the autonomy of consumers by using these mechanisms and others, such as rights statements and second psychiatric opinions to enable consumers to make or participate in decisions about their treatment. Substitute decision making, when an authorised psychiatrist consents to treatment on a consumer's behalf, can occur in prescribed circumstances when a consumer subject to a compulsory treatment order does not have capacity to give informed consent or does not give informed consent and the authorised psychiatrist is satisfied there is no less restrictive way for the person to be treated. The establishment of an independent Mental Health Tribunal, able to make treatment orders and authorise ECT, was the most important new safeguard introduced by the MHA.

403 I consider that the reforms set out in the MHA largely continue to reflect contemporary practice and that they remain compatible with the Charter of Human Rights and Responsibilities Act 2006, the United Nations Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child. However, the implementation and uptake of the

mechanisms to give effect to those reforms has been variable, with the result that they should now be reviewed to determine why.

404 IMHA has reported that their advocacy requests suggest supported decision making is not the dominant model in practice, with substitute or shared decision-making being frequently used by mental health services.[96]

405 For example, the take up rate for nominated persons and advance statements remains very low with only 2.6 per cent of registered consumers having a nominated person and 2.83 per cent having an advance statement.[97] Research on advance statements suggests several factors are contributing to the low uptake.[98] These include a lack of acceptance and inclusion by clinicians, and the unenforceable nature of advance statements.

406 These numbers are reflected in Mental Health Tribunal data about supported decision making mechanisms, where only 3 per cent of hearings have nominated persons in attendance and 5 per cent have carers in attendance.[99]

407 Care relationships are not consistently recognised by mental health practitioners and some carers report they do not always have access to information, support and skills to maintain their caring role or their own wellbeing.

408 Carer consultants, Tandem (carer peak organisation) and carer peer workers also advise that there is insufficient engagement of families and carers in treatment and discharge planning, leading to critical information being excluded from treatment planning; inappropriate discharges being made to the care of families and carers despite the risk of self-harm for consumers or violence against families and carers; and inappropriate caring capacity.

409 Requests for second psychiatric opinions, discussed above at paragraph 157, seem to be low as a proportion of the number of adults on compulsory treatment orders, and it appears some requests are abandoned due to consumers being discharged before a second opinion report

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[96] Independent Mental Health Advocacy, *IMHA Third year report August 2015 to August 2018* <https://www.imha.vic.gov.au/about-us/news/our-third-year>.
[97] Department of Health and Human Services 2019, *Victoria's Mental Health Services Annual Report 2018-19* <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report> Melbourne.
[98] Maylea, C.; Jorgensen, A.; Matta, S.; Ogilvie, K.; Wallin, P, 2018, 'Consumers' Experiences of Mental Health Advance Statements', *Laws* 7, 22.
[99] Mental Health Tribunal 2019, *Mental Health Tribunal Annual Report 2018-2019* <https://www.mht.vic.gov.au/news/2018-2019-mental-health-tribunal-annual-report-published>, Melbourne.

can be provided. A review of second psychiatric opinions could consider greater flexibility about the way opinions are delivered - for example, summary verbal advice may sometimes be appropriate as it is more timely.

410 Legal representation before the Tribunal is currently at 13 per cent with most of those lawyers being provided by Victoria Legal Aid.[100] Although the MHA provides a right for consumers to be represented before the Tribunal, it does not include a right to access legal representation. Tribunal hearing data shows an increase in the number of ECT matters being classified as urgent and listed for hearing before the Tribunal within 1-3 days of an application being filed.[101] This increase would have resulted in consumers and carers having less time to prepare for hearings and to arrange for legal representation.

411 The question of how best to support the rights of consumers and carers is multi-factorial. The impact of legal representation on hearing outcomes is complex. While more funding for legal representation can assist individuals, an increase in the number and reach of non-legal advocates may also be a cost-effective way to provide support, consistent with the principles of supported decision making.

412 I note the submission by Victoria's Mental Health Tribunal to the Productivity Commission Inquiry, in which comparisons are drawn between the New South Wales and Queensland systems for providing legal representation. That submission states '*As such the differences in the rates of representation are stark, but the profile of hearing outcomes is vastly different to what might be expected in that both Tribunals revoke or refuse far fewer orders than the Victorian Tribunal.*'[102]

413 The low uptake and effectiveness of some of these reforms may in part be due to funding constraints at implementation after commencement of the MHA. Those funding constraints did not allow for extended support for culture change to embed recovery and supported decision making. It may also be unrealistic, however, to expect increased supported decision-making uptake in the context of current system performance. The MHA does not describe the mental

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[100] Mental Health Tribunal 2019, *Mental Health Tribunal Annual Report 2018-2019* <https://www.mht.vic.gov.au/news/2018-2019-mental-health-tribunal-annual-report-published>, Melbourne.
[101] Mental Health Tribunal 2019, *Mental Health Tribunal Annual Report 2018-2019* <https://www.mht.vic.gov.au/news/2018-2019-mental-health-tribunal-annual-report-published>, Melbourne.
[102] Mental Health Tribunal 2020, Productivity Commission Mental Health Inquiry: Submission by the Victorian Mental Health Tribunal in response to the draft report <https://www.mht.vic.gov.au/news/our-submission-productivity-commission-inquiry-mental-health>, Melbourne.

health workforce beyond the statutory roles and does not allocate statutory roles to those with lived experience as consumers or carers. Any consideration of how best to achieve the objectives of supported decision making – whether through amendments to the MHA or changes to policy and operations – must be directed by those with lived experience. The research confirms that adequate resourcing and leadership are both needed to facilitate system change. Continuity of care is also critical for successful supported decision making.[103]

414 As part of my statutory role to promote the rights of persons receiving mental health services, my office is leading the Promoting Consumer Rights project, which aims to build a stronger, more strategic and consumer-driven foundation for the ongoing and effective promotion of consumer rights.

Appropriateness of custodial settings for the provision of compulsory treatment

Question 31: The Victorian Government's submission to the Royal Commission identifies that there 'is a significant gap in responses for prisoners suffering severe mental illness who require compulsory treatment that can only be provided in a hospital setting'. Could the provision of compulsory treatment into custodial settings assist in responding to this gap? (a) What are the considerations when contemplating providing compulsory treatment in custodial settings in Victoria?
Question 32: Noting other jurisdictions provide compulsory treatment in a number of settings, including custodial, in what settings do you consider compulsory treatment is most effective?
Question 33: What are the lessons that have been learnt from the experiences of other jurisdictions who provide compulsory treatment in custodial settings?

415 As noted in the Victorian Government's submission to the Royal Commission, there 'is a significant gap in responses for prisoners suffering severe mental illness who require compulsory treatment that can only be provided in a hospital setting'.[104]

416 Permitting compulsory treatment under the MHA in custodial settings may appear to be a pragmatic and cost-effective response to the challenges of providing access to treatment for mentally ill prisoners. However, delivering compulsory treatment in gaol gives rise to concerns about the potential for human rights violations and it also has serious clinical implications. The

[103] Kokanovic, R, Brophy, L, McSherry, B, Hill, N, Johnston-Ataata, K, Moeller-Saxone, K, and Herrman, H, 2017, *Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems,* Melbourne Social Equity Institute, Melbourne.
[104] State of Victoria, 2019, *Victorian Government submission to the Royal Commission into Victoria's Mental Health System* <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/5215/6514/1027/Victorian_Government.pdf>, Melbourne, p. 25.

term 'custodial settings' is used here to refer to correctional facilities such as adult prisons and youth justice settings, not secure forensic mental health hospitals such as Forensicare.

417 The correctional and coercive culture of a prison is not therapeutic. There is an inherent conflict between an environment to provide punishment and one that is to provide treatment and care for people experiencing serious mental illness. The administration and operational imperatives of prisons, which focus on security and placement, are in conflict with the culture and purpose of a hospital. There is a risk that prison management will use compulsory treatment in prison, including the forcible administration of medication, as a means of social and behavioural control or to punish prisoners.

418 In custodial settings, deterioration in a prisoner's mental health and behaviour can lead to management conditions that are restrictive, distressing and traumatising for prisoners, many of whom have already experienced significant trauma. For example, prisoners with mental illness have experienced being isolated, locked down in their cells and restrained.

419 Restrictive interventions are not therapeutic and can be re-traumatising; they are intrusive practices used as a last resort to prevent serious and imminent harm to the individual or another person. The use of restrictive interventions in mental health services are monitored by my office and there are safeguards in place in the MHA to protect consumers. Custodial services do not use restrictive interventions in the same way, and they can be used as mechanisms for control and punishment.

420 I am aware of voluntary mental health treatment for prisoners being disrupted as a consequence of prison lock downs or prisoner movement and isolation. If compulsory mental health treatment were offered in custodial settings, these operational imperatives are likely to conflict with and constrain the delivery of the compulsory treatment, with serious adverse consequences for the prisoners.

421 Governance and accountability structures would need considerable focus in any consideration of compulsory mental health treatment in custodial settings, with clear separation of custodial and treatment requirements. Clinical mental health services would need to be unequivocally under the governance of mental health services, including decisions about placement, treatment and care and safety, and the use of restrictive interventions. For example, if prison officers became involved in administering medication or there was an operational decision to lock a prisoner in their cell, significant risks such as over-sedation and the possibility of positional asphyxia through physical restraint would arise. Such risks are very carefully managed in psychiatric hospitals.

422 The conflation of clinical and custodial roles would also upset the delicate balance that allows clinical psychiatric services to function in custodial settings in a humane and effective way: there would be a loss of therapeutic trust between prisoners and clinicians who work in prisons, and that trust is necessary to manage risks such as suicide and self-harm, as the clinicians become seen as just part of the prison system. Prisoners would learn that disclosing mental distress may, ultimately, result in their being forcibly administered medication in a non-therapeutic setting, such that they would not disclose symptoms at an early and more readily treatable stage.

423 There is also a potential for a conflict of laws if compulsory treatment was permitted in prisons. Both the *Corrections Act 1986* and the MHA establish oversight mechanisms and safeguards. The obligations to monitor the provision of mental health services in custodial settings owed by the Secretary to the Department of Justice and Community Safety Victoria and the Chief Psychiatrist overlap and create a potential conflict. For example, the Chief Psychiatrist has no power to enter prisons without the agreement of the Secretary and the Commissioner for Corrections. If compulsory mental health treatment in custodial settings were to be considered, facilitative provision would need to be made for the Chief Psychiatrist to provide oversight of the quality and safety of treatment and care in custodial settings.

424 Section 67 of the MHA does not currently permit compulsory treatment in prisons. This is consistent with a long-established principle in Victoria that compulsory mental health treatment must not be provided in correctional settings, and the National Statement of Principles for Forensic Mental Health endorsed by all Australian Health Ministers.[105]

425 Providing compulsory mental health treatment in a place of custody potentially engages a number of human rights protected under the *Charter of Human Rights and Responsibilities Act 2006* (the Charter), including the right to protection from torture and cruel, inhuman or degrading treatment and the right to humane treatment when deprived of liberty. The Charter provides that limitations on rights should be reasonable and demonstrably justified, which requires consideration of whether there is a less restrictive way to achieve a policy objective. Providing compulsory mental health treatment in a custodial environment is not the least restrictive method of providing such treatment. The least restrictive method is to provide treatment in

[105] The National Statement of Principles for Forensic Mental Health states that 'legislation should not allow coercive treatment for mental illness in a correctional setting' (Australian Health Ministers' Advisory Council, 2006).

designated mental health services, which are established under the MHA for the purposes of providing compulsory mental health treatment.

426 RANZCP is committed to eliminating compulsory mental health treatment in custodial settings.[106] They have stated that compulsory mental health treatment should only occur in appropriately designated mental health services, outside of custodial environments, that are appropriate to individual clinical and risk management needs.

427 Compulsory treatment occurs in custodial settings in some other Australian jurisdictions, but I am not aware of any jurisdiction that has been able to adequately address the concerns listed above and also ensure equivalence of mental health care for prisoners with the services provided in the broader community. In New South Wales, compulsory treatment can occur within a correctional centre. Long Bay Hospital, located in the Long Bay Correctional Complex, operates three specialty units including a 40-bed Mental Health Unit which provides compulsory treatment to prisoners. Those prisoners are subject to regular independent reviews of their legal status, but concerns have been expressed about the equivalence of the mental health services provided.[107]

428 I understand that in Western Australia if prisoners meet the criteria under the Mental Health Act 2014 (WA) for assessment for involuntary treatment, they are referred under that Act, which requires that they be transported to specialist mental health facilities.

429 Whilst compulsory treatment may be authorised in South Australia within a custodial setting, I understand that, in practice, alternatives to delivering compulsory treatment are preferred. Prisoners who do not consent to treatment and actively resist treatment are generally transferred to a general mental health inpatient service or a secure forensic mental health facility (James Nash House) for administration of medication.

430 Compulsory mental health treatment in custodial services also occurs internationally, including in some jurisdictions in Europe and the United States of America. However, I have not found any analysis of how it works in practice.

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[106] https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody#:~:text=The%20RANZCP%20supports%20legislation%20that,in%20the%20criminal%20justice%20system.

[107] S. Spenser and K. Dean, 2019, 'Involuntary psychiatric treatment in custody', *Australian and New Zealand Journal of Psychiatry*, vol. 53(9), pp. 839 –840.

431 The United Nations and the World Health Organization advise that prisons are not an appropriate place for people with acute mental illness and recommend that prisoners should be transferred to specialist psychiatric care as soon as possible. [108]This principle seeks to ensure there is no confusion between coercion for the purposes of treatment versus coercion for the purposes of containment and good order of a detention facility.

432 United Nations human rights instruments state that all individuals have the right to access health care appropriate to their needs regardless of their legal status. This is known as the 'principle of equivalence'. It is recognised in the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), and the Convention on the Rights of Persons with Disabilities (2008). The principle of equivalence requires that prisoners be transferred out of prison if compulsory treatment is needed, to ensure they receive appropriate care with proper safeguards.

433 Compulsory treatment in custody also compromises the 'principle of reciprocity'. This principle holds that society has no right to remove civil liberties from individuals for the purpose of treatment if resources for that treatment are inadequate.[109,110] If a prisoner experiences psychiatric symptoms that are so acute that compulsory treatment is needed, they should receive it from a specialist multidisciplinary team at a hospital; the care available in prison is not an adequate substitute, particularly in situations where prisoners require treatments with the potential for serious side-effects.

Continuity of care between jurisdictions

Question 28: How do current cross border arrangements for people on compulsory treatment orders work? (a) What is being done to ensure continuity of care for people wishing to transfer jurisdictions?

434 The states and territories in Australia are responsible for their own mental health legislation, which has resulted in different criteria for compulsory treatment in each jurisdiction. It also

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[108] United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela rules). Vienna: UN Office on Drugs and Crime, Justice Section; 2015, rule 109. (https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf). Trecin statement on prisons and mental health. Copenhagen: WHO Regional Office for Europe; 2007 (https://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2007/trencin-statement-on-prisons-and-mental-health).

[109] Eastman N 1994, 'Mental health law: civil liberties and the principle of reciprocity', *British Medical Journal* vol. 308, p. 43.

[110] Fistein, E. C., A. J. Holland, I. C. H. Clare, and M. J. Gunn 2009, 'A comparison of mental health legislation from diverse Commonwealth jurisdictions', *International Journal of law and Psychiatry* vol. 32 no. 3, pp. 147-155.

means that mental health orders made under the legislation of one jurisdiction often do not have effect in another.

435 In Victoria, Part 13 of the MHA provides for the interstate application of mental health laws using cross-border bilateral ministerial agreements that recognise other jurisdictions as having corresponding orders. The bilateral ministerial agreements set out agreed administrative arrangements to harmonise the differences and support the continuity of care for persons moving between jurisdictions. Division 8, Part 11 of the MHA also deals with interstate security patients.

436 There are cross-border bilateral ministerial agreements for both civil[111] and forensic patients. For example, the civil agreements enable: persons in one state to be assessed for compulsory treatment in another (when we share a border with that state); consumers subject to a compulsory treatment order to be transferred interstate; and persons absent without leave from interstate facilities to be apprehended and returned using an interstate apprehension order. The forensic agreements provide for the apprehension and return of forensic patients who are absent without leave in another state.

437 During the last 20 years, Victoria has entered into cross-border bilateral ministerial agreements with New South Wales, Queensland, South Australia and the ACT. Currently Victoria has civil ministerial agreements with New South Wales, South Australia and the ACT and forensic ministerial agreements with New South Wales and the ACT. Bilateral agreements have proven to be an unsatisfactory vehicle to support the interstate application of mental health laws. Bilateral agreements are resource intensive because they take time to negotiate and require resources to maintain their currency because an agreement will require revision whenever the parties' mental health laws are significantly revised.

438 For example, Victoria's cross-border bilateral ministerial agreements with Queensland ceased to operate following the expiry of transitional provisions after the commencement of a new Mental Health Act in Queensland. Victoria's current ministerial agreements are difficult to read and understand because they predate the commencement of the MHA and so refer to the repealed provisions of the 1986 Mental Health Act.

439 In response to these issues my office routinely provides advice and support on cross-border issues to mental health services. This may include advice about a cross-border bilateral

[111] The term 'civil patients' refers to compulsory patients as defined in the *Mental Health Act 2014* (persons subject to an assessment order, a court assessment order, a temporary treatment order or a treatment order under that Act) and persons subject to an equivalent order under a corresponding law in a participating State.

ministerial agreement if applicable, but more often these matters are resolved by the spirit of collaboration and cooperation that exists between the chief psychiatrists in each jurisdiction. For example, I recently assisted with the transfer of two young people from Tasmania who required acute inpatient treatment because that state does not have inpatient child and adolescent mental health services.

440 As part of my role as Chief Psychiatrist, I am a member of the National Mutual Recognition Project Interjurisdictional Project Steering Committee (Steering Committee) of the Australian Health Minister's Advisory Council (AHMAC) to oversee the development of an agreed national legislative scheme to support mutual recognition of civil mental health orders. Forensic orders are out of scope for the scheme. The project will explore the development of model legislation or provisions to enable the recognition of other jurisdictions' mental health orders to improve continuity of care for people moving between jurisdictions. The project commenced in November 2019 however the project times lines are being revised because of the impact of COVID-19.

441 The work of the Steering Committee builds upon Action 26 of the Fifth Plan which commits Australian governments to improving consistency across jurisdictions in mental health legislation.

442 Pending the development of draft national legislation, the Mental Health and Drugs Branch is in discussion with its counterparts in New South Wales, Queensland and Tasmania to explore the development of cross-border memoranda of understanding that set out agreed principles to assist clinicians with cross-border decisions. Those principles would seek to drive consistent best practice, based on the applicable legal and human rights frameworks. Once draft documents have been developed, my office will be involved in consultations about the draft principles.

443 I note the legislative differences between jurisdictions do not usually limit the access of seriously unwell people to interstate mental health services in border areas because the statutory criteria for compulsory treatment in each jurisdiction are sufficiently similar to apply to this cohort. Universal access applies irrespective of the person's state of origin or whether they are already subject to a compulsory treatment order made by another state.

Reducing rates of compulsory treatment through improved engagement

Question 25: Are there other alternative methods to compulsory treatment to engage people in treatment? If so: (a) what are they? (b) what factors needs to be present in an individual for these methods to work?

(c) what features or circumstances need to be present at a systemic level for these methods to work? (d) to what extent could these methods be replicated in Victoria?
Question 29: Other than legislation, what other mechanisms could be used to reduce rates of compulsory treatment use? Please consider policy, funding and operational levers. (a) How could they be deployed in Victoria? By whom could they be deployed? (b) What is required to ensure the use of these levers are successfully implemented?

444 The rate of compulsory treatment is linked to the factors that support people to engage in treatment because when people are given appropriate support to engage in treatment in a way that is meaningful for them, there is likely to be less need for compulsory treatment.

445 Reducing compulsory treatment requires a broader range of treatment and support options and an understanding of the risk factors that make it more likely a person will be subject to compulsory treatment.

446 The current mental health system is based on a biomedical understanding of mental illness with treatment offered in bed-based hospital settings or the community, with limited step-up or down options and services delivered by clinical staff expert in the administration of psychotropic medications. While the concept of 'trauma informed care' is now better understood, its application has not resulted in any fundamental change to the biomedical model.

447 Limited resources in the current system also restrict access to treatment for the most acutely unwell. Improved engagement in treatment requires the ability to intervene earlier to avoid escalation to crisis situations and emergency presentations of high acuity mental illness, as well as a lower triage threshold that allows assessment and treatment at an earlier stage of illness.

448 There should be greater responsiveness in the system to incorporate evidence-based innovation in the services provided. The literature emphasises the value of peer-led initiatives and family involvement, less restrictive alternatives to traditional hospital-based care, and support options such as advance planning and supported decision-making.[112] While there will always be a need for a biomedical response, a shift is required to incorporate a broader psychosocial understanding of mental illness. This would increase the availability of environmental therapies (for example, individual behavioural therapy, family and group therapy, and therapeutic communities), improve our understanding of their effectiveness and increase their range and quality.

[112] Gooding, Piers; McSherry, Bernadette; Roper, Cathy and Grey, Flick (2018) Alternatives to Coercion in Mental Health Settings: A Literature Review, Melbourne: Melbourne Social Equity Institute, University of Melbourne.

449 Promoting the development of psychological therapies that increase wellness and reduce risk would increase less restrictive options for treatment and potentially reduce the need for inpatient or community compulsory treatment or facilitate earlier discharge from those arrangements.

450 Incorporating a broader psychosocial understanding of mental illness would require greater resourcing of a diverse workforce, experienced in a range of treatment modalities across a range of settings – for example, staff education and training to build new skills with some services delivered by or in partnership with non-health organisations. Ultimately this would enable more options that could be better tailored to the needs of individual consumers.

451 These changes could increase capacity across the system to allow earlier access to treatment and support before a person is in crisis. They would also improve access to mental health services across different systems – including broader health, custodial, disability and child protection – to enable parallel service delivery.

452 Any increase in the modality of services and service settings needs to be accompanied by a cultural change that reduces coercion and enhances autonomy and self-determination. New services would be co-designed with persons with lived experience as consumers, carers and peer workers. People with lived experience will also need to have an ongoing role in directing and delivering the services, to ensure they meet the needs of consumers into the future. Peer-led alternatives to inpatient care have been explored in New Zealand, as acknowledged in the Royal Commission's interim report, and there have been some innovative pilots in the United States of America.[113]

453 Consumers, carers and families need to be better supported so they can direct and participate in decisions about their treatment. Strong models of family involvement include the Open Dialogue program in Finland, which takes the approach of working with families and social networks in their own homes and helping those involved in a crisis situation to be together and engage in dialogue.[114]

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[113] Grey F and O'Hagan M, 2015, *The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the Mental Health Commission of New South Wales*.
[114] Open Dialogue, 'Open Dialogue: An international community' <https://www.open-dialogue.net> [accessed 28 June 2020].

454 Evaluation and research have also identified advocacy and crisis planning as effective ways to support consumers, carers and families.[115,116] The current mental health advocacy service, IMHA, could be expanded to support more people. Nominated persons and crisis planning mechanisms, such as advance statements, require re-examination to understand the barriers to their effectiveness. More timely access to second opinions is also needed to ensure they can be considered in treatment planning.

Addressing clinical, structural and social factors

455 We also need to address the factors that influence the risk of a person being subject to compulsory treatment. Current research indicates those factors fall into three categories: clinical, structural and social.[117]

456 The clinical risk factors for compulsory treatment include a diagnosis of a psychotic disorder, previous compulsory hospitalisation and perceived risk of harm. Psychosis can have an impact on a person's ability to make informed decisions, with a common symptom being a lack of insight or belief that the person has an illness. The very nature of the mental illness, for example with paranoid delusional thinking, may make the consumer believe in other external explanations for their mental experience, such as auditory hallucinations. This may impact on the consumer accessing early treatment which could minimise the serious consequences of their illness for themselves and their family. In all cases, clinicians need to undertake a comprehensive assessment to determine the best approach. It is imperative that the views of a person's carers are obtained and their perspectives taken into account. The level of family and carer support also needs to be assessed so as not to overburden a carer beyond what may be reasonable and safe for all parties, and the risks for individuals without carer or family supports need to be evaluated carefully. Structural factors include the availability of less restrictive options including community treatment, crisis planning and advocacy. As discussed above, a diverse range of less restrictive options are likely to reduce the use of compulsory treatment. Crisis planning mechanisms have been shown to significantly reduce the risk of compulsory treatment by averting crisis and providing consumers with some control over the treatment

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[115] Maylea C, Alvarez-Vasquez S et al, 2019, *Evaluation of the independent mental health advocacy service (IMHA)*, Melbourne, Social and Global Studies Centre, RMIT University.
[116] de Jong, M. Kamperman, A. et al, 2016, 'Inteventions to reduce compulsory psychiatric admissions a systematic review and meta-analysis', *Journal of American Medical Association Psychiatry* vol. 73(7): 657-664.
[117] Walker,S. Mackay,T et al, 2020, 'Clinical and social factors associated with an increased risk for involuntary psychiatric hospitalisation: a systematic review', *Lancet Psychiatry* vol. 6, pp. 1039-1053.

provided.[118] More research is required to identify what would be the most effective mechanisms for the Victorian system.

457 The social determinants of mental health are well known and include poverty, both at a population level and the deprivation experienced by individuals. Unemployment, social isolation and a lack of affordable housing all contribute to poor mental health and increase the risk of compulsory treatment. Supported accommodation designed to assist with mental health needs could go some way to addressing this, as could an examination of the role of community intensive home outreach support – such as mobile intensive support teams – for people who require intensive support to remain in their home environment.

458 Belonging to an ethnic minority or having English as a second language increases the risk of compulsory treatment. Recent Queensland research suggests this is also true for Aboriginal people.[119] More resources are required in the system to support consumers to ensure the services provided are culturally appropriate and that consumers and families can navigate and communicate their desires and preferences.

459 Making changes to Victorian mental health services will not significantly reduce compulsory treatment unless both the State and Commonwealth governments target the social determinants of poor mental health in a coordinated and sustained way.

Restrictive interventions

460 The use of restrictive interventions has a long history in mental health services. Nationally and internationally there are ongoing efforts to reduce and prevent the use of restraint in mental health environments.

461 In mental health service settings, restrictive interventions have the effect of restricting the rights of a person with a mental illness. They are intrusive practices used as a last resort to prevent serious or imminent harm to a consumer or another person. Restrictive interventions are not therapeutic, and should only be used after all possible preventative practices have been tried or considered, and have been found to be unsuitable.

462 Part 6 of the MHA regulates the use of restrictive interventions, and requires services to report to me on the use of any restrictive intervention on a person in a designated mental health service. Attached to this statement and marked '**NC-6**' is a copy of the Chief Psychiatrist's

[118] Walker (2020) and de Jong (2016) (above n 116 and 117).
[119] Kisely, S. Moss, K et al, 2020 'Efficacy of compulsory community treatment and use in minority ethnic populations: a statewide cohort study', *Australian and New Zealand Journal of Psychiatry* vol. 54(1), pp. 76-88.

guideline *Restrictive interventions in designated mental health services*, which sets out best practice requirements for the conduct, monitoring, oversight and recording of restrictive interventions.

463 The Chief Mental Health Nurse and I share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services. This commitment aligns with the Fifth Plan and the work of the Safety and Quality Partnership Standing Committee, of which I am a member, and which works across jurisdictions to support state and territory governments to eliminate the use of restrictive interventions.

464 Eliminating the use of restrictive interventions is a key focus of my office and the OCMHN, and there has been extensive work over a number of years to reduce their use, including through the *Creating safety: addressing restraint and seclusion practices* project in 2006, the 2013 *Providing a safe environment for all: Framework for reducing restrictive interventions*, the implementation of the MHA, and the Safewards program, which I discuss further at paragraphs 519 to 532 below. Our offices continue to work closely with services to monitor their use at a service level and support practice change.

465 Our ultimate aim is to eliminate the use of restrictive interventions, and planning has commenced for a long-term program of work to eliminate the use of restrictive interventions in Victoria. This is an ambitious objective which will require fundamental change and sustained efforts in partnership with mental health services, consumers and carers, and industrial bodies. Leadership, commitment and motivation will be critical to the success of this work, as will a change culture underpinned by recovery with a focus on workforce and training.

Restrictions on human rights

Question 38: What psychological and physical impacts can restrictive practices have on consumers and workers?

(a) How does the use of restrictive practices impact on consumer rights and empowerment?
(b) Do restrictive practices have the potential to be traumatising or re-traumatising? If so, why?
(c) What are the impacts of extended periods of seclusion or restraint? Under what circumstances would extended periods of seclusion or restraint be necessary?
(d) In your experience, can experiences of seclusion or restraint in a mental health service hinder consumers from seeking help for mental health problems in the future?
(e) Can the use of restrictive interventions impact on workers within mental health services? If so, how?

466 By their nature, the use of restrictive interventions limits the rights of consumers. When the MHA was introduced, the Statement of Compatibility with the Charter of Rights and Responsibilities acknowledged that multiple rights from the Charter were impacted. These include the right to protection from torture and cruel, inhuman or degrading treatment; the right

not to be subjected to medical treatment without informed consent; the right to freedom of movement; the right to privacy and reputation; and the right to freedom of expression.

467 Consumers' rights are affected when their freedom of movement or ability to communicate is restricted through practices such as seclusion and restraint. While any limitations on consumers' rights must comply with the MHA and be reasonable and demonstrably justifiable, the impact is nevertheless disempowering for the person.

Impacts of restrictive interventions

468 For consumers, restrictive intervention techniques can result in both physical and psychological impacts.

469 A small number of deaths have been causally related to restrictive interventions. Death can potentially occur through positional asphyxia through prone restraint, which is the basis for the 2013 *Practice of prone restraint: Chief Psychiatrist clinical practice advisory notice*.[120] Deaths have also occurred in cases where a consumer has had a physical illness and/or psychotropic drug use, and the practice of seclusion has reduced the opportunity for staff to maintain close physical observations. Other potential physical impacts include compromised airway due to aspiration or choking, neck or chest compression, bruising, dehydration, loss of muscle strength and mobility, incontinence, needle stick injury, and deep vein thrombosis.[121]

470 In terms of psychological impacts on consumers, it has been found that use of restrictive interventions can evoke feelings of distress, anxiety, neglect, anger, fear, loneliness, humiliation, insecurity, powerlessness, mistreatment and punishment.[122]

471 Use of restrictive interventions can also result in an exacerbation of psychiatric symptoms, and has the potential to be experienced as a traumatic event or to trigger previous traumatic

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[120] Department of Health and Human Services 2013, *Practice of prone restraint: Chief Psychiatrist clinical practice advisory notice* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/prone-restraint-chief-psych-clinical-practice-notice>, Melbourne.

[121] Department of Health and Human Services, *Restrictive interventions in designated mental health services: Chief Psychiatrist's guideline* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-restrictive-interventions>, page 10.

[122] Department of Health and Human Services 2013, *Reducing restrictive interventions: literature review and document analysis* <https://www2.health.vic.gov.au/about/publications/researchandreports/reducing-restrictive-interventions-literature-review-2013>, Melbourne.

experiences for all individuals involved, including staff. Responses can include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression.[123]

472 The experience can be potentially both more traumatic and more dangerous for some individuals. The Chief Psychiatrist's guideline *Restrictive interventions in designated mental health services* notes the importance of gender sensitive care and understanding how trauma manifests in people when they are in acute distress. It also emphasises the care that must be taken to communicate effectively with consumers in order to avert the use of a restrictive intervention and to minimise any associated trauma, including:

(a) Aboriginal consumers who may perceive or interpret the use of a restrictive intervention in relationship to their cultural background and personal experiences of colonisation

(b) culturally and linguistically diverse consumers, who may not be able to understand what is happening or may be unable to communicate their questions or concerns, and whose personal experiences such as being a refugee or survivor of abuse or torture may affect their perception of events

(c) consumers with sensory impairment, who may be unable to fully understand what is happening or communicate questions or concerns, and for whom specific interventions may prevent effective communication.

473 Extended periods of seclusion or restraint can have an effect on the consumer's wellbeing, therapeutic engagement between staff and consumers, and the consumer's overall care plan. As well as restricting consumer rights, the documented effects on consumers' wellbeing extend to trauma, control, isolation, dehumanisation and 'othering', as well as anti-recovery. In addition, physical health impacts can include disruption to sleep patterns, physical activity and exercise. Circumstances in which services use extended periods of seclusion or restraint include:

(a) where there is prolonged clinical deterioration that is unable to be stabilised, and close observation is required

(b) when the risk to the health and safety of the consumer and staff escalates to a level that cannot be managed in a low dependency unit

[123] Department of Health and Human Services, *Restrictive interventions in designated mental health services: Chief Psychiatrist's guideline* <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-restrictive-interventions>, page 6.

(c) when medication requirements cannot be managed in a low dependency unit.

474 In my experience, consumers' experiences of seclusion and restraint in mental health services can impact on the development of trusting relationships between people receiving care and clinicians. In addition, the experience can impact on an individual's willingness to reengage with mental health services. Individuals may be particularly reluctant to seek treatment in acute inpatient units following an experience of seclusion or restraint. Research has also found that people who are physically restrained while in an emergency department are less likely to attend for mental health outpatient follow-up treatment than those who are not restrained.[124]

475 The use of restrictive interventions can also have a negative impact on workers within mental health services. Even where a restrictive intervention may be clinically necessary, workers may feel that their participation in a restrictive intervention compromises their principles, and conflicts with the ideal that the environment should provide the least restrictive care possible.

Changes to the use of restrictive practices

Question 36: Have changes to any of the following influenced when and how frequently restrictive practices are used within Victorian mental health services:

(a) Legislative and policy settings
(b) Patient characteristics:
    (i) Consumer demographics (e.g. age, gender)
    (ii) Acuity (e.g. following delayed access to help)
    (iii) Presenting behaviours due to changing patterns of alcohol and other drug use (e.g. methamphetamine use)
(c) Service operating models (e.g. type of service, workforce profile etc.)

476 Changes to the legislation governing restrictive interventions have impacted on the use of those interventions in Victorian designated mental health services. The MHA introduced regulation of physical restraint, in addition to mechanical restraint and seclusion. It also sought to improve the safety of restraint and seclusion by increased oversight and accountability.

477 Policy work has also influenced the use of restrictive interventions, with extensive work to reduce their use by my office and the Chief Mental Health Nurse. These policy initiatives have an important role to play in creating a culture of change, to support mental health services to reduce and work towards a goal of eliminating these practices, and restrictive interventions data in the *Chief Psychiatrist's annual report 2018-19* shows Victoria's progress towards this goal.

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[124] Department of Health and Human Services 2013, *Reducing restrictive interventions: literature review and document analysis* <https://www2.health.vic.gov.au/about/publications/researchandreports/reducing-restrictive-interventions-literature-review-2013>, Melbourne, page 1.

Attached to this statement and marked '**NC-7**' is a copy of the *Chief Psychiatrist's annual report 2018-19*.

478 Policy work has included:

(a) development of the 2013 *Framework for Reducing Restrictive Interventions*, which sets out the principles that underpin the task of reducing the use of restrictive interventions

(b) best practice guidance for services, provided in the Chief Psychiatrist's Guideline *Restrictive interventions in designated mental health services*

(c) the *Reducing Restrictive Interventions* initiative, led by the Chief Mental Health Nurse, which is a statewide initiative to support mental health services to work towards reducing and, where possible, eliminating the use of restrictive interventions. Every mental health service across Victoria has participated in developing local action plans (LAPs) for reducing incidences of restrictive interventions. LAPs employ a range of strategies, including workforce development, enhanced consumer and carer participation, strengthened clinical governance, innovative therapeutic interventions and sensory modulation.

(d) the *Creating Safety* online training program, which aims to assist staff to reduce the use of restrictive interventions in adult acute inpatient units

(e) statewide rollout of the *Safewards* model, discussed further below at paragraphs 519 to 531.

Factors contributing to the use of restrictive practices

Question 34: What factors contribute to the use of restrictive practices? (a) What factors contribute to the use of restraint? (Please comment on different types of restraint including mechanical, bodily and chemical forms) (b) What factors contribute to the use of seclusion?

479 When considering the use of restrictive interventions, there are contributory factors at both the organisational level and at the level of an interaction with an individual consumer.

480 Organisational factors contributing to the use of both restraint and seclusion include organisational culture and systems, the environment, the capability of staff to anticipate need and manage escalation. The level of acuity of symptoms being experienced by consumers on a particular unit, as well as unit culture (for example, a culture that is coercive or creates conflict, rather than a positive clinical culture) can also influence the use of restrictive interventions.

481 Factors affecting the decision to use restraint or seclusion in a specific instance include:

(a) the organisation's policies and procedures, which should set out the types of restraint options in the service

(b) the assessment by clinical staff – using their clinical knowledge and evidence based assessment tools – that there is a high probability that the person will (or within the near future will) seriously harm themselves or another person, and that it is 'necessary to prevent imminent and serious harm to the person or to another person'[125]

(c) the need to respond to challenging behaviour and to manage risk

(d) the treatment that is needed, and the use of physical restraint that follows in order to administer treatment – for example, medication may be used to target symptoms of mental illness and reduce acute arousal (noting, however, that the use of medication to restrict movement can be hazardous, and has no defined place in the MHA or in practice).

482 In my experience, restrictive interventions are less likely to be used where recovery-oriented practice, trauma-informed care, supported decision making, and family and carer inclusive practice inform workplace practices. For instance, for people experiencing deliberate self-harm or suicidal ideation, the preferred model is for therapeutic engagement by the workforce – and particularly the peer lived experience workforce which is highly regarded by people in distress – rather than seclusion, which is never seen as therapeutic.

483 The *Mental Health Intensive Care Framework,* developed and in the process of being implemented by the OCMHN, provides a framework for providing care in a way that responds to individual vulnerabilities and risks when the severity of symptoms, distress or other factors affect a person's ability to self-manage. The provision of intensive care is not reliant on a fixed environment or treatment setting. Rather, when considering service environments, compatibility and the most appropriate setting for a person's needs, there are a number of factors to balance, and all possible alternatives should be explored before environmental restrictions are applied or freedom of movement is restricted.

Variations in practice

Question 35: How does the use of restrictive practices vary within and between mental health services? Please provide your views on the reasons for any variation.

[125] Mental Health Act 2014, ss. 110 and 113.

(a)	Are there any differences in the use of restrictive practices within private mental health services, compared to public mental health services?
(b)	Are different approaches to the use of restrictive practices adopted across different age demographics? i. Do services place any age restrictions on who can be restrained or placed in seclusion?
(c)	In your experience, how often is seclusion and restraint used to address risks of self-harm, rather than to address challenging and aggressive behaviours?
(d)	Consumers may experience seclusion and restraint on a single occasion during an episode of care within a mental health service, or they may experience multiple instances of seclusion and restraint within the one episode of care. In your experience, are there common characteristics among consumers who experience multiple instances of restrictive practices?

484 The use of restrictive interventions varies within and between mental health services. Differences can be associated with both the setting (public or private, and the corresponding legislative framework, environment, and clinical governance and responsibilities) and consumer characteristics.

485 There is no legal framework for the use of restrictive interventions outside of designated public mental health services, and they should not occur in these settings. As such, private health services should not have seclusion rooms or mechanical restraint devices. If restrictive interventions are required due to safety risks, an assessment order under the MHA should be sought and the person should be transferred to the public mental health system, where I have oversight of the use of restrictive interventions.

486 The Chief Psychiatrist's Guideline *Restrictive interventions in designated mental health services* provides guidance on specific factors that designated mental health services should take into account when developing local policies and procedures, including specific considerations for older persons and children and youth.

487 In relation to older persons, the guideline advises services to consider the ramifications of restrictive interventions. It notes that restrictive interventions can have physical impacts and exacerbate underlying confusion and agitation and recommends that older adults should receive one-to-one care in preference to using a restrictive intervention. Data indicates that it is rare for an aged person to be secluded, and the rate of physical restraint is also lower than that for adults.[126] This likely reflects models of therapeutic engagement and redirection generally

[126] The *Chief Psychiatrist's Annual Report 2018-19* <https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2018-19> reports the rate of seclusion for aged persons at 0.7 seclusion episodes per 1,000 occupied bed days in 2018-19, compared with a rate of 9.2 for adult programs. The rate of physical restraint for aged persons, which in 2018-19 was 5.9 episodes per 1,000 occupied bed days, is also lower than the rate for adults (10.4 episodes per 1,000 occupied bed days).

used in environments with older people with cognitive impairment and behavioural and psychological symptoms of dementia.

488 For children, as for all consumers, a restrictive intervention may only be used in the circumstances permitted by the MHA. In addition, the MHA requires that children and young people have their best interests recognised and promoted as a primary consideration.[127] The Chief Psychiatrist's Guideline advises that the use of a restrictive intervention with a child under the age of 12 should be avoided, and that the developmental status of a young person should be a consideration in any decision. In practice, a family model – rather than the use of other restrictive interventions – is emphasised for the under 12s in statewide units. In this model, staff provide support and guidance to parents and guardians to manage disruptive behaviours.

489 Work is underway with all services, including CAMHS, to reduce the use of restrictive interventions. In 2018-19, child and youth inpatient units were funded through the Strengthening the Workforce initiative of the Victorian State Budget to employ a clinical nurse consultant, whose responsibilities include implementing Safewards and other activities to reduce restrictive interventions. A similar role had already been established at Orygen Youth Health.

490 In my experience, seclusion and restraint is most often used to prevent imminent and serious harm to another person, rather than to address risks of self-harm. Consumers may experience seclusion and restraint on a single occasion during an episode of care within a mental health service, or they may experience multiple instances of seclusion and restraint within the same hospital admission, although this is less common.[128] In my experience, multiple episodes of seclusion and restraint usually arise when aggressive behaviours, which pose a risk to others, remanifest before other intervention measures have become effective.

Question 41: Are there any differences in how consumers presenting with challenging behaviours are responded to in mental health wards/units compared to the emergency department or other areas of a health service? If so, what are the differences?

491 There can also be variations in practice in different areas of a health service. Consumers presenting with challenging behaviours can experience a different response in an emergency department as compared with a mental health unit. Reasons for this include:

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[127] Mental Health Act, section 11(1)(i).

[128] The *Chief Psychiatrist's Annual Report 2018-19* reports that, when seclusion episodes were reported within a single admission in 2018-19, they represented a single occurrence within the whole period of the admission 64 per cent of the time. Restraint episodes also represented a single occurrence 57 per cent of the time (pages 21-22).

(a) the legal requirements in relation to restrictive interventions, noting that the regulatory protections in Part 6 of the MHA apply only where a person is subject to an Order under the MHA. Management of all other patients – including those apprehended by police under section 351 of the MHA – is governed by the legal and ethical obligation to provide reasonable emergency care to a person.[129] While most organisations have operational procedures relating to these circumstances, there is currently no standardised process or requirement to document or report restraint use.

(b) emergency department care often requires complex decisions to be made under pressure. The individual may not be well known to staff, or only limited background information may be available, and the decision making capacity of the person may not be clear.

(c) the emergency department environment, which may contribute to a person's agitation or distress. A review commissioned by the Department of Health and Human Services found that, across five Victorian emergency departments in 2016, the most commonly documented reasons for a restrictive intervention being used were agitation or aggression, risk of harm to self or others, risk of absconding, or attempting to self-harm.[130]

(d) the staff mix in a particular emergency department, and whether it includes mental health clinicians and other members of the mental health workforce. Often, emergency department and general medical ward staff are not trained in mental health, and there can be very limited access to mental health trained staff to provide advice and support in these settings.

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[129] The report *Restrictive interventions in Victorian emergency departments: a review of current clinical practice* <https://www2.health.vic.gov.au/about/publications/researchandreports/restrictive-interventions-emergency-departments-review>, commissioned by the Department of Health and Human Services, reviewed emergency department presentations in five hospitals over 2016. The report found that, at the time a restrictive intervention was first used, only a quarter of patients were being managed under the MHA. Half of the patients that required a restrictive intervention arrived with police pursuant to section 351 of the MHA, and the requirements of part 6 of the MHA therefore did not apply.

[130] Department of Health and Human Services 2019, *Restrictive interventions in Victorian emergency departments* <https://www2.health.vic.gov.au/about/publications/researchandreports/restrictive-interventions-emergency-departments-review>, p. 6.

(e) the triage and referral systems in operation, and the availability of a PAPU or other environment for assessment and shorter-term support that reduces the amount of time spent in the emergency department.

492 It is hoped that the trial of the Safewards program in emergency departments, discussed below at paragraphs 519 to 531, will reduce the likelihood of restrictive interventions in these settings.

Role of security staff

Question 42: What proportion of emergency departments, inpatient mental health units or other areas of health services have security staff present?

(a) Why are they present? What role are they required to undertake?

(b) When did the presence of security staff start? Why did it start?

(c) In your experience, how often are security staff required to intervene in mental health presentations in

(i) emergency departments?

(ii) inpatient mental health units/wards?

(iii) other areas of a health service?

493 Security services in health services play an important role in ensuring a safe environment for staff and consumers, and in preventing and managing occupational violence and aggression.

494 The Department of Health and Human Services does not require health services to report on their security arrangements and does not routinely collect data on the proportion of emergency departments, inpatient mental health units or other areas of health services that have security staff present.

495 Locating security staff in emergency departments, short stay units and mental health inpatient units has become more routine, and some services have moved to positioning security staff close to the emergency department and including them as part of the clinical team in a mental health inpatient unit. This may be in response to:

(a) the level of occupational violence across various areas of the service, including emergency departments, general wards and acute inpatient units, and increasing awareness of this as a workplace safety issue.

(b) high demand for inpatient treatment resulting in increased acuity in inpatient units.

(c) the impact of substance use (particularly amphetamine/ice and other similar psychoactive stimulants).

496 The Violence in Healthcare Taskforce's 2016 report *Taking action to reduce violence in Victorian hospitals*[131] provided recommendations to the Minister for Health and the Department of Health and Human Services to prevent and manage violence and aggression. In relation to security, the taskforce found significant variation in security staffing, management and response to incidents across Victorian public health services.

497 In response to this recommendation, and to assist health services to develop a more consistent and coordinated approach to their security arrangements, the Department of Health and Human Services released the *Guide for security arrangements to manage occupational violence and aggression: guiding principles*[132] in 2018. The principles require:

(a) all Victorian public health services to have security arrangements in place to protect staff, patients and visitors.

(b) each health service to determine their own security requirements by conducting comprehensive site-specific risk assessments, which should consider factors such as the clinical service provided, practices being undertaken at the site (such as seclusion, restraint, weapons searching and management), staffing roles and numbers across all shifts, staffing capacity and capability, and proximity of security-trained personnel to the highest risk areas of the site.

(c) the roles and responsibilities of security personnel to be clearly defined. Roles may include participating in Code Grey, Code Black and Code Brown teams; responding to security and fire alarms; responding to threats and dangers, including moving staff, patients and visitors to safety; presence in high-risk and crowded areas; undertaking weapons searching and management; escorting staff to vehicles; implementing safe physical restraint practices; reporting security related incidents; providing input into security issues and audits and participating in post-incident reviews.

(d) security practices to be tiered to deliver least restrictive interventions.

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[131] Department of Health and Human Services 2016, *Violence in healthcare taskforce report – taking action to reduce violence in Victorian hospitals* <https://www2.health.vic.gov.au/about/publications/researchandreports/violence-in-healthcare-taskforce-report>.

[132] Department of Health and Human Services 2018, *Guide for security arrangements to prevent and manage occupational violence and aggression: guiding principles* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/guide-for-security-arrangements-to-prevent-manage-ova>.

(e) security personnel to receive additional healthcare specific training.

(f) governance structures and functions to be in place to support appropriate security arrangements.

498 Health services are not required to report each interaction involving security staff to the Department of Health and Human Services, although some of these would be captured in incidents reported in VHIMS.

National approach to restrictive interventions

Question 37: Why is there variation between jurisdictions in relation to rates of seclusion and restraint?

499 At a national level, work towards eliminating the use of restrictive interventions is supported by the Australian Health Ministers' Advisory Council through its key mental health committees, the Safety and Quality Partnership Standing Committee and the Mental Health Information Strategy Standing Committee.

500 Twelve national forums on restrictive interventions have been held to share results and support broader change efforts to shift seclusion and restraint out of mental health units entirely, with Victoria presenting its restrictive interventions data at the most recent forum in November 2018. The forums provide an opportunity for clinicians, policy makers, researchers and people with lived experience of mental illness from across Australia to share innovative ideas and be informed about evidence-based policy and service delivery directions.

501 The Australian Institute of Health and Welfare published hospital-level data for seclusion and restraint for most states and territories in December 2018. Nationally, there is considerable variation in seclusion and restraint practices between hospitals, however the reported data indicates that Victoria continues to have some of the highest rates of restrictive interventions.[133]

502 Caution should be used in interpreting these data, especially the comparability between states and territories – each have different definitions of restraint, different policy and legislative requirements on its use and different processes and systems for collecting relevant data.

503 I have a high degree of confidence the data for Victoria reflects the experience of service users in relation to the use restrictive interventions.

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[133] Australian Institute of Health and Welfare 2020, *Mental Health Services in Australia* <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices>.

504 Reasons for Victoria's relatively high reported rates of seclusion and restraint include:

(a) a strong emphasis on accurate recording of restrictive interventions and strict application of the definitions for seclusion and restraint.

(b) regular review and oversight of results with continuous improvement activities being driven through the OCMHN at an individual unit and area mental health service level.

(c) a relatively high admission threshold, with higher acuity of consumers on admission and associated behavioural disturbance.

(d) lower than optimal access to community clinical mental health services, which has increased emergency presentations.

505 Different definitions affect comparability, and the Australian Institute of Health and Welfare rolls up the age groups together in its reporting. However, Victoria – where restrictive interventions are unusual in aged person's mental health services, but rates are higher in adult and CAMHS services – does not roll up all age groups in its public and non-public reporting.

Reducing the use of restrictive interventions

Question 39: What actions can service providers take to reduce the use of restrictive practices? Please consider the role of workplace and service characteristics (e.g. rostering, routines), leadership, culture and workforce capability.
(a) What makes it difficult to reduce restrictive practices and why?
(b) What factors enable professionals to employ alternate strategies and make seclusion and restraint the practices of last resort?
(c) What training and skills do staff need to reduce the use of restrictive practices?

506 The work of my office and the Chief Mental Health Nurse supports services to take action to reduce restrictive interventions through governance, guidance, training, resources and support for evidence-based interventions, and this has been a key focus in our work on the Safewards program and the recently released Mental Health Intensive Care Framework.

Organisational approach

507 *Providing a safe environment for all: framework for reducing restrictive interventions* sets out an organisation-wide approach to assist services to reduce restrictive interventions. The framework describes the factors that are essential to enabling professionals to employ alternate strategies and make seclusion and restraint the practices of last resort. Conversely, the absence of these factors makes it more difficult to reduce restrictive interventions. Four

interconnected capabilities support the mix of interventions that will enable a sustainable reduction in restrictive interventions (see paragraph 514 below).

508 Leadership and accountability are needed to set targets, develop methods to monitor and reflect, enable front-line accountability, model the expected culture, and establish and support effective change management processes.

509 Organisational systems – including policies, models of care, environments, and all components governing service delivery – need to align with the service's vision for reducing and eliminating restrictive interventions, be responsive to the local environment, be collaboratively designed with consumers and carers, and enable structures to support practice change.

510 It is essential that processes support self-determination, by respecting and facilitating a consumer's rights and wishes to plan for their recovery and focus on the issues that are important to them. Key to this is embedding collaborative practice in both individual practice and service design, ensuring that people with lived experience, carers and staff work together on strategies to reduce restrictive interventions.

511 Model of care considerations should include the incorporation of programming that increases access to allied health professionals and the lived experience workforce, in particular the peer support workforce, to assist in the prevention of restrictive interventions. Alleviation of boredom, thorough and timely discharge planning and assistance with rebuilding or maintaining healthy relationships are all key elements of reducing conflict, and conflict in turn can lead to restrictive interventions.

512 All members of the workforce – including health professionals, people with lived experience and carers – need role clarity, to understand the application of contemporary practice, and to have mechanisms in place to support accountability and reflection.

513 All efforts to reduce the use of seclusion and restraint must be underpinned by an approach to care that is recovery-oriented and trauma-informed. Understanding and working with risk is also essential to creating a safe environment that balances flexibility, responsiveness and people's unique circumstances and preferences with risk management obligations.

514 The Mental Health Intensive Care framework identifies the following four enabling factors to reducing restrictive interventions:

(a) organisational culture and systems that align with organisational values and objectives to reduce restrictive interventions, and that support practice and continuous improvement.

(b) a healthy environment, which considers the physical setting, social dynamics and cultural behavioural patterns that impact on the inpatient unit environment and therapeutic milieu, which acknowledges people's experiences and preferences, and which supports open dialogue and a positive learning culture.

(c) the ability to anticipate need and manage escalation in a way which involves the person with a lived experience, their support people and health professionals.

(d) review and quality assurance, and the effective use of data and feedback, to contribute to continuous improvement in the reduction of restrictive interventions.

515 With this underpinning, professionals are more likely to be able to effectively employ alternate strategies, leading to improved decision making that is consumer- and carer-inclusive, and that is not merely a reactionary response.

Training

516 Effective training is essential so that all staff understand the importance of reducing restrictive interventions, and are able to develop the skills and knowledge relevant to their role and confidence in using these. Consistent with the Chief Psychiatrist's Guideline *Restrictive interventions in designated mental health services*:

(a) all direct care staff and security staff should be trained in the service-approved approach to restrictive interventions, noting that training requirements may vary across disciplines depending on functions and roles.

(b) training should develop understanding and proficiency in a number of areas, including evidence based preventative strategies (such as de-escalation techniques and the use of sensory modulation); the legal framework, departmental guidelines, and local policies and procedures; use of approved techniques, monitoring requirements, recognising signs of physical distress, and emergency responses; the need to consider the use of restrictive interventions within a framework that promotes recovery-oriented practice and trauma-informed care; an awareness of consumer experiences of restrictive interventions and of the impact of staff behaviours and attitudes on consumers; and an understanding of the causes of aggressive and threatening behaviour.

517 In addition, organisations need to ensure that training is accessible, available and appropriate for building the knowledge and skills that enable staff to reduce and work towards eliminating restrictive interventions.

518 The national forums on restrictive interventions, discussed at paragraph 501 above, also provide a powerful opportunity to share work and challenge thinking on restrictive interventions, engage leaders and promote cultural shifts within services.

The Safewards model

Question 40: What is the SafeWards model? (a) How widely is it used in Victoria? (b) Has the use of the SafeWards model impacted on service delivery and use of restrictive practices? If so, in what ways?

519 Safewards is a model of providing mental health care that was originally developed for inpatients units in the United Kingdom. It was based on a broad body of evidence, including several large research studies conducted by the team that developed the model, and a review of more than 1,000 other studies from around the world.

520 Safewards is designed to reduce levels of conflict that may lead to aggression, violence and absconding and, in response to these events, the use of restrictive interventions such as seclusion and restraint. It aims to improve safety for both staff and consumers by teaching staff to identify, avoid and respond to 'triggers' of conflict.

521 It examines aspects of six domains (patient community, patient characteristics, regulatory framework, staff team, physical environment and outside hospital) that can give rise to 'flashpoints' – that is, situations where conflict could arise. The flashpoints are addressed through ten practical, evidence-based interventions.

522 Safewards' implementation in Victoria has so far targeted adult, aged, youth and secure extended care mental health inpatient units. The Chief Mental Health Nurse has overseen the implementation, with support from the Victorian Managed Insurance Authority.

523 A Victorian pilot of Safewards was established in seven services (18 inpatient units) in 2016.

524 The statewide rollout of Safewards (Phase One), was subsequently completed in 2017-18. The OCMHN delivered Safewards training and implementation support to all in-scope mental health services. Visual resources have been developed, enhanced by consumer perspectives and reflections from the trial. Services have also received funding to incorporate sensory modulation items into their recovery model and to improve the physical environment – for example, by creating sensory courtyards and communal spaces.

525 Safewards Victoria is now a recognised resource in the National Safety and Quality Health Standards and can be used as evidence in meeting health service accreditation requirements.

Continued interstate and global interest has established Safewards Victoria as a best practice framework for conflict reduction and increased safety.

526 International evaluations, including a randomised controlled trial conducted by the development team in the United Kingdom, have shown that Safewards is successful in reducing conflicts in mental health inpatient units. Safewards' implementation in Victoria is still subject to intensive evaluation, but early indications are very promising as to its effectiveness.[134]

527 Phase One of the implementation was achieved through a collaborative model of implementation with a dedicated project team in the OCMHN, a consumer advisor, expert clinicians, the Safewards community of practice, the Safewards faculty and an evaluation team.

528 The OCMHN is planning to build on the foundational work that Safewards is delivering for Victorian mental health staff and patients. It is expected that the model will be extended to a range of non-acute mental health and general medical services over the coming years. Peninsula Health has recently completed a trial of Safewards in a general ward and has reported benefits for both staff and patients.

529 Work has begun to introduce Safewards to emergency departments in Victorian public hospitals. This is a world first, and the model is being trialled at Peninsula Health and Bendigo Health. The planning and training phases of the pilot have been completed, and implementation of interventions is currently occurring. The University of Melbourne is evaluating the trial project, and this is due for completion in December 2020.

530 The emergency department trial has adapted some of the interventions and included two new interventions. There are nine interventions that will be trialled for suitability in emergency departments: soft words, talk through, positive words, delivering bad news, know each other, calming methods, reassurance, senior safety round, and perception and awareness.

531 Further to the evidence from the trial, staff have reported increased feelings of safety and cooperation. Safewards is providing services with a best practice model and framework that promotes therapeutic environments to support recovery. The program continues to show a growing evidence of not only therapeutic support, but also culture change improvements in services that have keenly taken up Safewards.

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[134] Centre for Psychiatric Nursing 2016, *Safewards Victorian Trial: Final Evaluation Report* <https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0004/2472718/Safewards-Victoria-Evaluation-Final-Report-July-2016-3.pdf>

Reducing restrictive practices through oversight, monitoring and reporting

Question 43: How can oversight, monitoring and reporting of restrictive practices minimise their use?

532 The oversight, monitoring and reporting of restrictive interventions is a core component of the work of my office and the OCMHN, and enables us to support Victorian mental health services to work towards the elimination of restrictive interventions.

533 In recent years, our strong engagement with services has strengthened clinical leadership at the service unit level and has improved data recording and data governance. This is reflected in the data reported by services, which shows increased rates of physical restraint but a shorter average duration[135] and may reflect improved understanding of reporting requirements and more rigorous reporting of any type of hands-on restraint.

534 A detailed process has been implemented by the OCMHN for reviewing service-level data and providing timely feedback to services. Data is reported on a monthly basis via the CMI in each service, and is reviewed by a team that includes clinical and lived experience advisers. The Chief Mental Health Nurse and I make contact with service directors when benchmarks are breached, or when a trend becomes apparent over a three-month period or more. Services are then asked to reflect on the data and provide feedback on the reasons for the variance, and on circumstances and factors that have contributed to the use of restrictive interventions. The Restrictive Interventions Statewide Committee, which oversees the work program to reduce restrictive interventions, reviews the data and key themes.

535 The Chief Mental Health Nurse and I have used this information to identify trends, reflection and continuous improvement initiatives at service and systems level, providing guidance and practical support to change practice. In doing this, it is critical to understand the circumstances, models of care and physical environments. This understanding is achieved through consultation, collaboration and site visits, including garnering advice from consumers and carers. These processes can assist in identifying nuanced service level practices that may also be occurring at a broader, more systemic scale and leading to unnecessary use of restrictive interventions.

536 Reporting is a valuable tool, as it enables services to review their individual results against other states and territories, national rates and like services. The Inspire Report has enabled statewide benchmarking on the use of restrictive interventions. Public reporting by the Australian Institute

[135] Department of Health and Human Services 2019, *Victoria's Mental Health Services Annual Report 2018-19* <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report> Melbourne, p. 72.

of Health and Welfare also allows this to occur nationally. These resources aid services and clinicians to reflect on their position relative to peer services, identify variations in practice across these areas, and proactively work to deliver care that is least restrictive, person-centred, safe and trauma-informed.

537 Further gains could be made through:

(a) improvements to the CMI/ODS system, as described at paragraphs 90 to 92, to support more timely reporting, analysis and feedback on restrictive interventions data.

(b) mandating the capturing and reporting of the same data on restrictive interventions from all areas within a health service, including acute care settings and emergency departments, in addition to mental health inpatient units.

(c) emphasis on a commitment to whole-of-health service elimination of restrictive interventions in health service Statements of Priorities, with immediate attention to duration of seclusion episodes and the use of physical restraint.

Towards elimination of restrictive interventions

538 It is clear from consumers, families and carers and workforces that the impact of restrictive interventions is traumatic and not in the therapeutic interest of consumers. In my opinion, we should work towards elimination of restrictive interventions, rather than searching for standardised or safer ways in which to apply them.

539 The limitations of our current system – in terms of capacity and infrastructure – will mean that elimination of these practices will require significant resources, training and support to enable the workforce to use therapeutic interventions that engage and support people in distress.

540 It will also require further consideration of treatment environments – for example, different environments to provide initial support for people with drug intoxication and withdrawal – where people's immediate needs can be supported by therapeutic interventions.

Secure extended care

541 SECUs provide medium to long-term inpatient treatment and rehabilitation in a secure environment. They provide treatment for consumers with a severe and often unremitting mental illness within a model of recovery-oriented service provision.

542 SECUs are not physically based in every area mental health service. SECUs are located at three metropolitan and three regional hospitals. Each area mental health service in Victoria has a dedicated allocation of beds within a nominated SECU.

543 Area mental health services refer consumers to the SECU that hosts their respective bed allocation, which may be located in a different area mental health service, and there are established referral and discharge pathways between the referring service and host unit. There are also additional statewide beds for consumers who are homeless. Clinical and operational governance is maintained by the area mental health service that physically operates the SECU.

The SECU model

Question 44: Can you describe the model of care delivered in Victoria's secure extended care services? (a) How, if at all, it has changed over time?
Question 45: Is the SECU model consistently applied across Victoria? If not, why not?

544 The SECU model was introduced when mainstreaming commenced, and the intended role and function of SECUs has not fundamentally changed since that time. The emphasis on secure treatment was intended to respond to the cohort's high levels of psychosocial disability and vulnerability, which made the prospect of living safely in the community or in a CCU setting unlikely.

545 The SECU model of care was last reviewed in 2012, which resulted in the development of guidelines that placed a greater emphasis on recovery-oriented practice, provided a framework for SECUs to work from, and promoted consistent eligibility criteria.

546 Since that time, system pressures have resulted in increasing demand and client complexity within all subacute services, including SECUs. All subacute services have reported increases in referrals, with both community and inpatient programs increasingly considering PARCs, CCUs and SECUs as options to address a range of needs including homelessness. Services report an increasing level of acuity and behavioural disturbance in SECUs, which poses a significant challenge for maintaining safety within the existing physical design and model of care. In addition, SECUs are now commonly used as a 'step down' option from forensic services, which has compounded the effect of limited bed stock.

547 Individual SECUs have adapted their service delivery models to meet demand and respond to their local needs, with the intent of improving services and outcomes for consumers. Individual subacute services will engage with the broader services required by their consumer cohort,

such as housing support, access to acute and primary healthcare, and drug and alcohol withdrawal, management and treatment.

548 However, this has resulted in different models of care, eligibility criteria, staffing profiles and staffing levels, as well as infrastructure and environmental design. Across different units, there are variations in relation to:

(a) the degree to which recovery-oriented practice is understood and delivered

(b) the variety of psychosocial and evidence-based interventions offered, which can be dependent on expertise within the service and available partnerships with community supports and the NDIS

(c) the management of acute presentations, which some services manage in the SECU, but others transfer consumers to their local inpatient unit or emergency department if no beds are available

(d) whether a unit will accept consumers with significant drug and alcohol and forensic issues, due to the mix of consumer profiles and vulnerabilities in small environments

(e) whether a unit will accept return of an individual due to challenging behaviour

(f) intake processes and requirements: after screening and prioritisation by the referring health service, in-depth assessments are needed to determine needs and suitability. However, this process can vary in timeliness due to staff availability. In addition, SECUs generally require consumers to be in an inpatient treatment unit or have an inpatient treatment order, and to have demonstrated a period of stability in a low-dependency area before they will be accepted for care

(g) bed availability, with services consistently experiencing long waiting lists, and SECUs experiencing bed flow challenges due to the lack of safe housing and supported residential care facilities that would enable discharge.

Barriers to access

549 Access to appropriate care is compounded by:

(a) a shortage of SECU beds

(b) a lack of specialist SECU beds outside of Thomas Embling Hospital for consumers who require a medium-secure setting with a staff profile similar to an acute inpatient unit, and appropriate amenity for recovery over a long period of time

(c) a lack of flexible bed stock to accommodate people with diverse needs

(d) patient flow issues across acute inpatient, SECU, CCU and forensic beds. Length of stay data indicates there are considerable numbers of consumers with a prolonged length of stay both in acute inpatient units (designed for acute short-term care) and in other settings

(e) little turnover in beds specifically dedicated to homeless consumers, located at one area mental health service but servicing the whole state, due to the complexity of consumers' needs.

550 Another common barrier to discharge results from NDIS participants receiving inadequate support to access suitable housing and accommodation. There are currently a number of consumers in SECUs who have or are eligible for NDIS packages, and who could potentially receive support through the NDIS to live in supported residential accommodation settings.

551 Specialist Disability Accommodation (SDA) is an NDIS capital payment for NDIS participants who have extreme functional impairment or very high support needs. There are currently very low levels of SDA funding for NDIS participants with a primary psychosocial disability. Typically SDA is funded for the psychosocial disability cohort only where they have complex needs associated with a dual disability. Moreover, even where consumers receive funding for SDA, the market for SDA is still maturing, resulting in shortages of SDA properties and vacancies. As the SDA market matures, consumers with very high support needs may over time face fewer barriers to transitioning from bed-based services to SDA.

552 NDIS participants can also receive a Supported Independent Living package, which is a package of supports which can be received in a supported disability accommodation setting or independently in the community. However, a lack of affordable housing and accommodation options and inadequate NDIS support to identify and access housing and accommodation remain a barrier to discharge. This includes inadequate levels of NDIS funded support coordination, or a lack of a proactive approach from this support type to resolving housing related barriers to discharge.

553 The introduction of the Psychosocial Disability Recovery Coach support item from 1 July 2020, which will have responsibility for working with clinical mental health services to coordinate and

streamline care for NDIS participants with a psychosocial disability, may resolve some of these issues. This includes by participating in joint discharge planning to support timely discharge and a smooth transition to community. Improvements in NDIS-related discharge delays have also been achieved through the implementation of NDIA Health Liaison Officers who are responsible for improving communication and providing a direct line of escalation between health services and the NDIA.

554 A time-limited Intensive Support Team within the Department of Health and Human Services has been acting as an NDIS transition team, and frequently has contact with my office to discuss access issues for consumers with complex needs moving between settings such as prison, SECUs and residential placements. The team also assists my office to find options for adults in acute inpatient units where a SECU would not meet their clinical needs. In addition, funding was allocated to ten health services in October 2017 to establish a mental health program lead to develop NDIS readiness, implement practice change to support and sustain an effective operational interface, and resolve local issues. Further funding was secured in 2019-20 for NDIS program leads in six remaining clinical mental health services for one year.

Effectiveness of the SECU model in responding to consumers with complex needs

Question 46: How effectively does the current SECU model respond to consumers with very complex treatment and support needs? (a) Are changes required to the model of care, governance or system safeguards to ensure effective treatment and support in SECUs consistent with the principle of least restriction in the Mental Health Act?
Question 47: What is the Chief Psychiatrist's role in facilitating access to SECU services for consumers with very complex treatment and support needs? (a) Can you please describe a recent practical example or examples of your role in relation to facilitation of SECU access?

555 The current SECU model is outdated and lacks the capacity to adapt to the changing and diverse needs of consumers with very complex treatment and support needs.

556 In my experience, SECUs are not configured or staffed to respond to consumers who have complex needs such as intellectual disability, autism spectrum disorder, substance use or personality disorder, and housing issues in addition to persistent or fluctuating mental illness acuity.

557 It is not the role of the Chief Psychiatrist to direct and manage access to bed-based services. There are clear processes managed by area mental health services for referral and access to SECUs.

558 However, since joining the OCP in December 2011, my assistance has been regularly sought by services, consumers, families and carers, and other agencies in situations where:

(a) consumers have high levels of acuity, disability, complexity and co-morbidity, and they seek my assistance to facilitate access

(b) consumers have had a prolonged length of stay in an acute inpatient unit, specialist forensic unit in Thomas Embling Hospital or a prison hospital ward, but are unable to access secure extended care because existing SECUs cannot provide an appropriate level of care for their complex needs

(c) complex negotiations have been required for the transfer of civil consumers from Thomas Embling Hospital to an area mental health service, and vice versa

(d) transition to a SECU has not been successful, and has resulted in the serious assault of staff, other consumers and a visitor.

559 My office devotes substantial time and effort to assisting Clinical Directors to negotiate places for consumers. This is a complex process of considering availability, consumer personal and clinical history, staff resources and consumer mix. My ability to assist, however, is limited by the options that are available.

Ensuring effective treatment and support for consumers with complex needs

560 In my view, changes are needed to the model of care, governance and system safeguards for SECUs to ensure that consumers can receive effective and appropriate treatment in the least restrictive way possible, consistent with the MHA principles.

561 Crucially, the shortage of SECU beds needs to be addressed. It is essential for beds to be available in local areas to enhance consumers' connections with family, environment and culture. This requires consideration to be given not only to resourcing, but also to the current governance and bed allocation arrangements that see issues arise when services exhaust their bed allocation at the host site, or host sites with vacant beds are unprepared to accommodate a consumer because of the high level of risk.

562 Contemporary and consistent models of care across the state are also required. Models of care need to address the needs of subgroups, and the benefits for both consumers and staff in separating consumer cohorts are described at paragraphs 263 to 285 above. Models of care also need to be supported by investment into specialised training and supervision for the workforce to provide evidence-based treatment for complex needs and intensive psychosocial

rehabilitation. Without a streamed approach, consumers with specific needs requiring specialist input are cared for alongside others with very different needs. This includes small numbers of young people with severe developmental disorders such as autism spectrum disorders, as well as involvement with child protection and youth justice; long-term forensic patients needing slow-stream rehabilitation into the community; adults with various conditions and risk of severe violence towards other consumers, visitors and staff; and small numbers of people who will be unlikely to be able to transition to less restrictive community care and need long term care options.

563 Additional options, and a variety of models, are needed to ensure that consumers with complex needs can receive effective and appropriate treatment.

564 There are some examples of non-SECU facilities providing cohort-specific options, including two TSUs that are intended to provide a step-down alternative to SECUs, and a transition option between a SECU and a disability-enhanced mental health setting. In addition, the Brain Disorder Unit at the Royal Talbot campus of Austin Health is a statewide specialist program that provides community and inpatient based neuropsychiatric rehabilitation for individuals aged 16 to 64 with cognitive and psychiatric disability. These options alone, however, do not provide the diverse service mix and capacity to ensure effective treatment and support for consumers with complex needs.

565 The involvement of my office in individual cases, as well as my collaboration with senior practitioners and others within the Department of Health and Human Services as described at paragraph 601 below, assists in resolving some SECU access issues and coordinating service responses for people with very complex needs. Without more options for providing appropriate care, however, our ability to help those whose needs cannot be met by the current service system is limited.

566 As highlighted throughout this statement, the lack of appropriate and supported accommodation for consumers with complex needs remains a key issue that needs to be addressed. Greater collaboration between mental health and housing services, and opportunities to give housing stock nomination rights to designated mental health services to support transitions in partnership with local housing support services, could expand current options.

567 Current work underway in developing an activity based funding model has the potential to more specifically channel funding to those persons with complex needs. Work on the funding classification to date uses level of complexity (using the Health of the Nation Outcome Scale (HoNOS), Life Skills Profile (LSP) scores and diagnosis) to place consumers in 'complexity classes' which will have associated levels of service delivery. In the current system, this will be

an expected level of service hours and contacts – for example, a consumer in a high complexity class may be expected to be provided with, on average, ten hours of care per month. Further developments will also see the collection of intervention codes against contact hours and activities, which will allow this kind of funding approach to specifically require and hold services to account for provision of key, evidence-based interventions (such as medical review, provision of psychotherapy, peer support, psychoeducation, etc.)

Responding effectively to consumers with complex needs

568 My involvement is often sought in relation to service gaps for consumers with complex needs.

569 Some individuals with dual disability and co-occurring needs relating to mental health, substance abuse or cognitive impairment may also have social and communication difficulties, display challenging behaviours, and have needs relating to acute and chronic health conditions, housing, and poverty. They may have involvement with services across multiple sectors, including health, disability, child protection and justice, and may be difficult to engage in treatment.

570 Such individuals may face barriers to accessing the services they need due to varying eligibility criteria for different sectors, the lack of availability of appropriate services, the inability of standard service responses to be tailored to individual needs, a lack of coordination between services, and the capability and willingness of services to manage challenging behaviours and risk of violence.

571 I have described some of the challenges in providing care for consumers with complex needs, and particularly the lack of supported residential options, in my discussion of SECU services from paragraph 541 above. Further challenges are discussed in more detail below.

Consumers with dual disability

572 The introduction of the NDIS has resulted in an increase in social admissions and subsequent discharge delays for participants with complex needs associated with dual disability.

573 Social admissions involve participants being relinquished by their carers or NDIS providers at emergency departments and subsequently admitted into inpatient care, without a clinical need to be admitted or remain in hospital. This cohort often presents with complex support needs, primarily in relation to acute behaviours of concern associated with multiple disabilities which in many cases are not related to their mental health condition.

574 The key drivers of social admissions and subsequent discharge delays are:

(a) withdrawal or refusal of support by NDIS providers to participants with high levels of complexity/behaviours of concern due to risk to staff, insufficient prices and associated cost pressures

(b) inadequacy of NDIS supports (where the person's NDIS plan is inadequate, or the person requires more support to implement their plan and engage with NDIS supports) and/or plan underspend (where a person is not fully utilising the funding in their NDIS plan) leading to breakdown in a person's informal support network, upheaval in the family home and neighbourhood fatigue (that is, impacts on members of the local community due to behaviours that are not addressed or adequately managed)

(c) lack of suitable, affordable housing and accommodation options for this cohort, including difficulties accessing SDA, and very low levels of support to access housing in NDIS plans

(d) lack of capacity and/or commitment by the NDIA, Local Area Coordination (LAC) partners and NDIS funded Support Coordinators to work with health services to ensure a proactive, coordinated response to shared clients/participants, including protocols for sharing information.

575 Clinical mental health services are currently reliant on the Department of Health and Human Services to escalate and broker solutions with the NDIA and NDIS providers, with many cases being referred to my office and the Department of Health and Human Services' Intensive Support Team for resolution.

Consumers with comorbid substance use

576 Mental health consumers have a high co-morbidity with substance use, with estimates that up to half alcohol and other drug clients may have a mental health disorder.[136]

577 Stigmatisation of people with mental health issues and a dual diagnosis of substance use serves as a significant barrier to seeking help and support, which can be exacerbated by experiences of discrimination based on ethnicity, race, culture or sexual orientation.

578 Effective early intervention needs to be implemented to better detect and prevent escalation in people with low acuity needs and emerging drug use. Opportunities being explored to support

[136] Lubman DI, Allen NB, Rogers N et al. 2007, 'The impact of co-occurring mood and anxiety disorders among substance-abusing youth', *Journal of Affective Disorders*, vol. 103, pp. 105-12.

this cohort include building capacity of primary care to support people with substance use issues, flexible and multidisciplinary outreach teams that allow for a more targeted intervention and expanded regional/rural outreach to promote more equitable access to services.

579 Opportunities could also be explored to provide tailored intervention services to those people with co-occurring needs who are involved with the justice system, which as well as increasing health and wellbeing, supports broader community safety efforts through reducing recidivism.

580 While the capability of the mental health and AOD workforce should continue to be developed, a balance needs to be achieved between specialisation and co-occurring skills. Vast improvements to primary care, mental health and AOD practice can be made by through strong cross-disciplinary protocols, comprehensive assessment practices, interdisciplinary training, and shared resources and specialist expertise. This includes a shared appreciation of the role that substance use plays in the way people manage their mental health and how AOD services and principles, such as harm reduction, can be adopted in clinical mental health practice.

581 There are some mental health and AOD specialist skills, however, that require specific investment and support, such as pain management and addiction medicine specialists.

582 A 'no wrong door' policy where people can get access to the care they need, along with seamless care approaches that meet people where they are, is required. The mental health and AOD service system should anticipate a high degree of co-morbidity in its clients and consumers and plan accordingly. This is not only a matter of providing a higher baseline of service availability, but improved responsivity to people's individual circumstances, from their underlying health, social and economic needs through to integrated practice. Greater coordination of care and integrated treatment will improve outcomes for clients.

583 Just as treatment stability is critical to people with co-occurring mental health and AOD needs, so too is economic and social stability. In particular, coordinated national effort on ensuring stable housing is available to all will have immediate and longer-term benefits to all Victorians.

Mental health consumers on supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997

Question 48: Can you describe the current role of the Chief Psychiatrist in oversight of services to people with complex needs under the *Crimes (Mental Impairment and Unfitness to be Tried) Act*?

584 As part of my statutory role, I sit on the Forensic Leave Panel for forensic patient hearings.[137] In addition, I maintain a broad monitoring role in relation to the treatment and management of

[137] Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, s. 59.

mental health consumers on supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA), some of whom have complex needs.

585 The role includes receiving:

(a) copies of documentation related to the making of supervision orders, including the order, clinical reports prepared for the court, the certificate of available services, the clinical report required under section 41 of the CMIA and any available information concerning the offence

(b) copies of the annual report required under section 41(3) of the CMIA

(c) ad hoc clinical reports (as necessary) concerning the treatment and management of individual people.

586 As part of this role, I respond to issues identified through this monitoring process on an 'as required' basis. For example, I have responsibilities for suspension of leave (special, off-ground and extended leave) if the safety of the person on leave or members of the public will be seriously endangered if leave is not suspended.[138] I also have a key role in supporting the functions of the Mental Health and Drugs Branch and Legal Services at the Department of Health and Human Services under the CMIA (primarily focused on activities related to court hearings) by providing expert advice and consultation and by liaising with mental health service providers as required.

587 I also provide instructions to the Department of Health and Human Services' Legal Services branch in relation to the Secretary to the Department of Health and Human Services' position for all proceedings under the CMIA.

588 I may also be consulted and involved in facilitating a resolution where there is a dispute regarding responsibility for the treatment and case management of a person on a non-custodial supervision order, and this cannot be resolved through an internal escalation process.

Changes to CMIA oversight arrangements

Question 48(a): How, if at all, could current oversight arrangements change in future?

589 The Victorian Ombudsman's report of the *Investigation into the imprisonment of a woman found unfit to stand trial* was tabled in the Victorian Parliament in October 2018. The investigation concerned 'Rebecca', a 39-year-old woman who spent over 18 months in prison after being

[138] Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, ss. 55 and 58.

found unfit to stand trial and not guilty because of mental impairment under the CMIA after breaching an intervention order.

590 'Rebecca' has complex needs, demonstrated by a long history of challenging behaviours and compounded by disagreement between mental health and disability services about her diagnosis. The Ombudsman found that 'Rebecca' remained in prison because services were not made available in the community to meet her complex needs.

591 The Ombudsman recommended the Department of Health and Human Services designate a senior officer to:

(a) coordinate and oversee the Department of Health and Human Services' service responses to people subject to CMIA proceedings; and

(b) act as a contact point regarding the Department of Health and Human Services service responses and advice for agencies and people involved in CMIA proceedings.

592 As an interim step, the Deputy Secretary Health and Wellbeing was appointed to be the accountable officer for the coordination and oversight of the Department of Health and Human Services service responses to people subject to CMIA proceedings and act as a contact point.

593 The Department of Health and Human Services is developing operational arrangements to support the Deputy Secretary in this role. Proposed arrangements involve establishing an advisory panel to consider service delivery options for people subject to CMIA proceedings or CMIA supervision orders who are at risk of poor outcomes because their needs fall outside standard service responses, the system does not have appropriate options, or existing pathways have been ineffective or unsustainable. I will chair this panel, in addition to my current oversight responsibilities.

Multiple and Complex Needs Initiative (MACNI)

Question 49: What is the Chief Psychiatrist's role in engaging with, and supporting, the operation of the Multiple and Complex Needs Initiative established under the *Human Services (Complex Needs) Act*?

(a) From your perspective, what policy, legislative, resourcing or operational changes are needed in future to ensure the MACNI program provides effective support to people with complex needs as defined by the Act?

594 Under the *Human Services (Complex Needs) Act 2009* (HSCNA), the Secretary to the Department of Health and Human Services has powers and functions related to the operation

of the Multiple and Complex Needs Initiative (MACNI). The Secretary may delegate any powers and functions (other than the power of delegation) to give practical effect to the operation of MACNI.[139] Many of the functions are delegated to departmental officers in operational divisions, consistent with MACNI's localised service delivery approach. No specific powers or functions are delegated to the Chief Psychiatrist.

595 However, as Chief Psychiatrist I sometimes assist MACNI staff to navigate the service system in situations where barriers in accessing mental health services are encountered, and local escalation has not been successful.

596 The current MACNI program has strong governance and oversight in place and regularly undertakes internal reviews of the operation of the program to enhance service provision. The *Service provision framework: Complex needs* has undergone review and update in December 2017, August 2019 and more recently in March 2020.

597 The HSCNA sets out the eligibility criteria for access to the program. The *Service provision framework: Complex needs* notes the need for a broad interpretation of the diagnostic eligibility criteria in the HSCNA which align to the definitions of 'mental illness' and 'severe substance dependence' in the MHA and *Severe Substance Dependence Treatment Act 2010* respectively.[140] Both Acts provide definitions with the intention to narrowly define eligibility for compulsory/mandated treatment of persons under those Acts. A broad interpretation by MACNI ensures that the initiative is available to those most in need, and that it is used for people where significant effort to assist has been unsuccessfully tried by the current service system.

598 In 2018-2019 an additional $2 million was allocated to the MACNI program to enhance service access at a local level and to expand the program response to clients with complex needs. However, some people with complex needs continue to face barriers to accessing services or experience service gaps. MACNI is currently limited to people aged 16 or over, cannot use assertive outreach to overcome access barriers, and has no statewide escalation pathways. I outline work to address these limitations at paragraphs 599 to 602 below.

Collaboration with senior practitioners within the Department of Health and Human Services

Question 50: How is the Chief Psychiatrist currently collaborating with other senior practitioners within DHHS on improving service responses to people with very complex needs at high risk of serious harm to others? (a) What is the status of this work and what are its aims?

[139] Human Services (Complex Needs) Act 2009, s. 6.
[140] Department of Health and Human Services 2020, *Service provision framework: complex needs* <https://www.dhhs.vic.gov.au/publications/service-provision-framework-complex-needs>.

599 I regularly collaborate with other senior practitioners within the Department of Health and Human Services, including the Chief Practitioner Human Services, the Senior Practitioner, Disability and other departmental leaders to improve service responses for people with very complex needs who are at risk of poor outcomes because their needs fall outside standard service responses, the system does not have appropriate options, or existing pathways have been ineffective or unsustainable. This includes developing individual service responses and considering systemic improvements.

600 The Department of Health and Human Services is currently developing policy, processes and services that would enhance support and improve outcomes for people with complex needs who pose an unacceptable risk of harm to others. I am collaborating with other senior practitioners and leaders from the Department of Health and Human Services, as well as with experts from the sector, to ensure this design and development work is informed by expert advice.

601 This work aims to enhance support and improve outcomes for people with complex needs, while also reducing risks to community safety, by exploring new or expanded service options for assertive outreach, earlier coordinated support and service coordination, as well as any changes to existing legislative frameworks required to establish service system leadership, governance and coordination. This work takes into account the significant barriers that people with complex needs can currently face accessing services, as well as the current challenges coordinating appropriate services within existing legislative and governance arrangements.

602 This work is currently at the development stage and will inform future departmental advice to government on possible service system improvements and investment.

Safety and quality of mental health treatment delivered in prison and youth justice settings

Question 51: What is your current role in oversight of the safety and quality of mental health treatment delivered in prison and youth justice settings?

(a) What is your view on the appropriate oversight powers of the Chief Psychiatrist insofar as they relate to mental health care and treatment delivered in prison and youth justice settings?
(b) What changes, policy or legislative, would be required to clarify this role?
(c) Do you have any observations of good practice safety and quality oversight models in prison and youth justice settings in Australia or internationally?

603 In practice, I have no direct oversight of the safety and quality of mental health treatment delivered in prisons and youth justice settings. Justice Health, under the direction of the Secretary to the Department of Justice and Community Safety, is responsible for the delivery of health services for persons in Victoria's prisons, including contracting services, setting the

policy and standards for health care, and monitoring and reviewing health service provider performance.

604 Under the Corrections Act, the Secretary to the Department of Justice and Community Safety is responsible for monitoring the provision of all adult correctional services to achieve the safe custody and welfare of prisoners. Mentally ill prisoners have the right to have reasonable access within the prison or, with the Governor's approval, outside a prison to such special care and treatment as the medical officer considers necessary or desirable in the circumstances.

605 The MHA is not explicit about my powers in custodial settings. I am responsible for clinical leadership and regulation of mental health service providers, some of whom deliver services in custodial settings. For example, the mental health service provider Forensicare delivers mental health services in all adult public prisons in Victoria, and Orygen delivers mental health services in youth justice facilities. While I understand that my powers can be interpreted to extend to custodial settings, there are inherent tensions between the operational requirements in a custodial environment and the provision of therapeutic treatment (which I described in relation to compulsory treatment in paragraph 417 above, and which are also relevant to voluntary treatment in a custodial setting). There are also practical difficulties in performing my monitoring role as set out in the MHA in prisons and youth justice facilities. For example, the Chief Psychiatrist has no power to enter prisons or youth justice facilities without the agreement of the Secretary and the Commissioner for Corrections. As a consequence of my not having oversight, I have limited access to information about the provision of mental health services in prisons or youth justice facilities.

606 In 2014, it was agreed between the Department of Justice and Community Safety and the Department of Health and Human Services that the Chief Psychiatrist would not exercise any power under the MHA in relation to prison-based mental health services.

607 The current framework means the mental health services provided in custodial settings are not subject to the same oversight by me as services in the broader community. Other bodies such as the Victorian Ombudsman, the Commission for Children and Young People's Independent Visitor program, the Victorian Equal Opportunity and Human Rights Commission, the Victorian Auditor-General's Office, the Coroners Court of Victoria, the Office of the Public Advocate, and the Victorian Independent Broad-based Anti-corruption Commission provide some oversight of these settings. However, these bodies do not have the specialist expertise to provide oversight of mental health services. In my view, it would be appropriate for me to have oversight of mental health services in prisons and youth justice facilities.

608 In other Australian and many international jurisdictions (e.g. Queensland, New South Wales, England and Wales), the Department of Health has oversight of health services in custodial settings in accordance with its system manager responsibilities. This also supports the integration of custodial health services and community health services (per the principle of equivalence of care) and makes it more likely that health staff working in prisons have the sole purpose to care for and advocate for the health and wellbeing of prisoners.

609 However, this does not always guarantee effective oversight. I am aware that the Queensland Government has recently established the Office for Prisoner Health and Wellbeing (OPHW) in response to similar concerns relating to primary health care, as set out in the Offender Health Services Review 2019. OPHW was established even though the Queensland Department of Health already had system manager responsibilities for offender health services, because there were barriers to the Queensland department being able to exercise leadership in that area.

610 It is too early to assess the effectiveness of the OPHW, but the benefits of resourcing a body with a clear remit to address governance and systemic issues has the potential to improve primary healthcare services for prisoners in that state. It could also provide some learnings for us about the oversight of mental health services in custodial settings in Victoria.

611 Effective oversight by me of the mental health services delivered in custodial settings would be facilitated by amendment of both the MHA and the *Corrections Act 1986* to clarify the scope of my powers in custodial settings and youth justice facilities. It would also require changes to the current policy and operational arrangements to facilitate my oversight. Such changes could only occur with the support of the Department of Justice and Community Safety and Corrections Victoria.

612 Adding oversight of custodial settings to my functions has implications for the scope of my role. Currently my focus is specialist mental health service providers (as defined in the MHA) delivering compulsory treatment. Voluntary, not compulsory treatment is delivered in custodial settings and mental health services are delivered by a variety of organisations, not just mental health service providers. Extending my role to voluntary mental health services provided in custodial settings and youth justice facilities would be a significant change to the scope of the Chief Psychiatrist role.

613 To provide effective oversight of mental health services in custodial settings, my office would require significant additional resources in the form of funding and staff to be able to monitor the services being delivered to the large numbers of people currently detained in Victoria.

COVID-19

Emerging changes in mental health service delivery as a consequence of COVID-19

Question 52. What are your observations of the emerging changes in mental health service delivery as a consequence of COVID-19?

614 There has been a striking change to the way in which mental health services have been delivered since the advent of 'social distancing' requirements in late March 2020.

615 It might have been expected that presentations to mental health services would increase in response to public anxiety about the pandemic, but this was not observed initially. Attached to this statement and marked '**NC-8**' is a copy of VAHI's report *Impact of COVID-19 on mental health services in Victoria: preliminary measures of access, activity and outcomes* for the week commencing 1 June 2020. When compared with data from January to March 2020, there were initially significant reductions in all of the following domains: contacts with mental health triage services at all levels of urgency, presentations to emergency departments for reasons related to mental health and alcohol and drug use, and entry to mental health services by new consumers. The number of admissions to inpatient units fell, with a commensurate rise in the average length of stay, but has since begun to return to pre-pandemic levels with notably high levels of acuity. Similar trends have been observed after other public emergencies, both in Australia and internationally (see paragraph 632 below).

616 With respect to ambulatory services, the total number of contacts with consumers has fallen slightly. There have been fewer face-to-face contacts and more by telephone and video. Consultation times have been shorter on average. The take-up of videoconferencing ('telehealth') has been notable.

617 The Department of Health and Human Services entered into an agreement four years ago with the Commonwealth Department of Health and some other jurisdictions to develop a telehealth platform, Healthdirect Video Call, managed by Healthdirect Australia.[141] It was purpose-built for the health care setting and can be accessed anywhere with a good internet connection. It offers a very high level of security. Its use has escalated recently and feedback to date has been excellent.

618 Where assessments and treatments cannot be delivered by telephone or by video, consumers have continued to attend in clinics or at home.

[141] Healthdirect Australia, 2020, Video Call <https://about.healthdirect.gov.au/video-call>.

619 A number of service providers have expressed concern that provision will need to grow for consumers made homeless by the pandemic, particularly for those who decline offers of emergency housing. Many have very severe, persistent mental disorders and are more than usually vulnerable to illness.

620 The Department of Health and Human Services, through its data link with the Coroners Court, is tracking the number of suicides in Victoria on a week by week basis. There had been no change at the time of writing. This will continue to be monitored.

621 Restrictions in physical access to inpatient units by the agencies charged with oversight of consumers' rights – the Mental Health Tribunal, Victorian Legal Aid, IMHA advocates and Community Visitors – are using telephone and video calls. Mental Health Tribunal hearings are now paperless and happen using teleconferencing, with plans to move to video conferencing. The Tribunal reports that participation rates by consumers and carers have actually increased following the move to teleconferencing. There are enormous opportunities to create consumer choice, improve flexibility and improve reach at this time. However, there are multiple factors impacting on the experience of consumers, and review and analysis is required to capture the benefits and potential improvements to capitalise on the potential.

622 Health services have reported a reduction or even cessation of face-to-face supports by NDIS providers to consumers with psychosocial disabilities. For people with complex needs, this has resulted in some instances in escalating behavioural symptoms, increased carer burden and admissions to hospital.

623 In my view, NDIS support workers should continue to provide face-to-face support to severely disabled clients with appropriate screening for COVID-19. In reality, NDIS providers have varied in their practices and the NDIA has provided no clear direction. Its only requirement to date is that providers comply with its standard code of practice. This situation will require careful monitoring. Once care in the community fails, it can take months to establish new accommodation and supports. In the interim, clients with conditions like developmental disabilities who return to hospital will wait for lengthy periods on busy, noisy inpatient units that struggle to meet their needs.

Longer term opportunities for new approaches to service delivery for the benefit of consumers and carers

Question 53. Could these changes emerge into longer term opportunities for new approaches to service delivery, for the benefit of consumers and carers?

624 The innovation and accelerated change generated by responses to the COVID-19 pandemic are reflected in the National Mental Health and Wellbeing Pandemic Response Plan.[142] The Plan identifies a range of immediate and ongoing actions which jurisdictions are encouraged to take across the response and recovery phases of the pandemic, and is underpinned by principles that seek to align the immediate work of responding to the pandemic with ongoing reform work and long-term system improvement. In addition, the Commonwealth's appointment of a Deputy Chief Medical Officer for Mental Health acknowledges the importance of mental health and wellbeing in the broader pandemic response, and provides an opportunity to support and strengthen the delivery of mental health system reforms.

625 In terms of specific approaches to service delivery, telehealth has the potential to improve access to mental health assessments, support and treatment for people who have difficulty accessing clinics because of work commitments, physical restrictions or place of residence.

626 Videoconferencing has been available for many years but take-up was limited by a reliance on specialist equipment that was often of poor quality. The pandemic has prompted a surge in the use of Healthdirect Video that can be accessed securely by any computer or tablet device anywhere in Victoria with a minimum of training.

627 The use of this platform is likely to continue, especially for follow-up visits in regional and rural areas where clinicians' lengthy travel times can be put to better use. This will require a formal evaluation of the platform's strengths and limitations and the development of a model of care that describes its place in clinical practice. It will be important to include consumers' and carers' perspectives so that losses in amenity (for example, socialisation with other consumers) can be off-set.

628 The fall in admissions to mental health inpatient units warrants formal analysis to determine if care at home has equal or superior efficacy for people with particular types of conditions or in particular situations.

Impacts of prolonged quarantine and social distancing measures

Question 54. What does research suggest about prolonged quarantine or social distancing measures on wellbeing and mental illness? In the short and the longer term? (a) How could any negative impacts be mitigated?

629 There is little published research as yet on the effects of the COVID-19 pandemic on mental health and wellbeing, but the consequences are likely to be profound. While Australia has

[142] Australian Government 2020, *National Mental Health and Wellbeing Pandemic Response Plan* <https://www.mentalhealthcommission.gov.au/mental-health-and-wellbeing-pandemic-response-plan>

escaped wide-spread infection to date, the closure of schools, universities and businesses, and the requirement that people remain at home for all but essential purposes, can be expected to generate high levels of social stress.

630 This impact is not likely to be distributed equally. Groups with greater than average psychological vulnerability to the present and emerging situation can be expected to include: (a) those at increased risk of infection by reason of age or physical co-morbidity; (b) those with pre-existing mental health conditions; (c) those who lose employment or housing or fear the loss of employment or housing; (d) those separated from family and friends; or (e) health care professionals and other workers exposed to COVID-19 through their work.[143]

631 Australia has a distinguished track record of research into the mental health sequelae of natural disasters and exposure to combat. After the Ash Wednesday bushfire of 1983, 42 per cent of the respondents in a survey a year later met criteria for 'probable mental disorder' (mostly anxiety and depression) based on scores on a widely-used rating scale. This ongoing psychological morbidity was predicted not just by levels of threat and loss at the time of the fire but by prior coping style and previous levels of psychological symptoms. Once established, though, these conditions were often persistent.[144]

632 The consequences of disasters tend not to be apparent immediately. Admissions to mental health inpatient units fell by 20 per cent in the aftermath of the Christchurch earthquake in 2011. This was followed, however, by an increase of 40 per cent in rates of post-traumatic stress disorder, anxiety and depression in those exposed to the earthquake compared to unexposed groups.[145]

633 Loss of employment and financial stressors are well-recognised risk factors for suicide. There was a rise of nearly 50 per cent in suicide rates for men during the Great Depression of the 1930s, for example, followed by a sharp decline during the Second World War.[146] During the

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[143] Gunnell D, Appleby L, Arensman E et al, 2020, 'Suicide risk and prevention during the COVID-19 pandemic', *Lancet Psychiatry*, published online 21 April 2020. https://doi.org/10.1016/S2215-0366(20)30171-1.
[144] McFarlane AC and van Hoof M, 2014, 'Learning for the future: the challenge of disaster research', *Australian and New Zealand Journal of Psychiatry*, vol. 48, pp. 600-2.
[145] McFarlane AC and van Hoof M, 2015, 'The counter-intuitive effect of a disaster: the need for a long-term perspective', *Australian and New Zealand Journal of Psychiatry*, vol. 49, pp. 313-4.
[146] Bastiampillai T, Allison S, Looi JCL, Tavella A, Agis U, 2020, 'Why are Australia's suicide rates returning to the hundred-year average despite suicide prevention initiatives?' *Australian and New Zealand Journal of Psychiatry*, vol. 54, pp. 12-14.

SARS epidemic in Hong Kong in 2003, there was a 30 per cent increase in suicide among people aged 65 years and older.[147]

634 In the current pandemic, there have been reports locally of a rise in calls to mental health and family violence help lines. These changes in help-seeking behaviours, which act as markers of social stress, might not remit quickly. While restrictions to social contacts will lift shortly, the economic consequences of the pandemic are likely to be long-lived.

635 Evidence suggests that these economic changes are likely to be the major drivers of new-onset or exacerbated mental disorders in coming months and years. The present lull in presentations to specialist services is predictable and will be followed by a rise later, especially to primary health care providers before progressing to specialist services.[148]

Mitigation of negative impacts

636 Given the clear connection between economic stress and mental disorder, the Commonwealth and State governments' investments in financial support to individuals and businesses to maintain employment and buffer the effects of job loss are likely to prove helpful.

637 Many of the evidence-based interventions recommended by international and local experts have now been implemented as part of the National Mental Health and Wellbeing Pandemic Response Plan. At a population level, strategies to improve mental health include social messaging to limit alcohol and drug use, support by emergency and social services for people affected by family violence, and neighbourhood events to offset social isolation.[149]

638 For members of the community with significant psychological symptoms, interventions include an increase in funding to telephone and online counselling services; more digital assessments and interventions by suitably qualified organisations; and support to recruit and train new clinicians and volunteers.

639 Within mental health services, recommended interventions include simple 'one door' referral pathways, telehealth and face-to-face assessments; access to psychological and psychiatric therapies with online therapies as an option; and crisis hotlines for people with urgent levels of

[147] Holmes EA, O'Connor RC, Perry VH et al, 2020, 'Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science', *Lancet Psychiatry*, published online 15 April 2020. http://doi.org/10.1016/S2215-0366(20)30168-1.
[148] McFarlane AC and van Hoof M, 2015 (above n 145).
[149] Holmes EA et al, 2020 (above n 147).

distress. Research is also required to monitor levels of distress, uptake of help and rates of suicide.

sign here ► Neil Coventry

print name Dr Neil Coventry

date 29 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-1

This is the attachment marked 'NC-1' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Curriculum vitae

3 June 2020

Neil Coventry

PERSONAL DETAILS

Name:	Neil Coventry
Work Address:	Office of the Chief Psychiatrist Department of Health & Human Services 50 Lonsdale St Melbourne VIC 3000
Present Position:	Chief Psychiatrist, Victorian Government Department of Health and Human Services

QUALIFICATIONS

1990	Family Therapy training – Williams Rd Family Therapy Centre
1986	Foundation Member – Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (RANZCP)
1985	RANZCP – Fellowship RANZCP – Certificate of Advanced Training in Child Psychiatry
1977	Faculty of Medicine (Clinical School – Austin Hospital – MB, BS)

EMPLOYMENT HISTORY

2016 – Current
Chief Psychiatrist, Department of Health and Human Services

2015 – 2016
Acting Chief Psychiatrist, Department of Health and Human Services

2014 – 2016
Deputy Chief Psychiatrist, Children and Youth, Office of the Chief Psychiatrist, Department of Health and Human Services – full time position

2011 – 2014
Deputy Chief Psychiatrist, Children and Youth, Office of the Chief Psychiatrist, Department of Health – on secondment on a part time basis.

2010 – 2011
Berry Street, Victoria, Sessional Consultant and Take 2 Therapeutic Program

2003 – 2010
Berry Street, Victoria, Board of Directors, Board Member (Honorary)

1996 – 2001
Wangaratta Health, Visiting Consultant, North East CAMHS

1996, 2004 and 2006 – 2008
Director, Mindful Training Program for Developmental Psychiatry, Heidelberg (part time). This is the training program for advanced training in child psychiatry for psychiatry registrars, psychologists and allied health disciplines.

1993 – 2014
Austin Health, Director of Clinical Services, CAMHS.
Acted as Medical Director, Mental Health Clinical Services Unit, Austin Health, covering leave periods

1991 – 1993
Monash Medical Centre, Consultant Psychiatrist and Team Leader, Adolescent Inpatient Unit

1987 – 1994
Pathway Centre, Adolescent Unit (the forerunner of Albert Road Centre for Health) – part-time private practice, including periods as Acting Medical Director

1986 – 1991
Travancore Child and Family Centre, Flemington
Consultant Psychiatrist and Team Leader, Adolescent Unit, Deputy Superintendent
Visiting Consultant, Geelong Hospital CAMHS

1984 – 1985
Advanced Training Child and Adolescent Psychiatry
South Eastern Child and Family Centre, South Melbourne
Travancore Child & Family Centre, Flemington

1980 – 1983
Larundel Psychiatric Hospital – Psychiatric Registrar

1979
Family Medicine Trainee – College of General Practitioners

1978
Intern, Repatriation Hospital, Heidelberg

UNIVERSITY APPOINTMENTS

1993 – 2014

- Senior lecturer, University of Melbourne
- Senior lecturer, Monash University
- Senior lecturer, La Trobe University
- I lectured in undergraduate and postgraduate courses in medicine, psychiatry, psychology and related fields

TEACHING

Department of Human Services – Child Protection
- Various courses for Child Protection Practitioners
- Basic orientation
- Advanced training

Mindful Centre for Advanced Training in Development Psychiatry
Various guest lectures including leadership module in psychiatry, trauma in childhood, and neurodevelopmental psychiatry.

Berry St, Victoria
- Regular secondary consultation and teaching to Take 2 Therapeutic Program (this is a clinical treatment service for clients of Child Protection in out of home care with history of severe trauma)
- Consultation to aboriginal team

Education and Early Childhood Development
- Regular teaching to Student Support Staff and Welfare Officers in government schools

COMMITTEES AND WORKING PARTIES

Current
- National Safety and Quality Partnerships Standing Committee (a Standing Committee of the national Mental Health Principal Committee) – Victorian member
- Clinical Network in Mental Health, Safer Care Victoria, Department of Health and Human Services – committee member
- Berry Street Victoria – Risk, Quality and Safety, and Governance Board subcommittees

Past
- Mindful Centre for Advanced Training in Developmental Psychiatry
- RANZCP – Faculty of Child Psychiatry, Victorian Branch, Secretary and committee member for 15 years
- RANZCP – Victorian Postgraduate Training Committee. From 2006 to 2008 I was state-wide Director of Postgraduate Training in Child & Adolescent Psychiatry
- Mental Health Foundation of Australia, Executive Committee Member
- Centre for Excellence in Eating Disorders (CEED) – Advisory Committee
- Paediatric Clinical Network, Department of Health – committee member
- Child Protection Clinical Practice Standards – committee member
- Various Ministerial Committees
    - Bushfire Recovery Advisory Committee
    - Therapeutic Treatment Orders Committee (program for juvenile sex offenders)
    - Victorian Child Death Review Committee for Child Safety Commissioner
- Coronial subcommittee for investigation of suicide clusters in Barwon Region
- Headspace Collingwood
    - Member of consortium
    - Advisory Committee
    - Clinical Governance Committee
- Victorian Aboriginal Child Care Agency, Clinical Governance Committee
- Take 2/Berry St Victoria
    - Board Director
    - Consortium member, Take 2
- President, Austin School Council – 1994 – 2014

LEGAL EXPERIENCE

- Court expert witness for cases in Children's Court, Family Court and Supreme Court
- Evidence as expert witness to assist the court in complex child and adolescent issues, in determining the best interests of the child
- Assisted in coronial inquiries as independent expert witness

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC-2

This is the attachment marked 'NC-2' referred to in the witness statement of Dr Neil Coventry dated 29 July 2020.

Safer Care Victoria

Victorian sentinel event guide

Essential information for health services about managing sentinel events in Victoria

To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or email info@safercare.vic.gov.au

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Available at www.safercare.vic.gov.au

VICTORIA State Government

Purpose of this guide

This guide has been prepared to help health services in Victoria fulfil their obligations when managing and reporting sentinel events.

Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals. All health services are required to report adverse patient safety events in accordance with the Australian national sentinel event list.

The national list provides guidance on 10 main event categories. But it is not comprehensive; some sub-categories of adverse patient safety events fall outside the 10 main categories.

This Victorian guide has been prepared to help fill in the gaps – to help Victorian health services and their staff manage sentinel events not covered in detail in the Australian national list. As such, this guide should serve as a supplement to the national list, not a substitute for it.

The guide contains descriptions, examples and case studies to help health services identify sentinel events under Victorian category 11: *All other adverse patient safety events resulting in serious harm or death.*

It also includes an overview of what is required of health services when reporting and reviewing sentinel events.

The case studies in this guide are for illustrative purposes only, and reflect learnings from the Victorian sentinel event program. The case studies do not represent actual sentinel events, nor an exhaustive list of examples.

For support and advice on determining if an any adverse patient safety event meets sentinel event criteria please contact the incident response team at sentinel.events@safercare.vic.gov.au or 03 9096 1546.

Background

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient[1].

Sentinel events are relatively infrequent, clear-cut events that:

- occur independently of a patient's condition
- commonly reflect hospital (or agency) system and process deficiencies
- result in unnecessary adverse outcomes for patients[1]

In January 2019 the Australian Commission on Safety and Quality in Healthcare (ACSQHC) published a revised national sentinel event category list. It came into effect on 1 July 2019.

In addition to the 10 national sentinel event categories, all Victorian health services are required to adhere to category 11: *All other adverse patient safety events resulting in serious harm or death*. Thus, Victorian health services must report for:

- 10 national categories
- One Victoria-only category.

The national sentinel event categories are listed in opposite.

Australian sentinel events list (version 2)

1	Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
2	Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
3	Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
4	Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
5	Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
6	Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
7	Medication error resulting in serious harm or death
8	Use of physical or mechanical restraint resulting in serious harm or death
9	Discharge or release of an infant or child to an unauthorised person
10	Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death
11	All other adverse patient safety events resulting in serious harm or death

[1]Australian Commission on Safety and Quality in Health Care, Australian Sentinel events list, available at https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list/

What's required of health services

Safer Care Victoria (SCV) oversees the sentinel event program in Victoria. All sentinel events must be reported to us by all public and private health services.

Each year, we report national sentinel events to the independent hospital pricing authority (IHPA), and national sentinel event numbers are reported annually by the Australian Productivity Commission.

Under Victoria's sentinel events program, health services are required to:

- notify SCV within three business days of the service becoming aware of the event
- review and analyse the sentinel event using root cause analysis (RCA) methodology
- submit an RCA report (parts a and b) within 30 business days of the notification
- submit recommendations from the RCA (part c) within 50 business days of the notification
- submit a recommendation monitoring report within 120 business days of the notification.

Include external members

We advise all teams reviewing sentinel events to include an external member and a consumer representative.

Multi-agency reviews

When a sentinel event occurs across different health services, all services involved in the care of the patient should participate in a multi-agency review of the event.

The health service that provided the final care should be responsible for notifying the event, initiating the RCA review and engaging the other health services.

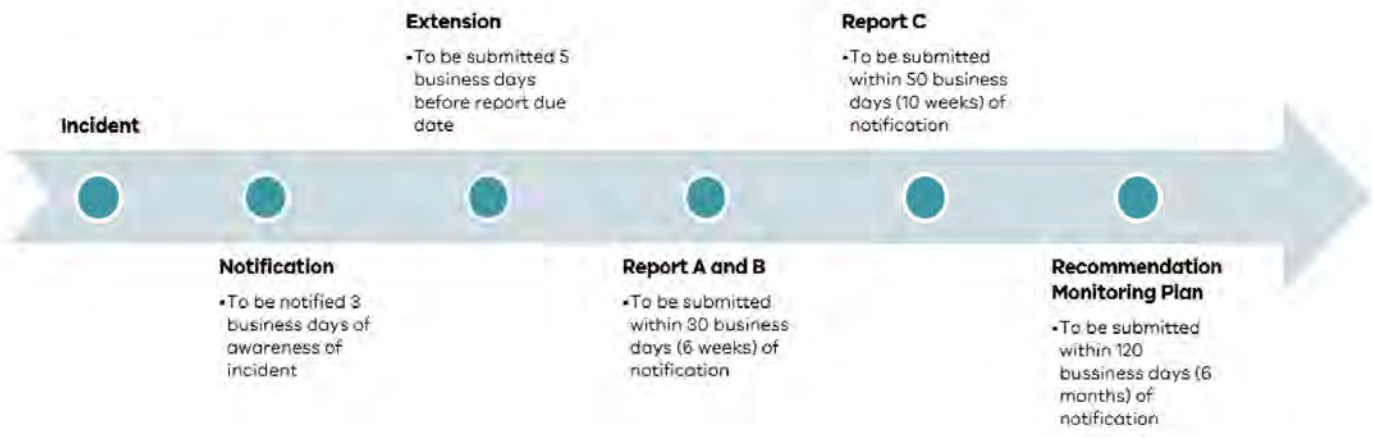
Involving patients and families

Please consider the patients, their families, carers and/or friends during the review process. Families can provide crucial and insightful information during the review of a serious adverse event.

Performance issues

The RCA methodology is not to be used for performance-management issues. Such issues should be handled by the relevant personnel in a performance-management context.

Sentinel Event Program overview



Victorian category 11

This guide aims to help Victorian health services manage adverse patient safety events that fall outside the 10 national sentinel event categories. It is an essential part of a system that aims to drive learning and improvements to the safety of the health system. The Victorian category guide also provides public accountability and transparency to patients, families, carers, health services and the government.

Definitions

The Victorian category 11 includes all adverse patient safety events resulting in serious harm or death that are not included in the 10 national categories.

An adverse patient safety event is an event that results in unnecessary or avoidable harm to a patient. Harm implies impairment of structure or function of the body and/or any harmful effect arising from disease, injury, suffering, disability or death.

Serious harm is considered to have occurred when, as a result of the incident, the patient has:

- required life-saving surgical or medical intervention, or
- shortened life expectancy, or
- experienced permanent or long-term physical harm, or
- experienced permanent or long-term loss of function.[2]

When determining whether or not serious harm has occurred, health service staff should adopt a consumer-focused approach.

Non-sentinel events

An adverse event should not be reported as a sentinel event when:

- there are contributing factors related to the patient's disease or the management phase of their chronic illness
- the incident is subject to review under the Victorian or Commonwealth criminal justice systems
- the incident involves a murder or allegations of sexual or physical assault.

Incident management systems

Most parts of the Victorian health system use the Victorian Hospital Incident Management System (VHIMS), which applies an incident severity rating (ISR) to all events entered into the system. The Victorian category 11 encapsulates adverse patient safety events that are allocated an ISR 1.

For health services that do not use the VHIMS, any incident resulting in serious harm or death to a patient should be considered equivalent to an ISR 1.

ISR	Degree of impact
1	Severe/death
2	Moderate
3	Mild
4	No harm/near miss

[2] ACSQHC, 2019 Sentinel event categories. Retrieved from https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list/

Health services that are required to report sentinel events in Victoria

All public and private health services, and all services under their governance structures, are required to report sentinel events to SCV.

Examples of health services include:

- Ambulance Victoria
- bush nursing centres
- Forensicare (Thomas Embling Hospital)
- public sector residential aged care facilities
- Hospital in the Home services
- private day surgery facilities.

SUB-CATEGORIES OF VICTORIAN SENTINEL EVENT CATEGORY 11

Within the Victorian category 11: *All other adverse patient safety events resulting in serious harm or death,* a number of sub-categories have been identified to provide clarity and guidance on the types of events that need to be reported.

The sub-categories are based on (though not identical to) the World Health Organization's International Classification for Patient Safety.

The sub-categories are:

- Clinical process or procedure
- Falls
- Deteriorating patients
- Self-harm (behaviour)
- Communication of clinical information
- Medical device or equipment
- Nutrition
- Resource or organisational management
- Healthcare associated infection
- Patient accidents.

This guide provides descriptions, examples and case studies for each of these sub-categories.

SUB-CATEGORY 1 – CLINICAL PROCESS OR PROCEDURE

Description

This sub-category of reportable adverse events covers a range of potential situations involving clinical procedures and processes. It can include:

- Any **diagnosis** or **assessment** not performed when indicated or that was incomplete or inadequate, resulting in serious harm or death of a patient.
- Any **procedure**, **treatment** or **intervention** not performed when required, or that was incomplete or inadequate, or involved the wrong body part, side or site, resulting in serious harm or death of a patient.
- Any **test** or **investigation** not performed when required, performed for the wrong patient, or not acted upon or communicated, resulting in serious harm or death of a patient.
- Any mix-up of **specimens** or **results,** including incorrect labelling, resulting in serious harm or death of a patient.

Examples

Events involving:

- screening, prevention or routine check-up
- diagnosis or assessment
- procedure, treatment or intervention
- general care or management
- tests or investigations
- specimens or results.

Case study 1

A 52-year-old patient experiencing chest pain had an ECG investigation. The ECG tracing, once taken, was placed in the patient's file and not reviewed. The patient deteriorated over the next four hours, suffered a cardiac arrest and died. On review, it emerged that the ECG showed the patient was experiencing an acute myocardial infarction that was not diagnosed.

Should this be reported as a sentinel event?
Yes. The patient suffered serious harm that led to death as a result of a missed diagnostic opportunity.

Case study 2

A 22-year-old patient with severe respiratory distress required airway support. Ten minutes after artificial airway intervention (intubation) was administered, it was discovered the artificial airway was in the wrong location (oesophagus). The patient suffered a cardiac arrest, resulting in death.

Should this be reported as a sentinel event?
Yes. The patient suffered serious harm that led to death resulting from an incorrectly performed procedure.

SUB-CATEGORY 2 - FALLS

Description

This sub-category covers events involving serious harm or death resulting from falls.

Example

Head injuries suffered as a result of a fall.

Case study 3

An 88-year-old had a fall in a residential aged care facility in a public health service, sustaining a head laceration and becoming confused. The patient was subsequently diagnosed with cerebral bleeding and, after a family meeting, it was decided not to proceed with surgical intervention and palliation. The patient died 12 hours after the fall.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that led to death.

Case study 4

A 56-year-old patient in declining health with a chronic and complex medical history fell while ambulating to the toilet. The patient was considered at high risk of falls, and prevention strategies were in place before the fall. The patient sustained a fractured hip, which required transfer to a larger health service for surgery. But the patient's advanced care directive stated a wish for no surgical intervention. The patient continued with comfort care and died three weeks later.

Should this be reported as a sentinel event?

No. Although the fall resulted in harm to the patient, the harm was not life limiting. The contributing factors to the death were related to the patient's disease, or the management phase of the patient's chronic illness.

SUB-CATEGORY 3 - DETERIORATING PATIENTS

Description

This sub-category covers adverse events involving a lack of **recognition**, **escalation** or **response** when there is clinical deterioration in a patient, resulting in serious harm or death.

It includes a failure to recognise or respond appropriately to physiological signs and symptoms, or changes in behaviour or mood (mental state), that would indicate clinical deterioration.

Examples

- Not monitoring physiological observations consistently, or not understanding changes in physiological observations.
- Lack of knowledge of signs and symptoms that could signal deterioration.
- Lack of awareness of the potential for a person's mental state to deteriorate.
- Lack of awareness of delirium, and of the benefits of early recognition and treatment.
- Lack of formal systems for responding to deterioration.
- Lack of skills to manage patients who are deteriorating.
- Failure to communicate clinical concerns, including during clinical handover.
- Mistakenly attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition.

Case study 5 (recognition)

The family of a 45-year-old man called an ambulance service due to his slurred speech, inability to move his left arm and incontinence. He had a history of heavy drinking and drug use. An ambulance attended and the patient was assessed and informed that transport to hospital may not be required. The patient and his family decided to stay at home. The next day, the patient was found unconscious in bed by his family and another call was made to the ambulance service. The patient suffered a respiratory arrest on the way to hospital and died.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that led to death after a delay in the recognition of his clinical deterioration on the initial ambulance attendance.

Case study 6 (escalation)

A 67-year-old woman returned to a hospital ward after a significant surgical procedure. Two hours later her blood pressure was noted to be decreasing and her heart rate increasing. These changes were attributed to the anaesthetic that would soon wear off. Despite the situation meeting Medical Emergency Team (MET) call criteria, no escalation was made. Six hours after returning to the ward the patient became unconscious and required urgent transfer to the Intensive Care Unit. She was placed on life support and suffered permanent kidney damage, which necessiated ongoing dialysis and ultimately a kidney transplant.

Should this be reported as a sentinel event?

Yes. The patient suffered serious and permanent harm due to a delay in escalation of the deterioration in her clinical condition.

Case study 7 (response)

A woman who was 37 weeks pregnant presented in early labour with a history of decreased fetal movements in the last 48 hours. A fetal heart rate monitor was applied, and after two hours the trace was interpreted as abnormal. At the time, the activity in the maternity unit was high, with many women requiring care. The midwifery staff escalated the abnormal trace. The fetal heart rate monitoring continued, but there was a period of loss of contact, making the trace difficult to interpret. A fetal scalp electrode was applied for more accurate monitoring, but this took some time. Five hours after escalation of the abnormal trace there was a prolonged fetal bradycardia. An emergency caesarean was performed, and the baby was born pale and not responsive. The baby could not be resuscitated and died.

Should this be reported as a sentinel event?

Yes. The patient suffered death due to a delay in the response to an escalation of concern regarding clinical deterioration.

SUB-CATEGORY 4 - SELF HARM

Description

This sub-category covers events involving intended self-harm that results in serious harm or suicide. (For such events in acute psychiatric facilities, see national sentinel event category 6).

It can include the suspected suicide of an individual within an acute health service (non-psychiatric facility), sub-acute service or rehabilitation service, or the suspected suicide of a compulsory client while they were on approved or non approved leave.

Some deaths are required to be reported to the Office of the Chief Psychiatrist. Please see its website for more information.

Examples

- Suspected suicide of a mental health or non-mental health patient in a medical or surgical ward in an acute hospital.
- Serious self-harm sustained intentionally by a mental health patient in a mental health inpatient unit, emergency department or acute hospital.
- Suspected suicide of a mental health patient on a Mental Health Act order who has taken approved or unapproved leave from an acute mental health inpatient unit, emergency department or acute hospital (within 48 hours of leaving).

Case study 8

An 83-year-old patient was diagnosed with advanced cancer. After a family meeting the decision was made to provide palliative care. A few days after this decision she was found unconscious on the bathroom floor with a dressing gown belt around her neck. Resuscitation attempts were unsuccessful, and the patient died.

Should this be reported as a sentinel event?

Yes. The patient died by suicide on the medical ward of an acute health service.

Case study 9

A 54-year-old patient presented to an emergency department with an acute mental health illness, intoxicated and expressing a plan to self-harm. It was decided to apply an Assessment Order and admit the patient to an acute mental health bed. While waiting for the mental health bed he absconded from the emergency department. Police notified the health service 24 hours later that the patient had died after jumping from a height.

Should this be reported as a sentinel event?

Yes. The patient took his own life after absconding from an emergency department while on a Mental Health Act order.

Case study 10

A 19-year-old patient hanged themself after being admitted to an acute mental health inpatient unit. The patient was revived and transferred to the intensive care unit, after which it was discovered the patient had sustained a permanent brain injury that inhibits independent living.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm while in the care of a health service.

SUB-CATEGORY 5 - COMMUNICATION OF CLINICAL INFORMATION

Description

Several types of events leading to serious harm or death can fall within this sub-category, including:

- an incident involving a process or problems with the **administration or documentation of clinical information,** resulting in serious harm or death of a patient
- any **administrative process** not performed when required, not completed or inadequately completed, or involving a mix-up of patients, processes or services.
- incidents involving missing or unavailable documents, delays in accessing a document, use of the wrong document or unclear, ambiguous, illegible or incomplete information in a document.

Examples

Events involving:

- waitlist delays
- inter-hospital transfer delays
- delays to investigation or procedure
- delays to referral
- handover
- transfer of care
- task allocation
- consent
- patient identification
- labels/stickers/identification bands/cards
- letters/e-mails/records of communication
- reports/results/images.

Case study 12

A 56-year-old woman was referred to an outpatient department to investigate bleeding and a change in bowel habit. The referral was triaged and given a category 1 – urgent for a colonoscopy to investigate symptoms within 30 days. However, no appointment was made. Twelve months later she was diagnosed with advanced colon cancer. She died several weeks later.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that resulted in death following an administrative delay that prevented timely care.

SUB-CATEGORY 6 - MEDICAL DEVICE OR EQUIPMENT

Description

This covers errors associated with medical **devices** or **equipment** resulting in serious harm or death.

Examples

- Lack of availability of a product.
- Use of a product that is inappropriate for the task.
- Use of an unclean or unsterile product.
- Malfunction of a product.
- Dislodgement, faulty connection or removal of a product.

Case study 13

A 48-year old woman had a percutaneous coronary intervention (PCI) for an acute myocardial infarction in a cardiac catheter laboratory. Upon retrieval of the guide wire during PCI, the wire snapped and became lodged in the vessel. The patient required transfer to a larger hospital for surgery to retrieve the guide wire. On the way to the larger hospital the patient's condition deteriorated. She suffered cardiac arrest on arrival and died.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that resulted in death following the malfunction of the guide wire.

SUB-CATEGORY 7 - NUTRITION

Description

This covers various types of errors associated with provision of nutrition and food to patients, resulting in serious harm or death.

Examples

- Delivery of food to the wrong patient.
- Delivery of the wrong food.
- Delivery of the wrong food to patient with known allergies.
- Provision of the wrong quantity.
- Delivery at incorrect frequency.
- Incorrect consistency or incorrect storage.

Case study 14

A 79-year-old man had been living in a public sector residential aged care facility for two years. In recent months his ability to swallow had declined. After a speech therapy assessment, the decision was made to start a vitamised and thickened fluid diet. Sometime after this assessment a full diet was delivered to his room. The resident was assisted with feeding and, after eating a piece of roast meat, he started coughing, experienced facial colour changes and collapsed in the chair. The resident had a not-for-resuscitation order and advanced care directive in place, and no resuscitation measures were commenced.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that led to death due to the provision of incorrect food.

Case study 15

A 92-year-old woman had a swallow assessment after being admitted with general decline and pneumonia. The assessment ordered a vitamised diet and thickened fluids, stating supervision was required for all meals. During lunch she began coughing on the vitamised vegetables. The supervising staff removed her meal. Overnight she developed a fever and had an increased respiratory rate. The patient and family had an advanced care directive and the patient wanted no further medical intervention. She died three days later from pneumonia.

Should this be reported as a sentinel event?

No. The patient had received a risk assessment and strategies were put in place to ensure safety.

SUB-CATEGORY 8 - RESOURCE OR ORGANISATIONAL MANAGEMENT

Description

This sub-category covers events where a lack of resources, or deficiencies in organisational management, contribute to errors resulting in serious harm or death.

Examples

Events involving:

- workload mismanagement
- staff resourcing and accessibility
- bed availability or management
- policy, procedure or guideline availability and/or adequacy.

Case study 16

A 48-year-old woman underwent abdominal surgery in hospital. After the surgery, her condition deteriorated. She was assessed, and a decision was made to return to surgery for further exploration of suspected internal bleeding. She was placed on the waiting list for emergency surgery behind three other patients. While waiting for surgery she suffered a cardiac arrest and died.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that led to her death due to a lack of availability of operating theatres.

Case study 17

A 59-year-old man had a stroke while in hospital. It was decided to administer medication (thrombolytic)nto treat the stroke, and the thrombolytic guideline was followed. However, the guideline did not include advice on how to treat the patient's high blood pressure, which continued to increase. The patient's condition deteriorated further, resulting in a cardiac arrest and death. During a review of the case, the health service discovered the management of high blood pressure when administering thrombolytics was outlined in the appropriate stroke guideline, but a different guideline without such guidance had been relied upon.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm that led to death due to the failure to access the appropriate guidelines.

SUB-CATEGORY 9 - HEALTHCARE ASSOCIATED INFECTION

Description

This sub-category covers infections acquired in the healthcare setting resulting in serious harm or death. It includes bloodstream, surgical site, intravascular cannula or urinary drain infections.

Examples

- Surgical site infections.
- Infections associated with peripheral or central intravascular devices.
- Infections from urinary catheters.

Case study 18

A 56-year-old man had a peripheral intravenous cannula inserted. Seven days after the insertion the area around the cannula was painful, red and inflamed. The cannula was removed, and the patient was discharged and sent home with oral antibiotics and instructions to follow up with his general practitioner within five to seven days. Two days after his discharge, the patient's partner was unable to wake him in the morning and called an ambulance. Soon after arrival at the hospital emergency department he suffered a cardiac arrest and died.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm and death as the result of an infection associated with the peripheral intravenous cannula inserted while he was in hospital.

SUB-CATEGORY 10 - PATIENT ACCIDENTS

Description

This sub-category covers patients in care who are involved in accidents resulting in serious harm or death. Such events could involve blunt force trauma, penetration injury, or thermal or chemical injury.

Examples

- Bed entrapment.
- Drowning.
- Excessive heat or fire.
- Poisoning.
- Electrocution or radiation exposure.

Case study 19

A 51-year-old patient in a brain injury rehabilitation unit was receiving pressure injury care every four hours. Pillows and rolled up blankets were used to maintain the correct pressure injury prevention position. After several hours the patient was found unconscious, trapped in the bedside rails. Resuscitation attempts were unsuccessful, and the patient died.

Should this be reported as a sentinel event?

Yes. The patient suffered serious harm and death as the result of entrapment in the bedside rails.

Case study 20

A 25-year-old patient with an altered state of consciousness fell from a stretcher while being transferred between health services. The patient suffered cerebral bleeding, which resulted in an acute brain injury and the permanent inability to live independently.

Should this be reported as a sentinel event?

Yes. The patient sustained serious and permanent harm from an accidental fall while in the care of a health service.

Terminology used in this guide

Australian Commission on Safety and Quality in Health Care (ACSQHC)
Leads national improvements in safety and quality in healthcare

Business days
Days falling between, and including, Monday and Friday

Consumer representative
A health consumer who has taken up a role to provide advice on behalf of consumers with the overall aim of improving healthcare

Electrocardiogram (ECG)
Measures electrical activity generated by the heart when it contracts

External team member
A review team member who does not work within the health service (including visiting medical officers)

Incident severity rating (ISR)
The severity of impact to a patient when an incident occurs. ISR is measured on a scale of 1-4 (with 1 being most severe)

Independent Hospital Pricing Authority (IHPA)
The independent Commonwealth Government agency established as part of the national health reform agreement

Intensive care unit (ICU)
A unit in a hospital where patients receive specialised critical care when they are extremely unwell

International Classification of Patient Safety (ICPS)
A World Health Organization (WHO) approach to classifying patient safety information

Medical emergency team (MET)
A skilled clinical team that responds to patients with clinical deterioration

Patient safety event
An event in which a person receiving healthcare is harmed

Public sector residential aged care services
Residential aged care beds funded by the Victorian Government

Root cause analysis (RCA)
A method of problem solving used for identifying the root causes of an adverse outcome

Safer Care Victoria (SCV)
The peak body for quality and safety in healthcare in Victoria

Victorian Hospital Incident Management System (VHIMS)
A system used in many Victorian health services to manage patient safety events

World Health Organization (WHO)
Directs and coordinates international health within the United Nations system

Safer Care
Victoria