Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 1

This is the attachment marked 'Curriculum Vitae' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Curriculum vitae

18 JUNE, 2019

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 '2017-18 Chief Psychiatrist's Annual Report' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

WIT.0003.0004.0069

Chief Psychiatrist's annual report 2017–18

VICTORIA State Government | Health and Human Services

Chief Psychiatrist's annual report 2017–18

To receive this publication in an accessible format phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email the Office of the Chief Psychiatrist <ocp@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, October 2018.

ISSN: 2207-1482 (Online)

Available on the Chief Psychiatrist's webpage <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist.

Chief Psychiatrist's message

I am pleased to present the Chief Psychiatrist's annual report for 2017–18.

As Victoria's Chief Psychiatrist, my responsibilities under the *Mental Health Act 2014* include clinical leadership and quality and safety improvements across the Victorian public mental health system.

People experiencing mental illness are often highly vulnerable and may be treated on a compulsory basis. This is why it is so important that the mental health system has strong mechanisms to monitor practices and help service providers continuously improve the safety and quality of their services. Together with the Mental Health Tribunal and the Mental Health Complaints Commissioner, my role is a cornerstone of the Victorian Government's clinical governance framework for mental health services.

The Office of the Chief Psychiatrist (OCP), which includes the Office of the Chief Mental Health Nurse (OCMHN), had another busy and productive year in 2017–18. While it is not possible to capture all the activities of these teams, this report describes some highlights of the year. These include several new guidelines and practice resources for mental health services in areas such as responding to family violence, providing clinical supervision for staff, meeting the needs of people who require intensive mental health nursing and improving sexual safety in mental health inpatient settings. We also continued to rollout the Safewards program, which has proved effective in driving better cultures and practices in inpatient units.

These initiatives are in addition to our day-to-day work, which includes: monitoring restrictive interventions in mental health services; investigating serious clinical incidents; undertaking reviews and supporting mental health services to address issues of concern; liaising with mental health and other services to improve outcomes for individual consumers; and responding to many calls, letters and emails from consumers and carers seeking assistance and advice regarding access to mental health services. This year has seen a marked increase in the number of direct contacts from mental health service providers seeking advice and assistance from my team; this is a clear indicator of our increasingly robust and productive relationships with services, showing the value of our collaborative approach to clinical leadership.

The OCP and the OCMHN are privileged to have strong links and daily contact with mental health clinicians and service users as well as and staff of agencies such as the Mental Health Tribunal, the Office of the Public Advocate and Safer Care Victoria. This gives us access to a wealth of 'frontline' knowledge that informs our policy and quality assurance endeavours. I wish to thank the many clinicians, service leaders, consumers and carers who have shared their expertise and experiences with us.

I am fortunate to lead a multidisciplinary team of skilled and compassionate people who are dedicated to improving Victoria's mental health system. This report highlights the contributions of two new staff members with lived experience of mental illness and mental health services. Through their own work and their advice and support to other team members, these staff remind us to keep the rights and recovery needs of mental health consumers and carers at the forefront of everything we do.

I also take this opportunity to acknowledge and thank the Chief Mental Health Nurse, my deputies, the OCP manager and the clinical advisors, project officers and administrators in my team for their unflagging commitment and support during the year.

Dr Neil Coventry

Chief Psychiatrist

Contents

Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, carers, service providers and members of the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2017–18 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health Act 2014*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The Mental Health Act aims to improve the treatment experiences of people with a mental illness by actively involving and supporting them, and their families and carers, in making decisions about their treatment and exercising their rights.

The Act has a number of core principles and objectives including that:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under s. 119 of the Act, the Secretary to the Department of Health and Human Services ('the department') can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s. 120 of the Act, is to:

- provide clinical leadership and expert clinical advice to mental health service providers in Victoria
- promote continuous improvement in the quality and safety of mental health services
- promote the rights of people receiving mental health services
- provide advice to the designated minister and the departmental Secretary about mental health services.

Under the Act, 'mental health service providers' are designated mental health services (often public or denominational hospitals) and publicly funded mental health community support services. Often referred to jointly as 'public mental health services', these services include a range of hospital and community-based clinical mental health services and the Victorian Institute of Forensic Mental Health (known as 'Forensicare').

Further information about the Mental Health Act and how it relates to the role of the Chief Psychiatrist can be found on the department's website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health services. Supported by the OCP, the role promotes quality and safety in services provided to some of Victoria's most vulnerable people. The Act, under s. 121, summarises the functions of the Chief Psychiatrist as:

- to develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- to develop and provide information or training, and monitor service provision, to promote quality and safety
- to assist mental health services to comply with the Act, regulations made under the Act and codes of practice
- to conduct clinical practice audits and clinical reviews of mental health service providers, and investigations in relation to service provision
- to analyse data, undertake research and publish information about Victoria's mental health services
- to publish an annual report
- to give directions to mental health service providers regarding service provision
- to promote cooperation and coordination between mental health services and providers of health, disability and community support services.

The Office of the Chief Psychiatrist and the Department of Health and Human Services

The Act defines the statutory role of the Chief Psychiatrist, who also holds an executive officer role in the department, as leading the OCP.

As the department's quality and safety 'arm' in the stewardship of clinical mental health services, the OCP supports the Chief Psychiatrist's responsibility to provide clinical leadership to the sector. The OCP undertakes a wide range of activities including:

- monitoring restrictive and invasive interventions, which include seclusion, restraint and electroconvulsive treatment (ECT)
- responding to serious clinical incidents
- working with mental health and other service providers to improve care for individual consumers
- helping to embed new practices and models of care.

The OCP incorporates the work of the OCMHN. The Chief Mental Health Nurse provides nursing leadership and supports mental health nursing through education/training, through promoting best practice and through workforce planning and development. The OCMHN supports the practical implementation of the OCP's work with policy, procedures and workforce development initiatives.

Structure of the report

This annual report outlines the OCP's activities from 1 July 2017 to 30 June 2018 and has been divided into two sections.

Section 1 relates to leadership and quality and safety improvement across Victoria's mental health system. These activities include: providing advice to services and ministers; clinical leadership; and reviews, audits and investigations to promote continuous improvement in quality and safety.

Section 2 covers the OCP's statutory reporting requirements under the Mental Health Act including monitoring ECT, restrictive interventions (use of seclusion and restraint) and reportable deaths.

Section 1: Leadership and quality and safety improvement

The year in review

The OCP, including the OCMHN, undertakes many and varied activities as part of its clinical leadership and quality and safety functions. In 2017–18 our teams:

- completed three major investigations
- wrote two major reports based on data collected by the department
- undertook audits of ECT at three health services and held an education and training forum on ECT quality and safety
- carried out reviews of mental health services and monitored quality and safety actions plans at two health services
- conducted 447 reportable death report reviews
- established a new case and data collation system to improve future reporting and trend analysis
- created and published four new guidelines and reviewed and reissued two existing guidelines
- developed new policy and practice frameworks on clinical supervision and physical health
- conducted 14 health service site visits
- hosted two quality and safety forums – on incident reporting and risk management, respectively – involving more than 100 stakeholders each
- held the third annual Safewards Victoria forum involving 200 delegates, six Safewards Victoria community of practice meetings, six Safewards Victoria faculty meetings, eight Safewards Victoria workshops and one masterclass workshop, as well as Safewards 'train the trainer' programs at five area mental health services
- held quarterly forums for health services' authorised psychiatrists, three meetings of the restrictive interventions committee, two meetings of the morbidity and mortality committee, a meeting of the ECT committee and meetings of the sentinel events review committee every six weeks
- held monthly forums with senior mental health nurses from across the state and two forums each for community nurses, adult acute inpatient nurse units managers, aged care nurses and child and adolescent mental health nurses
- monitored implementation of the Hospital Outreach Post-suicidal Engagement (HOPE) program at six sites.

We also worked in collaboration with other parts of the Mental Health Branch, other areas of the department and other government departments and agencies on a range of government initiatives and programs.

Continuing the trend from recent years, we were busier than ever in 2017–18. Compared with 2016–17 we experienced:

- a 53 per cent increase in overall contacts from mental health services, carers, consumers and members of the public. The largest increase was in contacts initiated by mental health services, which were 139 per cent higher than the previous year
- 58 contacts from departmental colleagues to provide advice to joined-up service strategies for individuals, representing a 263 per cent increase on the 16 contacts in the previous year
- a 72 per cent increase in direct contacts from consumers

- a 44 per cent increase in direct contacts from carers
- a 322 per cent increase in incident reports, due largely to a sexual safety reporting pilot project and changed reporting requirements
- a 40 per cent increase in correspondence prepared on behalf of the Minister for Mental Health.

The box below gives an example of a day in the life of one of our clinical advisors.

A typical day in the life of an OCP clinical advisor

8.30 am: Clinical team meeting

Clinical meetings occur twice a week. The team discusses clinical matters that have been recently brought to the OCP's attention and any other ongoing clinical issues. Team members seek advice from others and work together to plan how to manage presenting issues.

9.30 am: Responding to emails

Emails to OCP advisors come from a range of sources including departmental colleagues and managers, ministerial officers, mental health services and external agencies. Some will require urgent action – for example, arranging for an area mental health service to assess someone who has contacted a statutory agency making threats of self-harm.

10.00 am: Phone duty

Clinical advisors take turns to answer incoming calls to the OCP's enquiry line. Calls come from health services and from consumers and carers seeking assistance with accessing mental health services. For example, a clinician from a mental health service might ask the OCP for help interpreting a provision of the Mental Health Act in a particular clinical situation. OCP clinicians will often seek advice from legal officers in the department to respond to such queries.

12.00 pm: Record keeping

Record actions and status updates from morning work on the OCP's clinical management database.

12.15 pm: Lunch with colleagues in the office kitchen

12.30 pm: Unscheduled case conference with Chief Psychiatrist

The Chief Psychiatrist is often called on to act in clinical matters that require coordination between many different parties. As an example, he could convene an urgent case conference between clinicians from an area mental health service, Forensicare and other service providers involved with a person who has perpetrated an act resulting in harm to members of the public. In a case like this, the clinical advisor may be asked to check the person's records on the department's central mental health service database and write a briefing for departmental executives and/or the Minister for Health.

1.30 pm: Statutory reporting meeting

OCP clinical advisors regularly meet to review all episodes of restrictive interventions in mental health services. They particularly focus on 'outlier' episodes – for example, people who are secluded for longer than usual or who have experienced multiple episodes of restraint – and will contact the relevant services to discuss these events.

As well as looking at individual cases, the team reviews aggregate data to identify any trends for individual services and across the system.

3.00 pm: Sentinel event teleconference

The Chief Psychiatrist convenes regular face-to-face meetings and teleconferences with service providers to discuss sentinel events. The clinical advisor's role in these meetings includes reviewing 'root cause analysis' documentation for all sentinel events reported to the OCP, summarising this information, sending it out in a secure form before the meeting, and presenting the information verbally to meeting participants. Participants include clinical directors and quality/safety managers from mental health services and representatives of Safer Care Victoria and the OCP.

4.30 pm: Desk work

Clinical advisors contribute to the bureaucratic work of the department such as responding to letters on behalf of the Minister for Mental Health, preparing briefings on the progress of key initiatives and reviewing service policies, plans and evaluations.

Highlights

While it is not possible to describe all the work of the OCP/OCMHN, this section details some of our key achievements in 2017–18.

Family violence

The Victorian Royal Commission into Family Violence directed two of its recommendations specifically to the Chief Psychiatrist. It recommended that the Chief Psychiatrist issue a guideline on family violence for mental health services and – in consultation with relevant professional peak bodies – develop a family violence learning agenda.

The *Chief Psychiatrist guideline and practice resource: family violence* was finalised in June 2018. This guideline outlines the Chief Psychiatrist's expectations of Victorian public mental health services about responding to people who experience family violence and improving the way they work with those who perpetrate it. The guideline sends a strong message that effective responses to family violence should be integrated into usual mental health treatment, and provides practice advice, examples and information resources to help mental health services achieve this objective.

While mental health clinicians are not expected to become family violence specialists, they are required to become skilled in recognising, understanding, enquiring about and taking appropriate action in relation to family violence. Together with the new specialist family violence positions funded in the Victorian Government's 2017–18 State Budget, the Chief Psychiatrist's guideline is an important resource for mental health services to use in improving clinicians' family violence knowledge and skills.

The mandate for mental health services to develop their clinicians' skills in this area will be strengthened through the forthcoming release of a joint statement of commitment to a learning agenda by the Chief Psychiatrist, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian and the Royal New Zealand colleges of general practitioners and other professional bodies. This was an outcome of a project advisory group with representatives from these bodies, which the Chief Psychiatrist convened in 2017.

Clinical practice framework and training for mental health intensive care

Another highlight of 2017–18 was the Chief Mental Health Nurse's project to develop a new clinical practice framework and training program for intensive mental health nursing. The purpose of the project was to improve therapeutic engagement and safety for people who require intensive care due to increased needs and vulnerabilities associated with an acute mental illness.

The framework distinguishes mental health intensive care as a specialist care type that is determined by the consumer's need rather than a particular service setting. Consumers may receive this type of care in a dedicated mental health intensive care area (formerly a 'high dependency unit') or in another treatment environment such as a general inpatient unit or an emergency department.

The framework was informed by a review of high dependency units in Victoria, a review of the Chief Psychiatrist's 2002 policy guideline on high dependency units, and the concurrent development of a training and skills development program (see below). It supports decision making about using mental health intensive care, as well as developing local policies and procedures to ensure consistent and high service standards.

The framework emphasises that all decisions and practices regarding mental health intensive care must consider consumers' rights and recovery goals and the risks and anticipated benefits of the care. Seven core practice principles underpin the framework. These principles specify that mental health intensive care should be recovery-oriented, trauma-informed, human rights-focused, family-

inclusive, responsive to diversity and provided in the least restrictive way possible, and should facilitate supported decision making. The framework also describes expectations of services in five interconnected clinical practice domains: therapeutic environment, staffing skills and requirements, collaborative planning, therapeutic interventions and supporting safety.

The OCMHN's senior consumer and carer advisors, in collaboration with clinical advisors, created and delivered an innovative program of training and skills development based on the actual experiences of consumers, carers and clinicians. They were assisted by the Mental Health Intensive Care Working Group, which included:

- consumer and carer representatives
- a director of nursing (project ambassador)
- nurse practitioners specialising in high dependency units and intensive care
- nurse unit managers
- nurse educators
- OCMHN project staff
- an academic from the University of Melbourne's Centre for Psychiatric Nursing.

The training program is delivered via a multimedia platform with videography and face-to-face training modules presenting research-based evidence on attitudes and values, recovery and trauma-informed care principles, and therapeutic engagement foundations.

The training package was piloted at a service where there was an immediate need for developing the skills of nursing staff. Evaluation and feedback on the training has informed how the program will be delivered across the state.

Clinical supervision framework

The OCMHN provides leadership, training and professional development, promoting evidence-based best practice for mental health nurses employed in Victorian public mental health services.

In 2017–18 the OCMHN team launched *Clinical supervision for mental health nurses – the framework for Victoria*. The framework, developed with the support of an expert reference group from across Australia, addresses an identified need for more consistency and clarity about expected standards of clinical supervision.

Released in May 2018, the framework is designed to:

- promote a common understanding of clinical supervision
- enable mental health nurses to negotiate with and have their clinical supervision needs met by mental health services
- ensure that nurses have regular access to safe spaces where they can reflect on practice
- support the government's response to occupational violence, service quality and safety issues as well as workforce retention in mental health services
- communicate information about how dedicated reflective practice can improve outcomes for consumers
- clarify the roles and responsibilities of nurses, supervisors and employers regarding clinical supervision.

A five-year implementation plan will support the framework's implementation. The plan's consultation phase involves a 12-month dedicated clinical supervision training program for senior mental health nurses and mental health nurses involved in clinical supervision across the state. This leadership group will provide key drivers for the remaining four years of the implementation plan. The five-year

plan provides a platform on which to develop standards for clinical supervision and training programs across Victoria, aligned with national peak bodies and expert groups.

Advance statements and nominated persons

The Mental Health Act contains various provisions designed to uphold the human rights and recovery goals of mental health service consumers and their families and carers. These include a statement of rights, a set of recovery principles and requirements for supported decision making.

A central tenant of the Act is the presumption that people receiving compulsory mental health treatment have the capacity to make decisions about their treatment and to give informed consent (unless clinicians can provide evidence to the contrary at the time a treatment decision needs to be made).

Under the Act, consumers have the right to make an 'advance statement' setting out their treatment preferences in case they become unwell enough to need compulsory mental health treatment. They also have the right to elect a 'nominated person' to receive information and to support them if this occurs. These legislative provisions were designed to protect consumers' interests by ensuring they are able to exercise their rights and have their views and preferences about their treatment and recovery taken into account.

As part of a broader focus on consumer rights, OCP staff have reviewed the uptake and impact of advance statements and nominated person provisions. The aim was to improve understanding of the enablers and barriers to implementing the legislative provisions on advanced statements and nominated persons. The review included:

- a literature review
- a desktop review of current tools, resources and promotional materials supporting the legislative provisions
- an analysis of Client Management Interface / Operational Data Store (CMI/ODS) data by service type and region
- consultations with key stakeholders
- an electronic survey (executed via the peak body for mental health consumers, the Victorian Mental Illness Awareness Council).

The project provided a platform for information exchange and dialogue between the department, consumers/carers and clinical service staff on how to use advanced statements and how to apply nominated persons provisions. This included a successful forum to discuss the project findings with stakeholders from across the sector and to showcase actions and initiatives that promote supported decision making.

The recommendations arising from this project will form the basis of a work plan to improve ongoing data collection and practices relating to supported decision making and the use of the advance statement and nominated persons legislative provisions.

Sexual safety

Sexual safety in mental health services remains one of the Chief Psychiatrist's highest priorities.

The OCP initiated a review of the Chief Psychiatrist's guideline *Promoting sexual safety*, which deals with responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units. The OCP undertook this work in collaboration with consumers, carers and sector clinicians and service managers.

The review responded to several incidents of sexual assault in mental health services. The Chief Psychiatrist was also concerned that there were significant variations between services in the threshold for reporting incidents to the Chief Psychiatrist and the content of reports received.

The review led to a new reporting instruction, *Chief Psychiatrist standard operation procedure – sexual safety notification to the Chief Psychiatrist*. The Chief Mental Health Nurse managed a project to clarify and simplify the reporting process for mental health services using a new reporting checklist that was developed with expert researchers from the field. As part of a three-month trial of the checklist, from 1 March to 1 June 2018 mental health services' authorised psychiatrists were required to report all incidents of alleged sexual assault, sexual harassment and sexual activity on their acute psychiatric inpatient units. This is consistent with the Chief Psychiatrist's instruction that sexual activity is not appropriate in acute mental health treatment settings because consumers may be unable to consent in a meaningful way to such activity when they are acutely unwell.

The Monash Alfred Psychiatry Research Centre is currently evaluating the checklist. While awaiting the findings of the evaluation, mental health services have continued to use the checklist to report information to the Chief Psychiatrist and have given positive feedback about this process. The reported data will be analysed to understand patterns of sexual safety incidents across the state and, over time, to monitor services' progress in achieving sexual safety in mental health inpatient units.

The checklist evaluation and analysis of reported data will inform a revised Chief Psychiatrist's sexual safety guideline. The revised guideline will emphasise safety for all people in inpatient units (consumers, visitors and staff), incident prevention (for example, by better orientating consumers to the inpatient unit), early intervention, appropriate responses to incidents, and best practice standards for reporting to the Chief Psychiatrist.

The new reporting process and revised guideline will form part of the department's response to a recent Mental Health Complaints Commissioner review, which examined complaints relating to sexual safety in acute mental health inpatient environments. The commissioner's report, *The right to be safe: ensuring sexual safety in acute mental health inpatient units*, was released in March 2018. It makes several recommendations to the department, the Chief Psychiatrist and health services about improving sexual safety in acute mental health inpatient units.

The OCP is involved in a range of other activities that will contribute to the Chief Psychiatrist's sexual safety agenda and the response to the commissioner's recommendations. These include:

- working with the Victorian Health and Human Services Building Authority on a mental health infrastructure sexual safety audit in 2018–19 (this will include an assessment of women-only areas, safety features such as locks or swipe cards, and the viability of further reconfiguring facilities to establish single-gender areas)
- working with the Victorian Agency for Health Information to integrate reporting of sexual safety incidents into the Victorian Health Information Management System
- revising existing Chief Psychiatrist guidelines on discharge planning and transfers of care
- developing a new Chief Psychiatrist guideline on clinical risk assessment
- implementing the clinical practice framework and training program for mental health intensive care, as discussed on page 11
- developing a framework for Chief Psychiatrist investigations
- promoting best practice through the Chief Psychiatrist's Quality and Safety Forums, Authorised Psychiatrist meetings and service visits.

Safewards

Safewards was originally developed for mental health 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.

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 practices such as patient seclusion and restraint. It aims to improve safety for both staff and patients by teaching staff to identify, avoid and respond to 'triggers' of conflict. 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 10 practical, evidence-based interventions.

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. This collaborative model of implementation includes a dedicated project team in the OCMHN, a consumer advisor, expert clinicians, the Safewards community of practice, the Safewards faculty and an evaluation team.

The statewide rollout of Safewards, which began in 2016 following a trial in seven services (18 inpatient units), was completed in 2017–18. The OCMHN has now delivered Safewards training and implementation support to all in-scope mental health services. Visual resources have been developed using a unified theme of origami (signifying transformation), 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.

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 being subject to intensive evaluation, but early indications are very promising as to its effectiveness.

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. Preliminary work has begun to introduce Safewards to emergency departments in Victorian public hospitals. Workshops have been held with experts, including people with lived experience, and other key stakeholders. Two health services, Peninsula Health and Bendigo Health, will trial Safewards in their emergency departments in 2019.

Responding to and investigating challenging clinical issues

As mentioned in the Chief Psychiatrist's message at the front this report, the OCP/OCMHN has a generally strong and collaborative relationship with mental health services. We regularly receive feedback that services value the assistance of the Chief Psychiatrist, the Chief Mental Health Nurse and other OCP clinicians in helping them work through problems and manage difficult clinical issues.

A practical way in which the OCP helps services is by supporting care planning for consumers with complex needs. OCP clinicians often play a coordination role by bringing together different people involved in consumers' care – including family members in many cases – to understand their needs from multiple perspectives and to promote a shared understanding of the best way forward.

The following case vignette illustrates how the OCP was able to foster communication and trust between a mental health service and a consumer's family, for the benefit of all parties. Details of the case have been changed to protect the privacy of the people involved.

The father of 20-year-old man contacted the OCP to discuss concerns about his son. The young man, who lived at home with his parents, had a physical impairment as well as behaviour that caused significant risk to himself and others. His mental health diagnosis was unclear.

Family members were worried about the young man's medical and psychiatric needs and were unsure about how to get the help they needed. They perceived that there were limited treatments available within their local mental health system and that interventions by the area mental health service were crisis-driven rather than planned.

The OCP facilitated a case conference with the area mental health service regarding assessment and treatment planning for the young man. As a result, the service was able to clarify the next steps for his treatment. The service's clinical team also engaged with specialised support for involving family members in the treatment process and received advice about referral to other supports for the family.

The OCP interacts with a wider range of services and agencies each year as Victoria's health, mental health and community service system continues to expand and develop. The vignette below, again with details changed to protect privacy, is an example of a case referred to the OCP that resulted in involving the new Victorian Fixated Threat Assessment Centre (VFTAC). The centre brings together senior and experienced police and mental health clinicians to assess and respond to people with complex needs who may pose a risk of serious violence. The OCP has communicated with the mental health sector about the role of this new service.

Police found a 25-year-old homeless man with chronic psychotic illness trying to gain access to Parliament House. The police took him to a local hospital emergency department where he was assessed by a mental health clinician and admitted to a mental health inpatient unit for a week under the Mental Health Act.

During his admission the man expressed concerning views about a senior Victorian politician, who he believed had communicated with him over many months, and about his desire to make the 'ultimate sacrifice' for the state. The mental health service contacted the OCP for advice. The OCP discovered that the man had written to the politician several times about his ideas for making the state safe from invasion.

In consultation with the OCP, the mental health service referred the man to the VFTAC. Staff there assessed the risk to the community and looked at previous forensic contact. On discharge from the inpatient unit, the homeless team from the mental health service and the VFTAC worked with the man to monitor his adherence to treatment, his behaviour and signs of escalating psychosis.

As well as providing leadership, advice and support, the Chief Psychiatrist has general powers under the Mental Health Act to give directions to services. General directions must be preceded by an investigation of a particular incident, a pattern of behaviour or a series of complaints. The Chief Psychiatrist also has the option to conduct a clinical review and audits that do not have any particular criteria to initiate (but require the OCP to give the service 20 days' notice). As illustrated by the following de-identified vignette, the investigations and reviews conducted by the OCP may serve to inform government policy directions and investments in mental health services.

A 50-year-old woman with chronic psychotic illness was involved in a violent altercation in the city where a person sustained a severe head injury. The woman was subsequently imprisoned and remains in remand pending a court hearing. Forensicare is providing treatment.

The Chief Psychiatrist appointed an expert panel to conduct a formal investigation (under s. 122 of the Mental Health Act) of the woman's treatment by the area mental health service, where she was a registered client before the incident. The panel examined the case for two days, including a one-day visit to the service and a one-day review of documentation.

The report of the investigation contained recommendations for both the mental health service and the department. A key finding of the investigation was that although the mental health service had managed the woman's psychotic illness well, it had not adequately assessed or responded to her co-existing personality disorder. The findings and recommendations from the investigation have informed a new initiative funded in the 2018–19 State Budget to improve the identification and treatment of people with personality disorders within area mental health services.

Promoting rights and choice through lived experience expertise

Consumers and carers are central to identifying safety, quality and human rights issues in mental health services, as well as possible solutions. The Chief Psychiatrist must access the expertise of people with lived experience of mental health services and support them to participate in OCP/OCMHN work. This leads to more effective engagement and helps the sector move towards genuine co-production with consumers and carers.

In 2017–18 the OCP/OCMHN established new consumer and carer advisor positions, welcoming two full-time staff members with lived experience of mental illness and mental health services. Julie was appointed to the role of senior consumer advisor. Julie is experienced in consulting with people who have a mental illness and has advised the Commonwealth and state governments on mental health policy. Frances is the senior carer advisor. Before joining the team Frances was leading business development and implementation of the National Disability Insurance Scheme, working extensively with consumers, families and carers. She held executive roles in the mental health sector and is recognised for her commitment to family and carer strategy and policy. Kate, a principal clinical advisor and senior mental health nurse in the OCP/OCMHN team, supports the consumer and carer advisors, oversees their work and coordinates their input to the work of other team members.

The work of the consumer and carer advisors in 2017–18 has focused on consumer and carer rights. This pertains to one of the four statutory roles of the Chief Psychiatrist: 'to promote the rights of persons receiving mental health services' (s. 120, Mental Health Act). The OCP has, until recently, focused its consumer rights work on reducing restrictive interventions and promoting gender and sexual safety. While these issues remain high priorities, there is a need for the office to consider ways of promoting rights more broadly.

The consumer advisor is developing a guidance document on consumer rights for the sector and an action plan for the OCP. The consumer advisor has also established the Victorian Consumer Rights Advisory Group, which provides ongoing, expert advice to the Chief Psychiatrist. The aims of this body of work are are to:

- promote a clear, shared understanding of consumer rights in the mental health sector
- promote knowledge and influence values and attitudes about consumer rights
- contribute to monitoring the effectiveness of the Mental Health Act's provisions on consumer rights
- identify barriers and opportunities to better promote consumer rights.

The senior carer advisor is leading the OCP's work on advance statements and nominated persons, as discussed on page 13, to increase awareness of these rights and mechanisms that support decision making about treatment preferences.

The senior carer advisor is also supporting mental health service providers to operationalise key legislative provisions and policy principles to more effectively involve families and carers in consumers' care. In various reviews, the OCP has identified the need for increased engagement with families and carers. The Chief Psychiatrist will shortly release a new guideline, *Working together with families and carers*, which provides key directions and clinical guidance to services on including family, on carer issues and on responding to children.

In addition to leading their own projects, the consumer and carer advisors work as part of the collaborative, multidisciplinary OCP/OCMHN team. They participate in key work undertaken as part of the Chief Psychiatrist's statutory functions, including investigations, clinical reviews and developing practice guidance. Their participation serves to focus the attention of all team members on improving clinical practice in areas of high priority to consumers and carers. In the words of the senior consumer advisor:

> 'Just being present [in the OCP/OCMHN] has brought a heightened awareness of consumer rights and choices.'

The senior consumer and carer advisors also act as a conduit to bringing other consumer and carer voices into the OCP/OCMHN. They maintain regular contact with the Victorian peak agencies for consumers and carers – the Victorian Mental Illness Awareness Council and Tandem, respectively – as well as supervisors of the peer workforce in mental health services, consumer/carer academics and other lived experience staff employed in the department's Mental Health Branch. Both advisors have contributed to the Mental Health Branch's new lived experience engagement framework, which promotes a consistent and well-considered approach to engaging consumers and carers in the branch's work.

Quality and safety forums

The OCP has begun hosting mental health quality and safety forums. These events bring together mental health service administrators and executives, policymakers, clinicians, consumers, carers, researchers and other stakeholders for an open dialogue on current and emerging quality and safety issues.

Two forums were held in 2017–18. Designed in partnership with clinical leaders, consumers and carers, they comprised a mix of presentations from sector leaders and experts, consumer and carer perspectives and practical solutions components.

The inaugural forum in November 2017 was titled 'When things go wrong – how do services respond to serious incidents?' In debating the question, 'Do the current processes for investigating an incident minimise harm?', six speakers, including two consumers, explored the many perspectives, considerations and possible outcomes of reporting incidents. Later in the day, groups of participants discussed possible game-changing ideas to reduce harm and strengthen the therapeutic environment in mental health services.

The second forum, in June 2018, explored risk assessment and management in inpatient units, including the effectiveness of current risk assessment tools and possible alternative approaches to identifying and managing risk. The forum included a presentation by Professor Matthew Large from the University of New South Wales, who is an internationally noted commentator and researcher on methods of risk assessment in psychiatry.

Each of the forums generated great interest and reached full capacity (more than 100 guests each), with representatives from all Victorian mental health services. The feedback from participants has been very encouraging, and new events are planned for 2018–19. A summary of each forum will be made available on the OCP webpage in the coming months.

Section 2: Statutory reports

Under the Mental Health Act, services are required to report to the Chief Psychiatrist about ECT use, about the use of restrictive interventions such as seclusion and bodily restraint, and about reportable deaths. Gathering information in this way offers the opportunity to monitor trends, identify problems and improve clinical practices to enhance the safety and quality of services.

This section of the report provides data and analysis specific to each area for 2017–18.

Electroconvulsive treatment

ECT induces modified seizures by passing an electrical current through the brain while the person is anaesthetised.

It is an effective treatment for a range of mental illnesses including severe depression, mania, schizophrenia and catatonia. It may be recommended when other treatments have not worked, or take too long to work, or cannot be undertaken safely. ECT might also be recommended to people for whom the treatment worked well previously.

This evidence-based treatment is individually tailored to maximise benefit and reduce adverse effects including memory deficits. Side effects are minimised by applying stimulation to one side of the head (unilateral ECT) with the smallest possible dose of electrical stimulation. Treatments are typically administered on two or three occasions per week over a period of two or more weeks.

The Chief Psychiatrist and the Mental Health Tribunal oversee the use of ECT. Services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use.

Electroconvulsive treatment in public mental health services

In relation to ECT, the Chief Psychiatrist's special responsibilities include:

- receiving reports from public mental health services about ECT use
- reporting on the number of young people (under 18 years of age) who receive ECT.

The number of people who receive ECT has remained relatively static since 2013–14 (see Table 1), despite a significant increase over this period in admissions to inpatient units. There has been a modest increase in the number of individual treatments, reflecting a slight increase in the average number of treatments per person from 11.6 in 2013–14 to 12.9 in 2017–18.

Table 1: Number of treatments and people treated by ECT, 2013–14 to 2017–18

Measure	2013–14	2014–15	2015–16	2016–17	2017–18
Number of treatments	12,831	11,509	11,972	12,266	13,281
Number of people treated	1,109	1,025	993	1,031	1,029

Mood disorders accounted for nearly two-thirds of treatments in 2017–18, followed by schizophrenia and other psychoses (Table 2). The increasing percentage of treatments for mood disorders is likely due to better reporting rather than a shift in practice, as suggested by the marked reduction of missing diagnoses.

Table 2: Percentage of ECT treatments by diagnosis, 2013–14 to 2017–18

Diagnosis	2013–14	2014–15	2015–16	2016–17	2017–18
Mood disorders	52%	54%	63%	66%	62%
Schizophrenia and other psychoses	35%	34%	33%	30%	34%
Other conditions	4%	6%	2%	2%	2%
Not reported	8%	6%	1%	2%	2%

Table 3 shows that, overall, more women than men were treated with ECT across the life span. This is consistent with community-wide differences between the genders in the prevalence of mood disorders.

Table 3: Number of ECT treatments by age group and gender, 2017–18

Gender	18–29	30–39	40–49	50–59	60–69	70–79	80+
Men	747	822	1,236	861	1,026	721	213
Women	703	783	1,325	1,129	1,134	1,573	997

Electroconvulsive treatment and young people

The Chief Psychiatrist must collect data on the number of people aged under 18 years who receive ECT and their clinical outcomes. A subcommittee of the ECT Committee oversees this work. In 2017–18 only two people who received ECT were aged under 18 years.

Deaths of people receiving mental health treatment

The death of a person receiving treatment or support for a mental illness is a tragic event. The Chief Psychiatrist collects data from all public mental health services to learn from each incident, with a view to improving safety and reducing the number of preventable deaths.

All publicly funded mental health service providers must inform the Chief Psychiatrist of a client's death in specified circumstances. This requirement is articulated in the Mental Health Act as well as the *Coroners Act 2008*.

The Chief Psychiatrist is required to be notified of the deaths of all mental health inpatients where an inpatient is defined as *any person, regardless of legal status* who:

- has been admitted to a mental health inpatient unit
- is on approved leave from an inpatient unit
- has absconded from an inpatient unit
- has been transferred to a non-psychiatric ward during a mental health admission
- has been discharged from a mental health inpatient unit within the previous 24 hours.

In the case of deaths in the community, the Chief Psychiatrist must be notified of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of people in the community who were registered as a mental health consumer within the previous three months or who had sought care from a mental health provider within that period and had not yet received treatment
- all deaths of patients under community treatment orders or non-custodial supervision orders.

The Chief Psychiatrist also requires notification of the deaths of people detained in an emergency department or non-psychiatric ward under the Mental Health Act and those receiving service from a mental health community support service.

People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).

In addition, the Chief Psychiatrist holds the following role as part of the quality and safety leadership functions under the Act regarding reportable deaths:

- to maintain a database of reportable deaths of clients of public mental health services in Victoria
- to request the findings of coronial investigations and contribute to coronial processes if requested by a coroner
- to review clinical reports provided by services to identify systemic or management issues
- to identify statewide issues and provide guidance to mental health services to help reduce and prevent deaths and provide safe and effective services.

Reportable deaths in 2017–18

In 2017–18 mental health services reported 371 deaths, of which 36 were inpatient deaths. The comparable numbers of reportable and inpatient deaths in 2016–17 were 391 and 36 respectively. This represents a reduction in the rates of reportable deaths per 100,000 Victorian population from 6.34 in 2016–17 to 5.92 in 2017–18 (Table 4). The rate of death of people receiving care in a community setting within the three months prior to death was 5.35 per 100,000 population compared with 5.76 for 2016–17.

Of the 371 notified deaths in 2017–18, 283 were categorised as unnatural or unexpected deaths, 71 as deaths due to natural causes and two as deaths of unknown cause (Table 5). Most unnatural or unexpected deaths arose in the 20–59-year age group. Natural deaths were more frequent in older age groups.

Of the 36 deaths of inpatients, 21 were categorised as having unnatural or unexpected causes, including 12 suicides (compared with 11 suicides in 2016–17). The remaining 15 deaths resulted from natural causes. Five of the 12 suicides occurred within an inpatient unit. Others took place while on leave from an inpatient unit, after absconding from an inpatient unit, while waiting in an emergency department for a bed to become available, or within 24 hours of discharge.

Table 4: Reportable deaths per 100,000 Victorian population, 2013–14 to 2017–18

Reportable deaths	2013–14	2014–15	2015–16	2016–17	2017–18
Community deaths	5.36	4.81	5.70	5.76	5.35
Inpatient deaths	0.34	0.45	0.51	0.58	0.57
All deaths	5.70	5.26	6.21	6.34	5.92

Table 5: Reportable deaths by category, 2013–14 to 2017–18

Reportable deaths by category (%)	2013–14	2014–15	2015–16	2016–17	2017–18
Unnatural, unexpected	78%	75%	58%	71%	76%
Natural	19%	20%	31%	28%	19%
Not established	2%	5%	11%	1%	5%

The OCP views every suicide in care as potentially preventable. Every number represents a person who has suffered and left behind family and loved ones. The Safewards program (described earlier in this report) promotes greater engagement with inpatients from mental health clinicians with a view to addressing the concerns that might prompt thoughts of self-harm. In addition, services now regularly audit mental health inpatient units to identify and remediate physical elements of buildings that present risk. Within the community, initiatives such as the Hospital Outreach Post-suicidal Engagement (HOPE) project seek to reduce the numbers of suicides of people who presented to emergency departments after an episode of self-harm or with suicidal ideation.

Restrictive interventions – adult inpatient units

Restrictive interventions are defined in the Mental Health Act as the use of seclusion or bodily restraint. Seclusion is 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave' (s. 3(1)). Bodily restraint is 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs' (s. 3 (1)).

The Act provides that a person may only be placed in seclusion or restraint to prevent imminent and serious harm to the person or another person or, in the case of restraint, to administer treatment. The principles outlined in the Act specify that people receiving mental health services should be treated in the least restrictive way possible, meaning that seclusion and restraints can be applied only after all reasonable and less restrictive options have been tried or considered and been found unsuitable.

The Chief Psychiatrist and Chief Mental Health Nurse share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services, in alignment with the *Fifth national mental health plan*. A number of Victorian Government initiatives, such as Safewards, aim to encourage alternative clinical practices. Safewards and other initiatives that contribute to these efforts are described in section 1 of this report.

Data on the use of restrictive interventions are shown separately for inpatient and secure extended care units (SECUs). As a result, the numbers of events listed below cannot be compared directly with those listed in reports prior to 2016–17. This change in practice standardises Victorian reporting modalities across a number of formats.

Seclusion

Table 6 lists the numbers of episodes of seclusion in acute inpatient units per 1,000 occupied bed days. Rates have fallen significantly across the adult, child and youth and specialist clinical program areas over the past five years. Rates for these program areas, as well as the aged mental health portfolio, were uniformly below the current statewide maximum benchmark of 15 or fewer seclusion episodes per 1,000 occupied bed days. The high rate of seclusion evident in the forensic program is of concern. The rate, which has been monitored closely throughout the year, has been driven by the high acuity of illness among a small number of people for whom seclusion has been necessary to ensure their own and staff safety. The OCP works closely with Forensicare to develop strategies to reduce the use of restrictive interventions.

Table 6: Seclusion episodes per 1,000 occupied bed days, by clinical program, 2013–14 to 2017–18

Clinical program	2013–14	2014–15	2015–16	2016–17	2017–18
Adult	12.3	10.3	11.9	11.3	10.4
Aged	1.3	0.8	1.0	1.8	1.2

Clinical program	2013–14	2014–15	2015–16	2016–17	2017–18
Child and youth	6.8	5.5	5.5	5.4	8.8
Forensic	12.3	11.7	13.1	28.7	34.1
Specialist	12.2	2.2	0.5	3.1	0.6
All programs	9.8	8.0	9.1	9.9	9.7

Table 7 shows that 64 per cent of the people subject to seclusion in 2017–18 were secluded on a single occasion across their period of admission. Multiple episodes of seclusion were relatively uncommon.

Table 7: Frequency of seclusion episodes within a single admission, 2013–14 to 2017–18

Number of episodes	2013–14	2014–15	2015–16	2016–17	2017–18
1	845	860	903	950	894
2	264	253	260	258	242
3	101	94	118	96	119
4	60	54	61	54	54
5	31	35	52	35	30
6	26	15	20	28	23
7+	81	49	76	77	70

In 2017–18, seclusion episodes that lasted four or fewer hours accounted for 43 per cent of all episodes (Table 8).

Table 8: Duration (hours) of acute inpatient seclusion episodes, 2013–14 to 2017–18

Duration	2013–14	2014–15	2015–16	2016–17	2017–18
Fewer than 4 hours	1,671	1,509	1,735	1,624	1,506
4–12 hours	756	646	730	862	908
More than 12 hours	773	533	660	995	1,065

Restraint

Bodily restraint refers to physical restraint (placing hands on a person to restrict movement) and mechanical restraint (the use of devices, such as belts, for the same purpose). Applying mechanical restraint typically entails the use of physical restraint for very brief periods. The Act requires that mental health services inform the Chief Psychiatrist of both physical and mechanical restraint.

Table 9 shows bodily restraint episodes per 1,000 occupied bed days in acute inpatient units over a four-year period. Rates fell in adult inpatient units (the largest clinical program) and in most other programs. The increased rate in aged mental health units reflects a clearer understanding of, and compliance with, reporting requirements achieved through close engagement with the OCP throughout 2016–17.

Table 9: Bodily restraint episodes per 1,000 occupied bed days, 2014–15 to 2017–18

Program	2014–15	2015–16	2016–17	2017–18
Adult	1.5	10.0	9.8	8.4
Aged	0.0	6.3	5.0	7.3
Child and youth	0.1	29.5	13.9	17.8
Forensic	7.8	84.4	172.4	115.8
Specialist	2.2	1.5	1.8	1.1
All programs	1.9	17.5	25.6	19.0

In 2017–18, 57 per cent of people who were subject to restraint (whether physical or mechanical or both) were restrained on a single occasion within a period of admission (Table 10).

Table 10: Frequency of restraint episodes within the same hospital admission, 2014–15 to 2017–18

Number of episodes	2014–15	2015–16	2016–17	2017–18
1	835	809	843	867
2	214	274	210	276
3	85	98	98	113
4	53	59	69	65
5	29	39	28	34
6	23	17	26	26
7+	126	116	124	133

The number of all types of restraint episodes rose between 2016–17 and 2017–18, most probably reflecting improved reporting of the very brief periods of physical restraint associated almost invariably in the move to seclusion or the administration of injected medications (Table 11).

Table 11: Type of restraint episodes, 2014–15 to 2017–18

Restraint type	2014–15	2015–16	2016–17	2017–18
Physical	5,029	7,380	6,433	8,321
Mechanical	778	1.049	496	350
Physical and mechanical	523	1.062	301	169

Following from this, the number of episodes of any type of restraint in excess of 12 hours has fallen by 63 per cent relative to 2014–15 (Table 12).

Table 12: Duration of physical, mechanical and combined restraint episodes, 2014–15 to 2017–18

Duration	2014–15	2015–16	2016–17	2017–18
Fewer than 3 minutes	2,539	4,978	3,479	4,807
3–14 minutes	2,750	3,825	3,010	3,423

Duration	2014–15	2015–16	2016–17	2017–18
15–59 minutes	597	339	325	339
1 to fewer than 4 hours	223	186	282	163
4 to fewer than 12 hours	107	73	89	66
12 or more hours	114	90	45	42

Appendix: Restrictive interventions in secure extended care units

Data on the use of restrictive interventions in SECUs is provided separately.

Table A1 shows that seclusion episodes per 1,000 occupied bed days in SECUs increased relative to 2016–17 but is still well below the levels reported in 2013–14.

Seclusion

Table A1: SECU seclusion episodes per 1,000 occupied bed days, 2013–14 to 2017–18

Seclusion episodes	2013–14	2014–15	2015–16	2016–17	2017–18
Number of episodes	4.2	2.8	2.0	2.5	2.7

Of the people subject to seclusion within a SECU, 71 per cent were secluded on one or two occasions across the whole period of admission (Table A2).

Table A2: Frequency of SECU seclusion episodes within the same admission, 2013–14 to 2017–18

Number of episodes	2013–14	2014–15	2015–16	2016–17	2017–18
1	20	21	24	19	21
2	10	7	6	9	11
3	7	4	2	4	4
4	4	2	2	2	3
5	2	1	–	–	1
6	–	3	1	1	2
7+	3	4	1	3	3

Well over half of all episodes (68 per cent) of seclusion were for fewer than four hours (Table A3).

Table A3: Duration (hours) of SECU seclusion episodes, 2013–14 to 2017–18

Duration	2013–14	2014–15	2015–16	2016–17	2017–18
Fewer than 4 hours	82	71	47	41	68
4–12 hours	44	32	19	37	28
More than 12 hours	25	9	19	25	26

Restraint

In 2017–18 the use of restraint in SECUs returned to former levels after a reduction in the previous year (Table A4). The frequency of multiple restraint episodes within a single admission period also increased (Table A5). Most episodes involved physical rather than mechanical restraint (Table A6) and just over half (58 per cent) were for fewer than three minutes (Table A7).

Table A4: SECU bodily restraint episodes per 1,000 occupied bed days, 2014–15 to 2017–18

Bodily restraint episodes	2014–15	2015–16	2016–17	2017–18
Number of episodes	2.6	3.0	2.2	2.9

Table A5: Frequency of SECU restraint episodes within the same admission, 2014–15 to 2017–18

Number of restraint episodes within the same admission	2014–15	2015–16	2016–17	2017–18
1	18	14	27	17
2	10	6	2	4
3	2	4	1	8
4	1	2	3	2
5	4	1	–	1
6	2	–	–	1
7+	1	5	4	5

Table A6: Type of SECU restraint episodes, 2014–15 to 2017–18

Restraint type	2014–15	2015–16	2016–17	2017–18
Physical	105	103	85	121
Mechanical	1	19	5	7
Physical and mechanical	–	5	2	–

Table A7: Duration of SECU physical, mechanical and combined restraint episodes, 2014–15 to 2017–18

Duration	2014–15	2015–16	2016–17	2017–18
Fewer than 3 minutes	55	55	40	58
3–15 minutes	47	50	44	58
16–59 minutes	3	20	4	8
1 to fewer than 4 hours	1	1	3	3
4–11 hours	–	1	1	1
12 or more hours	–	–	–	–

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 3

This is the attachment marked 'Goulburn Valley Child and Youth Mental Health Service: Chief Psychiatrist's Report' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Goulburn Valley Child and Youth Mental Health Service:

Chief Psychiatrist's Report

October 2016

VICTORIA State Government | Health and Human Services

Contents

Executive summary

A recent review by the Goulburn Valley Health Area Mental Health Service identified staff and stakeholder concerns about its Child and Youth Mental Health Service.

In response to these concerns, the Victorian Chief Psychiatrist has worked closely with the service to clarify the underlying issues and help develop and implement a service redevelopment plan. This is consistent with the role of the Chief Psychiatrist, under the *Mental Health Act 2014*, to provide clinical leadership and expert clinical advice to mental health service providers and promote continuous improvement in the quality and safety of mental health services.

The Chief Psychiatrist is now confident that the service has a strong understanding of the challenges and opportunities for the Child and Youth Mental Health Service, and a clear plan to embed necessary clinical governance and practice changes. Key elements of this plan are:

Staff recruitment and retention strategy:

- There will be a sustained focus on actively recruiting to vacant positions, including the use of agency staff and short term secondments from other services.

Active management of the care pathway:

- The service will maintain a new system of holding a daily review meeting, including a videolink with Seymour staff, to assess and allocate all new cases.
- Each case manager will continue to regularly review his/her entire case load with the consultant psychiatrist and/or manager as part of the supervision process.
- There will be ongoing monitoring of the average time from triage to first appointment.

Intensive clinical oversight of complex, high need cases:

- Complex, high-need clients and families will continue to be discussed in clinical supervision and at a twice-weekly management meeting, with actions minuted and allocated.

Staff supervision and support:

- High-quality, discipline-specific supervision will be provided to all case managers, with arrangements made to purchase this externally if capacity does not exist within the service.

Consumer and carer participation:

- The service will develop and implement a plan for significant consumer and carer engagement, particularly the redevelopment process.

Documentation of policies, procedures and clinical records:

- The service will document its policies and procedures and maintain high standards of clinical record-keeping.

The Chief Psychiatrist will continue to work in partnership with the mental health service throughout the life of the redevelopment. He has asked the Divisional Clinical Director, Associate Professor Ravi Bhat, to provide updates via videoconference every fortnight or more frequently when required. The Chief Psychiatrist will also review documentation as it is developed for the new service delivery model and organisational structure, and visit the service as needed to review implementation progress.

The Chief Psychiatrist has appreciated the willingness of the mental health service to collaborate with his office to ensure that children and young people, and their families, in the Goulburn Valley receive high quality mental health treatment.

Introduction

The Victorian Chief Psychiatrist is working closely with Goulburn Valley Health to address issues relating to its Child and Youth Mental Health Service (CYMHS).

This report describes the outcomes of the collaboration, including key findings and progress to date, and outlines next steps to consolidate redevelopment of the CYMHS.

Background

On 5 August 2016, the Goulburn Valley Area Mental Health Service alerted the Chief Psychiatrist to concerns about its mental health services for children and young people. This followed a review of the CYMHS that identified a need for better operational oversight, stronger community partnerships, and systems to ensure timely access to high quality services.

In response to the concerns, the Victorian Chief Psychiatrist has worked closely with the service to examine the underlying issues and help develop and implement a service redevelopment plan. This is consistent with the role of the Chief Psychiatrist, under the *Mental Health Act 2014*, to provide clinical leadership and expert clinical advice to mental health service providers and promote continuous improvement in the quality and safety of mental health services.

On 15 August 2016, the Chief Psychiatrist conducted a video conference with senior clinical staff and managers of the service to develop a clear understanding of the issues. The Chief Psychiatrist visited the service on 19 August 2016 to ensure it had commenced appropriate corrective action and to discuss further strategies to improve the CYMHS and its relationships with stakeholders.

Subsequently, the service has demonstrated a willingness to work with the Chief Psychiatrist and a commitment to develop and imbed clinical governance and practice reforms into its CYMHS, which are strongly supported by the Chief Psychiatrist

Key issues

Challenges and opportunities for the CYMHS were examined in a formal review of the Child and Youth Mental Health Service initiated by Goulburn Valley Health earlier this year. The review included:

- participation by the staff team in a process to identify problematic issues within the service
- an online Child and Youth Mental Health Service user experience survey
- analysis of the Choice and Partnership Approach (CAPA), a demand management model used by the CYMHS (and several other Victorian CYMHS).

The review, and subsequent engagement with the Chief Psychiatrist, highlighted the following issues.

Choice and Partnership Approach

The Choice and Partnership Approach is a widely-known model of care developed in the United Kingdom. It encourages the use of brief interventions and service partnerships to help young people and their families establish clear goals and access appropriate services. In the first 'choice' appointment, the clinician seeks to understand what the young person and his or her family want to change – the goals of the intervention – and shares ideas about possible choices that may be helpful in reaching these goals.

While advocates claim that the CAPA achieves faster and better outcomes than other service delivery models, and better use of specialist resources, its success depends on a timely and responsive mental

health service and good partnerships with other agencies in the community. The CAPA also requires strong clinical supervision and systems to help clinicians actively manage their caseloads so that they can continue to take new referrals.

There were significant gaps in the implementation of CAPA in the Goulburn Valley CYMHS. Broadly, these related to workforce pressures, gaps in governance, and inadequate attention to community and stakeholder partnerships.

Workforce pressures

Goulburn Valley Health is not immune to the challenges faced by most regional services in attracting and retaining a skilled mental health workforce. This year, the CYMHS has experienced staff shortages as a consequence of issues occurring within the CYMHS, vacancies across Goulburn Valley Health's whole Area Mental Health Service, and normal attrition.

Gaps in clinical governance

Although the CAPA is highly regarded, a known risk of the model is that services can become pressured by demand unless there is robust clinical oversight, staff supervision and support for discharge of clients who no longer require specialist mental health services. Unfortunately, the necessary governance systems were not implemented at the Goulburn Valley CYMHS, resulting in a significant waiting list for non-urgent first appointments and further long waiting times for the second appointment for those identified as needed further treatment.

Inadequate development of community and stakeholder partnerships

The CYMHS received challenging feedback from its stakeholders in response to stakeholder surveys and interviews. Representatives of local community services perceived that CYMHS had difficult entry processes, a problematic organisational culture, and a lack of documented systems and staff supervision.

Redevelopment directions and progress to date

An interim Operations Director of the Goulburn Valley Area Mental Health Service was appointed in May 2016, and has helped oversee the change management processes within the CYMHS.

Reforms to address the issues of concern are outlined below. Key actions identified by the Chief Psychiatrist are shown in italics at the start of each section.

Workforce retention and recruitment strategy

There will be a sustained focus on actively recruiting to vacant positions, including the use of agency staff and short term secondments from other services.

The mental health service has developed an interim and long term workforce retention and recruitment plan for the CYMHS.

It has put in place an interim (approximately three-month) structure that involves CYMHS clients being distributed between other programs in the mental health service. Broadly, young children will be allocated to the primary mental health team, Early Psychosis Service clients to Headspace, and clients requiring acute responses or Intensive Mobile Outreach Services to the adult program.

This will allow CYMHS time to recruit for the long-term. The service has begun advertising and interviewing for a number of positions, and has already employed one new clinician for commencement in December 2016. It has also increased the hours of part-time clinicians, where possible. At the Chief Psychiatrist's suggestion, the Clinical Director has sought advice on recruitment

and retention strategies from a respected psychologist and manager from another service for children and young people.

The increased focus on support and supervision for CYMHS staff, and improved stakeholder relationships, are expected to have flow on benefits for recruitment and retention. The service is already reporting that changes to structure, processes and procedures are having a positive impact on staff morale.

Clinical governance reforms

Active management of the care pathway

The service will maintain a new system of holding a daily review meeting, including a videolink with Seymour staff, to assess and allocate all new cases.

Each case manager will continue to regularly review his/her entire case load with the consultant psychiatrist and/or manager as part of the supervision process.

There will be ongoing monitoring of the average time from triage to first appointment.

Triage

Goulburn Valley Mental Health Service operates a centralised triage service for all age groups, and uses the Mental Health Triage Scale common to all public clinical mental health services in Victoria.

Staff of the CYMHS had concerns about clinicians without CYMHS experience and expertise triaging children and young people as being at higher levels of immediate risk than warranted, and about the applicability of the Mental Health Triage Scale for this age group.

These concerns are being addressed through a process in which inappropriate referrals from triage are centrally logged by the CYMHS and reviewed by senior clinicians. Where required, feedback is provided to triage clinicians to improve their future practice. The continuing education of triage clinicians is also being achieved through a template, previously developed by CYMHS clinicians, to assist in the triage of children and young people. A CYMHS clinician also works part time with the triage service and facilitates understanding of issues for this age group.

Waiting list management and service intake

Responding to concerns about long waiting times for appointments and lack of follow-up of people on the waiting list, the interim CYMHS manager had contacted all young people and families on the waiting list, assessed their needs, and arranged appointments. A system has been put in place whereby all new referrals are discussed at a daily meeting attended by all clinical staff, including Seymour staff via video conference. Screening registers for new clients are printed out and allocated to a clinician at this meeting, eliminating the time previously taken between receipt of a referral and allocation to a clinician.

The CYMHS has also discontinued its previous practice, inherent in the CAPA model, of conducting a first appointment with the rostered clinician and then referring the case to a different clinician for further therapeutic interventions in line with the clinician's specialisations. The new arrangement has the same clinician responsible for both the initial assessment and further follow up appointment.

While these changes have reduced system inefficiencies, it will take some time for the service to its build its capacity, particularly with current staff vacancy levels.

Transition planning and discharge

The capacity to discharge clients from the CYMHS – for example, by supporting their transition to other services – has been limited by clinicians' high caseloads and competing demands (such as new assessments and acute responses), inadequate supervision of caseloads and management of workflows, and lack of community partnerships.

In response, the CYMHS has developed a system in which the interim manager and the Clinical Director (or another Consultant Psychiatrist) conduct regular caseload reviews with individual clinicians. The Clinical Director is supporting transition planning by being available to review children and adolescents prior to discharge.

Regular review of complex, high need cases

Complex, high-need clients and families will continue to be discussed in clinical supervision and at a twice-weekly management meeting, with actions minuted and allocated.

A clinical governance group has been established that includes the Divisional Operations Director, Divisional Clinical Director service managers, senior clinicians, the Consultant Psychiatrist and Clinical Director of CYMHS. This group meets twice weekly to identify and discuss complex, high need clients and families, including existing clients whose mental health has deteriorated. The meeting follows an agenda and minutes are recorded. The group delegates actions to a relevant clinician to ensure that a clear plan for each client is developed, including the level and frequency of contact required, liaison with community services, and the process for escalation if the situation deteriorates further. .

Supervision of case managers

High-quality, discipline-specific supervision will be provided to all case managers, with arrangements made to purchase this externally if capacity does not exist within the service.

Although the Area Mental Health Service has longstanding arrangements for discipline-specific clinical supervision, there were concerns that responsibility for supervision of CYMHS clinicians was falling to too few senior clinicians and that CYMHS social workers were not receiving discipline-specific supervision due to the absence of a senior social worker.

This has been reviewed as part of a service-wide strategy. The CYMHS now has arrangements in place for supervision by discipline seniors for all disciplines, with the exception of social work. The service has undertaken to ensure that external social work supervision is purchased as soon as possible from an alternative provider.

Consumer and carer participation

The service will develop and implement a plan for significant consumer and carer engagement, particularly the redevelopment process.

The Chief Psychiatrist emphasised the uniqueness of the CYMHS consumer and carer experience and the importance of the service having its own consumer and carer consultants. Currently, while the CYMHS has its own carer consultant, the Goulburn Valley's consumer consultant operates across the whole mental health service.

In response to the Chief Psychiatrist's request for a sustainable consumer and carer participation plan, the Divisional Clinical Director expressed his intention to work towards co-design of the CYMHS with consumers and carers. The successful youth advisory council established by headspace will play a role.

Documentation of policies, procedures and clinical records

The service will document its policies and procedures and maintain high standards of clinical record-keeping.

It is important that there is documentation of all new policies and procedures so that the improved practices will continue even when current staff members leave the service.

The service has contracted an external consultant to operationalise the redesign process, with a focus on documentation of policy and procedures. The new policies and procedures will include a system for random file audits, to promote good clinical record-keeping and monitor adherence to established policies and procedures.

Stakeholder liaison and communications plan

The service will develop and document a formal stakeholder liaison and communication plan.

Goulburn Valley CYMHS has begun a process of identifying and prioritising key relationships and developing a plan for stakeholder engagement (for example, regular meetings, advisory groups, and clinical care planning meetings).

The service has identified its relationship with Child Protection as an immediate priority. It has commenced regular high level communication with the Regional Manager Child Protection Services and plans to strengthen links with key child welfare agencies. Recognising the importance of partnerships with schools, the service has earmarked funding to consolidate its relationship with the education sector.

Conclusion and next steps

The Chief Psychiatrist is satisfied that the Goulburn Valley Health Area Mental Health Service is making progress in improving the accessibility, responsiveness and quality of its Child and Youth Mental Health Service.

The service has demonstrated a strong commitment to working with the Chief Psychiatrist and the local community to ensure it can deliver high-quality mental health services for children, young people and their families. Service leaders have undertaken to manage the change process with open communication and to tight timeframes.

For the short-term, the service has put in place an interim structure to strengthen clinical governance and utilise staff and resources to maximum efficiency while recruitment and redesign of the service is in progress. The service anticipates that a new rebranded CYMHS model of care will be launched in December 2016 and will commence in January 2016 to coincide with the start of the new school year. The service plans that the implementation of this new model of care will include frequent and regular communication with staff and other key stakeholders. The model of care will be reviewed after three months, six months and 12 months.

The Chief Psychiatrist will continue to monitor the quality and safety of the Goulburn Valley CYMHS, with a particular focus on the key areas identified in this report. This will be achieved through continued fortnightly video conferencing during the redevelopment, visits to the service, and reporting requirements. The Chief Psychiatrist will also assist as required in providing clinical leadership and review of the redesign and operation of the new service.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 4

This is the attachment marked '*Chief Psychiatrist guideline and practice resource: family violence* (June 2018)' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Chief Psychiatrist's guideline and practice resource: family violence

VICTORIA State Government | Health and Human Services

Acknowledgement

This guideline was developed with the assistance of the Chief Psychiatrist Guideline Family Violence Project Advisory Group (2017).

To receive this publication in an accessible format phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email <ocp@dhhs.vic.gov.au>

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.
© State of Victoria, Department of Health and Human Services, June 2018.
ISBN 978-1-76067-442-5

Available from the Chief Psychiatrist's webpage <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Contents

Summary

This guideline outlines the Chief Psychiatrist's expectations of Victorian public mental health services regarding family violence. It provides guidance for services about responding to people who experience family violence and improving the way they work with people who perpetrate family violence.

The guideline is part of the Victorian Government's response to the recommendations of the Royal Commission into Family Violence.[1] The royal commission highlighted the unique opportunities of health and mental health professionals to identify and intervene in family violence. It specifically recommended that the Chief Psychiatrist issue a guideline relating to family violence.

Key messages

Family violence is a fundamental violation of human rights and is unacceptable in any form.

Mental health services have a responsibility to address family violence. Mental health clinicians are expected to become skilled in recognising, understanding, enquiring about and responding to family violence. They are not expected to become family violence specialists.

Mental health services can identify and respond to family violence by:

- supporting those experiencing family violence
- facilitating safety and protection, especially of children
- holding those who perpetrate violence accountable.

Effective responses to the needs of women, children and others experiencing family violence should be integrated into usual mental health care. Equally, responding to people who perpetrate violence must be part of mental health care.

Members of mental health services' leadership groups have a responsibility to:

- undertake introductory training on family violence
- ensure family violence training and supervision is accessible to all clinicians
- create an authorising environment and provide leadership
- develop effective organisational policies and procedures for identifying and responding to family violence
- proactively support collaboration and partnerships with other service providers
- ensure the organisation follows the new Family Violence Information Sharing Scheme, the Child Information Sharing Scheme and the updated Family Violence Risk Assessment and Risk Management Framework ('FV framework') (from September 2018)
- ensure the organisation supports staff who are experiencing family violence.

Mental health clinicians have a responsibility to:

- undertake necessary family violence training and professional development appropriate to their level and role (including changes to be introduced under new information-sharing schemes and the new FV framework
- identify and respond to people who experience and those who perpetrate violence
- actively consult senior clinicians, supervisors or specialist family violence services to optimise their response.

Introduction

Every year, tens of thousands of Victorians are the victims of violence in their homes

Family violence takes many forms and covers a wide spectrum of behaviour. It includes physical, sexual, psychological, financial and emotional abuse or coercion, and other behaviours that hurt, frighten, intimidate, humiliate or isolate another person. Appendix 1 contains a full definition of family violence from the Family Violence Protection Act 2008 (Vic).

Examples of family violence include stalking, neglect and abuse of children, cruelty to pets, damage to property, financial abuse and preventing a person from interacting with others.

Perpetrators' attempts to exercise power and control over another person can escalate over time. Although every experience is unique, family violence is not a one-off incident for most victims/survivors. Family violence is understood as a pattern of repeated and coercive control, aiming to control another person's thoughts, feelings and actions.

While family violence remains one of the most underreported crimes, police data show alarmingly high rates of violence. Victoria Police recorded 76,497 family violence incidents in 2016–17, with women comprising three-quarters of the victims. Family violence accounts for 17.5 per cent of all crime in Victoria.

Family violence is a major public health problem across the world and is associated with many serious physical and mental health impacts.

Most victims of family violence are women and children and most perpetrators are men. However, both men and women can be perpetrators or victims of family violence (see the box on the following page). The most common and pervasive instances of family violence occur in intimate partner relationships. Gender inequality has been identified as the leading cause of family violence, particularly intimate partner violence.

However, violence can occur in all types of families, kinship networks and intergenerational relationships. Lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people experience violence in their relationships. Family violence can be perpetrated by young people against their parents or siblings, or by adult children against their elderly parents (elder abuse). Some family members and non-family carers perpetrate violence against people they care for, and violence is sometimes perpetrated against carers.

Certain people or communities are at higher risk of experiencing family violence. They are also more likely to experience barriers to accessing services or to receiving an appropriate response. The section on 'diversity and intersectionality' in this guideline provides further information.

Note

This guideline has been developed at a time of significant change following the royal commission's report and recommendations.

Some of the most significant changes relate to the Family Violence Risk Assessment and Management Framework ('FV framework', commonly referred to as 'CRAF' (*Crisis risk assessment framework*)), the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme.

Changes to information sharing has a focus on increasing the safety of victims/survivors and removes certain consent requirements if safety is at risk, especially children's safety.

While new legislation was introduced in February 2018, mental health services will be 'prescribed' to follow these changes by September 2018.

Information about changes, training, roles and responsibilities will be provided by Family Safety Victoria and the Centre for Workforce Excellence.

The gendered nature of family violence

Family violence is predominately perpetrated by men against women and children.[2]

In Australia, one in four women has experienced violence from an intimate partner.[3]

On average, at least one woman dies at the hands of a current or former partner every week.[4]

One in five women has experienced sexual violence, and 92 per cent of women who are physically assaulted by a male know the perpetrator – commonly (41 per cent of cases) this is a former partner.[3]

One in four children experiences family violence.[5]

While women are more likely to experience violence by a known person rather than a stranger, the reverse is true for men.[6]

Women are eight times more likely to experience sexual violence by a partner than men.[3]

Around 95 per cent of victims of all types of violence – whether women or men – experience violence from a male perpetrator.[7]

Three out of four affected family members (victims) are female, while one in four is male.[8]

One in 12 men in Australia (694,100 or 8 per cent) has experienced violence by a female intimate partner.[6]

Intimate partner violence contributes to more death, disability and illness in women aged 15–44 than any other preventable risk factor, including smoking and obesity.[9]

There are times when women and their children are at greater risk of intimate partner violence. For example, young women (18–24 years) experience significantly higher rates of physical and sexual violence than women in older age groups[3] and women are at higher risk of intimate partner violence during pregnancy and shortly after birth.[10]

Women with disabilities or long-term health conditions are more likely to experience violence.[6]

Women with mental illness experience higher rates of violence than those without mental illness.[11]

About this guideline

The guideline outlines expectations of mental health services managers and clinicians regarding their roles in responding to family violence.

Language

The term 'victim/survivor' is used to refer to those who experience family violence, reflecting the advice of the Victorian Government's Victim Survivors' Advisory Council.

The term 'perpetrator' is used to describe people who use family violence.

In this document, the word 'family' encompasses and acknowledges the variety of relationships and structures that can make up a family unit and the range of ways family violence can be experienced, including through family-like or carer relationships.

The term 'Aboriginal' is used to refer to both Aboriginal and Torres Strait Islander people.

The term 'clinician' is used to describe all who are involved in a person's mental health care. It is acknowledged that lived experience staff do generally not identify as clinicians. They are, however, included under the umbrella term 'clinician' in this document.

Appendix 1 provides further definitions of terms used in this document.

Scope and focus

The guideline applies to publicly funded clinical mental health services in Victoria, including all service settings (mental health inpatient units, community teams, subacute services, residential services, emergency departments and general hospital inpatient units) and services delivered in people's own homes. The document may also be used by private mental health services and mental health community support services; however, the Chief Psychiatrist does not direct these services.

The guideline focuses predominately, but not exclusively, on women and children as the main victims/survivors. Other forms of family violence are recognised, and the guideline provides information and practice suggestions to work with diverse groups, including men who use violence.

Sections

While the guideline can be read in its entirety, it has been organised into different sections that can be lifted out, copied and used in practice as prompts. The key messages, for example, could be copied and displayed to remind all clinicians of their responsibilities.

Section title	Focus	Greatest relevance
Summary	Short summary of the document's purpose and key messages	Management and clinicians
Introduction	Background information about family violence and introduction to the document	Management and clinicians
Guiding principles	Principles underpinning the guidelines	Management and clinicians
Organisational responsibilities	Responsibilities of the service's leadership group, including management, family violence sponsors and senior clinicians	Management
Clinical practice	Guidance and expectations of mental health service provision for clinicians, including practical examples and advice.	Clinicians
Appendices	Abbreviations and definitions; organisational checklist; key policies, guidelines and initiatives; practice resources; clinical checklist; myths about family violence	Management and clinicians

The Royal Commission into Family Violence

The Royal Commission into Family Violence report 2016[1] outlines 227 recommendations addressing a wide range of gaps across Victoria's service system. This guideline responds specifically to recommendation 97, which states that:

> 'The Chief Psychiatrist issue a guideline relating to family violence – including that family violence risk should be assessed when considering discharging or transferring care of a person receiving mental health services and when consulting with families or carers in relation to treatment planning.'

The guideline is also connected to recommendation 102, which states that the Chief Psychiatrist – in consultation with the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Psychiatrists and psychologists' peak bodies – coordinate the development of a family violence learning agenda. Findings from the project to develop this guideline will inform understanding of training needs in the mental health sector.

The guideline is just one component of the Victorian Government's response to the royal commission's report. The government's *Ending family violence: Victoria's plan for change*[12] outlines a vision of a Victoria free from family violence and a commitment to implementing all the royal commission's recommendations. Key reforms being progressed as part of this 10-year plan include:

- establishing 'Support and Safety Hubs' ('The Orange Door')
- the new Family Violence Information Sharing Scheme and Child Information Sharing Scheme
- reviewing and redeveloping Victoria's FV framework
- introducing routine antenatal screening for family violence
- an integrated model of care for responding to suspected elder abuse
- establishing the Centre for Workforce Excellence (within Family Safety Victoria), the *Family violence 10-year industry plan* and the *Responding to family violence capability framework*
- implementing the Strengthening Hospital Responses to Family Violence initiative across the state
- establishing family violence advisor roles in mental health services and alcohol and other drug (AoD) services
- introducing a broader range of interventions targeting perpetrators.

The impact of family violence on infants, children and young people

Approximately one in four children experiences family violence.[3] Recent data reflects that more than half of the women who experience violence had children in their care when the violence occurred, with more than three-quarters of children witnessing the violence.[3]

Children can be direct and indirect victims of family violence. The terms 'living with' and 'experiencing' family violence best describe the circumstances for a child in this environment.

Experiences of family violence include:

- suffering physical harm; for example, if a mother is holding a child when she is attacked; if a child is trying to protect his or her mother; or the child is the target of the violence
- feeling scared of those who they love
- seeing the consequences of physical violence
- having belongings destroyed
- distress caused by harm to a pet or threats that their pet will be harmed
- not being allowed to bring friends home or being unwilling to bring friends home because of shame they will witness family violence
- isolation from extended family
- feeling responsible for the violence
- disruptive schooling because of absences or changing schools
- having a parent who is struggling in their parenting role due to experiencing violence.

Some perpetrators use children or young people to maintain power and control. For example, a father who is perpetrating family violence might:

- use the child as a means of ensuring the mother returns home
- force the child to watch or participate in assaults
- interrogate or involve the child in spying on their mother
- undermine the mother by encouraging the child to have negative opinions of her.[1, 13]

Family violence trauma can disrupt child development and healthy attachment and compromise brain development.[14] The notion of children 'being too young to understand' has been challenged in the research literature on the impacts of family violence trauma. Children do not need to understand or have language to feel the impact of violence. Even if it is experienced before birth (during pregnancy), family violence has enduring detrimental impacts and significantly increases the risk of mental health disorders at all stages of life.[15]

Manifestations of this trauma include regression – for example, a child wetting the bed after previously having bladder control, developing sleep problems, withdrawing, being anxious or becoming aggressive. Some children develop chronic somatic problems. Older children and young people might engage with risk-taking behaviours such as using drugs or alcohol or experience suicidal ideation or other mental health difficulties.

Experiencing childhood trauma, especially severe trauma, is likely to have many effects on a person, including long-term effects on their mental health. Many people, especially women, who receive a diagnosis of borderline personality disorder have experienced childhood trauma. Complex trauma-related disorders such as borderline personality disorders are frequently not well understood within a trauma framework. This can lead to women with such a diagnosis to move between mental health, sexual assault and family violence services without coordinated support that assists with the impact of early childhood trauma.[16]

Family violence and mental illness

Experiencing family violence has a detrimental effect on mental health

Current and/or previous family violence, including childhood sexual abuse, can cause or exacerbate mental health problems and mental illness.[11, 17] The following studies are part of a large body of evidence showing a relationship between family violence and poorer mental health outcomes:

- An Australian study found that 'women who had experienced gender-based violence are more likely to experience mental illness over the course of their lifetime'. The study also found that 'approximately 77 per cent of women who have experienced three or four types of gender-based violence had anxiety disorders, 56 per cent had post-traumatic stress disorder and 35 per cent had made suicide attempts'. [18]
- A Victorian study found that one-third of people who suicided in Victoria had a history of 'exposure to IPV [interpersonal violence], present in almost half of female suicides and in one third of male suicides'. Women are more likely to be victims/survivors and men are more likely to be perpetrators of family violence. A larger proportion of the 517 women who died (n = 219, 42.4 per cent) had experienced violence than men (*n* = 554, 33.9 per cent).[19]

The main mental health impacts on people who experience family violence are depression, anxiety, post-traumatic stress and suicidal ideation.[20] Almost 60 per cent of the health impact relates to anxiety and depression, with women who experience family violence almost twice as likely to be depressed, anxious or use alcohol.[21] (Conversely, depressive symptoms can increase the risk of experiencing intimate partner violence.) There is also a link between intimate partner violence and postnatal depression.[16] Additionally, many people with other types of diagnoses, including bipolar disorder, psychosis, schizophrenia[16] and eating disorders, have experienced high levels of violence.[22] Many people who have experienced trauma, especially during early childhood, hear voices (this can include 'hearing the perpetrator', defending themselves or internalised shame). While within a mental health service context the existence of voices is generally seen as a symptom of psychosis, hearing voices can also be the effect of abuse (or a combination of psychosis and voices connected to abuse). [23]

Being abused during childhood increases the likelihood of experiencing abuse as an adult. The cumulative effect of different types of abuse over a lifetime increases the likelihood of health and mental health problems and mental illness.

Trauma, complex trauma and trauma informed care and practice

Awareness of the prevalence and impact of trauma has increased greatly in society and within health care over recent years. Trauma can has been defined as 'overwhelming stress. Interpersonal trauma includes sexual abuse, physical and emotional abuse, community and family violence as well as neglect.' [22]

Trauma can affect many areas of a person's life, in particular if it happened during childhood, if the person was not believed or did not receive appropriate support, or if the violence occurred at pre-verbal age. Having experienced trauma, a (perceived) threat can

be enough for a person to feel unsafe or threatened. While the initial experience lies in the past, its effects can be felt as if there was immediate danger (this is called being 'triggered').

Complex trauma is 'cumulative, underlying, and often interpersonally generated'.[24] Understanding the long-term impacts of trauma, in particular the cumulative effects of trauma experienced by many people who access mental health services, forms the foundation of becoming trauma-informed.

Trauma-informed care and practice (TICP) involves a shift to understanding the impact of trauma on a person's life, their health and mental health. TICP has five principles: safety, trustworthiness, collaboration, choice and empowerment. Organisations that apply a TICP framework ensure that these principles are applied throughout policy and mental health care. While this document does not allow for an in-depth look at TICP, organisations are advised to follow current best practice models (such as that provided by the Blue Knot Foundation <http://www.blueknot.org.au>).

People with mental illness as perpetrators of violence – myths and facts

People with mental illness are more likely to be victims than perpetrators of violence and crime

The belief that people with mental illness are likely to perpetrate violent crime is steeped in stigma and discrimination rather than facts.

Population-based studies of the relationship between mental illness and acts of violence have reported mixed findings. While most mental disorders are not related to violence, some studies have found an increased risk of violence by patients with schizophrenia compared with the general population.[25] However, systematic reviews of published research have concluded that most, if not all, of this increased risk is associated with comorbid substance abuse rather than the mental illness per se.[26] Without substance abuse, a person with mental illness is only as likely as anybody else in society to be violent.[27] Mental illness carries far less weight as a predictor of violence than variables such as gender, age and history of offending.[28]

People with a mental illness are more likely to be the victim of violence than to perpetrate violence. Women and men with all types of mental illness diagnoses report higher rates of family violence experiences than those without mental illness. As in the general population, women who use mental health services are more likely to experience family violence than male consumers. Among female consumers, studies report prevalence rates between 23 and 70 per cent, depending on the service setting and the type of abuse experienced. When childhood abuse (including sexual abuse) is considered, prevalence rates are up to 90 per cent for women with mental illness who access acute mental health services.[29]

Even though women are more likely to tell health professionals than others about intimate partner violence, it is rare that such disclosure occurs spontaneously. As discussed in the clinical practice section of this guideline, mental health clinicians must be open to the possibility of family violence, otherwise it is likely to be missed.

Families of people with mental illness

While mental illness is not a strong predictor of violent behaviour, some family members and other carers experience violence from the person with mental illness. Study findings suggest that between 10 and 34 per cent of family members have experienced physical assault by a family member with mental illness.[30,31] In some cases, the violence is directly related to the person's mental illness – for example, when individuals act on delusions such as voices telling them to harm someone. In these cases, addressing the symptoms of mental illness is likely to reduce the risk of violence. For others, the violence is not related to their mental health problems, and they are abusive or violent to their partner or family member irrespective of their mental state.

Conversely, families and other carers might perpetrate violence against the person with mental illness. Data on violence by family members, including carers, against people with mental illness are scarce, except for intimate partner violence (refer to 'the gendered nature of family violence).

In clinical practice, dealing with these forms of violence can be challenging, particularly when family members are involved in the person's care. Balancing the inclusion of family members (as part of good mental health practice) with the fact that family violence is present requires careful consideration of all family members and their safety. The safety of victims/survivors has to be the first priority, ensuring consent is sought and the wishes of the person affected by violence are adhered to.

Guiding principles

Five key principles underpin this guideline:

- responding to family violence
- trauma-informed care and practice
- working with families
- diversity and intersectionality
- collaboration.

Responding to family violence

Responding to family violence is a core element of good mental health practice. Mental health clinicians have a responsibility to enquire about safety and respond to the impacts of current and past family violence on individuals and their children and families. Equally, enquiring about violence and responding to individuals who perpetrate family violence are integral to good mental health practice.

The safety of individuals, whether consumers or family members, who are subject to or at risk of violence must be the first concern when family violence is identified. Ensuring the safety of children affected by violence is paramount, as reflected in the principles of the *Mental Health Act 2014*, the *Children, Youth and Families Act 2005*, the *Family Violence Protection Act 2008* and *Family Violence Protection Act Amendment 2017*.

Trauma informed care and practice

Trauma-informed care and practice creates an environment that is culturally safe and supportive, and which facilitates disclosure of family violence

The TICP approach acknowledges that most people who use mental health services have experienced abuse or other trauma and recognises the impact trauma has had on the person. It provides a way to understand past and current stressors and links these with the person's current level of distress and mental ill-health.

On an organisational level, it means adopting 'cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches'.[32] Trauma-informed organisations ensure all staff (clinicians and others) are well supported to provide trauma-sensitive care and create safer environments for consumers and family members to talk about all forms of abuse, including family violence.

Many people who have experienced trauma can be triggered through a range of circumstances and behaviours. Inpatient units and bed-based services in particular can be spaces that can be re-traumatising for people. A TICP approach includes understanding a person's potential triggers and providing sensitive support when this occurs.

It is acknowledged that consumers can find compulsory treatment under the Mental Health Act re-traumatising.

Even if organisations have not implemented TICP on a system-wide level, elements of TICP can be incorporated into clinical care by individuals and teams.[16, 33]

Working with families

Victoria's mental health legislative and policy frameworks emphasise that engaging and working with consumers' families and carers is part of good mental health practice. The Chief Psychiatrist expects mental health services to:

- in collaboration with the consumer, identify family members and carers and involve them in assessment, treatment and recovery
- be clear about privacy, confidentiality and information-sharing protocols
- respond to the needs of families and carers
- include families and carers in organisational governance
- have clear support and referral pathways (also see the Chief Psychiatrist guideline *Working with families* and carers).[34]

However, in situations where family violence has occurred, or is at risk of occurring, working with affected consumers can be challenging for clinicians. Adhering to principles of family involvement needs to be balanced with the safety of consumers, their children and/or other family members.

If family violence is occurring, clinicians need to respect the victim/survivor's wishes about the involvement of family members. The safety of victims/survivors and their children is paramount and trumps family involvement requirements if this is deemed unsafe by the person experiencing family violence.

If a person with mental illness is, or has been, violent towards their partner or other family members, the safety of family members should be central to decision making. Discharge planning needs to assess levels of safety and risk to family members (refer to 'Discharge planning and transfer of care' in the 'Expectations at different stages of the care pathway' section). Safety concerns expressed by family members need to be taken seriously and their wishes respected.

Experienced clinicians are often able to balance these tensions, while others will require assistance from more senior colleagues (such as their supervisor or manager) and/or consultation with a specialist family violence service.

Diversity and intersectionality

Victoria is made up of many diverse communities. Practising within a diversity framework requires an appreciation of difference beyond the obvious characteristics of an individual.

Although family violence is not part of any culture or unique to any community, people from 'diverse' communities are often confronted with intersecting and compounding risks relating to family violence. Family Safety Victoria's *Diversity and intersectionality framework* states:

> Intersectionality describes how diversity characteristics such as gender ethnicity and cultural background, language, socio-economic status, disability, sexual orientation, religion, age, geographic location or visa status and mental illness can interact on multiple levels to compound risk, create overlapping forms of discrimination and amplify service barriers.[35]

Intersectionality recognises the various ways people can face heightened risks and increased barriers (including systemic barriers) to getting support.[35] An intersectional approach means taking all characteristics or 'identities' of a person into account, including how the person experiences family violence.

Collaboration

> *'The most beneficial responses to people with special/diverse needs are provided when there are strong, collaborative, cross-sectoral partnerships which promote a sharing of expertise between specialist and other services to build capacity'* [36]

An effective response to family violence requires that mental health services work collaboratively with other services such as police, child protection, sexual assault and legal services.

Clinicians should also actively seek out specialist family violence services with specialised family violence knowledge and expertise for consultation, referral and co-working (for example, joint case management).

As well as supporting clinicians' collaborative relationships with other practitioners, mental health services should build relationships with other relevant organisations at a service-to-service level and as part of agency networks addressing family violence.

Organisational responsibilities

Mental health services are expected to have leadership and governance arrangements that enable effective responses to family violence

This section provides information and advice to help mental health services build a 'whole-of-organisation approach' to family violence, as recommended by the Royal Commission into Family Violence. It is targeted to the service's leadership group.

Mental health services are expected to develop their own policies and processes consistent with the broad guidelines provided here and in the *Family Violence Risk Assessment and Risk Management Framework* ('FV framework. These should be incorporated in planning and quality assurance mechanisms, including strategic and business plans. The Strengthening Hospital Responses to Family Violence resources, developed by the Royal Women's Hospital and Bendigo Health, provide more detailed guidance to support this work.[37] Appendix 2 contains a checklist that summarises organisational requirements.

Organisational policies and processes must comply with relevant legislation and Victorian Government policies (see Appendix 3) and be kept up to date with initiatives implemented as part of the government's response to the royal commission's recommendations.

Ideally, members of the leadership group will undertake the appropriate level of induction training delivered through the redeveloped FV framework (due for release in September 2018). In the interim, management may wish to use the one-hour modules of the Strengthening Hospital Responses to Family Violence resources[37] or training provided by the Domestic Violence Resource Centre.

Family violence roles

The new FV framework will outline roles and responsibilities regarding family violence. Consult the framework from September 2018 to clarify these and align with organisational policies and responsibilities outlined here.

Executive sponsor

The mental health service should identify a family violence executive sponsor from within the leadership group. This role is responsible for the organisation's response to family violence in collaboration with the members of the family violence committee.

Family violence committee

The executive sponsor will establish a family violence committee to oversee the implementation of this guideline and develop an organisational project plan and local implementation plans. The executive sponsor and the committee are responsible for aligning organisational policies and procedures with the most current FV framework and tools. The committee should include representatives of all clinical disciplines and people with lived experience (consumers and carers).

Reflective questions

- Have you thought of involving the specialist family violence advisor and the Families where a Parent has a Mental Illness (FaPMI) coordinator on your family violence committee? Have you involved or do you have a plan for involving people with lived experience in this work and on the committee?
- How and when will the committee report to the service's main executive committee?
- What authority do the executive sponsor and the family violence committee have, and where are ultimate decisions made?
- How does this committee relate to lived experience committees?
- Do you have the right combination of people on the committee?
- How will you communicate with the rest of the organisation about this work?

Clinical family violence champions

Mental health services are strongly encouraged to identify clinical family violence champions from a range of different programs and disciplines. Ideally, each team will have at least one clinical family violence champion.

The role of clinical champions is to support and assist other clinicians to identify and respond to family violence. Clinical champions should have sound knowledge of family violence issues and practices, and capacity to support others. Their family violence roles and responsibilities should be written into their position descriptions and performance plans.

Family violence policy

Mental health services are expected to develop a family violence policy or revise their existing policy to ensure consistency with this Chief Psychiatrist guideline and align with the FV framework. In developing or updating policies, it could be helpful to consider other mental health services' policies and/or the Strengthening Hospital Responses to Family Violence sample policy.[38]

Collaboration and partnerships

Collaboration provides both mental health and specialist family violence services with increased access to each other's expertise. Collaboration may also extend to services that are not specialist family violence services but provide family violence specific programs (such as community health services' and services for specific communities). The new Family Violence Information Sharing Scheme and the Child Information Sharing Scheme will provide guidance regarding information sharing between organisations.

The mental health service's leadership group, family violence executive sponsor and family violence committee members are responsible for establishing mechanisms for cross-sector collaboration. Over time, the mental health service will develop more formal agreements about referral pathways and secondary consultation arrangements between services. Liaison with Victoria Police forms part of organisational responsibilities.

If not already established, good working relationships with police need to be established through structured meetings with local police to ensure clear referral pathways and engagement regarding family violence.

Collaboration and partnering with other organisations can also occur by nominating mental health service representatives to cross-service regional family violence committees.

Active participation in Risk Assessment and Management Panels

In line with recommendation 98 of the Royal Commission on Family Violence, mental health services are required to be active participants of their regional Risk Assessment and Management Panel (RAMP). The RAMP is a formally convened meeting of key agencies and organisations that contribute to the safety of victims/survivors (including children) experiencing serious and imminent threat from family violence.

The management leadership group, and ultimately the mental health service's operational manager, is responsible for ensuring continuing participation in the RAMP, including key actions assigned to the mental health service. The family violence committee should receive regular updates on how contributing to the RAMP benefits other organisations, consumers and carers of the mental health service. This also provides an opportunity to review systemic issues highlighted by the RAMP.

Professional development, supervision and support

Mental health clinicians should be trained and supported to integrate family violence enquiry and response into their practice

Training and skills development

Position descriptions for clinical mental health roles need to convey an expectation that incumbents will have or acquire family violence skills and knowledge.

Training on family violence and related organisational policies should be part of induction training for new clinicians, and all clinicians should receive family violence training suited to their level of skill and experience. Senior clinicians are expected to have advanced knowledge and skills in this area. Family Safety Victoria's Centre for Workforce Excellence is central point of information on workforce development.[1]

Mental health services can access training through a variety of means and for different levels of competency. They might decide to access training from an external provider (for example, the Domestic Violence Resource Centre Victoria), an internal health service training unit, the mental health training clusters or the new Centre for Mental Health Workforce Development.

Training will also be provided regarding the new FV framework from September 2018. Staff are expected to participate in training as directed by their organisation.

1 For more information regarding the Centre for Workforce Excellence, see the Family Safety Victoria website <https://www.vic.gov.au/familyviolence/family-safety-victoria/the-centre-for-workforce-excellence.html>.

Clinical supervision

All clinicians, including the lived experience workforce, must have access to discipline-specific supervision. The clinician's usual supervisor is expected to provide supervision that develops skills and confidence in responding to family violence. Organisations need to provide clear expectations of staff about when and how to escalate a family violence situation to a senior staff member, including how to respond to high-risk situations. It is expected that such guidance will form part of an updated family violence policy and guideline. A clinician should not be left holding family violence risk on their own.

Consultation can also be obtained from internal specialist family violence advisors (as available), specialist family violence services or (once established) a Support and Safety Hub ('The Orange Door').[ii]

Support for staff affected by family violence

Prevalence rates of family violence in the general community suggest that many clinicians and other staff will have personal experience of family violence.

The family violence executive sponsor, members of the service's family violence committee and senior clinicians should be familiar with the organisation's policy on supporting staff who experience family violence.

Physical environment

The design of facilities and spaces can support disclosure of family violence. Where possible, the leadership group should make any changes needed to provide safe, private and friendly physical environments. Creating women-only corridors is one example of working towards improving safety for women in psychiatric inpatient units.

Staff need to be sensitive to the fact that the environment, in particular that of inpatient units, can be re-traumatising for many patients. Applying a Trauma Informed Care and Practice framework assists with understanding that people can be triggered through a range of situations and behaviours by others including staff, patients and visitors. Good clinical mental health care includes an awareness of and sensitivity to these issues and strategies to support patients who experience re-traumatisation.

ii. For more information about the Support and Safety Hubs, see the Family Safety Victoria website <https://www.vic.gov.au/familyviolence/support-and-safety-hubs.html>.

Clinical practice

This section outlines expectations of clinicians when responding to suspected or identified family violence by:

- describing key practice approaches and steps
- discussing specific clinical situations and considerations at different points in the pathway of care
- highlighting issues relevant to diverse communities
- giving advice on overcoming common barriers to effective family violence responses.

Appendix 4 provides links to further resources to help clinicians respond appropriately to family violence.

Key practice steps[iii]

Enquiring about and responding to family violence should be part of each mental health clinician's routine practice when assessing or treating people with a mental illness, and when planning and transferring their care.

Clinicians' responses to family violence will vary according to the person's circumstances, wishes, and level of risk, as well as the type of violence and whether a child is at risk. However, the practice steps described are applicable to all types of response.

While described as discrete entities, the steps can occur simultaneously or in overlapping or non-linear ways. In some circumstances, such as a triage assessment, not all the steps will be undertaken due to the brevity of the interaction.

Appendix 5 contains a checklist for easy reference to the main messages, which are to **enquire**, **support**, **assess risk**, **plan for safety**, **follow-up**, **consult**, **refer** and **collaborate**.

iii Family Safety Victoria is in the process of developing guidance on risk assessment. A suite of tools will be available online and training will be provided. The new risk assessment framework and tools will override this information once available.

Enquire

'Women are more likely to disclose domestic [family] violence to a healthcare professional than to the police' [39]

Routine mental health assessments and risk assessments include enquiring about family, partners, family relationships and dependent children. Given the high prevalence of family violence experienced by mental health consumers, questions that enable disclosure must form part of these assessments. The clinical picture is incomplete if the treating clinician does not know about current or previous family violence, including childhood abuse. A comprehensive mental health assessment has to address family violence.

Even though women are more likely to disclose family violence to a health or mental health professional, they are not likely to disclose *unless they are asked.*[1] Similarly, someone who uses violence against their partner or family member is unlikely to disclose this spontaneously. Initial and ongoing interactions with consumers should include questions about how they experience their family relationships, including any problems, concerns or conflict (see practice points 'enquiring about a partner and family relationships' and 'asking questions if family violence is suspected').

Enquiries that could lead to a disclosure of family violence should not occur in the company of the person's partner or other family members because this can increase risk to the person. While it is relatively unlikely that a person who perpetrates violence will disclose their behaviour, family members might discuss such violence with clinicians. If this has occurred, develop safe ways to check in with family members and to follow risk assessment and risk management protocols as outlined later in this guideline. Particular attention needs to be paid to such risk if the person perpetrating the violence is to be discharged into their family's care (also see later section on 'Expectations at different stages of the care pathways').

Practice points
Enquiring about a partner and family relationships

Start with broad questions such as 'How are things at home?' or 'How are you and your partner/teenage son/daughter getting on?'.

If appropriate, questions can become more direct, such as 'Do you feel safe' or 'Are you afraid (of your partner, family member)?'.

Following the intake and initial assessment processes, questions about (potential) family violence need to be revisited over time. Initially, consumers might suggest that things are not quite right with their partner but not be ready to say more. Over time, you should check in regularly about how significant relationships are going and whether the consumer would like to talk about anything.

Further information on 'asking questions' is available in the following publications:

- *Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook* [40]
- *Abuse and violence: working with our patients in general practice* [13]
- *Supporting patients experiencing family violence: a resource for medical practitioners* [41]
- *Can I ask...? An alcohol and drug clinician's guide to addressing family and domestic violence.* [42]

Practice points

Asking questions if family violence is suspected[iv]

If family violence has been disclosed or is suspected, questions about family violence should be introduced by providing the context for asking such personal questions. For example:

- 'I am a little concerned about you because [of what you just told me] or [you say your relationship hasn't been good] or [you said your partner won't let you go anywhere on your own].'

More direct questions can then be asked, as appropriate. For example:

- 'Has someone in your family (your partner) done something that made you or your children feel unsafe or afraid?'
- 'Have they controlled your day-to-day living or humiliated you?'

  [Prompt: controlled who you see, where you go, how much money you can have, when you can eat]
- 'Have they threatened to hurt you in any way?'

  [Prompt: threats include to harm you, your children or other family members or pets or threat to kill]
- 'Have you been hit, slapped, kicked or otherwise physically hurt by them?'
- 'Do you feel safe when you leave here?'
- 'Are you worried about your children?'
- 'Do you have any immediate concerns about the safety of your children or someone else in your family?'

Why someone might not disclose family violence (even if asked)

There are many reasons why people do not feel comfortable or ready to disclose intimate partner or other forms of family violence. For example, a woman might:

- not be ready
- not identify her experience as violence
- have had negative experiences when disclosing it in the past
- be scared that the perpetrator will find out that she has talked to you
- be concerned about cultural profiling
- be worried that her children will be taken away
- be worried about judgement if she is in a same-sex relationship
- be worried that a disclosure is interpreted as evidence of mental illness
- be worried that professionals won't believe her.

Reflective questions

- Which questions about family violence do you feel most and least comfortable with? What might be the reasons for that?
- Who do you feel most comfortable or least comfortable asking these kinds of questions to? Think about why that is so.
- What would assist you to get more comfortable and confident in enquiring sensitively about family violence risk?

iv The FV framework (due September 2018) will provide the most up-to-date questions.

Support

The clinicians' first response to (initial) disclosure should be conveyed through active listening and non-judgemental support.[20] This response will influence the person's level of comfort and trust in the clinician and the service, and whether they are likely to raise the issue again.

It takes a lot of courage to disclose something so personal and that is often associated with shame, blame and judgement. It is unacceptable that disclosures are shut down or brushed aside as 'delusions' of mental illness. Dismissive responses can exacerbate the victim/survivor's feelings of distress and isolation and could mean that the person continues to experience violence.

The clinician's response to disclosure of family violence, whether immediate or ongoing, will vary depending on the circumstances and level of risk identified (also see the 'Assess risk' section). Existing guidelines for other services' responses to disclosures of family violence encourage clinicians to 'listen, validate, believe, and respond'[43] or to 'listen, enquire about needs and concerns, validate, enhance safety and support'.[40]

Support can also include making sure the person receives the necessary information to make informed decisions. You might have access to some of the information or you might need to consult or refer to another organisation. Relevant information will vary and may include intervention orders, legal rights, child protection and specialist family violence support services. The fact that no intervention order exists (or the person does not want to take out an order) does not mean that family violence is not occurring.

The practice points below offer some specific ideas about how to validate and support people who have disclosed family violence.[13]

Practice points

Responding to disclosures of family violence

If a person has disclosed family violence to you, you are the best person to provide an initial supportive response. This can be as simple as listening and validating someone's experience or agreeing to talk in more depth when the person is ready (provided there is no immediate risk of harm to them or others, especially children).

The New Zealand Ministry of Health offers the following advice for validating people's disclosures of family violence:

- Let them know you believe them.
- Let them know you're glad they told you.
- Let them know you're sorry it happened.
- Let them know it's not their fault.
- Let them know you'll help.
- Don't overreact. A first disclosure is a critical moment. The person will monitor every reaction and might be frightened if the abuser has threatened them not to disclose the violence or has told them that no-one will believe them.[44]

Specific responses to a disclosure might include statements along the following lines.

- 'Everyone deserves to feel safe at home [in their relationships].'
- 'You don't deserve to be hit [or hurt or humiliated].'
- 'I am concerned about your safety and wellbeing.'
- 'You are not alone, I [we] will be with you through this. I support you.'
- 'You are not to blame; abuse is unfortunately common and happens in all types of relationships.'

You can express support by:

- being patient and taking time to listen
- responding in a non-judgemental way, with compassion and belief of experiences
- validating experiences and challenging incorrect assumptions (such as 'I deserve this')
- providing encouragement
- acknowledging the complexity of the issue
- respecting the safety concerns of the person and any dependent children, even if you have not met the person who is violent ('keeping the perpetrator in view')
- providing information on specialist family violence services if appropriate
- assisting the person to make their own decisions.[13]

Reflective questions

- Are there situations when you feel somewhat judgemental? If yes, when do you feel judgemental? Do you know what lies behind your judgement? What would assist you in becoming more understanding?
- Imagine a colleague dismisses a disclosure as being part of a woman's delusions. How would you go about increasing support for the woman and respectfully disagreeing with your colleague?

Assess risk

Assessing risks to self or others is a core mental health practice
Assessing family violence risk needs to become part of good mental health practice

Each disclosure of family violence should be met with an assessment of risk to the safety of those experiencing violence.

The Family Violence Risk Assessment and Risk Management framework FV framework) is the standard family violence risk framework in Victoria. An updated version of the framework will be published in 2018 and associated training will be publicised through the Centre for Workforce Excellence (Family Safety Victoria). The updated version will include roles and responsibilities regarding family violence risk assessment.

Mental health clinicians are encouraged to use the current FV framework to assess family violence risks. Clinicians not yet trained in using the framework are advised to collaborate with colleagues or a specialist family violence service.

The updated FV framework will be implemented from September 2018. From this time, mental health services will need to comply with new legislation and undertake family violence risk assessments according to the new framework (as they will be 'prescribed' – follow the latest information and expectations as outlined by Family Safety Victoria).

Routine mental health assessment processes ('risk to self or others') provide an opportunity to determine whether the person with mental illness is likely to perpetrate violence and, if so, to identify people at risk. If the person at risk of violence is a partner or family member, then this constitutes family violence or the potential for family violence and this needs to be assessed, following contemporary family violence risk assessment procedures.

It is important to find out whether there is an intervention order protecting the person with mental illness or against that person because this provides information about the severity and nature of the risk. A copy of the intervention order, if one exists, should be requested and kept in the case file.

Assessing family violence risk

Family Violence Risk Assessment and Risk Management:

- is the process of identifying the presence of risk factors and determining the likelihood of an adverse event occurring, its consequences and its timing
- allows for an informed, tailored and proactive response and interventions that can help reduce the risk that a person will be harmed
- considers the victim/survivor's self-assessment or risk, presence of risk indicators, and professional judgement to determine the level of risk.[45]

Understanding the relationship between likelihood, consequence and timing will promote structured decision making during risk assessment.

Plan for safety

Safety planning is part of routine family violence work in specialist services. Mental health clinicians can also undertake safety planning with people who experience family violence. The current FV framework needs to be used to undertake safety planning and utilise current evidence.

A safety plan can be formulated by taking the following into account:[v]

- Safety planning is the process of identifying and documenting the steps required to optimise a state of safety for all victims/survivors in a family.
- Safety planning can refer to any aspect of physical, social, emotional, financial or psychological safety. It typically involves planning to avoid serious injury, to escape violence (crisis management) and to ensure safety of children.
- Often a safety plan will be developed with the adult victim/survivor, and the child victim/survivor will be involved so far as their involvement will assist in increasing their safety.

Practice points

Developing a safety plan

Use the current *Victorian FV framework*.

If uncertain, discuss safety planning with a colleague trained in the framework, a family violence advisor (if available at your organisation) or a specialist family violence service.

The risk assessment framework advises that a safety plan should identify:

- emergency telephone numbers
- a safe place for the victim/survivor and any children to go to in an emergency, and how they will get there
- supportive family, friends or neighbours willing to assist
- people or organisations who can care for pets, if applicable
- all family members affected by the violence, where possible
- an available source of money
- a place to store valuables and important documents together
- a plan for exiting their home and where they can go to (at least initially)
- any specific needs or resources relating to diversity and intersectionality.

The safety of children is paramount. Referrals to Child First, Support and Safety Hubs ('The Orange Door') or child protection services should be made be according to organisational policies and procedures and the relevant legislation.

The Child Information Sharing Scheme provides clarity of what and when information can and needs to be shared about children at risk of harm (refer to earlier section). Mental health services will be prescribed from September 2018.

Reflective questions

- What do you need to consider before raising the idea of a safety plan with a consumer?
- What could you ask a colleague or specialist family violence staff member before discussing safety planning with your consumer?

v See The Lookout website <http://www.thelookout.org.au> (and follow links to safety planning)

Follow-up

Clinicians are expected to provide ongoing support following the initial responses to family violence disclosure. This can be done by enquiring often about the person's relationships and asking if there are any new concerns or support needs. Where children are involved, the clinician should enquire about each child in the family and their needs.

Risk assessments should be updated at regular intervals and whenever risk factors change, either for better or worse.

Reflective question

- What would assist you to stay engaged about family violence while providing other clinical care to the consumer?

Consult

Consultation with other practitioners is important, even for the most senior mental health clinicians. It not only helps the clinician provide good treatment and care in challenging situations but also supports the clinician's own wellbeing.

As a first step, clinicians will often consult people within their service – for example, an immediate supervisor, senior colleague or discipline leader, a clinical family violence champion, or the service's family violence advisor.

Families where a Parent has a Mental Illness (FaPMI) coordinators, who are available in all area mental health services, can assist mental health clinicians and partner agencies respond to family violence involving a parent with a mental illness. FaPMI coordinators can provide secondary consultation or suggest other services that can provide secondary consultation in cases involving parental mental illness.

Depending on the situation, supports available within the mental health service and their own expertise, clinicians will collaborate with other organisations to optimise their response and support for individuals and families affected by family violence. Relevant organisations include Support and Safety Hubs, Victoria Police, child protection services, Centres Against Sexual Assault or the Men's Referral Service. It can also be helpful to consult with other specialist services, such as Aboriginal, LGBTIQ, disability or youth services or organisations supporting culturally and linguistically diverse (CALD) communities.

Reflective question

- What specific support do you need from a consultation? It is helpful to write down some points before you seek advice from colleagues or others service providers.

Refer

Mental health clinicians are not expected to become family violence specialists and should engage specialist services, where necessary, as part of providing good clinical care.

All clinicians should have access to information about specialist family violence services available to people in their area.

Concerns regarding a child need to be responded to as per organisational policies, guidelines and current legislation. This may include referrals to Child First (to be integrated into Support and Safety Hubs) and reports to Child Protection.

Practice points

Referral to another service

If a person has disclosed family violence to you, you might be the best person to provide support in relation to this.

Before making a referral, consider what you or your service can provide. Clarify which information you can share according to current information-sharing schemes and legislation. Decide if a referral is necessary or if it might be better to consult with the specialist service provider.

If a referral is warranted, reach an agreement with the other service about what it can provide and what you will continue to provide. Refer to inter-organisational agreements if available.

Make sure you discuss the referral with the consumer and give information about what the other service will provide. Enquire about any specific service the consumer wishes to be referred to (including Aboriginal or LGBTIQ specialists).

If you will continue to be involved in the person's care, give reassurance that you will continue to provide support.

Reflective questions

- Reflect on your abilities, skills and experience in this area of work. Do you need a secondary consultation with a specialised service? Do you need to make a referral? Reflect on what assists you in making this decision or if you wish to discuss it with the specialist service.

Collaborate

Over time, mental health services will develop more formal relationships with the agencies they consult about family violence, including those that accept client referrals for providing specialist services.

Future collaboration between organisations and sectors will need to reflect changes in information-sharing legislation as it is introduced across Victoria between 2018 and 2020.[46] This is discussed further in the next section.

Reflective question

- How would you approach collaboration with a worker from a different sector? What has assisted in the past?

Sensitive practice

The Victorian Government funded the Royal Women's Hospital to collaborate with Bendigo Health in developing tools and resources to help Victorian hospitals to strengthen their response to family violence. The resulting Strengthening Hospital Responses to Family Violence toolkit describes sensitive practice as 'an approach to engage with [patients and] consumers in a way that increases or elicits their feelings of safety, respect and control'.[47]

The principles of sensitive practice are summarised below.

Respect the person and their experience, wishes and needs.

Take time to enquire, to listen and to respond.

Build and maintain rapport.

Share information. Let the person know what supports are available.

Stay supportive.

Engage respectfully. Convey respect in interactions and conversations.

Create a sense of control. Avoid 'doing to' or pushing one's own ideas onto the other person ('This is so bad, why don't you leave?').

Sensitive and appropriate practice requires that clinicians have non-judgemental attitudes and accurate information about family violence and its impacts. Appendix 6 outlines common societal myths that can shape people's attitudes to family violence.

Documenting and sharing information

Training for Victoria's new information-sharing legislation is being progressively introduced throughout 2018 and 2019

When family violence has been identified or is suspected, sharing information with family members should be considered very carefully. Clinicians should seek direction from the victim/survivor and secondary consultation as required. Information that could increase risk to the consumer should not be provided to the person who is violent, even if the consumer has previously identified the perpetrator as a 'nominated person' under the *Mental Health Act 2014*. In such situations, the consumer may wish to change their nominated person to someone else or limit which information can be provided. It is unacceptable that a consumer's wish is negated due to their current mental state. The consumer's safety is paramount and needs to take priority over a previous arrangements regarding a nominated person.

Information can be shared about the person perpetrating the violence, the adult victim/survivor, children and third parties if consent requirements are met and the information relates to assessing or managing a family violence risk (see the latest legislation on information-sharing schemes to be introduced in September 2018).

In a situation where a family member has disclosed that the consumer perpetrates family violence, file notes can be made, reflecting the family member's disclosure. At the same time, as a disclosure increases potential risk to the family member, information sharing (as with any third-party information) can be restricted by following the usual processes. The information can be marked as exempt from freedom of information laws and therefore will not be accessible to the consumer.

Victoria's new Family Violence Information Sharing Scheme and the Child Information Sharing Scheme[46] mean that information about victims/survivors and children at risk will be shared differently than in the past.[vi] These changes will be introduced over time, and organisations will be progressively 'prescribed' to comply with the new requirements. Family Safety Victoria is in the process of developing a training strategy for Victoria. Regular updates will be available on its website and through the Centre for Workforce Excellence (Family Safety Victoria).

vi These changes will include that consent is not required to share information if there is serious threat to someone's safety (follow newly introduced information-sharing schemes as prescribed). Discuss with senior staff if uncertain.

Practice points

Case documentation

Information about family violence should be recorded and passed on at each stage of the care pathway, from triage to other internal and external services, through to discharge.

Follow the health service's policy about documenting patient information, privacy and confidentiality, and for storing notes.

Document disclosures of family violence or intimate partner violence in the consumer's file. Be factual and succinct.

Document any risks, evidence of injuries, treatment provided, referrals made and any information the person has disclosed about the violence.

(Separate) documentation needs to occur for the person who experiences violence and the person who perpetrates violence.

In situations where a parent is the perpetrator of family violence or child abuse, consider the parent's access to the child or young person's file. Follow organisational procedures and consult senior clinicians and management to ensure that documentation requirements are met in a way that does not jeopardise the safety of children and young people.

The Royal Women's Hospital has adopted the following as standard for documenting family violence disclosure. It is suggested that mental health services adopt a similar, if not the same, standard for documenting family violence:

- date
- clinician's name
- person's name
- suspected family violence
- clinician's observations
- clinician's actions, including secondary consultation
- follow up – what actions need to be taken?

Expectations at different stages of the care pathway

The guidance provided in the preceding discussion of key practice steps applies generally to all types care that consumers experience in mental health services. Table 1 lists some expectations applicable to specific components of the care pathway.

Table 1: Expectations at different stages of the care pathway

Service component	Expectation
Mental health triage	If the person is not referred for further mental health services, and family violence has been identified, the consumer (or carer or other referrer) is to receive information about family violence support services and referral to these services following discussion and consent by the person. If the person is accepted for further assessment and/or treatment, any information about family violence is to be documented as part of the notes on the triage assessment. The clinical team receiving the referral from triage should be alerted to the need for further enquiry about and response to the violence. Regardless of whether the person is accepted by the mental health service, any immediate family violence safety concerns are to be referred to a specialist service or the police, depending on the circumstances and severity of the situation.
Stays in bed-based services	If information about family violence was obtained as part of previous service provision, it should be checked and updated. If family violence has been disclosed or is suspected, a treating clinician shouldz find out if intervention orders are in place and alert other staff to any people who are not allowed to visit the patient. If no intervention order is in place, consider discussing the possibility of getting an intervention order with the person.
Community mental health treatment	Given the likelihood of longer engagement with consumers and carers in community-based services, clinicians have opportunities to enquire about and revisit family violence issues over time. If the consumer has disclosed family violence, the clinician should provide ongoing support to the consumer (or family) and involve specialist family violence services as needed.
Discharge planning and transfer of care	A revised risk assessment is to be conducted and documented as part of discharge planning. It is unacceptable that a person is knowingly discharged into a situation where their safety is at serious risk (follow the FV framework). All efforts should be made to discuss safety concerns with the consumer and seek alternatives to the person returning to the violent situation. If a person is discharged into a situation of family violence, this fact has to be documented on the case file and any discharge notes sent to other service providers, along with details of the safety assessment, safety concerns raised by clinicians or family members and any referrals made to specialist family violence services. If the consumer has perpetrated violence towards a family member, discharge planning needs to include a discussion with affected family members. While respecting family members' wishes, including their acceptance of the person back into the family, safety concerns need to be addressed. This can also be a good time discuss concerns about violent behaviour with the consumer (and their family if safe to do so), provided such discussions have started earlier in the episode of care. If the person who has perpetrated violence is discharged back into a family situation, the relevant documentation is to include information on the reasons for this decision, actions taken to respond to the behaviour, referrals to other services, and copies of intervention orders. Communication regarding discharge and safety planning with family, a partner and carers before the person is discharged needs to reflect family, partner and carer preferences and concerns.

Specific clinical situations

When a woman's mental illness is used as family violence 'technique'

While family violence looks similar across any group in society, there are additional issues confronting women with mental illness. Some perpetrators (most likely intimate partners) use the woman's mental illness against her as part of perpetrating abuse, making it even harder for women to seek assistance. Techniques can include:

- telling her nobody will believe her because she has a mental illness or 'because she is mad'
- telling other people that she is 'crazy'' and makes things up
- threatening to tell others (for example, in her workplace) that she has a mental illness
- withholding medication or controlling when she takes it
- controlling appointments, always accompanying her, and dominating conversations (to prevent disclosure)
- threating to have her 'locked up'
- changing things in the house, denying having done so and telling her she it is part of her delusional thinking (also known as 'gaslighting')
- threatening to have the children taken away because she is a 'bad mother'
- turning the children against her by inflating how 'sick' she is
- lying to mental health professionals about how unwell she is (for example, making out that she is suicidal, has tried to harm herself or is not taking her medication) when this is not true.

Reflective questions

- What might assist you in identifying these behaviours?
- How might you begin to address controlling behaviour, if the partner is always in attendance?

Adolescent violence

Adolescent violence in the home is confronting and many parents are ashamed to talk about it.[48] *It challenges the expectation that parents have more power and authority than the young person* [49]

Victoria Police records show that 6.7 per cent of those who perpetrated family violence in 2016–17 were aged 17 and under; 64 per cent of these incidents involved a parent/guardian as the affected family member. The average age of the young person was 14.8 years.[50] The real incidence of this type of family violence is likely to be much higher.

Adolescent violence has many similarities to other forms of family violence, but there are some key differences.[51] The affected parent, sibling or family member *wants the violence to stop,* as in other forms of family violence, but usually does not want to consider separation from the child. The decision to involve police can be very difficult for parents, even if a police response is warranted. Taking out an intervention order against one's own child is even more challenging. Most parents do not want their child to get a police record, become involved with the youth justice system, or be removed. The situation is more complex still if the young person has an emerging mental illness.

Other points to note about adolescent violence are that it is:

- not the same as challenging behaviour, a single isolated incident or a strong reaction
- most often perpetrated by male adolescents against their mothers (and is more common in families led by single mothers); however, young women also perpetrate violence and fathers and siblings can also be the victim of such violence
- frequently connected to the child's own experience of family violence.

Parents typically do not seek help for adolescent violence until the behaviour has occurred over a long period and has escalated. Therefore, intervention should be offered as soon as possible. Interventions that involve the young person and their parent(s) can significantly improve family relationships and result in better outcomes for the young person.

Reflective questions

- What might assist you in identifying adolescent violence?
- How might you begin to address such behaviour when you work with a young person?

Elder abuse

'Incidents of violence and abuse of older people are sometimes dismissed as being the result of "caregiver stress"... [but] there is never an excuse for abusing another person, regardless of how much stress a caregiver is experiencing' [52]

It is estimated that between 2 and 10 per cent of Australians aged 65 or older are experiencing or are at risk of abuse by someone they know or should be able to trust such as a partner, family member or carer.[53]

While women experience higher rates of elder abuse, men can also be victims. Perpetration of elder abuse is not as gendered as other forms of family violence (where men are the main perpetrators); both men and women are known to perpetrate abuse towards elderly family members.

Elder abuse is a growing problem due to the ageing population, increased longevity and increased numbers of people with dementia. The most common forms of elder abuse are financial or psychological mistreatment,[54] although the abuse can be physical, social and sexual.

Elder abuse has similar risk factors to other forms of family violence and include family conflict, the victim/survivor's dependency on the perpetrator, social isolation and disability. Like other forms of family violence, it is underreported due to feelings of shame, fear and family responsibilities.

Practice points

Identifying elder abuse

What are the inter-generational relationships like in the family?

Does the son/daughter seem to make all the decisions for the elderly person or unnecessarily restrict the parent's autonomy?

Does the elderly person seem frightened, less certain or intimated when a certain family member is present?

When both people attend a mental health service as consumers

It occasionally occurs that both the person experiencing violence and the person perpetrating violence attend the same service. The practice points below suggest ways that the organisation can respond in these situations to increase the victim/survivor's safety and hold the person using violence accountable.

Practice points

Managing situations where both the perpetrator and the victim/survivor use your service

The needs of the victim/survivor and those of the perpetrator of violence should be addressed independently.

Separate clinicians need to be allocated to each individual.

Each person needs to be admitted to a separate inpatient unit.

Do not discuss suspected or confirmed abuse with the perpetrating partner unless the victim/survivor has consented to this.

Note: Disclosure of family violence is a time of increased danger for victims/survivors. Even if the victim has given consent, highest caution is warranted – seek advice from a men's service before you take this step. Specialist workers are ideally the ones to discuss violence with a perpetrator. While a referral or their involvement might not be possible, seek advice first. The victim/survivor's safety must be the highest priority (the new FV framework will provide further clarity).

If such conversation is to occur, a safety plan needs to be in place.

Ensure a 'team approach' – make good use of clinical review processes to increase safety and decrease risk.

Follow usual procedures regarding the safety and care of children.

Violence during pregnancy and early parenting

Pregnancy is a high-risk period for intimate partner violence. Violence sometimes begins or becomes more severe during pregnancy,[10] often because the pregnant woman's partner feels jealous or abandoned when she focuses on her pregnancy and baby.

Factors that pose an increased risk of intimate partner violence during pregnancy include:[55]

- violence prior to pregnancy
- young maternal age (women aged 18–24 years are at higher risk of family violence during pregnancy)
- unintended pregnancy, including pregnancies that occur in family violence contexts through rape or reproductive control (restricting productive autonomy).

Family violence during pregnancy is associated with several negative health and mental health outcomes for the fetus, mother and child,[56] including low birthweight, heightened stress for the fetus and newborn, and high levels of perinatal depression, anxiety and post-traumatic stress disorder among mothers.[57]

Practice points

Working with women who are pregnant or who have young children

Pregnancy can provide an opportunity to provide extra support if family violence has been identified previously.

Family violence can disrupt the maternal–child bond and the child's attachment to the mother. Approaches that foster mother–infant bonding, based on relational trauma and attachment theory, are helpful.

Consider co-working with the practitioners providing pregnancy care such as (enhanced) maternal and child health nurses, general practitioners and others.

Where possible, consider consulting with child mental health specialists such as staff of the Parent Infant Mental Health Initiative[58] or a FaPMI coordinator.

Consider the 'parenting after violence' programs provided by specialist family violence services, referral to or consultation with experts at the Royal Children's Hospital or the Royal Women's Hospital programs addressing family violence and mothering.

Men who perpetrate family violence

'Perpetrators of family violence ... often require a long journey to start to take some responsibility for their behaviour. It might take several significant events or "crises" stemming from their behaviour, over a period of months or years, before they develop some internal motivation to change' [59]

Prevalence rates and patterns of family violence indicate that clinicians will work with men who use violence against their partner, children or other family members.

Mental health clinicians are well placed to identify and respond to men who use violence and are encouraged to undertake training and other professional development activities to increase their skills in responding to family violence perpetrators. However, clinicians are not expected to work with men specifically on their violence, as this is the work of specialist services.

Each interaction with a service, including a mental health service, by a person who uses violence provides an opportunity to intervene to change the person's behaviour. This can be done while continuing a therapeutic relationship through respectful enquiry, support and mental health care.

While disclosure by a person perpetrating violence is rare, it might happen. If this is the case a referral to the Men's Referral Service might be appropriate, in particular if the person is ready to address their behaviour.

If family violence perpetration is suspected or has been identified, the highest priority is the safety of women, children and other affected family members. Support needs should be identified without jeopardising their safety. Where family members of a mental health consumer are at risk, someone other than the perpetrator's treating clinician (for example, another mental health clinician or a specialist family violence service provider) should develop the safety plan.

Questions that aid identification of family violence perpetration should be part of the service's routine intake, mental health assessment and risk assessment processes, which include questions about relationships. The practice points below provide specific advice.

It is appropriate for clinicians to respectfully encourage perpetrators to take responsibility for their actions. One way of doing this is through discussing the impact the perpetrator's behaviour has on partners and children and their role as a parent. Discussing the violence in this way keeps the focus on the problematic behaviour, the safety (or lack of) of partners, children and other family members.[47] Seek expert advice prior to discussion with person who perpetrates violence.

Work on responding to perpetrators and 'holding perpetrators accountable' is underway across the service system as part of the Victorian Government's current Family Violence Reform agenda. Staff of mental health services are advised to familiarise themselves with new publications and resources on working with perpetrators as they become available on the Family Safety Victoria website <https://www.vic.gov.au/familyviolence/family-safety-victoria.html>.

Practice points:

Working with men who perpetrate family violence

Questions about family violence should not be asked with the victim/survivor present if disclosure by the person perpetrating the violence has not occurred or if you have heard about the violence third hand.

Use open-ended questions that start broad such as 'How are things at home?', 'How is your relationship?' and 'What are the best and worst things about your relationship?'.[60]

You might need to put aside your own reactions to the behaviour and feelings of a need to 'intervene'[47] to protect the safety of the perpetrator's partner, children or family members – which must always be the highest priority.

Continuing a collaborative response is important when working with someone who perpetrates violence. Continue to be curious, respectful and invitational. Meet the person 'where they are at', approach the 'truth' as subjective and don't focus on the behaviour of the victim/survivor (perpetrators will often use the victim's behaviour as excuse – 'She didn't have the kids ready').

Examples to ensure you stay engaged while balancing safety of those affected include:

- Develop rapport, be interested in the person.
- Focus on the choice of violent behaviour, not judging the individual.
- Keep a check on your own emotional responses ('What is going on for me?')
- Use a safe preamble – 'May I ask you a hard question?'.

If concerns for children's safety have been identified, follow organisational procedures and professional requirements regarding mandatory reporting of child abuse to child protection services. Ensure you follow the new Child Information Sharing Scheme and the Family Violence Information Sharing Scheme (from September 2018).

People who use violence will often try to minimise, excuse, explain and not take responsibility for the violence, and use strategies to seek sympathy from others. Avoid colluding with the perpetrator – for example:[40]

- saying nothing when violence is disclosed or minimising the violence ('You were upset', 'At least you didn't...')
- focusing on the narrow view of violence (physical) and not picking up on other forms of abuse (emotional, verbal, financial)
- not challenging his stories and language used to minimise their behaviour or responsibility.

Make good use of supervision and secondary consultation. It can be hard to work with someone who perpetrates violence and to stay engaged with them. Ensure you have the professional support needed to discuss your concerns, reactions and needs.

Secondary consultation is strongly advised and can be obtained by phoning the Men's Referral Service (see Appendix 4).

Alcohol and other drugs

'A perpetrator of family violence can be more dangerous when they are under the influence of alcohol or other drugs. However, not all people who use alcohol or drugs become violent and not all people who are violent use drugs or alcohol' [42]

The relationships between AoD use, mental illness and family violence is complex.

Victoria Police reports that 22 per cent of family violence incidents involved alcohol use by the perpetrator, the victim, or both.[43] While there is a high co-occurrence of problematic AoD use and family violence,[61] alcohol and other drugs do not *cause* family violence.[56] The use of substances by a perpetrator can, however, greatly increase the severity of violence.

While people who perpetrate family violence might misuse drugs or alcohol, they are generally also violent when not using substances. Some victims/survivors use alcohol or drugs as coping strategy to deal with the impact of current violence and to manage flashbacks to previous violence.

AoD use can become part of violence perpetration – for example, if the perpetrator:

- forces the victim/survivor to take part in drug dealing or AoD consumption
- threatens to expose AoD use to services as part of threats to have children removed
- sabotages the victim/survivor's attempts to give up alcohol or drugs.

Practice points

Responding to family violence where perpetrators or victims/survivors abuse alcohol or other drugs

Focus on the safety of the woman and her children, taking AoD use into account.

Make sure you know about AoD harm minimisation strategies.

Consult with specialist AoD services as necessary.

Reflective questions

- How do you feel about working with someone who perpetrates violence?
- How could you talk to consumers and their families about your observations in situations where the consumer's mental illness contributes to their violent behaviour?
- Are you clear about your role in responding to someone who discloses that they perpetrate family violence? What would you need to do to hold the person accountable while still providing a mental health service to them and ensuring the safety of the victim(s)/survivor(s)?
- What supports do you need to provide good clinical care in responding to men who perpetrate violence?
- What does your organisation offer to support you in this work?
- Do you have a 'limit' when it comes to working with someone who perpetrates violence (for example, a type of violence or its severity)? What is it?

Working with diverse communities

While family violence affects all types of families, victims/survivors from diverse communities can face specific issues and/or barriers to getting help. Some perpetrators will, for example, use a person's characteristics or life circumstances against them as part of perpetrating violence, while discriminatory attitudes can hinder effective responses to victims/survivors.

It is important to keep in mind that many people belong to more than one 'group'. Applying an intersectionality lens (see the 'Diversity and intersectionality' section) can assist clinicians to appreciate multiple layers of discrimination and barriers to accessing services.

The following section provides brief summaries of some issues relevant to specific communities or groups.

Aboriginal and/or Torres Strait Islander people

Aboriginal people, and particularly Aboriginal women and children, experience significantly higher rates of family violence than other Victorians. In 2013–14 Aboriginal people were 7.3 times more likely than non-Aboriginal people to experience family violence.[1]

Aboriginal communities' understanding of family violence takes broader family and kinship networks into account. Family violence can occur outside the home and can involve several people.[1]

The Royal Commission into Family Violence reported a 'clear connection between the high rates of family violence and the high numbers of Aboriginal children in out-of-home care.'[1] The royal commission recognised the 'importance of understanding family violence in Aboriginal communities within the historical context and impact'. This includes the following impacts associated with white settlement:

- dispossession of land and traditional culture
- breakdown of community kinship systems and Aboriginal lore
- racism and vilification
- economic exclusion and entrenched poverty
- the effects of institutionalism and historical child removal policies
- inherited grief and trauma'.[1]

Practice points

Engage in a way that demonstrates cultural awareness, respect and recognition.[62]

Consider whether it is culturally safe for an Aboriginal woman to disclose violence in your organisation and think about what you could you do to make her feel safer.

Ask if the person wants an Aboriginal service to be involved or if they want to be referred to an Aboriginal service (but do not assume).

Consider what disclosure will mean to the person's connection with her or his family or broader community.

Recognise that violence can involve the broader family or kinship networks. Are you aware who is involved?

Understand the traumatic connection of family violence with past child removal practice while balancing safety concerns for children.

Culturally and linguistically diverse communities

CALD communities are not homogenous. The way family violence manifests or is experienced or perpetrated depends on many factors such as immigration status, level of English proficiency and access to culturally and linguistically appropriate services.

The Australian National Research Organisation for Women's Safety has identified four key types of barriers to responding to family violence and sexual assault among CALD communities:

- personal (such as isolation from family, feelings of shame and dishonour)
- cultural (such as fear of community rejection)
- information and language (such as inability to read or write in English)
- institutional (such as limited access to interpreters or lack of culturally sensitive services).

Practice points

Working with cultural and linguistic diversity

Consider what a disclosure will mean for the person in relation to their community. What is at stake? Do they believe that they will 'lose face' or 'bring shame' to their community?

Find out about the person's immigration status. Is he or she worried about being deported?

If they are not proficient in English, use interpreters. DO NOT use family members to interpret.

Reflective questions

- What might be some of the barriers that keep people from diverse backgrounds from disclosing family violence?
- What could you or your service do to increase opportunities to have conversations about family violence?

Women with disabilities

Women with disabilities experience higher rates of family violence than those without a disability. Women with intellectual disabilities are at particularly high risk. When violence against women with disabilities occurs, it is likely to be more frequent, severe and longer lasting [63]

While many women with disabilities experience the same kind of violence as other women, they also experience 'disability-based violence', such as when the perpetrator uses a woman's disability to control her.[63] If the perpetrator of family violence has a role as the person's carer, and in particular if it is her partner, the victim/survivor is likely to experience violence and control that entraps and isolates her further.

Examples of types of abuse include:[55]

- controlling when medication can be taken
- breaking or removing physical aids, such as wheelchairs, crutches and reading aids
- withdrawing care or not assisting with daily activities or physical care
- not letting the person do things they are capable of and want to do, such as looking after children.
- abusing a power of attorney.

Practice points

Working with people who have disabilities

Ask the victim/survivor about their support needs; don't make assumptions about what they need.

Ensure that information is communicated in an appropriate and accessible format. Find out if written or verbal information is preferred.

Engage an Auslan interpreter if required.

Recognise the family-like or interdependent relationships a victim/survivor may have with carers and other support people.

Allow for privacy and create opportunities for the person to disclose information without a carer or support worker present.

Consider the broad range of perpetrators who might use violence against victims/survivors with disabilities, including co-residents in care facilities who have a family-like relationship with the victim/survivor.

If the person has a National Disability Insurance Scheme plan, work with their support coordinator or local area coordinator.

Ask questions about whether perpetrator behaviours specifically affect the disability.

If the person has caring responsibilities for children, consider how the violence might affect them and their relationship with the victim/survivor.

Be aware that children with disabilities may also be victims/survivors in a family, with their own special needs.

Lesbian, gay, bisexual, transgender, intersex and queer people

People in LGBTIQ communities experience family violence at or above the same rate as non-LGBTIQ people. They face additional barriers to identifying, reporting and accessing safe and appropriate supports. These include the impact of past experiences of discrimination, the lack of visibility of LGBTIQ people in family violence discourse and the lack of LGBTI-specific services.

It is important to understand the historical and current context of discrimination against LGBTIQ people. This includes acts of public harassment and violence, social isolation and oppression, and legal discrimination that may deny LGBTIQ people some of the rights, protections and freedoms enjoyed by others.

Societal discrimination against LGBTIQ people can affect familial attitudes towards LGBTIQ family members, LGBTIQ people's own sense of their personal worth, and the perceived worth of their intimate relationships. [64]

While many experiences of coercion and control are like those in heterosexual and cisgendered relationships, there are some differences. The Victorian Office for Prevention and Women's Equality has identified the following forms of violence specific to LGBTIQ people:

- threats to 'out' or reveal the victim/survivor's sexual orientation, gender or biological sex
- exploiting the stigma that still surrounds violence in non-heterosexual relationships
- withholding or threatening to restrict access to hormones, medications, medical treatment or support services
- ridiculing or disrespecting gender identity or intersex status
- threatening the non-biological parent regarding custody of, or relationship with, their child
- young people being forced to leave home when they 'come out' about their sexuality or gender identity.

LGBTIQ victims/survivors

LGBTIQ people might mistrust mainstream services or be concerned about the response they would receive if they disclosed family or intimate partner violence. They may have previously had a negative response to their relationship or gender status.

The person may feel uncomfortable about their sexuality, which could compound their reluctance to disclose family violence.

Family and intimate partner violence against LGBTIQ people is often not well understood by others. For example, if a young person has been made homeless due to their sexuality, then that is family violence.

It might be difficult for police to distinguish between a victim/survivor and a perpetrator when attending a same-sex family violence incident.

People living in poverty

While family violence occurs in any socioeconomic group, lack of access to money can significantly limit victims'/survivors' opportunities to gain support or to leave the violent situation. Catching a taxi to safety, renting a hotel room, moving or paying for counselling is not possible for many people on low incomes.

Many women, in particular, experience loss of income as a result of family and intimate partner violence. A woman might need to take time off or lose employment because of the violence, she might need to attend court hearings or medical appointments, or be forced to move out of her home to be safe.

Rural, regional and remote communities

Victoria Police records show that the highest rates of family violence per 100,000 population are outside of metropolitan Melbourne.[1]

People living in these areas experience barriers to disclosing, reporting, seeking help and receiving appropriate services following family violence. The Royal Commission into Family Violence highlighted factors that influence the experience of family violence in these areas, namely social and geographic isolation, economic vulnerability and dependence, cultural norms, the position or reputation of the perpetrator in the community and access to firearms. Victims/survivors may be reluctant to seek help due to feelings of shame and social embarrassment within a small community.[1] Access to services is more challenging than in metropolitan areas. Informal supports play a vital role in women's decisions to seek help.[65]

Overcoming barriers

Table 2 lists some of the reasons why mental health clinicians may feel unable or unwilling to respond to family violence. The 'comments' in the right-hand column challenge clinicians to revise unhelpful attitudes and to try to address any barriers they experience in responding appropriately to family violence.

Table 2: Barriers to effective clinical responses to family violence

Barrier	Comment
High workload and lack of time	Not engaging may increase risk to a person and ultimately increase your workload.
'More pressing issues to deal with'	Family violence has major mental health impacts. It is pressing.
'Not part of my job'	It is part of your job.
Not being alert to the signs and risks of family violence	Increase your understanding of family violence through training and professional development, including online learning.
Being worried about placing the victim/survivor at risk	Sensitive enquiry includes understanding how and when to ask and when not to ask.
Feeling helpless about providing solutions	Supporting someone takes many forms. You may not need to provide any solutions. Sometimes victims/survivors just want someone to listen. Follow TICP guidelines. If you are really stuck, you can consult other practitioners.
Not knowing what to do or how to respond	This guideline gives you some ideas. Consult the suggested resources or speak with a colleague.
Not knowing how and where to refer for a specialist family violence response	Easy! Find out how to refer to the local specialist family violence service or the Support and Safety Hub. Colleagues might be able to help you.
Not feeling supported by the organisation, colleagues or supervisor	This guideline directs mental health services to support clinicians in responding to family violence. Access specialist family violence services for secondary consultation if necessary.

Appendices

Appendix 1: Abbreviations and terms used in this guide

Abbreviations

AoD	Alcohol and other drugs
CALD	Culturally and linguistically diverse (communities or people)
FaPMI	Families where a Parent Has a Mental Illness (program)
FV framework	Family Violence Risk Assessment and Management Framework
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, queer
RAMP	Risk Assessment and Management Panel
TICP	Trauma Informed Care and Practice

Definitions of terms

Carer	'Carer' is used to describe someone who is actively supporting, assisting or providing unpaid care to a consumer. A carer may or may not live with the consumer. A carer may be a family member, friend or other person, including a child or young person who has a significant role in the life of the consumer. 'Means a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.' [66]
Cisgender	Cisgender is a term for people whose gender identity matches the sex that they were assigned at birth.
Disability	'Disability' in relation to a person means— (a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which— (i) is, or is likely to be, permanent; and (ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and (iii) requires significant ongoing or long term episodic support; and (iv) is not related to ageing; or (b) an intellectual disability; or (c) a developmental delay. [67] Disability is a social construct and stems from the interaction of a person's functional impairment with a disabling environment. Disabling environments create structural, attitudinal and behavioural barriers – for example, by preventing people with functional impairments from accessing housing, education, work opportunities or transport. A specific type of disability arises from the interaction of a specific impairment with an environment that creates barriers. [63]

Economic abuse	This includes restricting or controlling access to money for essential needs (to pay bills, buy groceries), stealing from the other person, using their money without their consent and illegally taking, misusing or concealing funds, property or assets.
Emotional abuse	This occurs when a person is subjected to behaviours or actions that are aimed at preventing or controlling their behaviour with the intent to cause them emotional harm or fear. [17]
Family member	The Family Violence Protection Act 2008 defines 'family member' as: (a) a person who is, or has been, the relevant person's spouse or domestic partner; or (b) a person who has, or has had, an intimate personal relationship with the relevant person; or (c) a person who is, or has been, a relative of the relevant person; or (d) a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis; or (e) a child of a person who has, or has had, an intimate personal. The Act further outlines that the relationships can be of a sexual or non-sexual nature. It further states that the term includes any other person who the person regards as being like a family member (find further details relating to this last section in the Family Violence Protection Act, section 8). For definitions of 'domestic partner' and 'relative', see section 9 in the Act.
Family Safety Victoria	Family Safety Victoria was established in July 2017 to drive key elements of Victoria's family violence strategy and to coordinate support for families to help them care for children and young people.
Family violence	The Family Violence Protection Act 2008 defines family violence as behaviour by a person towards a family member of that person if that behaviour— is physically or sexually abusive; or is emotionally or psychologically abusive; or is economically abusive; or is threatening; or is coercive; or in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or causes a child to hear or witness, or otherwise be exposed to the effects of [that] behaviour ...

Intimate partner violence	'Any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship'.[40]
Nominated person	A consumer can nominate a person to receive information and to provide them with support in the event they become unwell and require compulsory mental health treatment. [68]
Risk Assessment and Management Panels	RAMPs provide a response to victims/survivors (including children) at critical levels of risk, who require the development of a comprehensive, multi-agency risk assessment and management action plan (see 'Family Safety Victoria' for further information).
Rural Regional Remote	Rural: non-urban localities of less than 25,000 with reduced service accessibility. Regional: non-urban centres with a population more than 25,000 with relatively good access to services. Remote: communities of under 5,000 with restricted service access. [69]
Sexual assault and abuse	Sexual assault includes rape, child sexual abuse and unwanted sexual behaviour such as unwanted kissing and touching. It also includes behaviour that does not involve actual touching. For example, forcing someone to watch pornography or masturbation is also sexual assault. Sexual assault does not have to include physical harm. Sexual abuse is often part of a broader pattern of violence perpetrated as part of family violence.
Social abuse	Isolating the victim from family, friends or other community contacts.
Specialist family violence advisors	The Specialist Family Violence Advisor Capacity Building Initiative will include creating specialist family advisors in major mental health services. These roles will provide family violence expertise in clinical mental health services to lead system and practice change and build workforce capacity to increase services' response to family violence. These roles are being implemented from July 2018.
Specialist family violence services	Specialist family violence services are designed to support victims of family violence. There are also specialist family violence services that work with male perpetrators.
Strengthening Hospital Responses to Family Violence	This is a framework for embedding the practice of identifying and responding to family violence experienced by hospital inpatients. It is system-wide approach and is currently being implemented across Victoria (as part of implementing the royal commission's recommendations).
Support and Safety Hubs	Support and Safety Hubs form part of the implementation of the royal commission's recommendations. Also referred to as 'The Orange Door', Hubs will provide a regional response to family violence (see the 'Family Safety Victoria' website for further information).
Victim/survivor	Victim/survivor is the term used by the royal commission to describe someone who experiences family violence. This term also encompasses children experiencing violence.

Appendix 2: Organisational checklist

Task	Timeline
Family violence policy updated, incorporating: • victims/survivors (child/young person, adult) • unborn children (responsibilities regarding family violence perpetration against woman) • responding to perpetrators (including responsibilities of clinicians) • latest Family Violence Risk Assessment and Risk Management Framework (September 2018)	
Family violence procedure updated in line with policy update, including: • 'How to ask' • 'How to respond' outline • responsibilities, documentation • discharge planning	
Family violence executive sponsor identified: role description, including responsibilities clarified and documented	
Management 'introduction to family violence' training undertaken	
Family violence committee established: • terms of reference, scope, responsibilities, membership, reporting structures identified	
Family violence advisor (if such role has been established): • departmental program guideline utilised • responsibilities and scope clarified • reporting structure clarified	
Clinical family violence champions identified: • role description, including responsibilities, clarified	
Family violence project plan developed	
Communication strategy developed	
Family violence workforce strategy identified: • decisions regarding introduction and advanced training • decisions regarding training for seniors/supervisors • opportunities for reflective practice created	
Continuous review processes clarified: • business plan updated to include the family violence project • annual quality assurance process • data collection on family violence reviewed, clarified and implemented • documentation of family violence reviewed, clarified and communicated • consider a discrete alert system regarding family violence for clinical files	
Risk Assessment and Management Panel: • participation clarified, clinician members' role clarified • review processes in place	
Health service's family violence executive sponsor consulted on family violence policy for staff: • ensure that management members are familiar with the policy	
Additional Items – add as required	

For further information (including project and organisational planning, role descriptions and committee terms of reference examples) visit the Have Your Say website <http://haveyoursay.thewomens.org.au/shrfv-project>.

Appendix 3: Key legislation and government policies

This guideline has been developed in the context of large changes and focus on family violence resulting from the Royal Commission into Family Violence. It is likely that changes will continue to occur beyond the publication of this guideline. The most up-to-date information can be found on the Family Safety Victoria website <https://www.vic.gov.au/familyviolence/family-safety-victoria.html>.

The following is a summary of legislation and policies that are most relevant at the time of writing.

Legislation

- *Children Legislation Amendment (Information Sharing) Act 2018*
- *Family Violence Protection Amendment (Information Sharing) Act 2017*
- *Mental Health Act 2014*
- *Carers Recognition Act 2012*
- *Family Violence Protection Act 2008*
- Children, Youth and Families Act 2005

Royal commission report and Victorian Government responses

- Family violence rolling action plan 2017–2020
- *Responding to family violence capability framework* (2017)
- *Free from violence – Victoria's strategy to prevent family violence and all forms of violence against women* (2017)
- *Ending family violence - Victoria's plan for change* (2016)
- *Royal Commission into Family Violence report and recommendations* (2015)
- Building from strength – 10-year industry plan for family violence prevention and response (2017)

Related state government policies and plans

- *Roadmap for reform: strong families, safe children*
- *Indigenous family violence 10-year plan – Strong culture, strong peoples, strong families: towards a safer future for Indigenous families and communities (2008)*
- *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*
- With respect to age – 2009 Victorian Government practice guidelines for health services and community agencies for preventing elder abuse

Mental health initiatives, guidelines and policies

In addition to the above, the following guidelines, policies and developments are relevant to this guideline.

- Centre for Mental Health Workforce Learning and Development (to commence 2018)
- Mental Health and Police response (MHaP)
- Department of Health and Human Services, Mental Health Branch: *Families where a Parent has a Mental Illness program guideline (2016)*
- *Department of Health and Human Services–Victoria Police protocol for mental health. A guide for clinicians and police (2016)*
- Victoria's 10-year mental health plan (2015)
- Department of Health, Mental Health Branch: *Service guideline for gender sensitivity and safety* (2011)
- Department of Health and Human Services, Mental Health Branch: *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units. Chief Psychiatrist's guideline* (2009) – under review
- Department of Health and Human Services, Mental Health Branch: *Working with families and other carers* (2005) – under review.

Appendix 4: Practice resources

Name of organisation or topic	Information / specific documents
Aboriginal Family Violence Prevention and Legal Service Victoria <http://www.fvpls.org/index.php>	An Aboriginal community-controlled organisation that provides assistance to Aboriginal and Torres Strait Islander victims/survivors of family violence and sexual assault and works with families and communities affected by violence
Adolescent violent towards parents <https://www.kildonan.org.au/programs-and-services/child-youth-and-family-support/family-violence/adolescent-violence/about-adolescent-violence/> <https://aifs.gov.au/cfca/2015/12/08/adolescent-violence-home-how-it-different-adult-family-violence>	Information, practical ideas and links to helpful documents regarding adolescent violence
Australian Institute of Family Studies <https://aifs.gov.au/>	Research and publications on a wide range of family violence topics
Alcohol and other drugs <http://nceta.flinders.edu.au/files/2713/6615/8232/EN488_2013_White.pdf>	*Can I ask...? An alcohol and drug clinician's guide to addressing family and domestic violence*
Australian Medical Association <https://ama.com.au/sites/default/files/documents/AMA%20Supporting%20Patients%20Experiencing%20Family%20Violence%20Resource%20Corrected%2025Feb16.pdf>	Supporting patients experiencing family violence: a resource for medical practitioners
Australian National Research Organisation for Women's Safety <https://anrows.org.au/>	Latest research, publications and statistics
blue knot foundation <http://www.blueknot.org.au>	National Centre of Excellence for Complex Trauma
Children and young people experiencing family violence <https://woah.org.au/>	Information for children 10–13, 14–17 year olds and adult allies
Centres Against Sexual Violence <https://www.casa.org.au/>	CASA forum – provides information and links to Victorian Centres Against Violence (CASAs)
Diversity and family violence <https://www.vic.gov.au/familyviolence/designing-for-diversity-and-intersectionality.html>	Family Safety Victoria: Diversity Unit
Elder abuse <https://seniorsrights.org.au/your-rights/> <http://www.dvrcv.org.au/help-advice/elder-abuse-and-family-violence>	Resources, information and links regarding elder abuse The Domestic Violence Resource Centre Victoria has practical suggestions and ideas of how to ask and what to do if elder abuse is suspected
Family Safety Victoria <https://www.vic.gov.au/familyviolence/family-safety-victoria.html>	Information and the latest updates about family violence reform in Victoria
Family Violence Protection Act 2008 and Family Violence Protection Act Amendment 2017 <http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/C94BEB3E0B1834A3CA258122000DC2F0/$FILE/17-019aa%20authorised.pdf>	Outlines the legal definition of family violence in the State of Victoria

Name of organisation or topic	Information / specific documents
Information sharing and risk management <https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html>	Information-sharing scheme – part of the family violence reform in Victoria
inTouch, the Multicultural Centre against Family Violence <http://www.intouch.org.au/>	A support and information service for migrant and refugee women experiencing family violence
LGBTIQ <https://www.dvrcv.org.au/help-advice/lgbtiq>	Domestic Violence Resource Centre Victoria
Male perpetrators <http://www.ntvmrs.org.au/> <http://www.ntv.org.au/about-family-violence/what-men-can-do/>	Men's Referral Service – support, information
Mental Health Act 2014 <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014>	Legislation governing the assessment and treatment of people with mental illness within the public mental health system
National Sexual Assault, Domestic Family Violence Counselling Service <https://www.1800respect.org.au/>	Confidential counselling and support service Resources and training for professionals
Royal Australian College of General Practice <https://www.racgp.org.au/publications/goodpractice/201704/abuse-and-violence/>	*Abuse and violence: Working with our patients in general practice* (2014, 4th edition)
Royal Commission into Family Violence <http://www.rcfv.com.au/Report-Recommendations>	Report and recommendations
Strengthening Hospital Responses to Family Violence initiative <https://www.thewomens.org.au/health-professionals/clinical-resources/strengthening-hospitals-response-to-family-violence/>	Toolkit with a range of helpful information from project management to policy and practice
The Lookout <https://www.thelookout.org.au/>	A range of information on family violence for staff of all sectors (including family violence risk assessment and safety planning)
Women with Disabilities Victoria <http://wdv.org.au/publications.htm#bte>	A range of publications and resources regarding women with disabilities and family violence
World Health Organization <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/> <http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf>	*Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook* (2014) *Responding to intimate partner violence and sexual violence against women*, WHO clinical and policy guidelines
Working with families and carers <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers>	*Working together with families and carers. Chief Psychiatrist's guideline* (2005) – note this guideline is currently under review
Young people experiencing family violence <https://woah.org.au/>	Information for young people about healthy relationships
Women's Mental Health Network Victoria <https://wmhnv.org.au/>	An advocacy, research and workforce-training network supporting and empowering women's lived experience

Appendix 5: Clinical checklist

Use when:

- engaging with a new consumer
- family violence has been disclosed during ongoing clinical care
- reassessing family violence following initial disclosure.

Enquire	About family violence as part of intake processes
Support	Person disclosing experience of family violence Person disclosing using violence
Assess (use the current Victorian family violence risk assessment)	Level of risk for victim/survivor and their children (preliminary) Level of risk person using violence may pose to partner, children, family members and others
Provide ongoing support	Continue to support, check-in, reassess, safety plan
Safety plan	Victim/survivor and their children: review any change to previous risk, discuss safety plan(s), have copy on file Person using violence: 'risk to self and others' – take note if 'others' are family members, partner or children; and level of risk
Consult	With senior clinician, supervisor, clinician with family violence expertise Specialist family violence service, Support and Safety Hub, Child Protection, Centre Against Sexual Assault, Victoria Police (as appropriate)
Refer	To a specialist family violence service, Support and Safety Hub, Child Protection, Centre Against Sexual Assault, police
Collaborate	Provide clinical care with added expertise from family violence specialists or other relevant services

- Keep other family members, the partner, carers and particularly children in mind.
- Be concerned and enquire about their safety.
- If the perpetrator is the partner or another family member, keep them in mind even if you never meet them.
- Enquire about levels of risk or levels of safety as part of routine mental health care.

Appendix 6: Myths about family violence

Myths about family violence are just that – myths.

They minimise, distort and at worst excuse violence. They contribute to 'victim blaming' rather than put the responsibility for violence on the person perpetrating it.

The table below lists some common myths about family violence and the reality.

Myth about family violence	Reality
It is not a widespread problem	Family violence, especially intimate partner violence, is a widespread problem across the world
There are as many male victims as female victims	Women are at much greater risk of family violence than men
Family violence overwhelmingly occurs in certain groups, such as poor families	Family violence occurs in all types of communities
Alcohol causes intimate partner violence	Alcohol does not cause violence
People could just leave family violence situations if they wanted to	See below

'Why doesn't she just leave?'

People experiencing family violence, especially women, are often asked 'Why don't you just leave?' when the question ought to be 'Why doesn't he stop the violence?'.

For example, as illustrated below, there are many reasons why a woman might remain with a partner or family member who is abusive.

Reason for not leaving a family violence situation	Comments
Fear arising from perpetrator threats	The reality is that women are increasingly unsafe immediately after they leave because perpetrators experience a loss of power and control
Fear of losing children or having children removed	This is a real concern, especially if mental illness is present
Isolation from friends, family and community	Part of family violence perpetration is making the victim/survivor socially isolated. Reaching out for help is much harder for someone when they have lost contact with family and friends
Income and financial issues, including loss of income, job, home, pets, possessions	Many women and children are forced to leave their home
Hoping the violence stops / still loving the person	Perpetrators are not necessarily always violent; there can also be good times
A deep emotional attachment	Letting go of a person and relationship can be hard, even when violence occurs
Fear of being on one's own	Getting used to being on one's own can be difficult and being a single parent can be hard. Women with disabilities may rely on their partner for physical and other care and care for children
Negative impact on children through loss of connection to school and friends	Moving, often several times (for example, into a refuge, then into temporary accommodation before finding a place to live) creates instability when stability is most needed
Having grown up with violence can mean that violence is seen as part of relationships	When violence was part of growing up it can be hard to appreciate that violence does not have to be part of relationships
Isolation from community, judgement or being ostracised	While communities can be supportive, they can also be judgemental and find fault with the victim/survivor rather than holding the perpetrator to account ('You've made your bed...')
Immigration status and fear of deportation	Women may not know about their rights regarding their immigration status and family violence. 'Having her deported' may have become part of trapping a woman in a violent relationship
Having to relocate into a different area or interstate	Depending on the severity of the violence and previous experiences of leaving, some women and children are forced to move a long way from home
Feelings of guilt and shame	Victims/survivors often blame themselves and are often blamed by others – for the violence, for tolerating the violence, for not leaving, for leaving
Pressure from family community to stay	There are many societal, cultural, religious and other norms that promote staying in a relationship over separation, even if violence is present

References

1 State of Victoria 2016, *Royal Commission into Family Violence: report and recommendations*, Melbourne.

2 Family Safety Victoria 2017, *Responding to family violence capability framework*, State Government of Victoria, Melbourne.

3 Australian Bureau of Statistics 2017, *Personal Safety Survey 2016*, ABS, Canberra.

4 Bryant W, Cussen T 2015, *Homicide in Australia: 2010–11 to 2011–12: National Homicide Monitoring Program report*, Australian Institute of Criminology, Canberra.

5 Indermaur D, Harding R, Blagg H, Atkinson L, Coase P, Francas M, Zappelli R 2001, *Young people and domestic violence*, Commonwealth of Australia, Canberra.

6 Cox P 2015, *Violence Against Women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012*, ANROWS, Sydney.

7 Diemer K 2015, *ABS Personal Safety Survey: Additional analysis on relationship and sex of perpetrator*, University of Melbourne, Melbourne.

8 Crimes Statistics Agency 2016, Family Incidents, year ending 31 March 2016, viewed 9 February 2018, <https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/family-incidents>.

9 Vic Health 2004, *The health costs of violence. Measuring the burden of disease caused by intimate partner violence. A summary of findings*, VicHealth, Melbourne.

10 James L, Brody D, Hamilton Z 2013, Risk factors for domestic violence during pregnancy: a meta-analytic review, *Violence and Victims*, vol. 28, no. 3, pp. 359–380.

11 Campbell JC 2002, 'Health consequences of intimate partner violence', *The Lancet*, vol. 356, no. 9314, pp. 1331–1336.

12 State of Victoria 2016, *Ending Family Violence. Victoria's plan for change*, Department of Premier and Cabinet, Melbourne.

13 The Royal Australian College of General Practice 2014, *Abuse and violence: Working with our patients in general practice*, 4th edn, RANCGP, Melbourne.

14 The Lookout 2017, Working with children and young people, viewed 30 January 2018, <http://www.thelookout.org.au/family-violence-workers/working-children-and-young-people>.

15 Carpenter GL, Stacks AM 2009, 'Developmental effects of exposure to intimate partner violence in early childhood: a review of the literature', *Children and Youth Services Review*, no. 31, pp. 831–839.

16 Middleton W 2012, In: Kezelman C, Stavropoulos P. *The Last Frontier. Practice guidelines for treatment of complex trauma and trauma-informed care and service delivery*, p. x. Adults Surviving Child Abuse (now blue knot foundation), Sydney.

17 Lum On M, Ayre J, Webster K, Moon L 2016, *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*, ANROWS, Sydney.

18 Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', *JAMA*, vol. 306, no. 5, pp. 513–521.

19 MacIsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K, Jelinek GA 2017, 'Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia', *Asia Pacific Journal of Public Health*, vol. 30, no. 1, pp. 36–44.

20 World Health Organization 2013, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, WHO, Geneva.

21 VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*, State Government of Victoria, Melbourne.

22 Khalihef H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard LM, 2014, 'Domestic and sexual violence against patients with severe mental illness', *Psychological Medicine*, no. 45, pp. 875–886.

23 Kezelman C, Stavropoulos P 2018, *Talking about trauma. Guide to conversations and screening for health and other service providers*, blue knot foundation, Sydney.

24 Courtois C, Ford J 2009, *Treating complex traumatic stress disorders*, Guilford Press, New York, p. 13.

25 Kooyman I, Dean K, Harvey S, Walsh E 2007, 'Outcomes of public concern in schizophrenia', *The British Journal of Psychiatry*, vol. 191, no. 50, s29–s36.

26 Fazel S, Gulati G, Linsell L, Geddes JR, Grann M 2009, 'Schizophrenia and violence: systematic review and meta-analysis', *PLoS Medicine*, vol. 6, no. 8, p. e1000120.

27 Elbogen EB, Johnson SC 2009, 'The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions', *Archives of General Psychiatry*, vol. 66, no. 2, pp. 152–161.

28 Mullen P 2001, *A review of the relationship between mental disorders and offending behaviours on the management of mentally abnormal offenders in the health and criminal justice system*, Criminology Research Council, Canberra.

29 Department of Health 2011, *Service guideline on gender sensitivity and safety. Promoting a holistic approach to wellbeing*, State Government of Victoria, Melbourne.

30 Kageyama M, Yokoyama K, Nagata S, Kita S, Nakamura Y, Kobayashi S, Solomon P 2015, 'Rate of family violence among patients with schizophrenia in Japan', *Asia Pacific Journal of Public Health*, vol. 27, no. 6, pp. 652–660.

31 Labrum T, Solomon PL 2015, 'Rates of victimization of violence committed by relatives with psychiatric disorders', *Journal of Interpersonal Violence*, vol. 32, no. 9, pp. 2955–2974.

32 Quadara A, Hunter C 2016, *Principles of trauma-informed approaches to child sexual abuse: a discussion paper*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 6.

33 Bateman J, Henderson C 2013, *Towards a cultural shift in policy reform across mental health and human services in Australia. A national strategic direction*, Mental Health Coordinating Council, Sydney.

34 *Working together with families and carers*. Chief Psychiatrist Guideline (2008 – currently under review).

35 Family Safety Victoria 2017, *Diversity and intersectionality framework*, State Government of Victoria, Melbourne.

36 Twisleton L, Coleman D, Coorey L 2017, *Interrupting male violence with men who use domestic and family violence*, NSW Health Education Centre Against Violence, Parramatta.

37 Royal Women's Hospital 2017, *Strengthening responses to family violence*, RWH, Melbourne.

38 Royal Women's Hospital 2017, *Strengthening responses to family violence: Identifying and responding to family violence policy*, RWH, Melbourne.

39 Howard LM 2012, 'Domestic violence: its relevance to psychiatry', *Advances in Psychiatric Treatment*, vol. 19, no. 2, pp. 129–136.

40 World Health Organization 2014, *Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook*, WHO, Geneva.

41 Australian Medical Association 2016, AMA position statement family and domestic violence, viewed 23 January 2018, <https://ama.com.au/position-statement/family-and-domestic-violence-2016>.

42 White M, Roche AM, Long C, Nicholas R, Gruenert S, Battams S 2013, *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

43 Australian Institute of Family Studies 2016, *Establishing the connection: guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors*, AIFS, Melbourne.

44 Fanslow JL, Kelly P, Ministry of Health 2016, *Family violence assessment and intervention guideline: child abuse and intimate partner violence* (2nd edn), Ministry of Health, Wellington.

45 Department of Human Services 2012, *Family violence risk assessment and risk management framework and practice guides 1–3*, State Government of Victoria, Melbourne.

46 Family Safety Victoria 2017, *Family violence information sharing guidelines: Guidance for Information Sharing Entities,* State Government of Victoria, Melbourne.

47 Royal Women's Hospital 2017, *Strengthening responses to family violence: project management guide*, RWH, Melbourne, p. 11.

48 Stewart M, Wilkes L, Jackson D, Mannix J 2006, 'Child-to-mother violence: a pilot study', *Contemporary Nurse*, vol. 21, no. 2, pp. 297–310.

49 Ibabe I, Jaureguizar J, Díaz Ó 2009, 'Adolescent violence against parents. Is it a consequence of gender inequality', *The European Journal of Psychology Applied to Legal Context*, vol. 1, no. 1, pp. 3–24.

50 Victoria Police 2017, Crime Statistics Agency, viewed 23 January 2018, <https://www.crimestatistics.vic.gov.au/family-violence-data-portal/family-violence-data-dashboard/victoria-police>.

51 Howard J 2011, *Adolescent violence in the home: the missing link in family violence prevention and response*, Australian Domestic, Family Violence Clearinghouse, University of New South Wales.

52 DVRCV 2017, Elder abuse and family violence, viewed 30 January 2018, <http://www.dvrcv.org.au/help-advice/elder-abuse-and-family-violence>.

53 Kaspiew R, Carson R, Rhoades H 2016, *Elder abuse: understanding issues, frameworks and responses*, Australian Institute of Family Studies, Melbourne.

54 Joosten M, Dow B, Blakey J 2016, *Profile of elder abuse in Victoria: analysis of data about people seeking help from Seniors Rights Victoria, final report*, National Aging Research Institute, Melbourne.

55 Frawlie P, Dyson S, Robinson S, Dixon J, 2015, *What does it take? Developing informed and effective tertiary responses to violence and abuse of women and girls with disabilities in Australia: State of knowledge paper*, ANROWS, Sydney.

56 Campo M 2015, *Domestic and family violence in pregnancy and early parenthood: CFCA practitioner resource*, Australian Institute of Family Studies, Melbourne, p. 4

57 Howard LM, Oram S, Galley H, Trevillion K, Feder G 2013, 'Domestic violence and perinatal mental disorders: a systematic review and meta-analysis', *PLoS Medicine*, vol. 10, no. 5, p. e1001452.

58 Austin Health 2018, Parent Infant Mental Health Initiative, viewed 6 April 2018, <http://www.austin.org.au/page?ID=357>.

59 INWMPCP 2017, Guideline for engaging people who cause family violence harm: policy guideline, viewed 23 January 2018, <https://www.lnwpcp.org.au>.

60 Hegarty K, Forsdike-Young K, Tarzia L, Schweitzer R, Vlais R 2016, 'Identifying and responding to men who use violence in their intimate relationships', *Australian Family Physician*, vol. 45, no. 4, p. 176.

61 Victoria Police 2017, *Policing harm, upholding the right: Victoria Police strategy for family violence, sexual offences and child abuse 2018–2023*, State of Victoria, Melbourne.

62 Department of Health and Human Services 2015, *Aboriginal family violence. Consultants' guideline*, State of Victoria, Melbourne.

63 Woodlock D, Healey L, Howe K, McGuire M, Geddes V, Granek S 2014, *Voices against violence paper one: summary report and recommendations,* Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre, Victoria.

64 Family Safety Victoria (internal document), *Overview of LGBTI family violence 2018*, Diversity Unit, Victorian Government, Melbourne.

65 Wendt S, Chung D, Elder A, Bryant L 2015, *Seeking help for domestic violence: Exploring rural women's coping experiences,* ANROWS, Sydney, p. 1.

66 *Carer Recognition Act 2012* (Vic)

67 *Disability Act 2006* (Vic)

68 *Mental Health Act 2014* (Vic)

69 Roufeil L, Battye K 2008, *Effective regional, rural and remote family relationships service delivery, Australian Family Relationships Clearinghouse: Briefing No. 10*, Australian Family Relationships Clearinghouse, Melbourne.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 5

This is the attachment marked 'Office of the Chief Psychiatrist: sector engagement summary' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Chief Psychiatrist

1. Chief Psychiatrist Quality and Safety Forums
   Frequency: 2-3 times per calendar year
   Purpose: Address priority quality & safety issues within mental health service deliver (eg: sexual safety in inpatient units, risk assessment protocols
   Participants: Up to 150 leaders within Vic mental health service

2. Mental health act statutory function - Electroconvulsive Therapy State-wide committee
   Frequency: Quarterly
   Purpose advise on the collection of information on ECT to be reported to the Chief Psychiatrist, review, and analyse information concerning ECT performed in designated mental health services, provide advice and recommendations to the Chief Psychiatrist concerning ECT performed in designated mental health services
   Participants: Invited clinical experts (medical, nursing, allied health), consumers, carers and academics

3. Mental health act statutory function - Restrictive interventions (RI) State-wide committee
   Frequency: Quarterly
   Purpose advise on the collection of information on RI to be reported to the Chief Psychiatrist, review, and analyse information concerning RI within designated mental health services, provide advice and recommendations to the Chief Psychiatrist concerning ECT performed in designated mental health services
   Participants: Invited clinical experts (medical, nursing, allied health), consumers, carers and academics

4. Mental health act statutory function – Reportable deaths (RD) State-wide committee
   Frequency: Quarterly
   Purpose advise on the collection of information on RD to be reported to the Chief Psychiatrist, review, and analyse information concerning RD within designated mental health services, provide advice and recommendations to the Chief Psychiatrist concerning RD reported by designated mental health services
   Participants: Invited clinical experts (medical, nursing, allied health), consumers, carers and academics

5. Sexual safety State-wide committee
   Frequency: Quarterly
   Purpose advise on the collection of information on sexual safety notifications reported to the Chief Psychiatrist, review, and analyse data concerning sexual safety notifications within designated mental health services, provide advice and recommendations to the Chief Psychiatrist concerning sexual safety in designated mental health services
   Participants: Invited clinical experts (medical, nursing, allied health), consumers, carers and academics

6. Authorised Psychiatrist State-wide forum
   Frequency: Quarterly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues with Authorised Psychiatrists within all designated mental health services
   Participants: Authorised psychiatrists within all Victorian designated mental health services

7. Monthly meetings
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues with respective organisations
   a. Royal Australian & New Zealand College of Psychiatrists monthly meetings
   b. Mental Health Complaints Commission monthly meetings
   c. Safer Care Victoria – Mental health clinical network monthly meetings

Chief Mental Health Nurse

1. Senior Mental Health Nurse Forums State-wide forum
   Frequency: Monthly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues with Senior mental health nurses within all designated mental health services
   Participants: Senior nurses within all Victorian designated mental health services

2. Specialist Senior Mental Health Nurse Forums State-wide forum – **Child and Youth**
   Frequency: Quarterly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues within specialist service type in all designated mental health services
   Participants: Specialist senior nurses within all Victorian designated mental health services

3. Specialist Senior Mental Health Nurse Forums State-wide forum – **Adult**
   Frequency: Quarterly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues within specialist service type in all designated mental health services
   Participants: Specialist senior nurses within all Victorian designated mental health services

4. Specialist Senior Mental Health Nurse Forums State-wide forum – **Aged**
   Frequency: Quarterly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues within specialist service type in all designated mental health services
   Participants: Specialist senior nurses within all Victorian designated mental health services

5. Specialist Senior Mental Health Nurse Forums State-wide forum – **Community**
   Frequency: Quarterly
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues within specialist service type in all designated mental health services
   Participants: Specialist senior nurses within all Victorian designated mental health services

6. Monthly meetings
   Purpose Discuss & share policies, initiatives and discuss current and emerging service delivery issues with respective organisations
   a. Victorian Mental Illness Awareness Council (consumer peak organisation) monthly meetings
   b. Tandem (carer peak organisation) monthly meetings
   c. Australian Nurse and Midwifery Federation (Victorian Branch) monthly meetings
   d. Health and Community Services Union monthly meetings

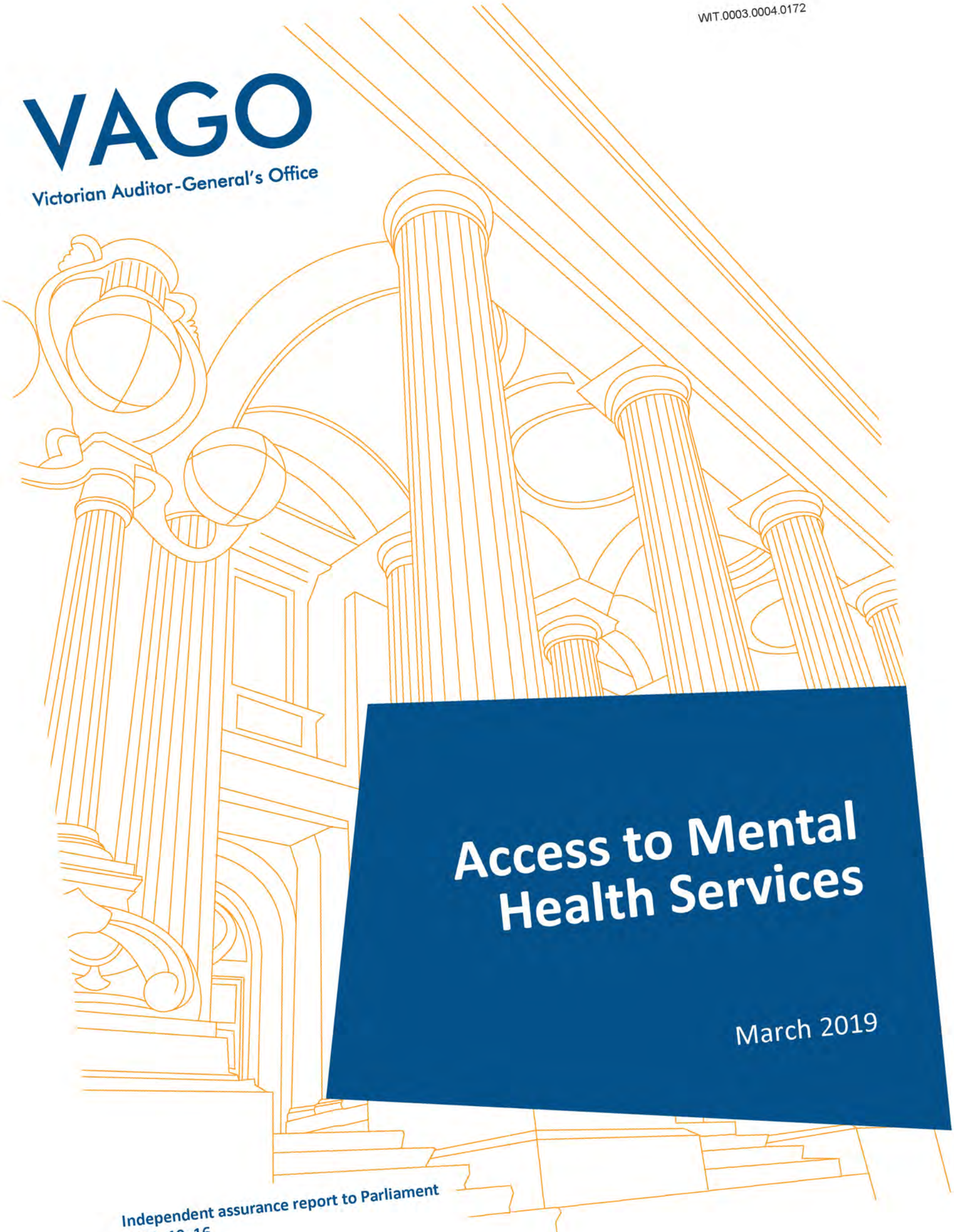
Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 6

This is the attachment marked 'Victorian Auditor-General's Office, Access to Mental Health Services report' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

VAGO

Victorian Auditor-General's Office



Access to Mental Health Services

March 2019

Independent assurance report to Parliament
2018–19: 16

VAGO
Victorian Auditor-General's Office

Access to Mental Health Services

Independent assurance report to Parliament

Ordered to be published

VICTORIAN GOVERNMENT PRINTER
March 2019

PP no 19, Session 2018–19

This report is printed on Monza Recycled paper. Monza Recycled is certified Carbon Neutral by The Carbon Reduction Institute (CRI) in accordance with the global Greenhouse Gas Protocol and ISO 14040 framework. The Lifecycle Analysis for Monza Recycled is cradle to grave including Scopes 1, 2 and 3. It has FSC Mix Certification combined with 99% recycled content.

ISBN 978 1 925678 40 6

VAGO
Victorian Auditor-General's Office

The Hon Shaun Leane MLC
President
Legislative Council
Parliament House
Melbourne

The Hon Colin Brooks MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report *Access to Mental Health Services*.

Yours faithfully

Andrew Greaves
Auditor-General

21 March 2019

Contents

Acronyms

AMHS	area mental health service
AIHW	Australian Institute of Health and Welfare
CCU	community care unit
CMI/ODS	Client Management Interface/Operational Data Store
DHHS	Department of Health and Human Services
ED	emergency department
LOS	length of stay
KPI	key performance indicator
MHCSS	Mental Health Community Support Services
MHET	Mental Health Expert Taskforce
MHNIP	Mental Health Nurse Incentive Program
PHN	primary health network
NDIS	National Disability Insurance Scheme
PAPU	psychiatric assessment and planning unit
PARC	prevention and recovery care
PBS	Pharmaceutical Benefits Scheme
SECU	secure extended care unit
SoP	statements of priorities
VAGO	Victorian Auditor-General's Office

Audit overview

One objective of the *Health Services Act 1988* is to 'ensure that an adequate range of essential health services is available to all persons resident in Victoria, irrespective of where they live or whatever their social or economic status'. Mental health care is one such service.

Mental illness affects not only an individual's wellbeing and quality of life, but also their physical health and engagement in employment, education and community; with flow-on effects to the human services, general health and justice systems.

With 45 per cent of the Victorian population experiencing mental illness in their lifetime, ensuring access to mental health care is vital to supporting a healthy and productive Victorian population. The demand for mental health care is growing, driven by multiple factors—including population growth, a reduction in stigma around seeking help, changes in legal and illegal drug use patterns, and increasing levels of social isolation in our community.

In 2009 the imminent gap in meeting demand for mental health services was forecast in the previous decade-long mental health plan titled *Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019*, which stated that:

> Action is needed not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in ten years' time.

In 2015, the Department of Health and Human Services (DHHS), the agency responsible for managing Victoria's public mental health system, acknowledged in *Victoria's 10-year mental health plan* (10-year plan), that:

> ...increasing and sustained demand pressure on services has not been matched with increasing resources. Shifting population and growth has left some services under even greater pressure. The result is longer waiting times to access services and higher thresholds for entry. The increased pressure on services creates a risk that people may receive treatment that is less timely, less intensive and shorter in duration than they want or need.

Given this acknowledgement, in this audit we assessed whether DHHS's current 10-year plan and supporting activities have started to address known access problems. Our audit objective was 'to determine if people with mental illness have timely access to appropriate treatment and support services'.

Conclusion

DHHS has done too little to address the imbalance between demand for, and supply of, mental health services in Victoria.

The lack of sufficient and appropriate system-level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported.

While DHHS understands the extent of the problem well and has been informed by multiple external reviews, the 10-year plan outlines few actions that demonstrate how DHHS will address the demand challenge that the 10-year plan articulates:

- there are no clear targets or measures to monitor progress in improving access
- there are no forward plans for the capital infrastructure needed
- the workforce strategy does not address the particular issues in regional and rural areas and fails to articulate specific targets
- there is no work to address barriers to access created by geographic catchment areas.

DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services; and in addressing historical inequities in funding allocations that do not align to current populations and demographics. This means many people wait too long or miss out altogether on services, and for those that do receive services, their clinical care can be compromised by the need to move them quickly through the system.

Real progress is unlikely within the life of the plan unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to operate in more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population.

The Royal Commission into Mental Health will undoubtedly highlight many areas for improvement across the system. However, the need for planning and investment to meet demand is already known and as such work to address this should not await the Commission's recommendations. Further delay will only amplify the problems the Commission seeks to address.

Findings

Victoria's 10-year mental health plan

Developing and implementing the 10-year plan

DHHS developed the 10-year plan through thorough sector and consumer consultation. The Mental Health Expert Taskforce (MHET) oversaw implementation. The group consisted of expert representatives from service providers, peak bodies, consumer groups, and academia.

Health services consistently raised that difficulty accessing services and coping with demand was a challenge. The 10-year plan reflects this and stresses the issue of 'higher demand and unmet need'. One of the 10-year plan's four focus areas is 'the service system is accessible, flexible and responsive to people of all ages, their families and carers and the workforce is supported to deliver this'.

However, little within the 10-year plan directly addresses improving access. It talks largely about the way services should be designed and delivered, such as through co-production with consumers, focusing on early intervention, integrating services, and implementing evidence-based practice. The AMHSs we audited expressed their disappointment in the plan because it is generic and lacks clear actions to address the demand and supply imbalance.

A role of the MHET was to inform 'waves of reform'—areas for DHHS to prioritise. The priority reform areas do not adequately reflect the underlying issue of lack of system capacity. Of the nine priority areas for the first two waves of reform, only two clearly relate to improving access; the development of a workforce strategy, and an action around 'managing clinical demand'. As such, while focusing action on useful activities—such as the development of frameworks for suicide prevention and supporting Aboriginal mental health, forensic service planning, and setting outcome measures—DHHS has made almost no progress in addressing the supply and demand imbalance.

DHHS has completed and released its workforce strategy, and through the 2018–19 budget secured funding for some new mental health workers. However, the workforce strategy does not include targets for the types or numbers of workers it aims to attract or retain and does not set action to address the significantly greater staffing challenges that regional and rural areas face. Further, the strategy is not integrated with service or infrastructure planning.

DHHS also completed a draft Clinical mental health services action plan 2018–2023, which better addresses the need of AMHSs and stakeholders to understand DHHS's direction in improving supply and access. The action plan informed DHHS's 2018–19 budget bid for mental health services, which secured growth funding for the sector. However, despite the investment of three-years' work in the plan, DHHS does not intend to release it publicly, which misses an opportunity to communicate DHHS's work in this area to the sector and stakeholders, and for stakeholders to hold DHHS to account for completing the work the action plan outlines.

Monitoring and reporting on progress

Other functions of the MHET were to develop a work program and advise the Minister for Mental Health on performance measures and targets. The MHET, though it considered and advised on progress indicators, did not develop a clear work program of actions, timeframes, or targets and subsequently neither the MHET nor DHHS have monitored plan progress against any agreed deliverables.

The MHET was disbanded in February 2018 as intended. The 10-year plan progress oversight now sits with the DHHS mental health branch. The mental health branch has reported only once to the DHHS Executive Board via the Health Reform Sub Committee—on the draft Clinical mental health services action plan 2018–2023. The lack of timely internal progress reporting significantly reduces accountability for achievement against the 10-year plan.

There are few measures in the outcomes framework for the 10-year plan that directly capture performance against providing access to services or increasing service reach—this is despite the acknowledged performance problems in this area—which shows a lack of focus on the most pressing issue the system faces.

Understanding and meeting demand

As system manager, DHHS has a responsibility to ensure service access by supporting the foundations of the system: funding, capital infrastructure and service distribution, and understanding demand and system performance to guide proper investment. In each of these areas, DHHS has done too little and now requires significant, prompt action if it is to make real progress against the 10-year plan.

Funding

Australian Institute of Health and Welfare (AIHW) data shows that between 2011–12 and 2015–16 national recurrent expenditure per capita on specialised mental health services grew an average of 0.7 per cent annually, while over that time in Victoria it declined by 0.3 per cent annually. In 2015–16, Victoria's per capita recurrent expenditure was $197.30, the lowest in Australia, with a national average of $226.52.

AMHSs advise that the allocation of growth funding over the last three state budgets has been partially directed to closing the existing gap between their service costs and the price DHHS pays, therefore AMHSs are not fully providing additional services. DHHS is aware of the price gap. A DHHS-commissioned review showed that DHHS pays 65 per cent of AMHS bed costs compared with more than 80 per cent of costs for general health beds.

DHHS has commenced funding reform, funding 'packages of care' to incentivise AMHSs to provide more community-based treatment services. However, without an adequate quantum of funding, the intended outcome is at risk.

DHHS's advice to government states that the new funding reform and four-year growth funding from 2018–19:

- provides each new community-based client with a maximum of six hours treatment per annum—the nationally recommended level is 72 hours
- enables DHHS to provide mental health services to 1.2 per cent of the population—a marginal improvement on the current 1.16 per cent—compared to the estimated 3.1 per cent of the Victorian population with a severe mental illness
- increases the price paid to only 67 per cent of AMHSs' costs.

DHHS also advises that the budget provides additional services for the most unwell patients, to be achieved within five years, but has not quantified this additional service provision.

DHHS has also moved bed funding to a slightly higher single price for all beds regardless of location or severity of illness, with the aim to begin addressing historical funding inequities. However, this does not account for the inherently higher operating costs that rural AMHSs face.

Planning to meet demand

Increasing demand combined with current service shortfalls are placing the whole mental health service under substantial stress. In 2017, DHHS commissioned an external review of the mental health system and the resultant report, Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System: Developing excellence in clinical mental health care for Victoria (Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System), highlights that:

- emergency department (ED) presentations have increased 9 per cent from 2015–16
- acute hospital admissions have grown at an annual rate of 2.4 per cent
- length of stay (LOS) in hospital trends down from 14.7 days to 11.2 days from 2009 to 2017 (with LOS stay in 2017–18 at 9.6 days)
- unplanned readmission rates for adult mental health patients at 14.4 per cent in 2017–18
- community mental health contacts per 1 000 people declining at a rate of 2.5 per cent per annum over the last 10 years.

These demand pressures have lifted the thresholds for access to services so that AMHSs only see the most unwell, which creates a flow on effect. AIHW reports the number of Victorian mental health patients that accessed acute services through police, ambulance and self-presentations to hospital EDs increased from 28 757 in 2004–05 to 54 114 in 2016–17.

To understand and respond to demand and access issues, DHHS needs data to reflect current service capacity and to calculate unmet demand. While it has developed a model to forecast service demand, it relies largely on historical activity data, which creates significant limitations to its use. DHHS is missing available information to understand unmet demand. It does not collate, assess and input to its forecasting model:

- data from mental health triage services to identify the number of people who contact triage but are not provided access to services
- people accessing services that are not registered with an AMHS.

Given DHHS acknowledges there is significant unmet demand, estimating this demand is critical to inform any future planning for the mental health system.

Capital infrastructure

Victoria has one of the lowest mental health bed bases nationally. As a result, all major acute psychiatric units continually operate at or above 95 per cent capacity—well above desirable levels of 80 to 85 per cent that would permit AMHSs to admit acutely ill patients as needed. A review commissioned by DHHS advised that Victoria's bed base needs to grow by 80 per cent over the next decade to reach levels of service provision of other Australian jurisdictions.

There are 53 new acute adult beds funded in 2018–19, with 21 now open and 34 in planning. There are also 24 sub-acute beds in the planning phase, and 10 mother and baby unit beds will operate seven rather than five days a week. While helpful, the additional beds will not meet the unmet demand nor shift Victoria towards the recommended bed numbers.

There are no further new beds in the capital pipeline, and while DHHS aims to complete a 'Detailed services and infrastructure plan for Victoria's clinical mental health system over the next 20 years' it will likely take DHHS some time to complete the plan; secure and allocate funding; and then plan and build infrastructure. DHHS should anticipate that Victorians with mental health issues will continue to face barriers accessing mental health beds across the remaining life of the 10-year plan, and that this will impact the effectiveness of any changes to funding or the service delivery model.

Catchment areas

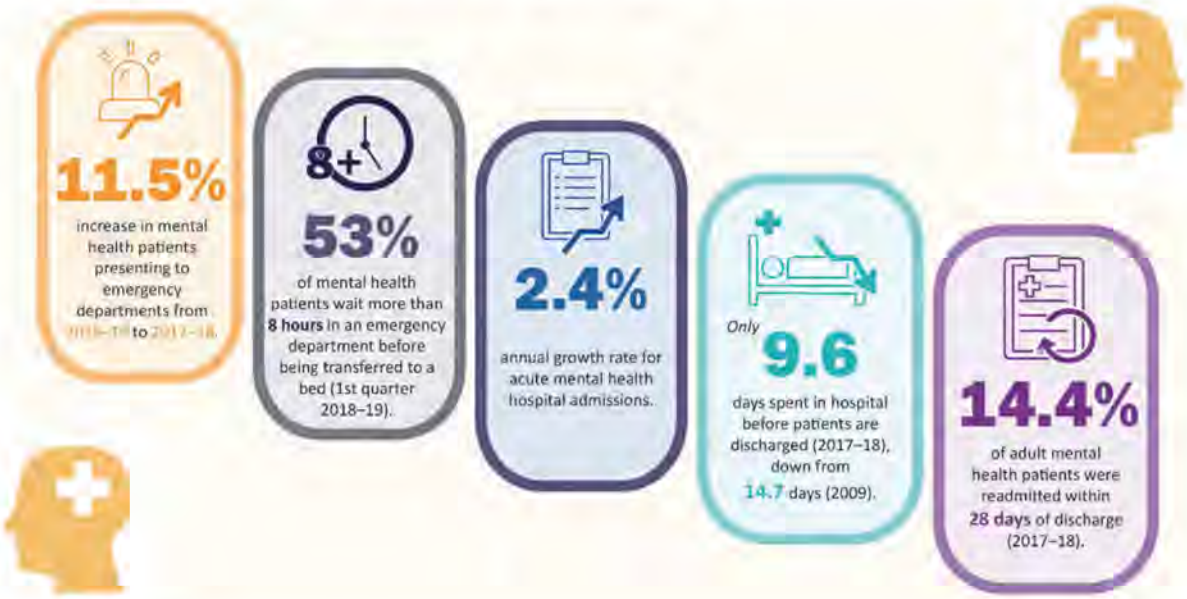
Clinical mental health services are provided in geographic catchment areas that were established in the 1990s. The consumer's place of residence determines which service or services they can access, which causes practical problems that hinder service access:

- the catchment areas are not aligned with other health and human service areas, or local government area boundaries, which makes service coordination difficult
- the geographic catchments do not align with age-based service groupings
- there is a lack of coordination between catchment areas when patients need to access services across catchment borders
- there is misalignment between service levels and types within a catchment and population growth and demographic changes in that area.

Despite understanding these issues for many years, and commissioning work to examine them and make recommendations, DHHS has taken no action to address them.

Figure A
Key numbers about the Victorian mental health system

Figure A
Key numbers about the Victorian mental health system—*continued*



Source: VAGO.

Recommendations

We recommend that the Department of Health and Human Services:

1. complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand
2. use this map to inform a detailed, public, statewide investment plan that integrates service, capital and workforce planning; setting out deliverables and time frames
3. set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public
4. undertake a price and funding review for mental health services, which includes assessing funding equity across area mental health services, and provide detailed advice to the Minister for Mental Health on the results and use this information to inform funding reforms
5. resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services
6. re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.

Responses to recommendations

We have consulted with the DHHS, Bendigo Health, Melbourne Health, Monash Health, Latrobe Regional Hospital, Peninsula Health, and South West Healthcare and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of the report to the Department of Premier and Cabinet.

DHHS provided a response. The following is a summary of its response. The full response is included in Appendix A.

DHHS accepted each of the six recommendations, with two accepted in-principle pending the outcomes of the Royal Commission into Mental Health. The department will undertake statewide mapping and assessment of current and future demand, develop a performance and accountability framework for mental health services, undertake a price review of clinical mental health services, and re-establish the MHET.

1 Audit context

1.1 Overview of Victoria's mental health services system

Nearly half (45 per cent) of Victorians will experience mental illness in their lifetime. Annually, one in five Victorians, or 1.2 million, suffer from a mental illness[1]. Of these 1.2 million people, based on 2017 population figures:

- 11 per cent will experience mild mental illness (670 000)
- 6 per cent will experience moderate mental illness (346 000)
- 3 per cent will experience severe mental illness (184 000).

The Victorian Government funds public mental health services covering clinical assessment, treatment, and case management in community and inpatient settings as Figure 1A shows.

A number of publicly funded specialist clinical mental health services are also delivered on a statewide basis, such as mother and baby services, eating disorder services, and forensic mental health services.

1.2 Agency roles and responsibilities

The Department of Health and Human Services

In relation to mental health services, DHHS is responsible for:

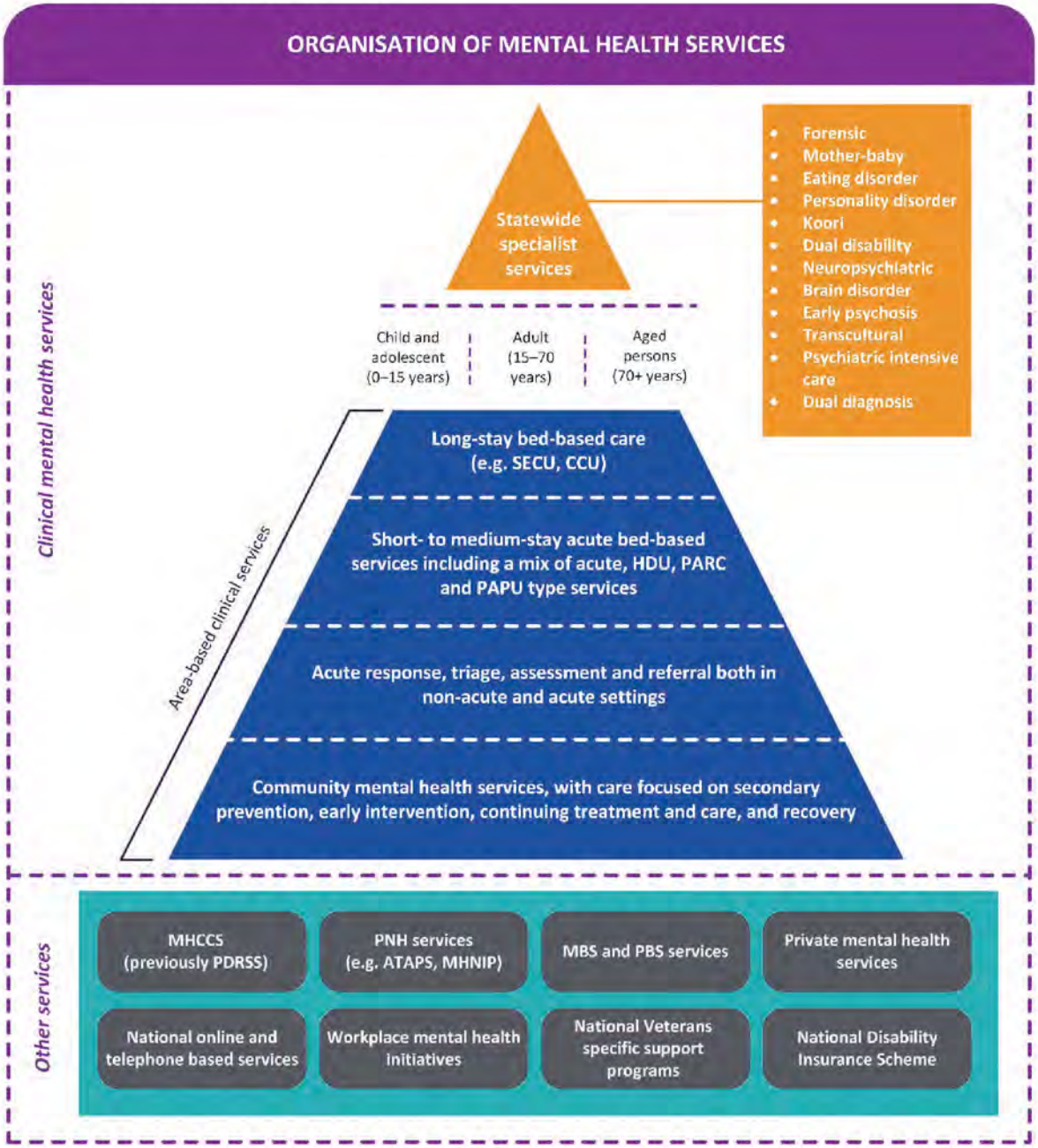
- funding
- developing policies and plans
- encouraging safety and quality of care
- monitoring and reviewing service provision
- developing performance measures to enable service comparison
- collecting and analysing data to support these functions.

These functions are undertaken by the mental health branch and other business units within DHHS.

---

1 Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017, page 20.

Figure 1A
Organisation of mental health services



Note: CCU = community care unit, SECU = secure extended care unit, HDU = high dependency unit, PARC = prevention and recovery care, PAPU = psychiatric assessment and planning unit, MHCSS = Mental Health Community Support Services, PHN = primary health network, ATAPS = Access to Allied Psychological Services, MHNIP = Mental Health Nurse Incentive Program, MBS = Medicare Benefits Schedule, PBS = Pharmaceutical Benefits Scheme.

Note: Services such as CCU, SECU and PAPU are described further in the next section.

Source: VAGO, based on Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, DHHS, 2017.

DHHS's 2018–19 mental health services budget was $1 605.7 million, or 6.4 per cent of its total budget. DHHS distributes the funding as set out in its annual policy and funding guidelines and annual statements of priorities (SoP)—the key accountability agreements between the government and health service providers. SoPs outline expected services and activity levels, performance measures and targets, and policy directions and requirements. DHHS monitors health services' performance against their SoP.

DHHS groups Victoria's clinical mental health services into age and regional cohorts. Aged-based service groupings are: child and adolescent mental health services (0–18 years), adult mental health services (16–64 years), and mental health services for older people (65+ years). Geographically, DHHS arranges services within catchments. The consumer's place of residence determines which service(s) they can access. The current range of services provided throughout Victoria includes:

- 13 child and adolescent mental health services, provided in five metropolitan and eight rural catchments
- 21 adult mental health services, provided in 13 metropolitan and eight rural catchments
- 17 aged persons mental health services provided in nine metropolitan and eight rural catchments.

Area mental health services

AMHSs provide a range of clinical mental health assessment and treatment services, and are managed by general health facilities such as hospitals. This audit focuses on the mental health services provided through these general health facilities—including:

- acute community intervention services (ACIS)—urgent response service providing telephone triage, community outreach, and support to EDs
- acute inpatient services—bed-based care for people acutely unwell, often provided within general hospitals
- community care units (CCU)—clinical care and rehabilitation in a home-like environment
- secure extended care units (SECU)—inpatient treatment and rehabilitation for people with unremitting and severe mental illness
- prevention and recovery care (PARC) services—short-term residential treatment services with a recovery focus
- psychiatric assessment and planning units (PAPU)—short-term (up to 72 hours) specialist psychiatric assessment and treatment for people experiencing an acute episode of mental illness
- clinical mental health services delivered in the community.

Figure 1B shows where the AMHSs are located across Victoria.

Figure 1B
Spread of AMHSs across Victoria against local government area boundaries

Regional and rural services

Metropolitan services

Source: Victoria's Clinical Mental Health System Plan, DHHS, 2016.

1.3 Relevant legislation and policies

Mental Health Act 2014

The *Mental Health Act 2014* (the Act) provides a legislative framework for the assessment of Victorians who appear to have a mental illness, and for the treatment of people with mental illness. The Act requires that people receive assessment and treatment with as few restrictions on human rights and dignity as possible. The Act has core principles and objectives, including:

- assessment and treatment is provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people is protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Policies

Several policies enable the provision of services to respond to the intent of the Act.

Victoria's 10-year mental health plan

DHHS published the 10-year plan in November 2015 in response to government election commitments. It is a long-term plan that sets the mental health agenda for the next decade that is intentionally ambitious, and outcome focused. The 10-year plan's goal is that all Victorians experience their best possible health, including mental health. The 10-year plan is not designed to document all the activities and initiatives needed to address the issues in the mental health system, but it aims to give strategic direction in mental health policy, funding and program development.

Victorian Government Suicide Prevention Framework 2016–25

The *Victorian Government Suicide Prevention Framework 2016–25* aims to halve Victoria's suicide rate by 2025 and supports the Commonwealth's *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan).

Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027

Balit murrup, meaning 'strong spirit' in the Woi-wurrung language, aims to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population. The framework sets out principles, strategic priorities and new investments to achieve this. In relation to access, one of four 'domains' included in the framework is 'improving access to culturally responsive services', with priorities for more Aboriginal people to engage in appropriate treatment and care, and for those services to be culturally safe and free from racism.

1.4 Why this audit is important

Mental health is an integral part of a person's capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work, pursue recreational interests, and to be able to make a positive contribution to society by making day-to-day decisions about education, employment, housing or other choices.

Disturbances to a person's mental wellbeing can negatively impact their capacity and the choices they make, leading not only to diminished functioning at the individual level but also to broader societal and welfare losses. There is significant flow on effect to other services if the mental health system is not functioning well, such as housing, justice and other health and community services.

Victoria's mental health system faces significant challenges and the 10-year plan is intended to set a pathway to address them. As DHHS is currently three years into this plan, it is timely to assess its progress in meeting one of the key challenges to the system: providing timely access to services in the face of increasing demand.

1.5 What this audit examined and how

Our audit objective was to determine if people with mental illness have timely access to appropriate treatment and support services.

DHHS and the broader mental health sector notes that Victorians with a mental illness do not have timely access to appropriate treatment and support services as expressed in the 10-year plan. For this reason, our audit focused on analysing whether the 10-year plan and supporting activities will start to address the existing access problem.

We examined how DHHS oversees the mental health system and whether it promotes increased accessibility. We examined DHHS's mental health policies, strategies and plans, the data it collects, and how this informs planning.

Alongside DHHS, we gathered evidence from six health services:

- Bendigo Health
- Melbourne Health
- Monash Health
- Latrobe Regional Hospital
- Peninsula Health
- South West Healthcare.

Pursuant to section 20(3) of the *Audit Act 1994*, unless otherwise indicated, any persons named in this report are not the subject of adverse comment or opinion.

We conducted our audit in accordance with Section 15 of the *Audit Act 1994* and the Australian Auditing and Assurance Standards. The cost of this audit was $760 000.

1.6 Report structure

The rest of this report is structured as follows:

- Part 2—Victoria's 10-year mental health plan
- Part 3—Meeting demand for mental health services.

2

Victoria's 10-year mental health plan

DHHS published the 10-year plan in November 2015 in response to government election commitments. Service accessibility is one of the primary considerations within the 10-year plan. Accessible mental health services mean they are available in the right place, at the right time and delivered by the right people with the right skills.

Demand for mental health services in Victoria is rising. The number of Victorians who require services, and the severity of illness, has increased. Population growth, different legal and illegal drug use patterns, and better mental health awareness are all driving this increased demand.

Without high quality and accessible services, many Victorians with mental illness are unlikely to receive timely help and support. Alongside the significant human cost, the lack of timely access to services has a substantial economic impact, and negative flow-on effects to other government services such as housing and justice services.

This part examines the extent to which the 10-year plan focuses on addressing demand.

2.1 Conclusion

While the 10-year plan clearly outlines the significant service demand and access issues facing the system, little within it directly addresses these issues. While effort has been directed to worthy activities such as new frameworks for suicide prevention and Aboriginal mental health and planning for forensic mental health services neither these initiatives, nor core services, can succeed while the system is overwhelmed. The priorities established in the 10-year plan do not reflect the most pressing challenges facing mental health services and their users.

DHHS's draft Clinical mental health services action plan 2018–2023, building on the 10-year plan, goes some way to addressing the challenges. The action plan details system changes to improve access to mental health services. However, while DHHS is using elements of the draft action plan to inform new initiatives, many of which government funded as four-year initiatives from 2018–19 onwards, it advises it is unlikely to finalise and release it. This misses the opportunity to communicate to stakeholders, who are in need of support, DHHS's goals for improving access, and also limits the ability of AMHSs, service users, and the public to hold DHHS to account in achieving its aims.

A completed 10-year plan priority action relevant to access is DHHS's workforce strategy. It includes new approaches to recruitment advertising and professional development, and helped inform a successful bid to government for funding for new mental health workers in 2019. However, the strategy has no concrete actions to address regional and rural workforce gaps, is isolated from service and capital planning, and has no measures or targets to show what DHHS hopes to achieve.

DHHS has not articulated any targets to measure progress against the 10-year plan's key challenge—providing timely access to the right services in the face of growing demand. Current measures that DHHS has aligned to the outcome of 'right services at the right time' either indirectly measure access, or do not measure access at all. While the measures focus on providing the 'right service', there are no measures addressing the 'right time' part of the outcome. If the focus of effort is truly to be on improving access, then DHHS must set relevant access measures and targets to drive performance and against which to publicly report progress. Compounding the lack of targets and measures is a lack of routine, senior level oversight of, and reporting against, the 10-year plan within DHHS, limiting senior executive attention to this high priority service.

2.2 Developing and implementing the 10-year plan

10-year plan aims

Victoria's 10-year plan is a high-level, outcome-focused framework for mental health service reform. DHHS's vision for mental health as outlined in the 10-year plan is that 'all Victorians experiencing mental illness get the best possible treatment and support, so they can live meaningful and fulfilling lives of their choosing'. The vision reflects one of the main objectives of the *Health Services Act 1988*, that 'an adequate range of essential health services is available to all persons, resident in Victoria irrespective of where they live or whatever their social or economic status'.

The 10-year plan aims to achieve its vision through four focus areas that contribute to sixteen outcomes as per Figure 2A.

Figure 2A
10-year plan focus areas and outcomes

Vision	ALL VICTORIANS EXPERIENCE THEIR BEST POSSIBLE HEALTH, INCLUDING MENTAL HEALTH
Domains	**Outcomes**
Victorians have good mental health and wellbeing	1. Victorians have good mental health and wellbeing at all ages and stages of life 2. The gap in mental health and wellbeing for at-risk groups is reduced 3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced 4. The rate of suicide is reduced
Victorians promote mental health for all ages and stages of life	5. Victorians with mental illness have good physical health and wellbeing 6. Victorians with mental illness are supported to protect and promote health
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	7. Victorians with mental illness participate in learning and education 8. Victorians with mental illness participate in and contribute to the economy 9. Victorians with mental illness have financial security 10. Victorians with mental illness are socially engaged and live in inclusive communities 11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system 12. Victorians with mental illness have suitable and stable housing
The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time 14. Services are recovery-oriented, trauma-informed and family-inclusive 15. Victorians with mental illness, their families and carers are treated with respect by services 16. Services are safe, of high quality, offer choice and provide a positive service experience

Source: Victoria's Mental Health Services Annual Report 2016–17, DHHS, 2017.

The fourth focus area, describing an accessible system, is particularly relevant to meeting demand. The 10-year plan links these outcomes to the statements:

- Universal access to public services—people with mental illness and their families and carers have access to high-quality, integrated services according to their needs and preferences.
- Access to specialist mental health services—people with mental illness, their carers and families have access to the public treatment and support services they need and choose, appropriate to their age and other circumstances, where and when they need them most.

While the 10-year plan articulates these overarching goals, the outlined approaches focus on the way services are provided and developed and do not highlight actions to address the unmet demand that the plan acknowledges exists.

Stakeholder engagement

DHHS consulted with a wide range of stakeholders in developing the 10-year plan, including six rural and regional public workshops and gathering input from more than 1 000 consumers, carers, workers and other sector stakeholders. Our review of the records of public consultations notes diverse issues and opinions. Access to mental health services was a key issue highlighted in all public consultation records reviewed, including the gap between the number of people needing public mental health services and the capacity of specialist clinical services and community mental health support services to meet those needs.

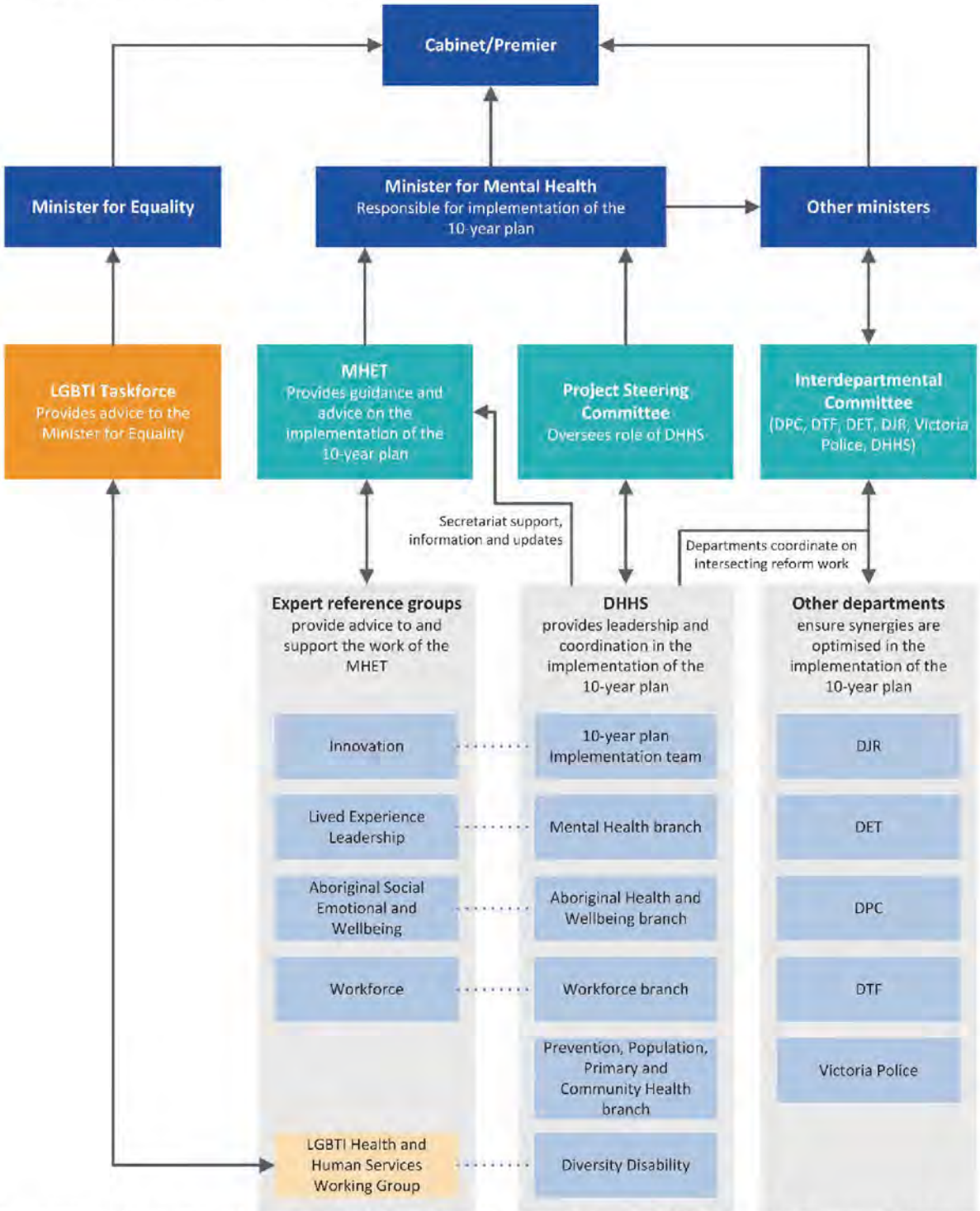
DHHS prepared discussion papers to assist with developing the 10-year plan that included diverse groups, including Aboriginal communities, refugees and asylum seekers, and lesbian, gay, bisexual, transgender and intersex persons. Consultation questions included 'How do we configure the way specialist mental health treatment services are delivered to improve access and responsiveness to the needs of...'. However, though access was a key issue put forward during these consultations, improving access, including for diverse groups, has not been adequately reflected in the 10-year plan.

Each of the audited mental health services were critical of the 10-year plan. These stakeholders all said that while the 10-year plan includes many relevant issues, there are too many generic statements in response to these issues. Each service would like practical guidance and a plan that clearly outlines the key deliverables. They indicated they would like DHHS to engage more with them and develop a plan that is achievable and aligned with contemporary practice. Access and demand issues were discussed strongly by each of the audited AMHSs, with issues such as workforce capacity and geographic reach identified as barriers to addressing access.

Governance arrangements

The MHET was established to monitor the 10-year plan's progress, as outlined in Figure 2B, and to provide guidance and advice on its implementation in the first two years.

Figure 2B
Initial governance structure for the 10-year plan



Note: LGBTI = lesbian, gay, bisexual, transgender and intersex; DJR = Department of Justice and Regulation; DET = Department of Education; DPC = Department of Premier and Cabinet; DTF = Department of Treasury and Finance.
Note: On 1 January 2019, a number of machinery of government changes came into effect, and consequently the Department of Justice and Regulation (DJR) became the Department of Justice and Community Safety.
Source: VAGO, based on information from DHHS.

The MHET included members representing service providers, peak bodies and other stakeholder organisations. The MHET's terms of reference included to:

- advise the minister on actions to achieve intended outcomes
- identify priorities and develop a work program of actions
- advise the minister on measures and targets to demonstrate achievement towards intended outcomes
- plan implementation activities.

Minutes from the MHET's meetings show discussion of a range of mental health issues, including taskforce priorities and updates on government activity. However, these documents do not show substantive discussion about access and demand. The taskforce also did not develop a clear work program of actions, with timeframes, and subsequently did not monitor progress against any agreed deliverables. The MHET, while considering and advising on progress indicators, did not set targets for them.

The MHET was disbanded in February 2018, at the completion of its fixed two-year term. Oversight for progress against the plan now sits with the mental health branch within DHHS, which reports only to higher levels within DHHS—the Executive Board via the Health Reform Sub Committee—on an ad hoc basis. Since the MHET disbanded, the mental health branch has reported to the executive once about just one of the four priority areas within the 10-year plan. This lack of internal progress reporting significantly reduces accountability for achieving against the plan.

Implementing the 10-year plan

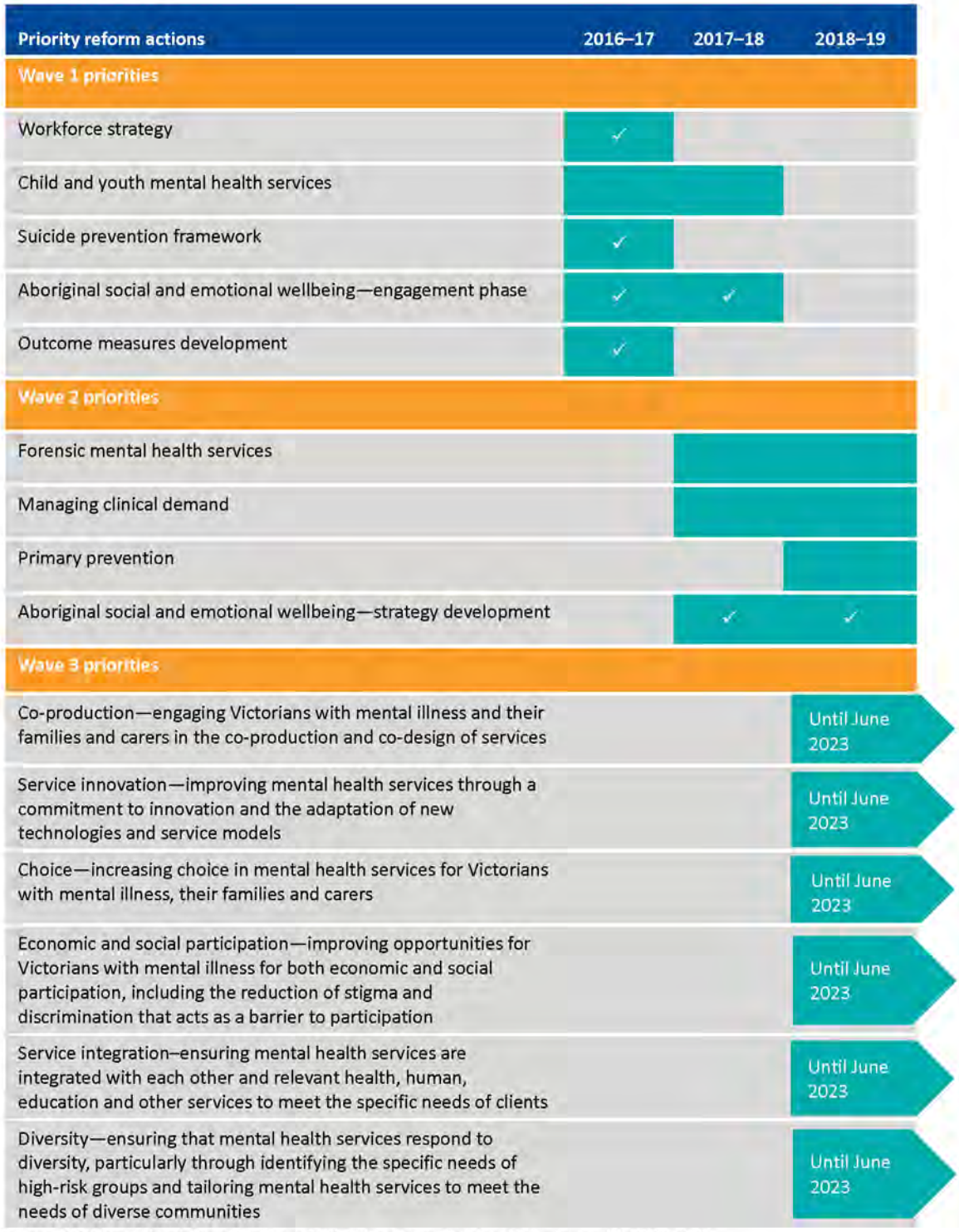
DHHS and other stakeholders have directed significant resources to implementing the activities underpinning the 10-year plan; however, there is no evidence of activity milestones, nor these being met.

A key DHHS focus was to create short and long-term implementation activities to achieve the plan's outcomes by identifying waves of reform that operate alongside other reform activities, shown in Figure 2C. The waves describe the order of priority actions over the first three years of the 10-year plan, as set out by the MHET. Key focus areas that are particularly relevant to access include the Workforce Strategy (Wave 1), Managing Clinical Demand (Wave 2), and in Wave 3, 'Diversity—ensuring that mental health services respond to diversity, particularly through identifying the specific needs of high-risk groups and tailoring mental health services to meet the needs of diverse communities'. *Victoria's Mental Health Services Annual Report 2017–18* (2017–18 Annual Report), published by DHHS, outlines several actions commenced to support access for diverse consumers including:

- the development of guidelines for interpreters working in mental health settings
- work to engage and support young people from refugee and asylum seeker backgrounds
- a grants programs to fund initiatives that support lesbian, gay, bisexual, transgender and intersex young people.

Figure 2C shows the priorities by wave, when DHHS identifies that it started to act on them, and priorities they report as completed (shown with a tick).

Figure 2C
Waves of reform



Source: VAGO, based on information from MHET planning material and interviews with DHHS staff.

We developed this progress report as DHHS does not track and report progress against the wave priorities.

2.3 Monitoring progress of the plan in improving access

DHHS's outcomes framework for the 10-year plan sets indicators against the planned outcomes. Figure 2D shows the indicators DHHS has aligned to the outcome related to access: 'the treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time', and results against these indicators, as reported publicly by DHHS.

Figure 2D
Results against mental health 'access' indicators 2014–15 to 2016–17

Indicator	2014–15	2015–16	2016–17	2017–18
Rate of pre-admission contact—reflecting whether the person is appearing for the first time to an acute facility	59.4%	57.2%	51.8%	59.4%
Rate of readmission within 28 days—indicating that the discharge from inpatient services may have been too soon, or the treatment or discharge planning may not have fully addressed the issue	13.8%	13.9%	13.4%	13.8%
Rate of post-discharge follow-up—an important service to support transition back into the community	85.7%	84.2%	77.7%	87%
New registered clients accessing public mental health services (no access in the last five years)	36.3%	35.7%	36.6%	36.8%
Proportion of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good or excellent—indicating general consumer satisfaction with the outcomes of the care provided	N/A	N/A	53.5%	55.2%

Note: No data is available for the 'consumer' indicators for 2014–15 and 2015–16.
Note: The result for post-discharge follow up for 2016–17 was impacted by industrial issues.
Source: Victoria's Mental Health Services Annual Report 2016–17 and the 2017–18 Annual Report, DHHS.

Except for the measure regarding new registered clients, these indicators only provide an indication of whether consumers received the 'right service'. The lack of improvement in the readmission rate suggests ongoing challenges in providing the 'right service', though there are improvements in the most recent year data for consumer experience, pre-admission contact and discharge follow up, which likely reflects recent increases in funded service hours. However, none of the measures are truly relevant to access, which considers the 'right time' part of the intended outcome. There are no measures of wait times for services, the numbers of consumers declined or delayed service due to capacity constraints, or consumer-reported experience of service accessibility. The measure of new registered clients could provide an indication of the system's capacity to support access; however, measured as a percentage of total clients, it gives no information on whether actual numbers of new clients are growing.

Further, DHHS has not articulated any targets for the measures that it has set. Without targets, it is unclear what level of improvement DHHS is aiming for.

As shown in Figure 2E, available service usage and capacity data for 2014–15 to 2017–18 shows recent improvements in the numbers of people accessing public mental health services; however, this reflects only a marginal increase in the proportion of people receiving care. The large gap against the target for timely access to a mental health inpatient bed from an ED persists. DHHS could use the information it already collects to set targets for improvements to access.

Figure 2E
Alternate indicators of mental health service accessibility

Indicator	2014–15	2015–16	2016–17	2017–18
Community service contacts (number)	2 058 909	1 935 262	1 675 772	2 407 730
Community service contacts (hours)	1 011 396	971 965	881 950	1 288 028
Total numbers of people accessing clinical mental health services[(a)]	67 030	67 559	66 487	72 859
Proportion of population receiving clinical care[(b)]	1.13%	1.12%	1.08%	1.16%
	Jul–Sep 2017	**Oct–Dec 2017**	**Jan–Mar 2018**	**Apr–Jun 2018**	**Jul–Sep 2018**
Audit mental health ED presentations transferred to a mental health bed within eight hours—target is 80%	55%	56%	56%	59%	53%

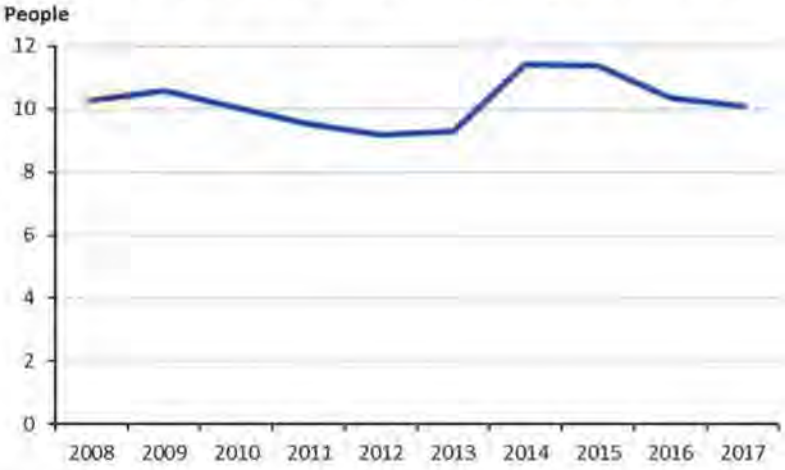
(a) 2015–16 and 2016–17 data collection was affected by industrial activity. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.
(b) Population estimate is based on *Victorian in Future 2014* projections.
Source: VAGO, based on information from *Victoria's Mental Health Services Annual Report 2016–17*, the 2017–18 Annual Report, and the Victorian Health Services Performance website www.performance.health.vic.gov.au, DHHS.

Suicide rates, while determined by multiple environmental factors, in part reflect the quality and availability of clinical supports. The only stated outcome of the 10-year plan with a clear target relates to the aim to halve the Victorian suicide rate by 2025.

The 2017–18 Annual Report states there has been a reduction in the number of suicides from 654 in 2015 to 621 in 2017. However, 10-year data available from the Australia Bureau of Statistics shows that there is no significant reduction. As shown in Figure 2F, the suicide rate has been relatively stable, varying slightly around 10 per 100 000 with an increase between 2013 and 2014 due to a change to incorporate cause-of-death post coroners' enquiries[2]. To halve the 2015 rate of suicides these numbers will need to decline to around 418 in 2025 based on current Victorian population projections.

[2] Australian Bureau of Statistics technical note 2 CAUSES OF DEATH REVISIONS, 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3303.0Technical%20Note22015?opendocument&tabname=Notes&prodno=3303.0&issue=2015&num=&view=, 2018.

Figure 2F
Victorian suicide rate per 100 000 population, by year, 2008 to 2017



Source: VAGO, based on Australian Bureau of Statistics data.

DHHS has not completed an evaluation framework to support the 10-year plan; however, DHHS's Centre for Evaluation and Research is planning a formal evaluation of the 10-year plan by 2020, five years into the plan. To properly complete this task, performance indicators relevant to improving access to services and more importantly, targets are necessary, particularly to ensure DHHS and AMHSs collect the right data for the evaluation.

2.4 The draft Clinical mental health services plan 2018–2023

The draft Clinical mental health services action plan 2018–2023 is a blueprint for transforming clinical mental health services in Victoria to address demand for, and access to, mental health services. The action plan supports the 10-year plan implementation. The action plan's focus areas are:

- transforming adult community-based services by:
  - increasing their capacity to treat more people and respond at earlier stages of illness
  - supporting clinicians to deliver evidence-based and best practice interventions
  - streamlining and improving service entry processes so that people can get timely assessment of their needs and referral to mental health or other services
- introducing new responses to help people experiencing a mental health crisis
- providing a balanced system of high-quality bed-based services, included enhanced sub-acute services to relieve pressure on acute inpatient units
- building links with and support for other services, with alcohol and other drug services prioritised for immediate action
- responding effectively to people with complex needs who present risks to community safety
- strengthening services for children and young people.

The key enablers are:

- a new funding model that incentivises health services to accept more patients and direct resources to the highest need patient groups
- a new Mental Health Performance and Accountability Framework that reflects the intended funding reform and creates greater transparency about service performance and consumer outcomes
- support for the mental health workforce, including in the delivery of evidence based and best practice treatment
- service and infrastructure planning to identify the optimum mix of community-based, sub-acute and acute inpatient services, taking account of the need for infrastructure to reflect demographic changes
- high-quality government policies, legislative frameworks and guidance for the sector
- strategic investment in research and evaluation to create a system that is continually learning.

Currently, this document is in draft form. It takes a step towards supporting AMHSs and their stakeholders by outlining more direct actions to reform the system and address capacity issues. While it took three years to develop, DHHS advises that it is unlikely to be finalised and released. DHHS is using elements of the draft action plan to inform new initiatives, many of which were funded as four-year initiatives from 2018–19; however, it is a missed opportunity for DHHS to not release the plan, particularly given the clear need of AMHSs for more communication about DHHS's intentions in this area.

2.5 Workforce strategy

Currently, there are over 5 000 people working in mental health, predominantly in roles such as psychiatry, mental health nursing, social work, psychology and occupational therapy, and increasingly, lived-experience workers (both consumers and carers) and other allied health professionals (such as speech pathologists). We found through our consultations with AMHSs that recruiting, retaining and managing their workforce is one of their most significant obstacles to providing access to services. They cited low morale and an ageing, stretched workforce as key challenges, in addition to stigma and negative community perceptions. The mental health workforce is impacted by:

- insufficient workers, particularly in rural and remote areas
- a change in service delivery needs from community mental health services to acute mental health services and the different skills needed
- risks to safety and wellbeing
- a lack of development opportunities
- inadequate undergraduate and other training opportunities.

DHHS is aware of these workforce challenges and has been actively trying to address them through a range of initiatives. The workforce strategy is a key focus area under wave 1 of the 10-year plan. DHHS published the new workforce strategy in June 2016, which builds on *Victoria's specialist mental health workforce framework: strategic directions 2014–24* and the previous 10-year plan *Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019*. The workforce strategy outlines five key objectives, with the first being most relevant to access:

- workforce availability and skill—right person, right place, right skill
- worker safety and satisfaction—places people want to work
- workforce integration—learning together, working together
- co-design and co-delivery with consumers and carers—shaping the future together
- workforce innovation—exploring and sharing new ways of working.

Initiatives within the workforce strategy that aim to support workforce availability and skill include:

- the provision of learning and development in priority areas through DHHS's new Centre for Mental Health Learning (see sidebar)
- a targeted mental health recruitment campaign, Hello Open Minds, to attract and retain a skilled and sustainable workforce (launched in July 2017)
- workforce planning, informed by routine workforce data collection, to highlight where development and growth need to be focused
- a range of actions to attract and retain Aboriginal people to the mental health workforce
- expansion of the paid 'lived-experience' workforce to provide consumers with more choice in the types of services they receive, including peer support and advocacy
- a commitment for further work to address issues of occupational violence that affect attraction and retention.

The Centre for Mental Health Learning will act as an umbrella organisation, coordinating and leveraging current mental health investments by partnering with statewide trainers, Mental Health Workforce Learning and Development Clusters, health services, clinical academics and other stakeholders.

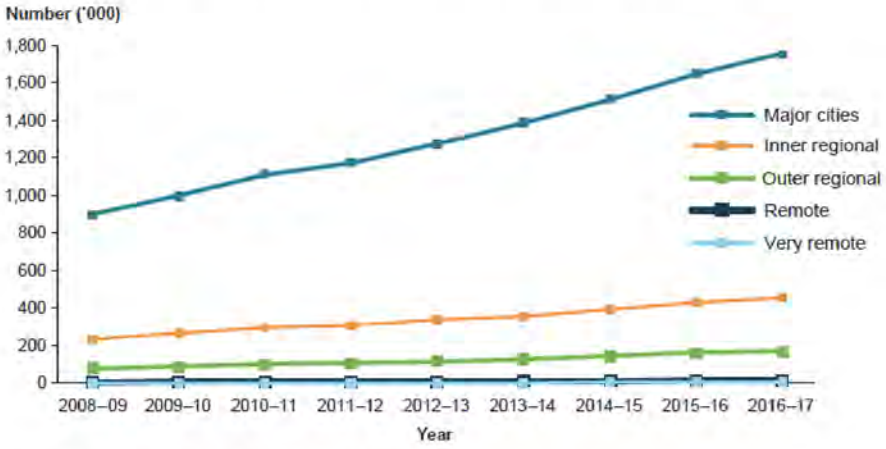
A number of activities relate to addressing access by increasing the mental health workforce with initiatives such as Hello Open Minds—a strategy to support recruitment—and the Centre for Mental Health Learning—aimed at improving the retention of the workforce through professional development and enhancing their ability to care for clients with complex needs. DHHS also requested and received funding to support workforce initiatives aimed at increasing the number of mental health staff. In 2019, additional clinical nurse consultants and mental health engagement workers will be recruited.

Despite this range of workforce activities, it is not clear what DHHS aims to achieve through its workforce strategy and initiatives, as it has not set quantifiable performance indicators or targets, and there are no plans for a formal evaluation. DHHS advice to government through its 2018–19 business case to 'Reform clinical mental health services', does articulate the need for growth funding, additional and different services and additional staff, but does not explain their interdependencies. DHHS requires a clear understanding of the numbers and types of staff needed, and where and when they are needed, to enable its broader service reforms to occur. This in turn, would inform specific targets. Without such ways to measure progress, DHHS cannot track whether its investment in the workforce strategy and initiatives is growing and supporting the mental health workforce. The strategy also does not directly address the identified issue of higher workforce gaps in regional and rural areas.

3 Understanding and meeting demand

Demand for mental health services in Victoria is increasing, not just in relation to the number of people who need services, but also in the severity of illness. The drivers of the increased demand include population growth, legal and illegal drug use, and heightened community awareness of mental health issues. The number of people experiencing mental illness in Australia has increased significantly in the last 10 years, as Figure 3A shows, and Victoria is consistent with this trend.

Figure 3A
Growth in number of Australians experiencing mental illness by area of residence



Source: Mental health services: In brief 2018, AIHW.

DHHS's intention for the mental health system is that, where possible, people are supported to remain in the community—which is often the best environment for the individual, and also reduces demand on bed-based services. However, achieving this aim relies on a system with the capacity to provide timely access to services.

This part examines the aspects of the mental health service system that underpin the provision of access to services; funding, demand, infrastructure and service distribution.

3.1 Conclusion

DHHS's 10-year plan includes 'enabling greater access to high quality, integrated services'—Outcome 13. Victorians have a right to expect this level of service from their public mental health services and to achieve this outcome, the system needs funding and infrastructure that matches demand and a service model that promotes, rather than impedes, access. Recent advice from DHHS to government, supported by multiple DHHS-commissioned reviews, clearly articulates the existing funding and infrastructure gaps. However, DHHS progress has been slow and the most important elements of change, such as funding reform, infrastructure planning, catchment area review, and improved data collection have only just, or not yet commenced. There is real risk that achievements intended within the 10-year plan's lifespan will not occur. Considerable acceleration of effort is required.

3.2 Funding

Victoria's public mental health services are subject to an input-based funding model. In this model, DHHS allocates a block of funding to AMHSs based on their number of inpatient beds or previous year's client numbers, which is indexed at 1.6 per cent per annum. The allocation is not sensitive to unmet demand, the needs and complexity of the mental health services' client cohort, contemporary population data, nor demographic changes.

AIHW data shows that between 2011–12 and 2015–16 national recurrent expenditure per capita on specialised mental health services grew an average of 0.7 per cent annually. Over that time in Victoria it declined by 0.3 per cent annually. In 2015–16, Victoria's per capita recurrent expenditure was $197.30, the lowest in Australia, against a national average of $226.52.

Funding for the mental health system since the 10-year plan was issued increased by $100.0 million in 2017–18 and $106.8 million in 2018–19. The Victorian State Budget 2018–19 provides $1 605.7 million in mental health funding, which will assist Victoria to address the funding disparity with other states and territories.

DHHS will spend $83.7 million during the 2018–19 financial year to begin clinical mental health services reform with a number of initiatives to help address access including:

- redesigning community-based mental health services
- strengthening the mental health workforce
- six new mental health and alcohol and drug service hubs
- growth in community mental health service hours
- increasing clinical capacity in sub-acute services.

Impact of funding shortfalls

Despite mental health system growth funding allocation over the last three state budgets, the lack of funding for more than 10 years has forced AMHSs to focus on acute and crisis treatment at the expense of earlier intervention services in the community. While community mental health received a share of growth funding, 2.3 per cent in 2016–17 and 7 per cent in 2017–18, AMHSs advise that this growth funding was largely directed to filling the existing gap between their service costs and the price DHHS pays, rather than providing additional services.

Because AMHSs often redirect resources from community to hospital settings to support consumers who need a higher level of care, AHMSs have limited capacity to intervene in the earlier stages of mental illness or deliver high quality interventions in the community to promote recovery. This limitation contributes to an increase in the number of people admitted to acute care without prior community contact. Between 2009 to 2016 acute admissions grew by 19 per cent, while community mental health contacts decreased by 17 per cent, which contributes to a cycle of increasing demand for costly emergency and inpatient services and further impacts AMHSs' ability to provide effective interventions during earlier stages of illness. Recent increases in funding for community services, however, have seen more people have preadmission contact, which begins to address this problem.

The audited AMHSs also advised that their bed day costs are higher than the price DHHS pays, and that they do not receive the necessary funding to meet demand. DHHS costings of acute mental health inpatient funding found that the price paid by DHHS meets only around 62 per cent of full costs to AMHSs, compared to 82 per cent of the price paid for general acute hospital beds. A DHHS commissioned review advised that the price paid should be 80 to 85 per cent of the full cost. All the audited AMHSs advised that, because of the current gap, AMHSs cross-subsidise their inpatient mental health services from other areas within the health service, which risks a negative impact on those services.

The case for funding reform

The introduction of activity-based funding in mental health services has been on the agenda in Victoria for over five years—DHHS's 2016–17 Acute Funding Review identified the need for mental health funding reform. DHHS's commissioned review 'Reform of Victoria's specialist clinical mental health services December 2017' (2017 review) also recommends that a future funding model should include output, input, block and outcome funding. Alongside this model is national health funding reform and the need for Victoria to align with the new Australian Mental Health Care Classification (AMHCC). The AMHCC is designed to provide consistency across health services, support integrated service delivery across services, and enable mental health services to be priced and funded on an activity basis.

Packages of Care—patients are classified into one of 13 levels by the complexity of their issues, phase of care and social connectedness, with funding matched to the needs of each classification level.

DHHS intends to provide AMHSs with a single annual payment based on their patient mix. Over time, DHHS will bundle funding for community care and acute care to provide the strongest incentive to substitute community mental health services for acute care where clinically possible.

In the interim, DHHS has started funding packages of care for high needs patients.

DHHS is now implementing funding reform for clinical mental health services that will move away from an input-based model towards bundling bed and community hours funding through 'packages of care' that are informed by the complexity levels of the client mix at an AMHS. The aim is to improve the support for clients most in need of mental health services and to incentivise AMHSs to assist people to remain well within the community setting. This is consistent with the findings and recommendations in DHHS's 2017 review which emphasises the need to increase community-based mental health treatment to reduce the demand on acute services. The four-year funding reform began in 2018–19 with a 'shadow' year to allow AMHSs to adjust to the changes. If this funding distribution method is successful, it will enable greater early access for consumers in need of mental health services and eventually alleviate demand for acute mental health services.

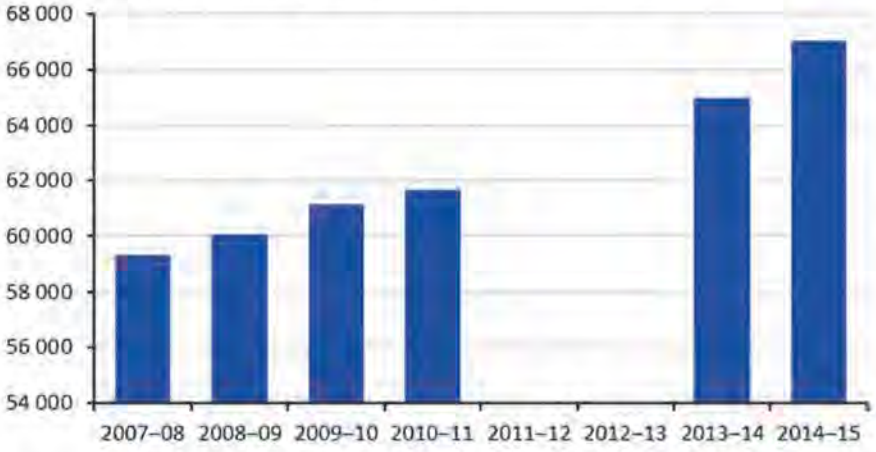
While the new funding model is well aligned to the intent to incentivise more community-based treatment, without an adequate quantum of funding (and the staff and infrastructure to deliver the services) there is risk that the intended outcomes will not be achieved. DHHS advice to government states that the new funding reform model aims to provide each new community-based client with a maximum of six hours treatment per annum and that the nationally recommended level is 72 hours per annum. DHHS also notes that the four-year growth funding will enable DHHS to provide mental health services to 1.2 per cent of the population in 2018–19 and thereon, only a marginal improvement on the current 1.16 per cent coverage compared to the estimated 3.1 per cent of the Victorian population with a severe mental illness. This growth funding also only increases the price paid to 67 per cent of AMHSs' costs.

Another change is that DHHS has moved bed funding to a single price for all beds regardless of location or severity of illness. It is unclear how DHHS is addressing the risk of disadvantaging some service providers such as rural AMHSs that have inherently higher operating costs.

3.3 Understanding and planning to meet demand

Demand for mental health services in Victoria has increased over the last 10 years, and this trend is likely to continue, as indicated by Figure 3B. This demand is exceeding population growth, as shown in Figure 3C.

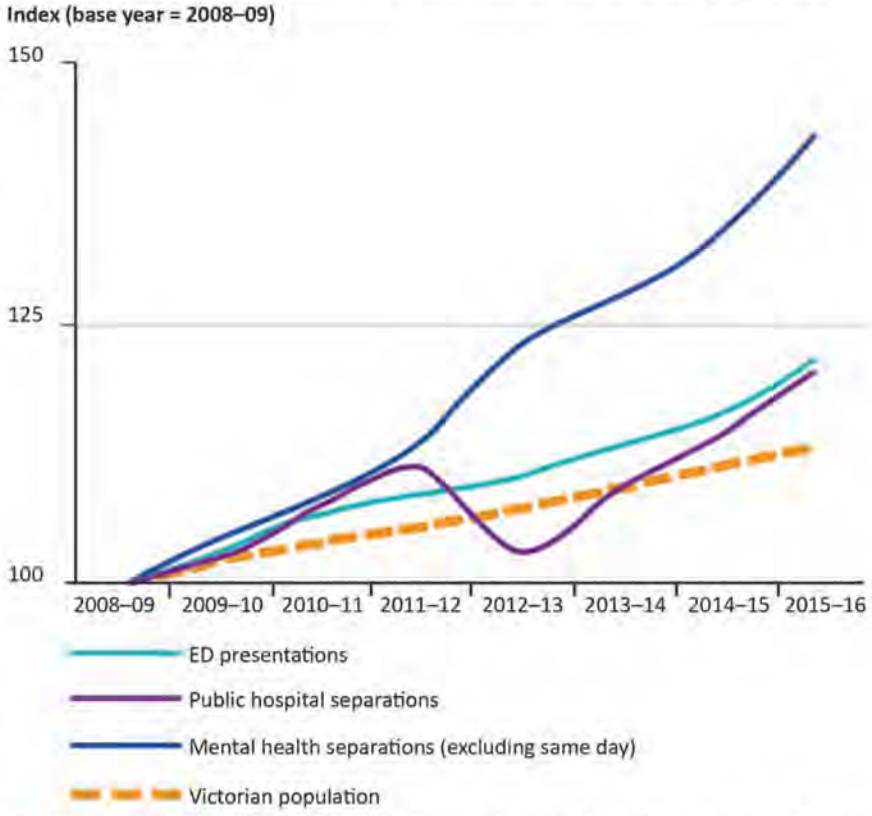
Figure 3B
Number of people receiving mental health services in Victoria



Note: Data was not available for 2011–12 and 2012–13.
Source: VAGO, based on *Report on Government Services*, Productivity Commission, 2017.

Mental health separations—when a patient formally admitted to hospital, receives at least one episode of care (and is in hospital for more than one day). Same-day services are counted separately.

Figure 3C
Indexed growth in Victorian health service-related events versus population



Note: Between 2011–12 and 2012–13 the negative growth in public hospital separations was due to a change in admissions policies (patients accommodated in the ED only were no longer counted as admitted). Once hospitals reconfigured their ED/inpatient interface, growth in separations has consistently increased.
Source: VAGO, based on information from DHHS using internal and Australian Bureau of Statistics data.

DHHS's 2017 review estimates that close to one million Victorians have a mental illness, with around 184 000 having a severe mental illness, as Figure 3D shows.

Figure 3D
Estimated number of Victorians with a mental illness

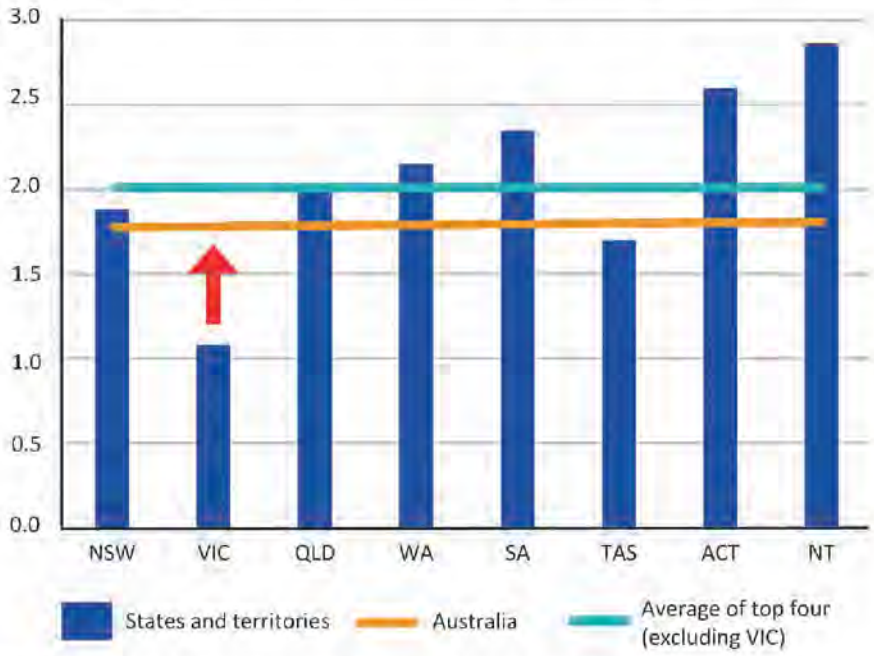
Severity of illness	Percentage of Victorians with a mental illness (%)	Number (thousands)	Percentage requiring treatment	Number needing treatment (thousands)	Primary government responsibility
Mild	9.0	537	50	268.5	Commonwealth
Moderate	4.6	272	80	217.6	State/Commonwealth
Severe	3.1	184	100	184	State
Total with mental illness	**16.7**	**993**		**670.1**	

Source: 2017 review, DHHS.

The table highlights the unmet demand for services in Victoria. In 2017–18 there were 72 859 registered users of mental health services, compared to the estimated 184 000 with severe mental illness that DHHS's 2017 review states need treatment.

Victoria falls significantly behind other jurisdictions and the national average in the proportion of the population receiving clinical mental health services, as Figure 3E demonstrates.

Figure 3E
Percentage of the Victorian population receiving clinical mental health services compared to other jurisdictions and the national average



Source: VAGO, based on information from AIHW's *Mental health services in Australia 2013–14* cited in Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, DHHS, 2017.

Increasing demand combined with current service shortfalls are placing the whole mental health service under considerable stress. The DHHS-commissioned Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System report states that increased demand has placed pressure across the mental health system over the last 10 years, which includes:

- ED presentations increasing 9 per cent from 2015–16
- acute hospital admissions growing at an annual rate of 2.4 per cent
- LOS in hospital trending down from 14.7 days to 11.2 days from 2009 to 2017—potentially not providing enough time for patients to become well
- unplanned readmission rates for adult mental health patients at 14.4 per cent in 2017–18
- community mental health contacts per 1 000 people declining at a rate of 2.5 per cent per annum over the last 10 years.

Figure 3F shows the increase in adult mental health admissions from 2009 to 2017. The increased number of presentations coupled with a shortage of mental health beds affects patients' LOS, meaning some patients likely do not receive the length of treatment they need. The 2017–18 Annual Report states LOS for adult acute mental health patients is just 9.6 days, a further decrease from that reported in the 2017 DHHS-commissioned review.

Figure 3F
Acute adult mental health admissions and average length of stay, 2009 to 2017

Source: Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services, by A.Cockram, S.Solomon, H.Whiteford, 2017.

DHHS's 2017 review found demand pressures have also increased the threshold for access to community-based services so that AMHSs only see the most unwell, which creates a flow on effect with AIHW reporting the number of mental health patients accessing acute services through police, ambulance and self-presentations to hospital EDs increasing from 28 757 in 2004–05 to 54 114 in 2016–17.

Mental health patients are also staying in EDs longer. Between 2015 to 2017 their average wait time in EDs has gone from 7.6 hours to 9.5 hours, well over the national target of 4 hours. Mental health patients are the most represented when wait times for movement from the ED to a bed exceed 24 hours—79 per cent of patients compared to 30 per cent five years ago. For patients experiencing acute mental illness, the ED environment is often clinically inappropriate, and at times the presence of acutely unwell patients in the ED presents risks to the patient and others around them.

Collecting data to understand the system

To understand and respond to demand and access issues, DHHS needs systems that capture necessary data to reflect current service capacity and use statistical techniques to calculate unmet demand.

DHHS's key data tool is its Client Management Interface/Operational Data Store (CMI/ODS). AMHSs use it to record the core data elements of their service provision as mandated under the Act.

All the audited AMHSs use CMI/ODS as part of their data collection. They input data up to three times a day and this data links to quarterly reporting against KPIs that measure, for example, the rate a patient is readmitted, use of seclusion, and rates of post-discharge follow-ups.

However, while DHHS and AMHSs consider the data recorded to be accurate, five of the six audited AMHSs reported shortcomings in the CMI/ODS system including lack of functionality and low useability. Due to this shortcoming, the audited AMHSs use their own bespoke systems in addition to CMI/ODS for collecting and analysing data, duplicating effort in what is an already stretched workforce.

DHHS's 2017 review highlights the lack of comprehensive mental health triage data at a statewide level. The review notes the limitations the lack of data places on understanding the people who AMHSs do not accept into the mental health system and the reasons. The report states there has been a 63 per cent increase over the last four years in the number of people seeking access to, but not accepted by, AMHSs. This is also supported by DHHS's data analytics work undertaken in 2017, which used some triage information to demonstrate service demand increased by 43 per cent between 2010–11 and 2016–17.

DHHS is aware of the gaps in its triage data collection and the need to review triage services. While DHHS has decided to delay triage reform until after funding reforms, there is still an opportunity to improve data collection and analysis now to better inform future change.

In 2017, data analytics work by the Victorian Data Linkage Centre within DHHS in conjunction with external consultants noted limitations in the current data set and made several recommendations, including:

- incorporating data on unregistered clients into CMI/ODS to give a more complete picture of service activity and demand

Mental health triage is the first point of system entry for potential consumers, or people seeking assistance on behalf of another.

A triage clinician assesses whether a person is likely to have a mental illness and the nature and urgency of the response required. Where an AMHS is not the most appropriate option for the person, they are referred to another organisation or given other advice. When specialist mental health services are likely to be suitable, the triage clinician comprehensive intake assessment is done.

The intake assessment may result in referral to another organisation and/or in the person being treated within the specialist mental health service. Only clients that receive treatment are recorded in CMI/ODS.

- integrating mental health triage (see sidebar) data into CMI/ODS to give a better picture of service demand and analysis of how quickly services are provided as is done in other jurisdictions
- including information about mental health clients that present to EDs for treatment to allow for analysis of preventable ED presentations
- including information about people that contact mental health triage and do not go on to receive services but later present at an ED.

Forecasting demand

Having an estimate of future mental health system demand is crucial to ensuring adequate future service access and to advise government of funding needs. DHHS lacks a comprehensive view of current mental health service demand, and until recently DHHS utilised only basic forecasting.

Capture-recapture is a statistical method to estimate the population of a subset of a population.

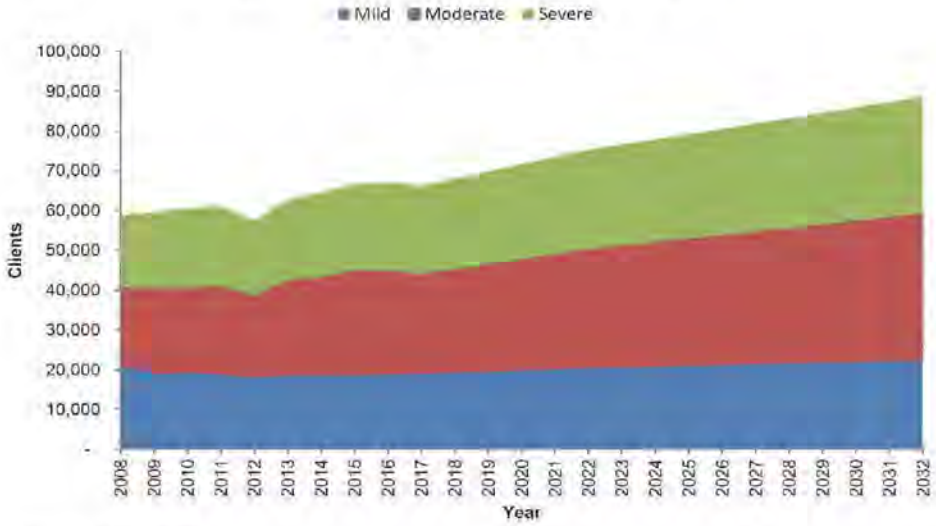
Typical applications include estimating the number of people needing particular services, or with particular conditions.

DHHS's current forecasting tool is available on its intranet and DHHS has committed to using this tool for its mental health work. It provides forecasting for system indicators including registered client numbers, acute admissions, community contacts and case length by taking historical data and aligning this with forecast population growth.

DHHS applies a statistical method of approximating demand known as 'capture-recapture', which informs its forecasting model that helps to estimate unmet demand by utilising DHHS data sources including ED presentations and information from its drug and alcohol, disability and child protection datasets. However, without the inclusion of data from the triage system and unregistered clients there remains a significant risk that using this statistical method, DHHS does not adequately capture the extent of mental health illness in the population and the true unmet demand for services.

Figure 3G is an example of forecasts using this tool, it projects the number of registered mental health clients will increase from 62 000 in 2017 to 80 000 in 2031—a 29 per cent increase—with the proportion of clients with moderate illness increasing from 38 per cent in 2017 to 42 per cent in 2032 and clients with severe illness being relatively stable at 33 per cent. Given the model limitations, the projection should be considered conservative, particularly as the number of registered clients for 2017–18, 72 859, already exceeds the projection for that year.

Figure 3G
Past and forecast registered active clients by illness severity



Source: DHHS, 2017.

3.4 Capital infrastructure

The other foundational factor needed to meet demand for mental health services is capital infrastructure: namely inpatient beds, including separate facilities for female inpatients. Responding to this need requires significant forward planning as new facilities take around five years to plan and build and, without accurate demand forecasting, can be already at or over capacity when they open.

Victoria's acute mental health beds are under significant pressure. There is sufficient evidence from the recent reviews that there are not enough mental health beds in Victoria to meet current, or future, demand. A DHHS review found that all major acute psychiatric units are continually operating at or above 95 per cent capacity, well above desirable levels of 80 to 85 per cent that allow AMHSs to admit acutely ill patients as needed.

The audited AMHS confirmed the capacity issue during our site visits. The impact on patients of high bed capacity is that AMHSs must make difficult decisions to manage bed availability. Audited AMHSs informed us that strategies used to manage bed availability include increasing the LOS in EDs, discharging the least unwell, and utilising other wards such as aged care, potentially placing a patient's care at risk.

In most facilities, males with acute mental health issues mix with female inpatients, which places women at significant risk of sexual abuse. Victoria's Mental Health Complaints Commissioner's *The Right to be Safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report* (The Right to be Safe: Sexual Safety Project Report) found that 74.4 per cent of sexual safety complaints from 2014 to 2017 related to mixing males with acute mental health issues with female inpatients as shown in Figure 3H. AMHSs cite challenges to separating males and females because of ageing infrastructure.

Figure 3H
The Right to be Safe: Sexual Safety Project Report

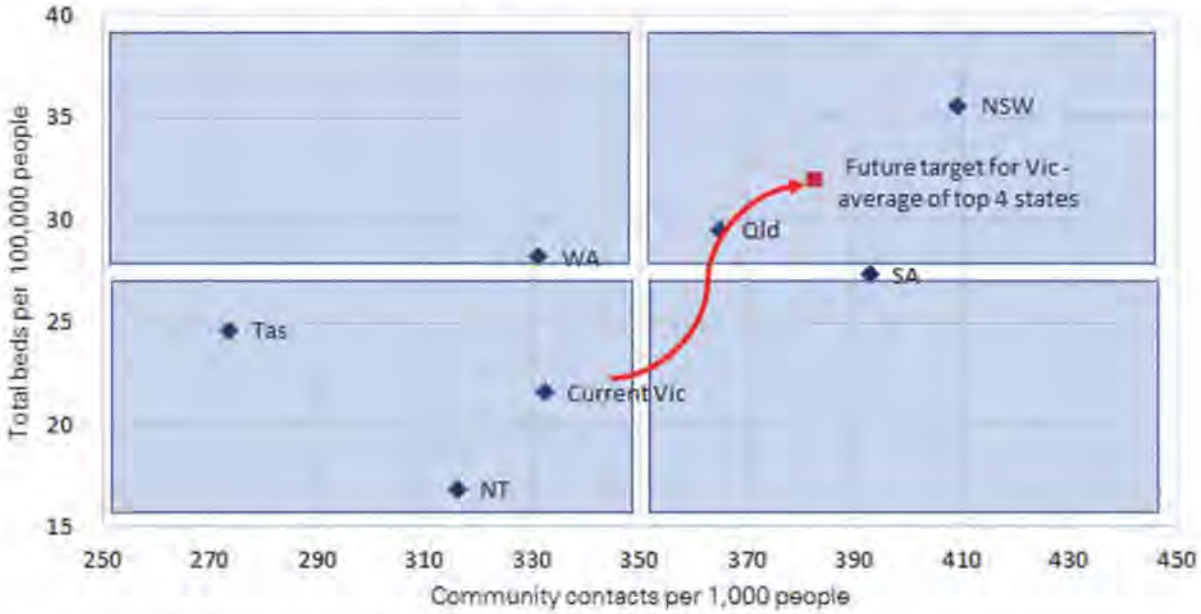
Victoria's Mental Health Complaints Commissioner's The Right to be Safe: Sexual Safety Project Report assessed 90 complaints from 1 July 2014 to 30 June 2017 that related to the sexual safety of acute mental health inpatients. The Commissioner found that most complaints related to breaches that occurred in the high dependency units or intensive care areas of the ward (40.4 per cent) or in bedrooms (34 per cent). The commissioner found that while most health services have some type of separate gender area, six cases occurred in women's only areas and for a further 22 cases, the health services reported that the service infrastructure (including gender separate areas) was not being adhered to. During our audit, all audited health services reported that they struggled to separate males and females due to a lack of appropriate infrastructure.

Source: VAGO, based on The Right to be Safe: Sexual Safety Project Report, Victoria's Mental Health Complaints Commissioner, 2018.

The availability of acute mental health beds is different across geographic areas, with outer suburban areas not keeping pace with population increases in growth corridors. Demographic changes in regional areas also impact bed requirements, for example at least two of the four regional AMHSs audited cited the ageing population in their catchment area and the need for more aged mental health beds.

To service current unmet need as well as future demand and to adequately support community-based treatment and care, the mental health bed base across Victoria must be increased. Victoria currently has the lowest bed base nationally as well as a comparatively low bed base globally. A review commissioned by DHHS advised that Victoria's bed base should increase in line with the bed base provided by other comparable states. The review estimates that the bed base would need to grow by 80 per cent over the next decade, which highlights the existing low bed base per head of population in Victoria shown in Figure 3I.

Figure 3I
Comparison of states and territories on per capita utilisation of mental health beds and community contacts



Note: Excludes forensic mental health beds.
Source: AIHW's *Mental health services in Australia 2013–14,* cited in DHHS-commissioned consultant report, Design, Service and Infrastructure Planning Framework for Victoria's Clinical Mental Health System, 2017.

There are 53 new acute adult beds funded in 2018–19; with 21 now open and 34 in planning. There are also 24 sub-acute beds in the planning phase, and 10 mother and baby unit beds will now operate seven rather than five days a week. No further new beds are in the capital pipeline and given population growth, current and planned beds will not meet the unmet demand nor move Victoria towards the recommended bed base. Delivering mental health facilities requires significant planning and construction time—around five years—in part due to the need for reinforced walls, egress and seclusion areas, outside space, and anti-ligature features.

DHHS intends to complete a 'Detailed services and infrastructure plan for Victoria's clinical mental health system over the next 20 years' and update it every five years to support the 'Statewide design, service and infrastructure plan for Victoria's health system 2017–2037'. However, given it will likely take DHHS some time to complete this plan, secure and allocate funding, and then plan and build infrastructure, DHHS should anticipate and plan for Victorians with mental health issues to continue to experience problems accessing mental health beds at least across the remaining life of the 10-year plan, and that this will impact the effectiveness of any changes to funding or the service delivery model.

3.5 Catchment areas

Clinical mental health services are provided in geographic catchment areas that were established in the 1990s. The consumer's place of residence determines which service or services they can access. DHHS's internally commissioned reviews highlight practical problems with the current area-based clinical mental health system that impact Victorians' ability to access services, which include:

- the catchment areas are not aligned with other health and human service areas, or local government area boundaries, which makes service coordination difficult for consumers and carers, many of whom need support from multiple services
- lack of alignment between geographic catchments and age-based service groupings
- lack of coordination between catchment areas when patients need to access services across catchment borders
- misalignment between service levels and types within a catchment and population growth and demographic changes in that area.

In August 2013, DHHS reviewed the mental health catchments. The review states that 'reconfiguring the catchment areas under which clinical mental health services are organised is a key step in delivering the kind of seamless, easy-to-navigate system that consumers and carers expect. It is also important for achieving optimal efficiency and effectiveness across the state'. Commitment to changing the catchment areas was included in the then Department of Health's strategy document, *Victoria's priorities for mental health reform 2013–15*. Despite this, DHHS has not implemented the changes to catchment areas.

In 2017, DHHS commissioned external consultants to develop the Design, Service and Infrastructure Planning Framework for Victoria's clinical mental health system. The framework recommended the following principles in reconfiguring service regions:

- Design service regions for populations between 500 000 to 1 000 000 people forecast by 2036, where appropriate and practical taking into consideration geographic placement of services and other factors.
- Improve access, outcome and demand management in growth corridors, including that sensible access to services overrides artificial geographical boundaries where appropriate.
- Align catchment areas with contemporary local government areas.

DHHS has not yet implemented these recommendations. While issues relating to catchments are complex and challenging, it is a critical piece of work that will contribute to improved access for consumers and we recommend that DHHS direct resources to this issue.

Appendix A
Audit Act 1994 section 16—submissions and comments

We have consulted with DHHS, Bendigo Health, Melbourne Health, Monash Health, Latrobe Regional Hospital, Peninsula Health and South West Healthcare and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of the report to the Department of Premier and Cabinet.

Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

RESPONSE provided by the Secretary, DHHS

Department of Health and Human Services

CPES UNIT
RECEIVED
07 MAR 2019
ITEM NO

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

e5071396

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Andrew Greaves

Thank you for your letter dated 22 February 2019, providing the proposed performance audit report on the accessibility of mental health services.

The Department of Health and Human Services (the department) has reviewed the report and accepts the recommendations. Enclosed with this letter, I present the department's action plan to address the report's recommendations. You note that, some of the recommendations will also be informed by the work of the Royal Commission into Mental Health.

That said, the department is committed to maintaining the momentum of efforts initiated under *Victoria's 10 Year Mental Health Plan*, to deliver safe, quality clinical mental health services. The audit provides a timely opportunity for the department to build on this foundation and strengthen the benefits of Royal Commission recommendations delivered in the years to come.

I would like to take this opportunity to thank your staff for their work, and the professional manner with which they engaged with department staff.

Yours sincerely

Kym Peake
Secretary

7 / 3 / 2019

VICTORIA
State Government

Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
1	That the Department of Health and Human Services complete a thorough system map documenting its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand.	**The department accepts this recommendation.** The department will undertake a state-wide mapping and assessment of current and future demand that will be aligned to locality planning already scheduled to take place as part of the *Statewide Design, Service and Infrastructure Plan for Victoria's Health System, 2017 - 2037.* This will be supported by a comprehensive workforce strategy, which will plan for the workforce required for new and repurposed capital infrastructure.	June 2019	November 2020
2	That the Department of Health and Human Services use this map to inform a detailed, public, state-wide investment plan, that integrates service, capital and workforce planning, setting out deliverables and time frames.	**The department accepts this recommendation in-principle.** The department will use this map to inform funding allocations within the program area's budget, and to inform annual budget planning and business case processes Implementation of this recommendation will also be informed by recommendations arising from the Royal Commission.	Following the delivery of the Royal Commission's recommendations in its final report.	Within a year of the Royal Commission's recommendations in its final report.
3	That the Department of Health and Human Services set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public.	**The department accepts this recommendation.** The department will consider the suite of available measures that to respond to known issues around access in the context of existing work to develop a performance and accountability framework for mental health services, and within the context of national reporting directions. The department recognises the need to be consider any unintended	May 2019	May 2022

WIT.0003.0004.0228

Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
		consequences that could occur as a result of changes to public reporting arrangements.		
4	That the Department of Health and Human Services undertake a price and funding review for mental health services, that includes assessing funding equity across Area Mental Health Services, and provide detailed advice to the Minister for Mental Health on the results and use this information to inform funding reforms.	**The department accepts this recommendation.** The department will undertake a price review of clinical mental health services. The department will establish a Mental Health Pricing Steering Committee, which will lead consultation with the sector. This work will inform the implementation of funding reforms currently underway.	July 2019	October 2020
5	That the Department of Health and Human Services resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services.	**The department accepts this recommendation in-principle.** In the short to medium term, the department will work with health services with respect to known catchment issues. Implementation of this recommendation will also be informed by recommendations arising from the Royal Commission.	Following the delivery of the Royal Commission's recommendations in its final report.	Within two years of the Royal Commission's recommendations in its final report.
6	That the Department of Health and Human Services re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.	**The department accepts this recommendation.** In the short term, the Mental Health Expert Taskforce will be re-established to provide external input into the work of the department on mental health system priorities. The department will continue to report to the Health Reform subcommittee of the department's Executive Board on progress against Victoria's 10 Year Mental Health Plan.	June 2019	Following the delivery of the Royal Commission's recommendations.

WIT.0003.0004.0229

RESPONSE provided by the Secretary, DHHS—continued

Access to Mental Health

Department of Health and Human Services response to VAGO recommendations

No	Recommendation	Proposed action	Proposed start date	Proposed end date
		Future governance arrangements will be implemented once the recommendations of the Royal Commission are known.		

RESPONSE provided by the Chief Executive, Melbourne Health

MELBOURNE HEALTH

The Royal Melbourne Hospital
300 Grattan Street
Parkville VIC 3050
Australia

Professor Christine Kilpatrick
Chief Executive
Telephone: +61 3 9342 7762
Facsimile: +61 3 9342 8813
thermh.org.au
ABN 73 802 706 972

5 March 2019

Mr Andrew Greaves
Victorian Auditor General's Office
Level 31
35 Collins Street
Melbourne VIC 3000

Dear Mr Greaves

Thank you for providing a copy of the proposed report on Access to Mental Health Services and for your worksheet acquitting your consideration of the comments we made regarding an earlier draft.

We do not wish to provide further comment.

Yours sincerely

Christine Kilpatrick
Chief Executive

First in Care, Research and Learning

The Royal Melbourne Hospital

Auditor-General's reports tabled during 2018–19

Report title	Date tabled
Local Government Insurance Risks (2018–19:1)	July 2018
Managing the Municipal and Industrial Landfill Levy (2018–19:2)	July 2018
School Councils in Government Schools (2018–19:3)	July 2018
Managing Rehabilitation Services in Youth Detention (2018–19:4)	August 2018
Police Management of Property and Exhibits (2018–19:5)	September 2018
Crime Data (2018–19:6)	September 2018
Follow up of Oversight and Accountability of Committees of Management (2018–19:7)	September 2018
Delivering Local Government Services (2018–19:8)	September 2018
Security and Privacy of Surveillance Technologies in Public Places (2018–19:9)	September 2018
Managing the Environmental Impacts of Domestic Wastewater (2018–19:10)	September 2018
Contract Management Capability in DHHS: Service Agreements (2018–19:11)	September 2018
State Purchase Contracts (2018–19:12)	September 2018
Auditor-General's Report on the Annual Financial Report of the State of Victoria: 2017–18 (2018–19:13)	October 2018
Results of 2017–18 Audits: Local Government (2018–19:14)	December 2018
Professional Learning for School Teachers (2018–19:15)	February 2019

All reports are available for download in PDF and HTML format on our website www.audit.vic.gov.au

Victorian Auditor-General's Office
Level 31, 35 Collins Street
Melbourne Vic 3000
AUSTRALIA

Phone +61 3 8601 7000
Email enquiries@audit.vic.gov.au

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 7

This is the attachment marked 'State-wide Mental Health Triage Scale Guidelines' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Statewide mental health triage scale

Guidelines

A Victorian Government initiative

Victoria The Place To Be

Statewide mental health triage scale

Guidelines

Accessibility

If you would like to receive this publication in an accessible format, please phone 9096 5092 using the National Relay Service 13 36 77 if required.

This document is also available in PDF format on the internet at: www.health.vic.gov.au/mentalhealth

Published by the Victorian Government Department of Health, Melbourne, Victoria.

© Copyright State of Victoria, Department of Health, 2010.

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

Authorised by the Victorian Government, 50 Lonsdale Street, Melbourne.

Printed by Stream Solutions, Level 3, 157 Spring Street, Melbourne, Victoria 3000

May 2010 (100501 FM)

Contents

Part 1: Introduction and background

The Department of Health (the department) is introducing a uniform statewide mental health triage scale for Victorian area mental health services (MHSs).

The Victorian Chief Psychiatrist has led the development and implementation of the scale in consultation with the Mental Health Triage Scale Advisory Committee, which comprises senior clinical experts from the mental health sector, consumer and carer representatives, and members of the department's Mental Health, Drugs and Regions Division.

The scale is informed by an evaluation of the pilot of a draft triage scale across 13 sites in 2008 involving a mix of metropolitan (7) and rural (6) locations and including adult (6), child & adolescent (4) and aged person (3) mental health services. Guidelines were prepared to support pilot testing of the draft triage scale.

The pilot project was supported by consultants (Learn PRN), who provided initial training and ongoing support to triage clinicians at the selected sites. The Mental Health, Drugs and Regions Division also engaged the School of Nursing, University of Melbourne (Dr Natisha Sands & Dr Marie Gertz) to conduct a formal evaluation of the draft triage scale.

The scale is being implemented against a backdrop of reform signalled by the government in the *Because mental health matters: Victorian mental health reform strategy 2009-2019* (the strategy). As part of the strategy, the government signalled an intention to reform pathways to care. This includes implementing reforms that will shift the orientation of psychiatric triage from that of 'gatekeeper' to the specialist mental health service system, to a 'referral portal' that proactively links people to the right care and supports local referral agencies and service networks. Further, it lays the foundations for working towards a triage/intake system that is able to (amongst other things):

- provide expert assessment for all age groups, drawing on age-relevant expertise as required
- deliver evidence based best practice triage assessment, including better integrating social, health and clinical risk assessment into triage practice.

Context for the triage scale

The mental health triage scale classifies the outcome of a triage assessment according to the person's eligibility and priority for mental health services, and the response required by mental health or other services.

The triage scale is designed to be used in community-based MHSs (encompassing child, adolescent, youth, adult and older persons services) to record the outcome of the triage assessment. The scale does not prescribe a standard statewide approach to triage assessment. Nor should it be confused with the mental health tool for the Australasian Triage Scale (ATS), which is used by general triage nurses in hospital emergency departments (Department of Human Services & National Institute of Clinical Studies 2006).

Ratings on the triage scale are made after an appropriately qualified and skilled mental health clinician has conducted a triage assessment, collecting sufficient demographic, social, health and clinical information to determine whether there is a need for further assessment or intervention by the MHS or whether referral to another service should be considered. The rating on the scale occurs at the end of the triage process: it records the outcome of the triage assessment. Mental health services must still ensure that well developed triage assessment protocols and tools are available and that staff are trained in their use, such as risk assessment tools, functioning assessment tools (for example the Children's Global Assessment Scale (CGAS)) and triage manuals/practice directions.

Because most triage in mental health services is conducted over the telephone, the triage scale does not assume that the clinician and the client are face-to-face: it can be completed based on information collected over the telephone.

Reasons for implementing a statewide triage scale

The triage function is a key part of the MHS clinical pathway. In accordance with the vision in the strategy, the function is also a key intervention point, ensuring people are linked to the right care and supports where an MHS response is not required. Decisions made at triage determine whether a person will receive further assessment by specialist mental health services and, if so, the type and urgency of the response. Delayed or inappropriate responses to people in psychiatric crisis increase the risk of self-harm, suicide or violence. This places consumers, carers and/or members of the public at risk. In lower acuity cases, inadequate triage responses can mean that opportunities for early intervention are missed and people are not afforded an opportunity to access the right care in a timely manner, to assist them to maintain good mental health.

Reasons for implementing a statewide triage scale are:

- to promote greater consistency in the response to consumers, carers and referrers seeking entry to MHSs
- to help ensure that initial service responses are appropriate to the person's level of clinical acuity and risk
- to help clarify the targeting and prioritisation of mental health services
- to provide a basis for improved communication between triage clinicians and other mental health service components
- to provide a structured approach to recording outcomes of MHS triage assessments
- to provide a basis for statewide monitoring of triage outcomes and identifying areas for service and/or system improvement
- to provide a basis for improved communication and referral pathways between MHS and other service providers where an MHS response is not required.

The implementation process

The triage scale and guidelines will be rolled out statewide during early 2010. It is expected that all MHS across all age groups will make any necessary practice changes and fully implement the triage scale by **1 July 2010.**

The roll out will be supported by a 'Train the trainer' training package. The department will target clinical leaders in triage services across MHS to participate in the training. These leaders will then return to their organisations to train, coach and orientate their peers and key stakeholders in the triage process (including referrers to triage services and referral points from triage services).

To support the continued implementation of the triage scale, the department will establish a Mental Health Triage Scale Reference Group. The group will comprise managers and clinical leaders in triage services across MHSs who have participated in the triage scale training. The role of the group will be: (1) to monitor implementation and triage data (to be collected as part of the triage minimum dataset), (2) to discuss and share solutions to implementation issues and practice challenges, (3) to identify opportunities for further practice and skill development in triage.

While implementing the triage scale, the department will also be implementing a minimum triage dataset to facilitate statewide monitoring of service demand and performance, which will contribute to decision making on strategic directions and service planning. The department has issued a data extract and file layout specification for the minimum triage dataset and the requirements were presented to the mental health information group at a forum hosted by the Division's Information, Analysis and Resources Unit in November 2009.

After a period of time to 'embed' the scale and a process of benchmarking service performance, the department proposes to work with MHSs to establish appropriate performance targets in relation to triage and service responsiveness.

About triage in area mental health services

Triage is the process of initial assessment to determine the need for service and the nature and urgency of the care required.

In the MHS context, the main purpose of triage is to decide whether or not the person requires further assessment by the MHS or other services, and the type and urgency of the response required from mental health or other services.

Mental health triage typically occurs over the telephone, but can occur face-to-face when someone presents in person. The Mental Health, Drugs and Regions Division has adopted the following definition of 'triage' and its relationship to 'intake assessment', the next phase of the MHS clinical pathway.

Box 1: Mental Health, Drugs and Regions Division definition of triage and intake assessment

Mental health triage is provided for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness) at the first point of contact with mental health services. Triage may also be used for assessment of current and former consumers who make unplanned contact with the mental health service. Triage is a clinical function. The role of the triage clinician is to conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required.

Where it is considered that area mental health services are not the most appropriate option for the person, he/she should be referred to another organisation or given other advice.

Where a mental health triage assessment indicates that specialist mental health services are required (or possibly required) a more comprehensive assessment is provided through the intake assessment. The intake assessment may result in referral to another organisation and/or in the person being treated within the specialist mental health service.

Note: *The Mental Health, Drugs and Regions Division's Mental health triage program management circular* (Department of Human Services, 2005) more fully describes the triage function in Victoria's area mental health services. This document can be found on the Division's website, <www.health.vic.gov.au/mentalhealth/pmc> (look for PMC05011).

Targeting of area mental health services

Mental health triage is a much broader function than 'screening out' people who do not meet the MHS targeting criteria. However, MHSs function like other secondary or tertiary health services. That is, they are targeted to people whose needs cannot be met in the primary health sector. Therefore, the person's need for specialist mental health services will determine whether they are seen by the MHS or referred to other services.

Adult mental health services and aged persons mental health services (APMHS) are targeted to people with more severe and enduring forms of mental illness or disorder, whose level of disturbance or impairment prevents other services from adequately treating or managing them. Commonly these people have a psychotic illness, such as schizophrenia or bipolar disorder. However, this group can also include people with severe mood, anxiety and eating disorders, behavioural and psychological issues associated with dementia and those who present in a crisis that may lead to deliberate self harm or harm to others.

Child and adolescent mental health services (CAMHS) have traditionally provided mental health services for those up to 18 years of age who have complex and severe mental health problems, and/or who are at high risk of harm. Mental health problems can present in a variety of guises for children and adolescents. Children may present with complex social, emotional and/or behavioural symptoms and families may be having difficulty functioning day-to-day. Many children and adolescents require the input of a multidisciplinary team, rather than an individual clinician, and a case manager to coordinate care.

The Because mental health matters: Victorian mental health reform strategy 2009-2019 signals potential changes to the deliver of mental health services across all age groups. For example, the strategy supports delivery of developmentally appropriate service delivery for children and young people 0-25 years. This is being piloted through two 4-year demonstration projects funded by the State Budget 2008-09. The strategy also flags a change in the entry point to specialist aged person's mental health services from 65 years to 70 years.

Over time, the strategy will ultimately lead to statewide changes in the way that MHSs target and respond to children and young people, adults and older persons. The impact on triage practice and the scale and guidelines will need to be monitored over time.

Issues in the targeting and prioritisation of mental health services are discussed further under *Triage decision-making factors* (Part 3, page 16).

Triage principles

The Mental health triage program management circular is based on four key principles.

- **Access:** Specialist mental health services should be accessible 24 hours a day, 7 days a week, and should proactively inform their communities about how to access triage points.
- **Responsiveness:** People who request help from specialist mental health services should have their mental health needs assessed by a clinician, who should demonstrate a helpful, 'customer-focused' approach. They should be offered appropriate advice, and if necessary, further assessment, treatment and/or referral to other services. Where the initial assessment indicates a need for specialist mental health services, there should be timely access to more detailed assessment and treatment, commensurate with the person's level of need and urgency. Where it is determined that the mental health service is not the most appropriate service, every effort should be made to proactively link the consumer (or carer/referrer) with a more suitable service. Where appropriate, the clinician should make contact with this service on behalf of the person requesting assistance.
- **Consistency:** Consumers, carers and referring professionals should be confident that their request for help will receive a similar response irrespective of their location or the individual clinician dealing with the request. Services should ensure that staffing arrangements maximise the consistency of triage service delivery, and that the triage role is clearly articulated and understood within the organisation.
- **Accountability:** Services should have a high standard of documentation and accountability for triage and intake decisions and outcomes.

Triage clients and roles

There are three main types of triage clients.

- Consumers and potential consumers. These include current and formerly registered mental health clients, and those seeking to access to mental health services for the first time.
- Carers, family members, friends and acquaintances of consumers/potential consumers.
- Other service providers, including emergency department staff, police, ambulance, and a range of community service providers (such as general practitioners, private mental health practitioners, community health providers, alcohol and other drug (AOD) workers, child protection workers, school counsellors, aged residential care providers, and many others).

The triage client group is therefore much broader than the target group for specialist mental health services. The strategy and the Mental health triage program management circular have strongly emphasised the need for a high level of responsiveness and 'customer-focus' in relation to all triage clients, not just those requiring immediate access to mental health services. This reflects the diversity of triage clinicians' roles and the re-orientation of triage as a referral portal. In addition to 'screening' requests and managing demand for mental health services, triage clinicians' roles include:

- helping people who do not require specialist mental health services to access more suitable services by proactively linking them to more appropriate services or providing self-help advice
- providing support and advice to current registered consumers, especially after hours
- supporting and advising carers and family members, and linking them with appropriate services to meet their needs providing advice and consultation to other service providers to assist them in treating and supporting people with mental health problems.

WIT.0003.0004.0243

Part 2: The mental health triage process

In essence, triage seeks information to answer the following questions (Knight & Lenten, 2006):

- Is it likely that the person has a mental heath problem? If so, what is the problem?
- Does the person need further assessment or treatment from the area mental health service?
- If so, which program should respond and how urgently is the assessment or treatment required? Are there any concurrent social or health problems that need to be considered?
- If the person does not require further assessment from the mental health service, to whom can he or she be referred?

Prerequisites for triage

Mental health triage involves difficult and complex decisions, which may have to be made at a time when the client is distressed, angry or confused, and when the causes of behaviour are unclear. In emergency situations, decisions may have to be made very quickly, based on minimal information. In other situations it is expected that triage clinicians will collect a range of demographic, social, health and clinical information. It might take several telephone calls between the triage clinician, the consumer, carers/family members and other service providers to determine the best course of action.

Mental health triage inherently carries significant clinical risk. It is therefore a role for experienced mental health practitioners. The following prerequisites are required for safe and appropriate decision making:

- adequate orientation to the triage role
- proficiency in mental health assessment, including risk assessment
- proficiency in screening for problematic use of alcohol and other drugs
- ability to assess the impact of a range of other health and social factors
- communication and negotiation skills
- access to well developed tools and protocols to guide assessment processes
- access to support and supervision from more experienced clinicians
- knowledge of other services available in the local area and appropriate referral pathways
- understanding of the *Mental Health Act 1986* and relevant provisions of other key legislation (for example, *Firearms Act 1996, Children, Youth and Families Act 2005, Alcoholics and Drug Dependent Persons Act 1968*).

It is assumed that triage clinicians using the mental health triage scale will have the prerequisite skills and knowledge so that the allocation of scale codes is informed by sound clinical judgement.

Limitations of telephone assessment

Most mental health triage work is conducted over the telephone and therefore the triage clinician is unable to see the person or conduct a physical examination. This can make it more difficult to develop rapport with the client and to provide an adequate mental state assessment. By the same token, triage clients rely entirely on what they hear over the telephone without being able to see the clinician's body language and facial expressions. In work conducted for the Bendigo Health Psychiatric Services, Knight & Lenten (2006) have suggested a range of strategies to help mental health clinicians compensate for the limitations of telephone triage. Some of their suggestions are replicated in Box 2.

Nonetheless, clinicians should be conservative in using the telephone to determine that a person does not have a mental illness or disorder requiring assessment: when in doubt, a face-to-face (intake) assessment should be arranged.

Box 2: Tips for effective telephone triage

Knight & Lenten (2006) offer the following general tips for conducting triage:

- remember the client's name–write it down
- refine your listening skills
- give clients enough time to explain their situation
- fully complete established assessment guidelines
- restate questions if answers are ambiguous
- refine your ability to elicit information needed to make a triage decision through questioning – use open-ended questions and offer suggestions to spur the caller's memory
- be very aware of your voice tone and use of language – maintain an even, unhurried tone of voice and a courteous manner at all times
- be aware of barriers to effective telephone communication – these include semantic barriers, such as the use of jargon, cultural and language barriers, and your own assumptions and prejudices
- ask callers to repeat instructions/advice when given and suggest they write them down
- ask callers whether they are comfortable with the topics discussed and the advice given
- encourage callers to call back if the situation changes or if further assistance is required
- document the call fully and precisely.

Adapted from *Bendigo Health Psychiatric Services Mental Health Triage Orientation Program* (Knight & Lenten 2006).

In a modification of Grossman's (2002) description of the telephone triage process, Knight & Lenten (2006) propose the following steps for mental health triage clinicians conducting telephone triage:

- introduce yourself and open communication channels
- identify yourself at the beginning of the call and explain the triage process
- perform the interview and complete the triage record form
- make the triage decision
- offer advice according to the established response category
- incorporate follow-up plans when concluding the call
- review the call and finalise documentation.

The consumer perspective

Feedback from consumers in relation to triage services shows that consumers want to feel listened to by a triage worker who is compassionate and who cares about improving their situation. Most consumers understand the pressures on mental health services and workers. However, they emphasise that the information, advice and 'listening' offered by triage clinicians can be helpful in itself, and can help in their recovery process. Consumers want to feel involved in choosing management and self-care strategies that will work for them. They also want triage clinicians to clearly explain why they have made particular decisions.

The nature of the contact with the triage clinician is critical for people with mental health problems, who are often distressed, fearful, confused or angry. The attitude and responsiveness of the clinician are very important, and can directly affect outcomes for the person seeking assistance.

Part of the mental health triage function is to provide support and advice to consumers, including currently case-managed clients who make unscheduled contact with the service, particularly after hours. Triage clinicians may be in a unique position to detect signs of relapse in current and recently discharged consumers, and to take steps to avert crises and the need for inpatient admission.

The carer perspective

Consultations with family members and carers of people with mental health problems show that, like consumers, they strongly value being 'listened to' and want triage clinicians to explain the basis for their decisions. Carers have expressed concern that triage clinicians do not always give appropriate weight to their experience and intimate knowledge of the person with mental illness. Unfortunately, in cases where critical incidents have occurred following triage contacts with mental health service, a frequent feature has been inadequate responsiveness to carer concerns.

Along with 'consumer participation', 'carer participation' is a key theme of the government's overall policy framework for mental health services. Subject to the legislative considerations mentioned below, triage clinicians should try to identify carers and/or appropriate family members and involve them in the assessment process. Families and carers often have knowledge that is essential information for clinicians: where possible, it is good practice for triage clinicians to substantiate and augment triage information with a family member, friend or carer of the person being assessed.

Under Section 120A of the *Mental Health Act 1986*, service providers have a responsibility to seek consumers' consent to the involvement of carers and/or family members. However, the Act allows information to be disclosed to family, primary carers and guardians if the information is reasonably required for ongoing care and the person who receives the information is involved in providing the care. The confidentiality provisions of the Act should be used sensitively. Where individuals are unable or unwilling to give consent, service providers should observe their legal duty of care and exercise sound judgement in meeting their dual responsibilities to consumers and carers/family members who may be affected by the individual's mental illness.

Carers who are involved in mental health triage events, particularly emergency situations or where the carer fears relinquishing care or fears loss of the consumer, often experience a great deal of stress and distress. Regardless of whether the consumer has consented to the carer or family member being involved in the current episode of care, triage clinicians should be responsive to carers' support needs. Support to carers could include:

- an opportunity to debrief following a crisis
- advice about managing mental health crises
- advice about coping with the day-to-day demands of living with a person who has a mental illness
- advice about how to handle situations in which the consumer is unwell but avoiding or resisting help
- information on mental health problems and local services
- information about services available to meet their own needs, such as respite care and peer support. One such service is the Commonwealth National Carers Counselling Program, which is available in 26 languages. In Victoria this is delivered by CarersVic on 1800 242 636.

The Bouverie Centre, Victoria's Family Institute, has developed a range of resources and training courses in family sensitive practice for mental health service providers (see <www.latrobe.edu.au/bouverie>). The Chief Psychiatrist has also released a guideline (*Working with families and carers* (April 2005)) setting out key principles for working with families and carers in mental health service delivery.

Special considerations in triaging children and adolescents

Mental health problems in childhood and adolescence may present in a variety of ways depending on the young person's age, developmental stage and the nature of the problem. Symptoms might be similar to those of adult mental health problems, including impaired reality testing, hallucinations, depression and suicidal behaviour. However, mental and emotional disturbance in childhood and adolescence often presents in other ways. Behaviours indicating distress and disturbance include social and family difficulties, hyperactivity, nightmares, fearfulness, bed-wetting, language problems, school refusal, abuse of alcohol and other drugs, and stealing. Many young people manifest some of these behaviours at one time or another. But they are not considered emotionally disturbed unless they exhibit a pattern or persistence of symptoms inappropriate to their age, developmental stage or circumstances. Older adolescents may often present in crisis with severe behavioural disturbances, self-harm and suicidal ideation whereby the behaviours have a great impact on their life but the diagnosis may be unclear.

Some children and adolescents are at higher risk of serious mental health problems. They include:

- victims of physical, sexual and/or emotional abuse
- those within the welfare and youth justice systems
- those with alcohol and other drug problems
- homeless youth
- those from severely disrupted homes
- those whose parents suffer from a mental illness and/or a dependence on drugs or alcohol
- those with developmental or learning difficulties
- those with chronic health problems and disabilities
- post-trauma and post-disaster victims.

Adolescents below the age of 18 years may be legally able to consent to assessment and treatment provided the young person has capacity and maturity to understand and provide informed consent.

Where a young person can give valid consent to assessment and treatment, the consent of the parent(s), guardian(s) or the Secretary (where a young person is under his or her care or custody) is not necessary. However, subject to the young person's right to confidentiality, parents and guardians should be involved in the decision wherever possible. Notwithstanding, if a young person is competent to consent to treatment on his or her own behalf, the person's right to confidentiality should be respected and permission should be obtained before the proposed treatment is discussed with a parent, guardian or the Secretary.

Self-referrals by adolescents who refuse parental or carer involvement comprise only a small part of MHSs work. However, in these situations it is important that triage clinicians respond by arranging a high urgency, urgent or semi-urgent MHS assessment (as appropriate) or by actively facilitating the young person's involvement with a more suitable service. Mental health services often only get one chance to engage these young people and it is particularly important to act when the young person's safety is at risk.

Triage clinicians need also be aware that children and adolescents may be the subject of a variety of different custody arrangements, care or accommodation orders. These include:

- an interim accommodation order
- a Custody to the Secretary order
- a Guardianship to the Secretary order
- a long-term guardianship order
- a therapeutic treatment order
- in safe custody as a result of a Protection application or breach of a Protection order
- placement with a suitable person or an out-of-home care service, declared hospital or declared parent and baby unit as a result of an interim accommodation order.

Triage clinicians need to be mindful of a child's legal status and who has capacity to consent to the assessment and treatment of an adolescent, where he or she is unable or unreasonably refuses to provide informed consent.

In accordance with section 597 of the *Children, Youth and Families Act 2005*, in specified situations Child Protection Services or authorised community service organisations providing out-of-home care can provide consent to medical services, including psychiatric assessment and treatment, for children subject to specified orders or arrangements. This provision applies where consent cannot be provided or is unreasonably withheld. Clinicians should contact their local Child Protection service if they need assistance to determine who is authorised to provide consent. The 1300 or 1800 numbers can be found at <www.cyf.vic.gov.au/child-protection-family-services/library/contacts>. In emergency situations during the after-hour period, clinicians should contact the Child Protection Emergency Service on 13 12 78. Where the clinical emergency necessitates priority access, the clinicians may contact 9843 5422.

In consultations for the mental health triage scale project, CAMHS providers and carer representatives made the following suggestions for effective triage of referrals involving children and adolescents:

- There is a need to look beyond the presenting mental health problem to identify factors that may place the child or young person at risk. Children and young people often display disturbed behaviour due to environmental circumstances, such as ongoing stress, trauma, abuse or drug use, and the behaviours may change and intensify over time.

- In making decisions about whether a young person requires face-to-face MHS assessment, consideration should be given to longer-term risks to the young person as well as short-term risk of harm. Examples of longer-term risks include seriously impaired emotional development, physical problems as a result of drug and alcohol misuse, disengagement from school, and social isolation.
- Triaging a child or adolescent should involve an assessment of the young person's behaviour and functioning across multiple domains: social, academic, emotional and behavioural. Appropriate assessment tools should be used to support clinical decision making. For example, assessment of a child or young person's level of functioning should be supported by completing the Children's Global Assessment Scale (CGAS).
- Parent/carer capacity and ability to cope is a key factor in determining the urgency of referrals of children and adolescents. It should not be assumed that because there is an adult present, the adult is capable of supporting the young person and managing the young person's symptoms and behaviour. Young people may be placed at risk as a result of parents' inability to cope with their children's mental health problems.
- The triage risk assessment should consider factors that may constrain parents' ability to provide a safe environment for their child, and any issues (such as financial problems) that may limit their access to alternative services.
- Providing support to parents and carers, and involving them in assessment and care planning, is critical to all MHS functions, including triage and intake. The triage assessment should consider the needs of other children in the family and what can be done to support them.
- Because the person being referred to MHS is a child or adolescent, it should not be assumed that they pose no physical threat to others, including adults, in the home.

According to CAMHS providers, the following common errors of judgement may be made by adult-focused mental clinicians when triaging child/adolescent referrals:

- not recognising lower-order autism spectrum disorders
- confusing PSTD (post-traumatic stress disorder) symptoms with psychosis
- failing to identify depression, especially when it is masked by aggression or other forms of acting out
- dismissing some symptoms (for example, self-harming behaviour in girls, rage attacks in pre-pubescent boys) as personality or behaviour issues not requiring mental health services
- underestimating the risks involved when self-harming behaviour is new, as opposed to long-standing
- not acknowledging that obsessive eating behaviours may be early signs of eating disorders.

Box 3: Case scenario

A psychiatric registrar has referred **Isabella** to a MHS for an urgent assessment. The psychiatric registrar is currently treating Isabella's mother. Isabella is a **17 year old** female starting year 12 next week. Her mother is an in-patient at a psychiatric ward with a chronic mental illness. Isabella's father allegedly physically and emotionally abuses her as well as her mother, but not her other two siblings. Isabella's situation has deteriorated over the school break as her mother has been hospitalised for three weeks. Her father pinched her on the bottom the other day when in the ward and an argument ensued which resulted in Isabella not getting a lift home from her father; she hid in the hospital toilets and slept there overnight. In the morning she returned home and her father hit her and allegedly threw her to the ground. She then ran away, threatened self harm, and later returned to the ward. She presents as depressed, vulnerable and at risk of self-harm. She has moved to her grandmother's house, and her grandmother reportedly has an intervention order on her father. The triage clinician spoke with Isabella who presented with a flat tone of voice, dysthymic, and self-rated mood 5/10. She denies feeling depressed, and 'does not see the point of attending MHS or counselling' as she feels it does not help. Isabella reports poor sleep and reduced eating with slight weight loss. She denies current suicidal or self-harm thoughts, plan or intent, and says she feels OK about starting school. Isabella was not very co-operative with the mental state assessment.

How would you triage this scenario?

It is suggested that a **Code D** may apply. Given concerns about Isabella's engagement with MHS, it is suggested that a **Code F** may also be considered, with referral to a GP to develop a mental health plan as well as advising the psychiatric registrar to discuss the family with the local or statewide FAPMI coordinator for advice.

Special considerations in triaging older people

One of the key differences between the triage of older people compared with younger age groups is the higher likelihood of co-morbid medical conditions. Medical conditions may imitate, exacerbate or mask psychiatric symptoms, and some treatments for mental illness can have significant physical side effects in both the short and longer term.

Provided the person is not at immediate risk of harm, it may be necessary for triage clinicians to obtain a medical evaluation before deciding on intervention required from the mental health service.

Assessment of physical co-morbidities and current medications is essential to assessing risk in older people. For example, chronic physical illness and pain can be associated with suicidal behaviour. Confusion associated with organic brain conditions such as dementia may place an elderly patient at physical risk, including risk of falls, because of disorganised, impulsive or disinhibited behaviour. Certain medications (for example cortisone) can cause side effects, including delirium, in an older person.

Warning signs of new or increased psychiatric disturbance older people include:

- self-neglect and/or neglect of the home
- sudden onset or escalation in confusion

- increasingly erratic behaviour
- any self-harming behaviour
- persistent somatic complaints without organic basis
- increased use of alcohol or other drugs, including persistent requests for hypnotic medication
- exhaustion of carers
- repeated complaints by neighbours or the police.

Referrals to aged persons mental health services typically come from carers, family members or service providers. Where others are involved in the person's care, their level of involvement and capability is critical to distinguishing between levels of urgency and risk. For example, a person in a residential care setting may have a lower level of risk/urgency than a person with comparable symptoms living alone in the community. Aged care staff can, with advice from mental health clinicians if necessary, provide support until the mental health service can see the person. Also, a person living at home in the care of an elderly spouse may have a higher level of risk/urgency than an older person living in the care of their child.

Box 4: Case scenario

A male currently living in Italy is ringing about his **elderly** grandmother, **Clara**, who lives alone in a block of units. Over the past month her grandson has noted that Clara has become more confused and forgetful and is claiming to have seen and heard deceased relatives in her back garden. The grandson also says he has spoken with his grandmother's neighbours and that they have verbalised concerns that Clara is having extensive work done to her unit including the construction of a carport when she does not drive a vehicle. Neighbours have also noticed that she had been handing out her clothes at the local bus stop. There are no family members currently in Australia and her son has asked the neighbours to keep an eye on her. The grandmother was treated for depression after his grandfather suicided eleven years ago. The grandson wants to have his grandmother assessed but only in the company of her neighbours because Clara does not trust her GP after he tried to place her on medication. The grandson is adamant that his grandmother does not pose a risk to others but says she is vulnerable because of her age and impaired judgment.

How would you triage this scenario?

Code D is the suggested triage outcome.

WIT.0003.0004.0251

Because mental health triage assessments and high urgency responses need to be available 24 hours, seven days a week, adult mental health services often have responsibility for APMHS (and CAMHS) triage functions outside of standard business hours. In consultations for the mental health triage scale project, APMHS clinicians and consumer and carer representatives made the following suggestions for adult-focused triage clinicians providing out-of-hours assessments of older people:

- Appreciate that many older people are not as assertive in dealing with service providers, less likely to complain, and less comfortable in talking about psychological and emotional matters. This may lead clinicians to underestimate the severity of the situation or to overestimate carers' ability to cope. Inadequate identification of, or responsiveness to, carer exhaustion may lead to neglect or even abuse of older people with mental health problems.
- Be aware that older persons, particularly single men, over the age of 80 years are at high risk of suicide.
- Obtain a reliable 'collateral history' of the presenting complaint. A cognitively impaired person will not be able to give essential information, and a deluded or depressed person may not give an accurate account of events. For example, alcohol and drug intake may be denied or downplayed. Equally, a carer or next-of-kin may find it challenging to disclose the full extent of the changes in the person's health due to fears and/or grief about relinquishing care and loss.
- Be aware of the need to identify any new or increasing risks that may occur against a backdrop of chronic risks, such as ongoing physical illness or disability and long standing psychiatric or cognitive problems. Risks should also be considered in context of the situation. An elderly person may not present an unreasonable risk to younger family members if living at home, but may present a significant risk of harm to co-residents in an aged care facility.
- An older person may have an advance directive or other order relating to their care and guardianship.
- Appropriate assessment tools should be used to support clinical decision making. For example, detection of delirium in an older person will be helped by use of the Confusion Assessment Method (CAM).

The most common presentations by older people are often referred to as the three Ds; dementia, delirium and depression.

Older people frequently present with classic depressive symptoms, but recognition can be more difficult because the depressed elderly person may:

- be less likely to admit to depressive symptoms spontaneously
- present with persistent pain or other physical complaints
- present with behavioural disturbance, especially in association with dementia
- present with apparent cognitive impairment or mental slowing, so-called 'pseudodementia'
- have a physical disability or illness that has overlapping symptoms with depression.

The *Royal Australian and New Zealand College of General Practitioners' Medical care of older persons in residential aged care facilities – The Silver Book* (4th Ed, 2005) provides a useful comparison of the clinical features of dementia, delirium and depression. (See table A). However, the features can co-exist making recognition extremely difficult.

Table A: Differentiation of dementia from delirium and depression

Feature	Delirium	Dementia	Depression
Onset	Acute/sub-acute depends on cause, often twilight	Chronic, generally insidious, depends on cause	Coincides with life changes, often abrupt
Course	Short, diurnal fluctuations in symptoms; worse at night in the dark and on awakening	Long, no diurnal effects, symptoms progressive yet relatively stable over time	Diurnal effects, typically worse in the morning; situational fluctuations but less than acute confusion
Progression	Abrupt	Slow but even	Variable, rapid-slow but uneven
Duration	Hours to less than one month, seldom longer	Months to years	At least two weeks, but can be several months to years
Awareness	Reduced	Clear	Clear
Alertness	Fluctuates; lethargic or hypervigilant	Generally normal	Normal
Attention	Impaired, fluctuates	Generally normal	Minimal impairment but is distractible
Orientation	Fluctuates in severity, generally impaired	May be impaired	Selective disorientation
Memory	Recent and immediate impaired	Recent and remote impaired	Selective or patchy impairment, 'islands' of intact memory
Thinking	Disorganised, distorted, fragmented, slow or accelerated, incoherent	Difficulty with abstraction, Thoughts impoverished, marked poor judgment, words difficult to find	Intact but with themes of hopelessness, helplessness or self-deprecation
Perception	Distorted; illusions, delusions and hallucinations, difficulty distinguishing between reality and misperceptions	Misperceptions often absent	Intact; delusions and hallucinations absent except in severe cases
Stability	Variable hour to hour	Fairly stable	Some variability
Emotions	Irritable, aggressive, fearful	Apathetic, labile, irritable	Flat, unresponsive or sad; may be irritable
Sleep	Nocturnal confusion	Often disturbed; nocturnal wandering and confusion	Early morning awakening
Other features	Other physical disease may not be obvious		Past history of mood disorder

WIT.0003.0004.0253

Part 3: Triage decision-making factors

This section provides a general overview of common factors that need to be considered in triage decision-making, and is not intended to substitute for formal risk assessment and other triage tools.

The Mental Health, Drugs and Regions Division has not prescribed a standard statewide approach to triage assessment. The triage scale only standardises the recording of the triage outcome and expected service response. Mental health services are expected to ensure that well developed triage assessment protocols and tools are available and that staff are trained in their use. Many area mental health services have developed their own triage resources. As part of implementing the statewide mental health triage scale, triage resources developed by MHS will be made available on a project website. These resources may include triage and/or risk assessment tools, triage manuals/practice directions or policies that represent good practice. MHS will be encouraged to proactively share such resources on the project website.

As discussed in part 2, the outcome of the triage assessment, and hence the code selected on the mental health triage scale, is based on decisions about:

- **the person's need for specialist mental health services**
- **the level of risk to the person and/or others**
- **the urgency of the response required from mental health or other services.**

While these dimensions are clearly interrelated, it is important that each one is adequately assessed. Part of the challenge of triage is the complexity of factors that must often be considered and weighed up in order to make a safe and appropriate decision. The presence or absence of any one factor should not be used to exclude further assessment by the mental health service. In addition to active mental illness symptoms and levels of short-term risk, a range of other factors influences the person's need for mental health services. It is essential for triage clinicians to consider the impact of other complex problems (physical, intellectual, addictive, social, and/or accommodation) in addition to mental health problems.

It is the clinician's responsibility to seek this information: the onus should not be on triage clients to 'prove' their eligibility for mental health services.

Outlined below is a brief discussion of triage decision-making factors. Part 4 provides a more detailed consideration of how particular factors might influence the choice of ratings on the mental health triage scale.

Need

The presence, severity and complexity of mental illness symptoms are key determinants of a person's need for specialist mental health services.

Studies have shown that most mental health clinicians are adept at recognising mental illness symptoms, even when the assessment occurs over the telephone. While diagnosing mental illness is **not** part of the triage role, the following symptoms may indicate that the person should receive a comprehensive face-to-face assessment from a mental health professional:

- suicidal ideation
- bizarre or unusual thinking or behaviour
- delusions
- hallucinations

- significant changes of mood or activity, including significant deterioration in basic functioning
- 'irrational' or overwhelming fear or anxiety
- aggression
- restless, agitated and disorganised behaviour
- confusion and disorientation.

A person may have a mental illness or disorder if he or she exhibits any of the above symptoms and the symptoms do not appear to be caused by injury, physical illness or drug/alcohol intoxication.

Where there have been negative events or client dissatisfaction following mental health triage assessments, a common criticism of the mental health service is that it has focused too narrowly on symptoms of serious mental illness and has not taken sufficient account of the person's increased vulnerability due a range of other factors. Some of these factors are discussed below.

Alcohol and other drug problems

Mental health and alcohol and other drug (AOD) services are working with increasing numbers of people who are experiencing both mental health disorders and drug/alcohol problems. The prevalence of 'dual diagnosis' (the co-occurrence of mental health disorders and problems with alcohol and other drugs) requires an integrated approach to assessment and treatment. The department has released a dual diagnosis policy (Department of Human Services, 2007) that requires mental health services to universally screen for substance use. Where this screening indicates that the person may have AOD problems in addition to a serious mental health problem, the mental health service is required to provide a full dual diagnosis assessment that results in integrated treatment of both problems.

Other co-morbidities

There may be complications to the person's mental state as a result of co-existing medical conditions, injuries, and physical or intellectual disabilities.

In order to arrive at an appropriate disposition, the triage clinician will need to form a preliminary assessment of the extent to which any additional problems are likely to increase the severity or impact of the person's mental illness, and his or her ability to recover from it.

Social/environmental vulnerabilities and supports

Examples of 'social and environmental' vulnerabilities include:

- absence of appropriate social supports or decreased capacity of social/family supports to cope in the immediate circumstances
- homelessness or unstable housing
- poverty
- exposure to domestic violence, neglect or abuse
- refusal to attend school/sudden onset truancy
- sudden refusal to attend work
- involvement with the criminal or youth justice systems
- problem gambling.

The presence of any of these factors should cause the triage worker to consider a higher-level triage disposition than would have been chosen based on mental illness symptoms alone. Where specialist mental health services are not suitable for a highly vulnerable person, particular effort should be made to connect the person with more appropriate services. This is consistent with the triage clinicians' role in proactively assisting people who do not require specialist mental health services to access more appropriate care and treatment to meet their needs.

In addition to risks and vulnerabilities, people can have significant supports or factors that help to stablise their mental health problems. These include the presence of a committed carer or family member and the ability to access other forms of support, including private sector services.

Functional status

The level of functional disability as a result of mental illness and/or co-morbidities and/or social/environmental vulnerabilities is an important factor in triage decision making. Indications of a person's functional status include his or her ability to maintain hygiene and bodily functions, to conduct activities of daily living (including attending work or school and physically moving about without unreasonable risk of falling), to fulfil family and occupational responsibilities, to maintain sufficient hydration and nutrition, and to interact with others.

Supply factors (need relative to others)

At a broad level, the targeting of mental health services is based on relative need: priority is given to people most severely affected by mental illness.

In a study of factors influencing triage decisions in three Victorian area mental health services, Grigg et al (2007) found that 'supply factors', including the perceived availability of a face-to-face assessment, also influenced mental health clinicians' responses to individual triage contacts. It is understandable that triage decisions are influenced by the person's needs relative to those who require access to the service at a given time. However, mental health services are strongly encouraged to promote consistency in triage decision-making (see *Triage program management circular,* Department of Health, 2005). To minimise the extent to which fluctuations in 'supply' have a bearing on triage decisions, triage clinicians are urged to make decisions (and triage scale ratings) based on their assessment of clients' need, risk and urgency, rather than staff availability at the time of contact. The mental health services' capacity, or lack of it, to provide responses consistent with triage determinations is an important indicator of how the service is coping with its day-to-day demands.

Risk

The study by Grigg et al (2007) found that along with the patient's mental symptoms, triage clinicians' perception of risk was the main 'patient factor' contributing to the triage outcome.

'Risk of harm' covers three domains:

- risk of harm to self (due to suicidal ideation, acts of self-harm, significant self-neglect, impaired judgement or impulse control, or high-risk behaviours)
- risk of harm to others (for example homicidal, aggressive or destructive acts or ideation, impulsivity or behaviour endangering others, and neglect of dependants)
- risk of harm from others (for example neglect, violence; exploitation, and sexual abuse or vulnerability).

Risk assessment is about identifying factors that impact on the probability of harm occurring. While not all harm can be foreseen, risk assessment and regular review are necessary to identify factors that raise the risk of a particular form of harm occurring. For example, we know that the risk of violence is increased when the person:

- has a previous history of violence
- is male
- is aged under 30 years
- abuses alcohol or other drugs
- has active psychotic symptoms
- is non-compliant with treatment.

We also know that the risk of suicide is high for men over the age of 70 years.

Risk markers such as these provide a guide, but the assessment must be individualised. Incidents of harm occur in a specific time, place and context, and risk is influenced by factors related to the individual such as:

- history/previous triage contacts (as discussed below)
- current environment, including people who may help to stabilise the situation and/or who may be subject to harm
- access to means of harm (potential weapons, medications)
- reactions to acute stressors
- thought, affect and intent. For example, if the person is experiencing command hallucinations, it is important to ascertain whether he or she feels compelled to act on them
- protective factors, such as supportive family and friends.
- Just as these factors can raise the probability of harm occurring, protective factors can also reduce risk, thereby impacting on the urgency of the response required. Particularly in triaging children and young people, by using a risk and protective factors framework the urgency of response and intervention can be appropriately determined.

Some of the factors that impact on the risk assessment have been discussed already: people with high level needs as a result of serious mental illness, poor functioning, few supports and co-morbid health or alcohol/drug problems are likely to be at increased risk of harm. Some further issues that are important in risk assessment are discussed below.

WIT.0003.0004.0257

Box 5: Risks to young dependants

Mental illness can create high levels of stress for families and at times may affect parents' ability to care for dependants.

It is now well established that children who have parents affected by mental illness are themselves at increased risk of developing psychosocial and mental health problems. The State Government's *Families where a parent has a mental illness* (FaPMI) strategy is directed to all services that work with families where a parent has a mental illness and aims to enhance their capacity to provide more effective, family focused care. It outlines a range of service development strategies to assist service providers recognise and respond appropriately to the needs of both parents and children. The strategy can be accessed at <www.health.vic.gov.au/mentalhealth/publications>.

When conducting a triage assessment, it is vital that clinicians establish and document whether adults referred to mental health services are carers of dependent children. Considerations of risks to children should be part of the overall risk assessment undertaken at triage, and should be a factor that is explicitly taken into account in determining the adult's need for mental health or other services, and the urgency with which intervention is required. In the context of parental mental illness, children may be at risk of harm due to:

the parent's inability to meet their basic physical and psychological needs

physical or sexual abuse (for example, parents or carers may have homicidal or hostile thoughts towards the child, or may be excessively irritable, agitated or lacking in self-control)

exposure to violence or other behaviour causing serious psychological harm (for example, children may be involved in adult delusions, hallucinations or obsessions)

neglect or harm due to the parent being substance affected.

All triage clinicians require a good understanding of their responsibilities under the *Children, Youth and Families Act, 2005*. A guide to the circumstances in which service providers should refer clients to family services (including Child FIRST (Family Information Referral and Support Team) or Child Protection) and the consent requirements associated with such referrals can be found at <www.dhs.vic.gov.au/everychildeverychance>.

Triage clinicians should also be aware of local supports and resources to help both clients who have parenting responsibilities and their children. A *families and mental health* resource kit is available on the <www.health.vic.gov.au/mentalhealth/publications> website. This provides helpful parenting information and links them to other resources such as the Children of Parents with a Mental Illness (COPMI) project website <www.copmi.net.au>, which lists relevant programs and services in Victoria.

Box 6: Risks to other dependants or animals

Just as mental illness can affect parents' ability to care for dependants, it can affect the ability of a person with a mental illness to care of non-child dependants such as elderly, sick or disabled relatives.

When conducting a triage assessment, it is vital that clinicians establish and document whether adults referred to mental health services are carers of other dependants. Considerations of risks to dependants who are elderly, sick or disabled should be part of the overall risk assessment undertaken at triage, and should be a factor that is explicitly taken into account in determining the adult's need for mental health or other services, and the urgency with which intervention is required.

As responsible members of the community, it is also expected that mental health service providers will alert animal welfare authorities if they become aware of animal cruelty, or situations where animals will be unattended. The RSPCA can be contacted on 03 9224 2222.

History/previous triage contacts

The person's history – for example, the severity, frequency, patterns and dates of past harm – is critical to effective risk assessment. In the pressured environment of mental health triage, people can sometimes be assessed in isolation from previous contacts or relevant information about the person's history.

The *Mental health triage program management circular* requires mental health services to have processes in place to identify unregistered clients who contact (or who are referred to) triage on repeat occasions. The reason for this is that some clients' need for specialist mental health services becomes apparent through a pattern of contacts over a period of time rather than through any single assessment. Multiple contacts suggest that the person's mental health concerns are not being resolved through alternative means, and that the mental health service may need to arrange a face-to-face assessment to examine in more detail the person's service needs.

Some registered clients also contact triage frequently. The screening register provides a mechanism to identify such clients, so that a review can be organised - in conjunction with the case manager - to ensure that treatment is appropriate to the person's needs.

As discussed on page 8, triage clinicians should, where possible, seek corroborating information about the client's history from family members (such as partners, parents, siblings and young carers) and other relevant people.

Chronic versus dynamic risks

Triage clinicians are frequently called upon to assess people who have a range of chronic risk factors (for example, a history of harming themselves or others, ongoing psychiatric, medical and/or social vulnerabilities). Against a backdrop of static or relatively stable risks, it is essential that triage clinicians are alert to factors indicating current increased risks. Recent significant life events, changes in medication or medication compliance, and recent increases in the use of alcohol/other drugs are examples of 'dynamic' risk factors. High levels of distress, hopelessness or anger are signals of reduced ability to cope and of increased risk. A critical question in the triage process is 'why is this person presenting now?'

Engagement

People with mental health problems vary greatly in the extent to which they recognise their difficulties, and their desire and ability to engage with potential sources of help. Poor engagement can increase the risks to the person and/or others, necessitating a higher level triage disposition. However, in lower acuity situations, the person's ambivalence or reluctance to seek help may make it more appropriate for the clinician simply to provide advice or information, leaving the client to decide whether or not to get help at this point. In some cases, deciding to get help is the most important part of the person's journey to recovery.

Box 7: Case scenario

James, a known local indigenous elder, calls in relation to **Riley**, who is a **17 year old** indigenous Australian male.

James reports that Riley has had a recent encounter with local police involving dangerous driving in the context of significant alcohol use. There is a history of chroming and it is noted that a CAMHS assessment took place some 18 months ago. Riley, however, did not attend for his follow-up appointment. The working diagnosis at that time was major depression.

James indicates that in recent times, Riley has been neglecting his self care, absenting himself from his family home for days at a time, isolating himself from usual friends and activities, has lost weight and reports that he hears the voice of his deceased grandmother who calls him to join her.

James indicates that this is out of character for Riley and that he is extremely concerned for Riley's wellbeing.

How would you triage this scenario?

Code C is the suggested triage outcome. The clinician should also consider recommending that Riley be seen at the earlier end of the 8 hour time frame for a Code C. Riley's previous failure to attend the follow-up appointment suggests that it is important to engage Riley at the earliest possible opportunity.

Urgency

Decisions about the urgency of the response needed by mental health or other services overlaps to a large extent with the assessment of risk and need. Key questions include:

- what is the nature of and severity of the risk?
- is the situation reasonably stable or are there indications of rapidly changing risks?
- will the opportunity to engage the person be lost if action is not taken in a particular timeframe?
- are capable carers or other support persons available? If so, how long can they reasonably be expected to maintain the situation?

The assessment of urgency focuses on short-term risk of harm rather than longer-term risks. However, longer term risks – which include the risk of ongoing psychiatric disability, social exclusion, poverty, and medical problems resulting from self-neglect or drug/alcohol abuse – may be very important in determining the person's need for service provision. This is comparable to what occurs in medical triage: for example, an otherwise healthy child with severe croup will receive a higher triage category than a cancer patient who has non-life threatening medication side effects – even though in the longer term the cancer patient's need for medical care will be far greater than the child's.

Part 4: The triage scale

The mental health triage scale maps mental triage assessments to seven categories (Codes A to G), reflecting different levels of need, risk and urgency. The most urgent clinical feature determines the code chosen.[1]

The first column of the scale provides the codes (A to G) and a brief description of the types of need, risk and urgency associated with each one.

The second column describes the type of response associated with each code and, if applicable, the timeframe in which the response is expected to occur.

- Code A is reserved for situations requiring immediate referral to emergency services (police, ambulance and/or fire brigade).
- Codes B to D are associated with a planned face-to-face mental health service response and expected timeframe, ranging from 'within two hours' to 'within 72 hours'.
- Code E is also associated with a planned face-to-face mental health service response but an expected timeframe is not specified. An appointment should be arranged at triage or in a follow-up phone call a short period after triage.
- Code F covers all situations in which the primary triage outcome is referral to an alternative service provider, either via advice to the client or referral facilitated by the triage clinician. In these situations, no further face-to-face assessment or treatment from the mental health service is planned in relation to the current triage episode.
- Code G covers a range of situations in which information or advice is given and in which the mental health service does not plan to follow-up the current triage 'episode' with a face-to-face assessment or treatment.

For each code, there is a list of 'typical presentations' (in the third column) and prescribed actions or responses for the triage clinician (the fourth column).

The last column lists additional actions that may assist in optimising the mental health service's management of the situation and/or outcomes for consumers and carers. Mental health services may wish to add service-specific actions to this column.

There is also a blank (free text) notes box at the end of the scale for the clinician to record any notes relating to the coding on the triage scale. This should include any specific advice given to the consumer (for example, advice to make an appointment with a general practitioner), and any specific additional actions required from the mental health service (for example, telephone referrer to give feedback on the triage outcome).

The role of clinical judgement

As discussed in Part 2, the application of the mental health triage scale assumes that an appropriately skilled mental health triage clinician has conducted an assessment of the person's mental health, risks and other health and social factors that might impact on their need for services.

The triage scale is designed for use in conjunction with triage protocols and assessment tools to help clinicians reach a safe and appropriate decision. However, even the best tools and instruments cannot replace the need for clinical judgement. There is no magic formula that incorporates and

1 For example, if the person is thought to have an early/first episode psychosis (an example of a typical presentation under Code D) but is also engaging in very high risk behaviour (Code B), the code chosen would be the higher of the two (Code B).

appropriately weights all possible factors that can impact on a person's need for mental health assessment/treatment.

The 'typical presentations' associated with each triage scale code are examples only and do not cover all situations that will be encountered in a mental health triage setting. Clinicians must exercise their judgement in these situations and, where there is doubt, err on the side of caution in determining the appropriate scale category.

Formal management plans

In general, clinicians should not assign a lower triage code than the scale suggests. An exception to this is where a consumer known to the service has a formal management plan documenting a response to specific behaviour that is typical for that individual. Where the management plan recommends a course of action that is inconsistent with that prescribed by the triage scale, the alternative course of action, and the reason for it, should be clearly documented on the triage record. However, care must be taken to avoid making assumptions based on past behaviour and ensuring that appropriate consideration is given to any new behaviours and risks.

Timeframes for face-to-face assessment

Clinician judgement should be exercised in relation to the timeframes associated with Codes B to E. The timeframes for Codes B to D specify the maximum time that the consumer should wait for a face-to-face assessment. Within each category, however, the triage clinician may specify a time for response (for example, the clinician may note that a Code C presentation should be seen 'that afternoon' or 'within 4 hours').

Box 8: Case scenario

The MHS receives a call from a paediatrician referring **Sarah**, a **14 month old** girl, who is reported as being irritable. He advises that Sarah is clingy toward her mother and that she becomes highly distressed when her mother leaves the room and she is very difficult to settle when distressed. The paediatrician reports that Sarah is fussy and does not accept new foods well. She is also generally described as miserable.

Sarah has been to sleep school and this has made some difference and Maternal and Child Health has been involved. The mother has a history of depression.

How would you triage this scenario?

Without additional complicating factors, this scenario might be categorised as a **Code E**. The clinician should consider recording that a face-to-face response should be arranged as early as possible and may record an indicative time frame, given Sarah's age and reported condition.

Tip: If faced with this scenario, it is suggested that a triage clinician should aim to gather more information about the mother's current mental health status and skills for coping with the current situation. The nature of Maternal and Child Health involvement and other support/protective factors would also be relevant.

When to apply the scale

As discussed in Mental health triage program management circular, the following factors distinguish triage from other contacts with area mental health services:

- Triage involves a specific request for advice or assistance.
- The request is made in the context of an unscheduled contact with the service.
- The request is made in relation to a particular individual – that is, it is not a request for general information or advice.

The triage scale is applied after the triage clinician has collected sufficient information to make a decision about what actions, if any, are required in response to the request. This may require contacts with multiple individuals and/or checking of written records.

Apart from some emergency situations, in which the triage decision is clear and needs to be made very quickly, the triage process normally involves full completion of a triage record (paper based or computerised) designed to collect relevant demographic, social and clinical information. While this process may require multiple phone calls, discussions or checking of records, the triage scale is completed only once in the triage episode–at the end.

Following its statewide implementation, the triage scale will be common across all area mental health services and will appear at the end of each service's triage record form, replacing any existing triage scales currently used by individual mental health services. The triage scale has been incorporated in the RAPID/CMI screening register.

When to revise a scale code

Once a triage code has been applied, any new contacts in relation to the individual will normally be treated as a new triage episode, requiring reassessment in the light of any changes to or new information to the individual's situation. However, where new information becomes available very soon after the original decision has been made, and before the service has responded, the triage code may be revised if required. The reasons for the revision should be documented in the notes box at the end of the scale.

Triage codes should **not** be revised simply because the triage clinician receives information that the mental health service cannot respond in the prescribed timeframe.

The triage codes

Triage Code A (emergency services response)

Code A covers emergency situations in which there is imminent risk to life. In these situations, the most pressing need is to provide physical safety for the person and/or others. The triage clinician's responsibility in these circumstances is to immediately mobilise an emergency service response (police, ambulance and/or fire brigade). There are guidelines for mental health service referrals to police.

If the person has taken an overdose or has otherwise inflicted serious self-harm, an ambulance must be called.

If injury to others has occurred or is an imminent threat, based on the clinician's judgement, the police should be called. While violence should never be condoned, the views of carers, family members and other referrers about the appropriateness of police involvement should be taken into account in deciding whether to allocate this code.

Things to consider

- It may be appropriate to keep the caller on the line awaiting an emergency services response.
- If possible, the triage clinician should provide specific harm minimisation advice to consumers/carers/referrers while awaiting emergency services.
- Consider carer/family member needs for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'.
- It may be appropriate to notify the crisis assessment and treatment (CAT) team.
- It may be appropriate to involve or inform the person's case manager.
- Mental health services have a role in the management of community emergencies (see the department's emergency management strategy at <www.dhs.vic.gov.au/emergency>. The role of the triage clinician in critical events could include providing consultative support to local agencies and emergency service providers, and/or the provision of counselling or referral to support services for people involved in the incident.

Box 9: Code A case scenarios

Case 1

The MHS receives a phone call from the 14 year old brother of a **16 year old** female, **Hannah**. He was given the number for psych services by Kids Helpline. The brother is very upset and frightened. He describes the recent history of his sister's erratic, impulsive behaviour in context of marijuana and alcohol abuse. He states that Hannah took magic mushrooms 'and other stuff' this evening, and is now 'completely out of control'. Hannah is currently barricaded in her room and is screaming intermittently and rambling incoherently. Hannah is breaking furniture in her room and threatening to set fire to the house 'to burn out the dirty bastards'.

How would you triage this scenario?

Code A is the suggested triage outcome. Clinicians may also consider alerting the appropriate service (for example the CATT or relevant integrated team).

Case 2

Dominic is a **56 year old** male referred by his neighbour. Dominic has been awake for several days, evidenced by much noise, yelling and banging overnight. Dominic's wife died in a motor vehicle accident three months ago, also involving Dominic's son who had been driving. Since then Dominic has had treatment for depression. Last night Dominic banged on the neighbours door aggressively at 2am accusing them of putting a 'magnet on my roof', he seemed terrified, suspicious, and at times incoherent. This morning Dominic was seen climbing on the roof with a toolbox and smashing roof tiles. The neighbour had also just received a phone call from Dominic to say he has a gun 'trained on your house'. This may be plausible, as he is an ex-farmer.

How would you triage this scenario?

Code A is the suggested triage outcome.

Case 3

The MHS receives a phone call from a young man regarding his **66 year old** father, **Harry**, who lives at home with his wife and has a three-year history of paranoid ideation. Harry believes that his neighbours are impostors who have been placed there by ASIO with the aim of having him killed. The son says that he received a phone call from his father half an hour ago and that his father had stated that he was going to take matters into his own hands because the Prime Minister's office has not responded to the letter he sent two days ago, explaining the plot to assassinate him and the Prime Minister. The son also reports that two weeks ago his father's GP had prescribed 2mg of Risperidone twice a day, but Harry told him he had been flushing the medication down the toilet because he suspected his home had been infiltrated. A phone call to Harry's wife reveals that she has noticed Harry has started carrying around various items he says are weapons to protect himself, as he fears the threat from neighbours is very real. He has become very agitated, sleeps very poorly, and has started yelling at voices. Harry's son feels that Harry is at risk of harming his mother (Harry's wife) and others and requests urgent action.

How would you triage this scenario?

Code A is the suggested triage outcome.

Triage Code B (high urgency mental health response)

Code B situations are also very high-risk situations in which the consumer's short-term safety is paramount. However, in these situations, the triage clinician has assessed that the person can wait safely (up to two hours) for a crisis assessment and treatment (CAT) response or is able to present to an emergency department (ED).

Where it is unclear whether Code A or Code B is most appropriate, the following factors should be considered.

- The presence of another person who is able to manage the situation for up to two hours.
- The likelihood that the person will abscond, deteriorate or become an immediate threat to themselves or others while awaiting the crisis assessment and treatment (CAT) team or while in transit to an ED.
- Where referral to an ED is being considered, the person's willingness and capacity to travel safely to the ED.
- Where police involvement is being considered, whether the risks of the situation outweigh the possible trauma to the consumer and/or carers and family members.

Things to consider

- If possible, the triage clinician should provide specific harm minimisation and care advice to consumers/carers/referrers while awaiting a service response.
- Consider carer/family member need for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'.

- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise the caller to re-contact the service if the situation deteriorates while waiting for a service response. Ensure that after-hours/emergency numbers are given.
- Provide an estimated time of arrival for the CAT clinician.
- Liaise with emergency services and/or emergency department if necessary.

Box 10: Code B case scenarios

Case 1

Jane, a PDRSS worker, rings regarding Alex, with whom Jane has recently started working. **Alex** is **27 years old** and has a history of borderline personality disorder. Alex has had extensive contact with the MHS. Alex has rung Jane stating she will not be attending group activities today as she intends to take an overdose.

Alex's management plan states that she should be encouraged to take responsibility for accessing services of her own volition and that she has previously demonstrated an ability to do so. Jane states Alex's long term relationship ended last week and Alex has been having trouble coping with this.

How would you triage this scenario?

Code B is the suggested triage outcome.

Case 2

The MHS receives a phone call from a mother about her **14 year old** daughter, **Chloe,** who is currently in year 9 at a private school. The mother states that Chloe was taken to the ED on the weekend on the advice of the GP. Chloe was taken to the GP after disclosing to her mother that she had been having 'bad thoughts', like 'what if I just cut my throat?'. Chloe was seen by a paediatrician in the ED, who prescribed diazepam and sent her home advising the parents to contact CAMHS intake in the morning. Chloe told the paediatrician that she did not want to die however could not control or stop these thoughts. Her mother notes that the diazepam had little to no effect and Chloe became 'hysterical' when they arrived home from the hospital. Chloe's parents sat with her all night, they removed all access to means of harm such as knives. Chloe slept for 2 hours and awoke this morning in a 'hysterical' state. Chloe continues to tell her parents that she has ongoing thoughts of harming herself. Her mother notes that for the past four weeks Chloe has had a labile mood. The mother states, 'one minute she's happy, the next she's sad/upset, she can't be reasoned with at all'. Chloe has become more withdrawn. There is no history of drugs or deliberate self harm.

How would you triage this scenario?

Code B is the suggested triage outcome.

Case 3

A GP rings triage to refer a **30 year old** married woman, **Samantha**, who has recently given birth to a baby boy after an emergency caesarean six weeks ago. Samantha has two other children aged three and four years old. The GP had seen Samantha four weeks after the birth and she was fine then, but recently she presented with low mood, and was teary and emotional. Samantha has progressively deteriorated. No medication has been prescribed. This morning, Samantha felt extremely homicidal and took a pillow to smother the baby. When she looked into baby's eyes she stopped and then rang the GP for an appointment. Samantha then rang her husband, who was not told of incident until he was at the surgery. Samantha has indicated she does not want the baby at all. She appears unemotional, detached and expresses no guilt. She states that she is a complete failure and that either she or the baby has to go. There is no past history of psychiatric illness, post-natal depression or psychosis. The husband does not seem to understand much about what's going on.

How would you triage this scenario?

Code B is the suggested triage outcome

Triage Code C (urgent mental health response)

While the need for swift action to ensure the person's safety is less acute than in the previous codes, Code C situations require an urgent (within 8 hours) response from the mental health service due to new or increasing psychiatric symptoms, high-risk behaviour due to mental illness symptoms, and/or the inability to perform basic activities of daily living. In these situations, either the CAT team will provide a response or the person will be allocated an urgent appointment at a community mental health clinic.

An additional requirement for this code is to ensure that the responding team/program contacts the caller within one hour of the triage contact to give an estimated time of CAT arrival or a clinic appointment time. This follow-up contact will allow an opportunity to collect additional assessment information, to review the situation, and to provide further advice/support to clients.

Things to consider

- Provide specific harm minimisation and care/self-care advice.
- Consider carer/family member needs for support during and/or after the event. It may be appropriate for the clinician to call the carer back after the event for 'debriefing'. Referral to support services should also be considered if necessary.
- Consider the need to provide telephone support to other service providers while awaiting MHS response.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise the caller to re-contact the service if the situation deteriorates while waiting for a service response. Ensure that after-hours/emergency numbers are given.

Box 11: Code C case scenarios

Case 1

Aged Care Hostel staff have referred a **92 year old** woman, **Ruby**, who has been a resident of their hostel since 2002. Ruby, who only speaks Armenian and a little English, is described as socially isolated and spends most of her time in her room. Ruby recently said she wanted to die. Over the last two weeks, staff have noticed that she had a decreased appetite and she has been awake over the last two nights. She has also been giving away her possessions, stating 'no need, no need'. This evening, staff noticed that she was extremely agitated and was trying to force her way into the kitchen. It appeared she wanted access to the cutlery cupboard, which contains butter knives and fruit carving knives.

How would you triage this scenario?

Code C is the suggested triage outcome. The triage clinician should also provide advice to the hostel staff on strategies to keep Ruby safe until an area mental health service clinician attends.

Case 2

52 year old Robert is referred by his general practitioner. Robert is a farmer living in an isolated rural location and hasn't taken his antidepressants for several months. Robert is despondent and is expressing thoughts of unworthiness. He tells his GP 'you should look after people who deserve it'. The GP reports that Robert's personal hygiene has significantly deteriorated – Robert hasn't changed clothes for several weeks and smells offensively. The GP advises that Robert's wife is very worried about him and has come to the GP seeking assistance. She reported to the GP that when she tried to get him to take his socks off last week Robert became quite agitated and resistant. She also reported that Robert has not been eating well and has been waking early.

Robert speaks very slowly with some mild poverty of thought. At first he denied having any suicidal thoughts but when pressed by the GP for further information he said he wanted to die and had considered shooting himself. Robert indicated he didn't have a plan but he has access to a gun if he needs to use it.

Robert had a previous admission for depression about five years ago and responded well to antidepressants.

How would you triage this scenario?

Code C is the suggested triage outcome. The clinician should consider a higher disposition, if Robert does not have strong family and social supports.

WIT.0003.0004.0269

Case 3

Triage receives a call from woman seeking urgent assessment of her **14 year old** step-daughter, **Bianca,** who has been having problems in the last 12 months since her biological mother committed suicide. The caller reports that Bianca went to counselling after her mother's death, but didn't engage well with the counsellor, and didn't want to continue. She describes Bianca as having a 'breakdown' last week, characterised by erratic moods and poor sleep. Bianca is highly suspicious, tearful and increasingly talks to herself. The woman and Bianca's father are very concerned about her mental state and fear she will self-harm. Bianca has no past history of suicide attempts, but is currently expressing suicidal ideas. She regularly dreams of her deceased mother and believes her mother communicates with her in dreams. She has recently been saying she hears mum talking to her all the time, telling her 'to do it quickly'. Bianca interprets this voice to mean she has to kill herself, and she been found twice with packets of Panadol and other prescription drugs under her bed in the past 2 days. This morning Bianca has deteriorated significantly. She is highly anxious, mumbling to herself, expressing paranoid ideas, yelling out at voices and is very distressed and frightened.

How would you triage this scenario?

It is suggested that this would be a **Code C.** The absence of appropriate support/supervision while awaiting a response or factors increasing concerns for Bianca's safety, such as current possession of Panadol or other Rx, withdrawal to a locked room in the house or disappearance, would suggest a higher urgency Code should be allocated.

Triage Code D (semi-urgent mental health response)

Code D situations, classified as 'semi-urgent', are those involving moderate risk factors and/or significant distress. They require face-to-face specialist mental health assessment within 72 hours. This could occur at a community mental health service during business hours or a CAT clinician could provide the response.

Things to consider

- Provide care/self-care advice.
- Consider carer/family member needs. It may be appropriate for the clinician to provide advice and supportive counselling. Referral to support services should also be considered if necessary.
- Consider the need to provide telephone support to other service providers while awaiting MHS response.
- Consider possible safety risks for CAT or other staff responding to situations in the community.
- Always advise caller to re-contact the service if the situation deteriorates while waiting for a service response. Ensure that after-hours/emergency numbers are given.
- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- An appointment time should be provided during the triage contact or, if this is not possible, the caller should be recontacted and this information provided within a short period.

Box 12: Code D case scenarios

Case 1

A general practitioner rings to refer a **23 year old** male, **Isaac**, who she has been seeing about his drug use (amphetamines, ice, heroin and cannabis). Five months ago, Isaac underwent a successful detoxification at Wellington House. At that time Isaac was experiencing paranoid and persecutory ideation. The general practitioner is unsure whether this was secondary to poly-drug use or whether there was an underlying psychotic illness. She commenced him on Zyprexa 5mg. When she saw him last week, the symptoms were still present so she increased the medication to 10mg. She would like a clarification of his diagnosis.

Isaac was contacted by mental health triage and he said he is on the waiting list for the Basin residential rehabilitation program. He indicated that his paranoid ideas continue, he believes that people look at him funny and he struggles to go out in public. Isaac states that he gets aggressive when he is out and has only gone out once or twice to the shop with friends. Isaac says that he is not using IVdrugs. He also reports he has no job or social life and recognises his life is deteriorating. Isaac acknowledges the impact of his drug usage. He also has assault charges pending.

How would you triage this scenario?

Code D is the suggested triage outcome.

Case 2

The area mental health service receives a phone call from school support worker requesting assistance with a **9 year old** boy, **Tyrone**. The worker advises that he seems to be deliberately hurting other people including children and teachers. The worker also advises he shows no remorse and gets upset and runs away after an incident. People are frightened of him. The school has learned that he has also started shop lifting.

An additional phone call from the school's assistant principal adds that Tyrone's behaviour has been worse over the past two months and has included him smashing windows of houses at random, shoplifting and foul language. The assistant principal reports that the school's usual behavioural management strategies have not been effective to manage the crisis. Academically Tyrone is a capable student who does the work especially if one on one.

The triage clinician calls Tyrone's mother who is aware of the school's referral. She reiterates that his aggression occurs on a daily basis. Earlier in the week he broke a photo frame and smashed windows in their home. His mother is additionally concerned because for the first time this week, in the midst of an aggressive outburst, Tyrone stated he wanted to kill himself. In anger he has run across a road without looking a few times.

How would you triage this scenario?

In this case, it is suggested that further details on the circumstances around the aggressive outburst, Tyrone's statement that he wanted to kill himself, and any other actions that increase concerns about Tyrone's safety would further assist in the triaging process.

Confirming the existence of protective factors, such as supportive family life and, potentially, school support services, is also a suggested action.

Without additional information, a **Code D** is the suggested triage outcome. If social and environmental vulnerabilities (including concerns about the family relationship) existed, clinicians should consider a more urgent response.

Case 3

Triage receives a phone call from GP requesting urgent assessment of an **81 year old** female, **Sophia**, with worsening psychiatric symptoms. The GP reports a very long history of depressive features (psychotic depression), with a worsening of mood over the last six to nine months despite trials on Aropax and Efexor. He acknowledges a worsening of complexity and frequency of hallucinations but he sees this as secondary to mood. The carer in charge of the hostel confirms the worsening of her mental state. Sophia sees children at the door, experiences other visual hallucinations and hears voices yelling derogatory remarks at her. She is becoming distressed and inconsolable. Staff members report that Sophia is becoming increasingly distressed, agitated, preoccupied and is crying and frightened. She fears something she is eating or drinking or her medication is causing the problem, so she is refusing to eat or drink. Staff report that she is very suspicious that staff are spiking her drinks. She is very difficult to manage due to fear and agitation. Efexor was prescribed recently, and one week ago Risperidone and Temazepam were introduced.

How would you triage this scenario?

Code D is the suggested triage outcome. The triage clinician may also explore management strategies for Sophia while awaiting the MHS response.

Triage Code E (non-urgent mental health response)

Code E (non-urgent) situations are usually low risk presentations requiring specialist mental health follow-up. However, certain situations involving moderate risk but high levels of support or stabilising factors may be classified as 'non-urgent.'

Code E presentations may involve clients known to the service who need non-urgent medication or care plan reviews. Where unknown clients are assigned to this category, the triage assessment should have been sufficiently comprehensive to exclude significant risk factors.

Things to consider

- Providing care/self-care advice.
- Consider carer/family member needs. It may be appropriate for the clinician to provide advice and supportive counselling. Referral to support services should also be considered if necessary.
- Consider the need to provide telephone support to other service providers while awaiting MHS response.
- Always advise the caller to re-contact the service if the situation deteriorates while waiting for an appointment. Ensure that after-hours/emergency numbers are given.
- Attempt to reduce subjective distress by providing reassurance and opportunity to talk.
- An appointment time should be provided during the triage contact or, if this is not possible, the caller should be recontacted and this information provided within a short period.
- Consider whether the consumer and/or carer should be contacted between the triage assessment and the appointment time, and at what intervals (for example, daily? weekly?).

Box 13: Code E case scenarios

Case 1

Triage receives a phone call from the mother of **10 year old** girl, **Leah**. For the past six months, Leah has been persistently worried about what would happen to her mother if she was out of sight. For the past two months, this has prompted repeated episodes of crying, refusal to go to school, and clinging behaviour. Her appetite has decreased during this time. She has lost 3 kilograms in weight and is waking two hours earlier than previously. Leah is worried about many things: her brother's safety, her father's drinking, her mother's driving, and her aunt's death. Leah performs well at school but the teacher has noted occasional complaints of abdominal pain. There is no evidence of a perceptual disorder or other strange behaviour. The main source of stress seems to be Leah's change of school nine months ago. She complains that the teachers in the new school are very strict and that she finds it difficult to make friends. She is sometimes made fun of by school friends. Leah recalls starting to worry about other people's safety around six months ago. She is also having problems getting to sleep.

How would you triage this scenario?

Code E is the suggested triage outcome. The clinician might also consider referring Leah to her GP to investigate any organic causes for the current situation and to school support services to explore strategies and support options, which can be commenced while awaiting the CAMHS response.

Case 2

A consultant psychiatrist calls triage requesting case management for **Alyssa**, a **40 year old** female he has seen intermittently over a period of 14 months. When contacted by phone, Alyssa conversed freely stating that she lived alone and sees her two children only every second weekend. Alyssa says she feels depressed most of the time, feels little joy and often spends days in bed. She reports sleeping poorly, has no energy and or motivation and a poor appetite. Alyssa often feels suicidal but denies any plan or intent because of feelings for her children. Alyssa has a longstanding history of cannabis abuse and her finances are limited. GP has prescribed 20 mgs of Lexapro and 250 mgs of Lithium twice a day.

How would you triage this scenario?

Code E is the suggested triage outcome. The clinician should also consider whether Alyssa has social and family supports.

Case 3

A **68 year old** widower, **Michael,** phones concerned that his anxiety and panic attacks have worsened over the last two years and he feels totally dependant on his friend. When he is not in the company of his friend during panic attacks, he becomes quite agitated. Michael claims he has great difficulty in answering direct questions and performing some physical manoeuvres like getting into a car where he cannot lift his leg into the vehicle. Michael claims that he walks long distances with his friend, usually three to five kilometres a week. Michael acknowledges some memory loss, but he is unable to account for his medical history as has always shunned GPs. Michael is requesting assistance because he feels life is 'slowly slipping away'.

How would you triage this scenario?

Given Michael's past reluctance to engage with GPs, **Code E** is the suggested triage outcome. However, in the absence of a reluctance to engage with GPs, the triage clinician may suggest assessment by the Primary Mental Health Early Intervention Team and engagement with a GP.

Triage Code F (referral to alternative provider)

Many people who contact triage do not require further assessment and/or treatment from a public specialist mental health service, and alternative services are more appropriate for resolving their concerns, for example, general practitioners, community health services, private practitioners. In these cases, the person should receive information or advice about alternative services and/or referral to a specific service provider.

Wherever possible and clinically appropriate, triage clinicians should facilitate referrals to other organisations, rather than merely providing information. However, for the purposes of completing the triage scale, the 'referred' category encompasses situations where people are given information about other services as well as those for whom facilitated referrals are made.

Even where people do not require public specialist mental health services, interventions by alternative providers will sometimes be time-critical. In these cases, it may be necessary for triage clinicians to facilitate referrals to other service providers. It is important that triage clinicians communicate clearly with the consumer/carer about the timeframe in which they should receive further assessment or treatment (for example, 'see a general practitioner within the next two days').

Subject to Section 120A of the *Mental Health Act 1986*, the consumer's informed consent will normally be obtained before other services are contacted. However, in certain situations the requirement for consent does not apply. See the *Confidentiality under the Mental Health Act 1986 program management circular* (November 2008), which is available at <www.health.vic.gov.au/mentalhealth/pmc/confidentiality.htm>.

Note that Code F should be used only where the MHS (including the Primary Mental Health Team) does not need to provide a face-to-face response to the contact. Where there is a referral to another service provider and a planned MHS response, one of Codes B to E should be used, as appropriate.

Things to consider

- Attempt to reduce subjective distress by providing reassurance and an opportunity to talk.
- Tell the consumer/carer/referrer the reasons why their request has not been assessed as appropriate for the MHS.

- Advise the caller to re-contact the service if the situation changes while waiting for their appointment with an alternative service. It might be appropriate for the clinician to tell the caller what to do if specific contingencies occur.
- Consider need to contact the 'referred to' service provider to give advice or information.

Box 14: Code F case scenarios

Case 1

A mother calls seeking 'referral to a specialist' for her **4 year old** daughter, **Ava**. The mother states that Ava is 'behind' the other children at kinder, who can all write their own names and toilet themselves. She has no concerns about her daughters mental state – she is described as happy and settled – but is worried about her intellectual development. The mother wants 'psychological and IQ testing'. No other problems are reported. The mother comes across as quite anxious. She also has private health insurance.

How would you triage this scenario?

Code F is the suggested triage outcome, with a referral to a private psychologist and/or an early childhood intervention service.

Case 2

Triage receives a call from a daughter about her **60 year old** father, **John**. John sent his sister an SMS message saying 'goodbye' and stating that he was going to kill himself. A family member then picked him up and took him to his daughter's address. Mental Health triage has spoken with John. He says that he is more settled now that he has spoken to his daughter, and that he no longer wants to kill himself. John separated from his second wife last week after she found his diary in which he had written that he felt like making a bomb and blowing up the house. John reports that he writes any of his thoughts in his diary and that they don't necessarily mean anything. He believes that he and his second wife will get back together eventually. John speaks at a normal rate, tone, volume and his voice does not sound flattened or monotonous. There is reasonable engagement. There is no current alcohol abuse and no psychotic symptoms are reported. The content of the conversation is appropriate to the questions, although he did not say he spent three months in hospital last year. His difficulties with his second wife began when she found out he was delusional about having served in the Vietnam War. John describes his mood as 7/10 and says that it fluctuates during the day. He wonders if his diabetes plays any part in this. John has an appointment with a private psychiatrist which he intends to keep. His daughter has suggested that he stay with her tonight. He says he will keep himself safe, take medication and go to bed. John is working 52½ hours per week.

How would you triage this scenario?

Code F is the suggested triage outcome. The clinician should ascertain when the appointment with the private psychiatrist is scheduled and provide details of the triage contact to the private psychiatrist and suggest coordination of an earlier appointment, if it is not scheduled within the next 24 hours, the clinician should consider a MHS response.

WIT.0003.0004.0275

Case 3

Matilda is an **89 year old** female referred by a charge nurse who reports that Matilda's daughter died unexpectedly one month ago. Since her death Matilda has been feeling low in mood, with no observable cognitive impairment. However she appears to be in pain. When asked, Matilda denies this and declines pain medication. Matilda has no appetite and her sleep is disturbed. There are no signs of suicidal ideation. The nurse reports that Matilda's only current concern is her grief. She is seeking advice and information about grieving.

How would you triage this scenario?

Code F is the suggested triage outcome. The triage clinician should provide referral to grief and bereavement services and other counselling options, where available.

Triage Code G (information only/No further action)

Code G covers situations in which triage clinicians determine that no further action is required of the mental health service and referral to another service is not required.

The code reflects the variety of roles that triage clinicians play in mental health services. For example, they frequently provide support and advice to existing and former consumers, who may be seeking advice or the opportunity to talk.

Triage clinicians may also provide advice and consultation to other service providers, and can often resolve their concerns without needing to involve other mental health clinicians.

In some cases, enquiries from members of the public can be resolved without the need for further mental health assessment or referral to another provider.

A further use of Code G to record situations in which the triage clinician determines that the mental health service needs to collect more information over the telephone before deciding whether a face-to-face assessment is needed. For example, this often occurs when adult services conduct triage for all ages overnight and pass referrals on to APMHS or CAMHS for further information collection during business hours.

Note that Code G should be used only where the caller has requested advice or assistance in relation to a particular individual. Triage clinicians often handle requests of a more general nature, for example, requests for information about signs of schizophrenia or types of services available. These are not 'triage' under the definition on page 26 and the triage scale should not be applied in these situations. At a local service level, these calls may be recorded as an activity but should not be recorded as a 'triage'.

Things to consider

- Attempt to reduce the subjective distress of the consumer/carer/referrer by providing reassurance and the opportunity to talk.
- Tell the consumer/carer/referrer the reasons why their request has not been assessed as appropriate for the MHS.
- Advise caller to re-contact the service if their situation changes. It might be appropriate for the clinician to tell the caller what to do if specific contingencies occur.
- Consider making a follow-up phone call to the client.

Box 15: Code G case scenarios

Case 1

Triage receives a call from a work colleague of a **32 year old** female, **Anna**, seeking information about support groups for alcoholics. The caller states that Anna has been having problems with drinking since breaking up from her partner and she wants to give her a number to call.

How would you triage this scenario?

Code G is the suggested triage outcome. The clinician may provide information about local Alcoholics Anonymous Groups and drug and alcohol services, including Directline.

Case 2

Tony is a **87 year old** widower who has been a permanent hostel resident since 2006. A staff member from the hostel has called triage to report that Tony is lonely and a bit down. They seek information about organisations that can arrange visitors for Tony and provide opportunities for him to socialise.

How would you triage this scenario?

Code G is the suggested triage outcome.

Case 3

Triage receives a phone call from the father of **7 year old** female who is concerned his daughter, **Heather**, who has not wanted to go to bed at the usual bedtime. Heather has also been answering back for the past two weeks since her mother moved out of the family home due to marital separation. She is still going to school and he is not aware of any concerns in the school environment.

How would you triage this scenario?

Based on the information provided, it is suggested that **Code G** be applied. It is also suggested that the clinician might explore other supports for Heather and her family, including school support services or local family services.

WIT.0003.0004.0277

Frequently asked questions

What if the triage clinician has assessed the person as being in 'Code D' (for example) but knows that a follow-up appointment with the mental health service is not available within the prescribed 72 hours? Should the triage clinician choose Code E instead?

Code D should be chosen. It is important that coding using the triage scale is based on the person's clinical presentation, not the service's capacity to respond. It is not expected that mental health services will be able to respond within the prescribed timeframes in 100 per cent of cases. Service planning and development will be guided by analysing service demand (which is based on clinical need) and the actual service response timeframes.

The triage scale is not quite right for our service. Can we adapt it to our needs?

It is important that there is a consistent approach across the mental health service system. Mental health services must classify all triage assessments according to the seven categories of the scale and must respond in a way that is consistent with the 'response type' described on the scale.

However, services may choose to collect additional, more detailed information within particular categories or codes. For example, where people who contact triage are referred to other services, many mental health services choose to record actual referral destinations (for example, GP, private psychiatrist).

Mental health services may also add an extra column to describe specific actions or operational procedures that their triage clinicians are expected to implement (for example, notifying primary mental health team of referral to GP).

If a person is classified as a Code B and referred to an ED, do they just need to present to an ED within two hours or do they have to be seen by an ED-based mental health clinician within this timeframe?

The timeframe refers to a person's arrival at the ED. Responses to Code B cases focus mainly on the consumer's safety. Consumers are considered safe once they are at an ED. It is recognised that rural services in particular may have difficulty in ensuring a specialist mental health response within two hours.

What happens if a person is given a follow-up appointment (say for two weeks time) at the mental health service and is also referred to another provider (for example, to a GP for urgent prescription of medication)? Would that be Code E or Code F?

Code E. Code F is specifically to record situations in which no further assessment by the mental health service is planned.

What happens if there is new information or changed circumstances after the triage assessment has been made (but before the mental health service has responded)?

The triage code may be changed to reflect the new information or circumstances. The reasons for the change must be clearly documented in the 'notes' section of the scale.

Why is there is no code covering referral to another area mental health service?

It is expected that mental health services will usually determine the person's place of residence before conducting a triage assessment and, if the person lives in another catchment, will make a referral to the appropriate MHS. The person's correct MHS will then conduct the triage assessment. In these cases, there is no need for the initially contacted service to complete a triage assessment or apply the triage scale.

In the case of urgent telephone or face-to-face contacts, the presenting MHS may need to respond to the client, regardless of their area of origin. Where a service provides further assessment and/or intervention for an 'out-of-area' client, the triage scale should record the response that was planned and provided.

In the event that a service conducts a triage assessment and then mobilises a service response (for example, CAT) from another MHS, the triage scale should be completed as if the initial service was making the response.

The purpose of the scale is to record the acuity of mental health triage presentations and the need for further specialist mental health assessment or intervention, regardless of which MHS is responsible for the follow-up.

Why is there no code to record the role of triage clinicians in providing bed-coordination?

Although triage clinicians are frequently called on to provide bed coordination and management, this function is conceptually different from triage.

In some emergency situations, the same clinician may have multiple responsibilities in relation to one person: conducting a triage assessment, deciding that he or she requires more detailed assessment, providing an intake assessment and locating an available bed. In these situations, it is expected that 'Code B' on the triage scale would be chosen, reflecting the fact that the person required very prompt intervention from the service.

Even in some fairly urgent and high-risk situations, our service sometimes responds by providing telephone support to another service provider (for example, a residential aged care worker). Can we count telephone support as an acceptable 'substitute' response to Code B, C, D and E presentations?

No. You must use the scale to accurately reflect the planned next stage of service delivery. Codes B to E are used when there is a plan for the mental health service to provide a face-to-face-assessment of the person with mental health problems. If this is not planned to occur, another code should be chosen.

If a client is being referred to a different service provider, that is not the service provider who contacted MHS triage, Code F is appropriate. Such referrals may sometimes be urgent, and may require the mental health service to provide telephone support to the service taking the referral. These requirements can be noted on the 'notes' section of triage scale.

If the intention is for the mental health service to provide telephone support to the service provider who instigated the contact with triage, then Code G should be chosen as it covers 'service provider consultations.' Again, details of any planned further contact with the referring service provider can be mentioned on the 'Notes' page.

Mental health triage scale

Code/description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/ response	Additional actions to be considered
A Current actions endangering self or others	**Emergency services response** **IMMEDIATE REFERRAL**	• Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress • Violence/threats of violence and possession of weapon	**Triage clinician to notify ambulance, police and/or fire brigade**	Keeping caller on line until emergency services arrive CATT notification/attendance Notification of other relevant services (e.g. child protection)
B Very high risk of imminent harm to self or others	**Very urgent mental health response** **WITHIN 2 HOURS**	• Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression • Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment requested by Police under Section 10 of Mental Health Act	**CATT or equivalent face-to-face assessment** **AND/OR** **Triage clinician advice to attend a hospital emergency department** (where CATT cannot attend in timeframe or where the person requires ED assessment/ treatment)	Providing or arranging support for consumer and/or carer while awaiting face-to-face MHS response (e.g. telephone support/therapy; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face MHS response Advise caller to ring back if the situation changes Arrange parental/carer supervision for a child/adolescent, where appropriate
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**Urgent mental health response** **WITHIN 8 HOURS**	• Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Unable to care for self or dependants or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse	**CATT, continuing care or equivalent (e.g. CAMHS urgent response) face-to-face assessment within 8 HOURS** **AND** **CATT, continuing care or equivalent telephone follow-up within ONE HOUR of triage contact**	As above Obtaining corroborating/additional information from relevant others
D Moderate risk of harm and/or significant distress	**Semi-urgent mental health response** **WITHIN 72 HOURS**	• Significant client/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Early symptoms of psychosis • Requires priority face-to-face assessment in order to clarify diagnostic status • Known consumer requiring priority treatment or review	**CATT, continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above

E Low risk of harm in short term or moderate risk with high support/ stabilising factors	**Non-urgent mental health response**	• Requires specialist mental health assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MHS appointment (with or without MHS phone support) • Known consumer requiring non-urgent review, treatment or follow-up	**Continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above
F Referral: not requiring face-to-face response from MHS in this instance	**Referral or advice to contact alternative service provider**	• Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person's current needs • Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and/or developmental disorder • Early cognitive changes in an older person	**Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	Facilitating appointment with alternative provider (subject to consent/privacy requirements), especially if alternative intervention is time-critical
G Advice or information only/ Service provider consultation/ MHS requires more information	**Advice or information only** **OR** **More information needed**	• Consumer/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Issue not requiring mental health or other services • Mental health service awaiting possible further contact • More information (incl discussion with an MHS team) is needed to determine whether MHS intervention is required	**Triage clinician to provide consultation, advice and/or brief counselling if required** **AND/OR** **Mental health service to collect further information over telephone**	Making follow-up telephone contact as a courtesy

NOTES: Document any information relevant to the triage decision, including where applicable

Advice given to consumer/carer/referrer

Specific 'additional actions' provided or required

Specific timeframe required (where this is shorter than the maximum timeframe for chosen triage code)

Post-triage information necessitating revision of the original triage code

WIT.0003.0004.0280

WIT.0003.0004.0281

State Government Victoria Department of Health

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 8

This is the attachment marked 'Quality and Safety Bulletin' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

Chief Psychiatrist's Quality and Safety Bulletin 2018/1

In this issue:

Purpose

The Chief Psychiatrist has undertaken to write two Quality and Safety bulletins each year summarising cases that highlight critical quality and safety themes for the attention of mental health services and mental health community support services. The bulletins cover a range of topics, including recent recommendations from the Coroners Court of Victoria. Services are encouraged to review their local practices and procedures and to take action where necessary to address any gaps.

This edition includes material from the private sector relevant to clinicians in public services. Patients' personal details have been obscured to maintain confidentiality.

Services are asked to share the bulletin with all clinical staff. Copies of the bulletins can be found on the Chief Psychiatrist's website.

1. Ligature point audits

A young woman with a diagnosis of Borderline Personality Disorder was admitted to an inpatient unit. She had history of repeated suicide attempts in context of difficulty in managing her emotions and interpersonal relationships. She had prolonged admissions to hospital in past and her overall care included regular risk assessments. During the most recent admission, she used a door handle in a visitor's toilet as a ligature point to hang herself with her pyjamas.

The Coroner investigated her medical care including management of self-harm behaviours and nursing observations on the inpatient unit and found them appropriate. The Coroner also focused on tools used for audit of ligature points and the training of auditors in application of the tools. The service had conducted a ligature audit previously but the door handle was not considered as a potential ligature point. Following the incident, the service re-audited the inpatient unit and the door handles were replaced with safer options. The service also submitted information to the Coroner about the new suite of audit tools used after the incident.

Coroner's recommendation

To improve the effectiveness of the required ligature point auditing tools, auditor training and their application in acute mental health units, the Department of Health and Human Services work with Area Mental Health Services to develop advice and examples of ligature audit tools that are assessed as being appropriate to the task, and effective in meeting their purpose.

Chief Psychiatrist's comments

The Coroner was concerned about the ligature audit process. Services must use standardised tools for ligature audit of all acute inpatient units at least annually. The audit team must include a staff member who does not work in the unit.

2. Shared care of patients between public and private sector

A middle aged man with a long history of psychiatric illness was under the care of a number of mental health services and clinicians in the years preceding his death. He had diagnoses of Bipolar Disorder and

Borderline Personality Disorder. He remained under the care of his private psychiatrist, psychologist and GP while also simultaneously being under the care of public mental health service. In the weeks and months preceding his death, he had multiple presentations to crisis team and emergency department with suicidal thoughts, violence and threats towards family members, and non-adherence with medications. Subsequently, he died by jumping in front of a train.

The Coroners Prevention Unit conducted a review of his treatment and identified the following issues –

- Difference of opinion among the clinicians regarding the diagnoses resulting in conflicting messages about management.
- Lack of involvement of the patient and carer in treatment decisions.
- Response to his deteriorating mental state with escalating presentations to the emergency department and whether the he should have been admitted to an inpatient unit as a compulsory patient under the *Mental Health Act 2014* especially in light of his repeated presentation with suicidal thoughts, non-adherence with medications and ongoing psychosocial issues.

The mental health service conducted an internal review and made a series of recommendations addressing the issues outlined above. The Coroner commented favourably on these recommendations.

The Coroner concluded that *"viewed separately, each of the clinicians acted reasonably and appropriately in their diagnosis and treatment of the patient".*

Coroner's recommendation

The Office of Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists develop a shared protocol or guidelines to provide guidance for clinicians who share the responsibility for the care of patients across the public and private sector. Matters that should be addressed include communication, transparency of arrangements with patients and carers, clinical responsibility in periods of crisis and negotiated care planning.

Chief Psychiatrist's comments

The Chief Psychiatrist endorses this recommendation. This issue has also been identified as a recommendation in internal reviews conducted by mental health services. The Office of Chief Psychiatrist will collaborate with the Royal Australian and New Zealand College of Psychiatrists to develop guidelines for shared care of patients between public and private sectors.

Elements of good shared care include agreed protocols for contacting various treatment providers within a specified time frame. This includes regular updates about the progress. It should also identify documented responsibilities for each provider besides the frequency and form of the communication between providers.

3. Discharge medications

A young man had repeated presentations with self-harm and suicide attempts over a short period of time. He had a diagnosis of Borderline Personality Disorder and alcohol abuse. He had multiple admissions to hospitals during this time. Following his last admission to an inpatient unit after a suicide attempt, he was discharged into the care of crisis team. At discharge he was prescribed and supplied three months' supply of medications. He died by overdosing on same medication two weeks later.

The mental health service conducted an internal review and identified issues with hospital electronic prescribing system, which was set as a default to order the PBS maximum quantity for any discharge medication. The service implemented changes to prescribing and dispensing of medications to patients on discharge limiting it to two weeks supply on discharge.

The Coroner accepted the response from the service and didn't identify any further opportunities for prevention.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the findings of the internal review. Services must have policies about the amount of medication prescribed and dispensed on discharge from the hospital. Further, consideration must be given to risk assessments for further ongoing prescribing of medications in the community. It is also imperative to check what other medications are prescribed for the patient and maintain liaison with other prescribers.

4. Discharge against medical advice

A middle aged woman with depression and suicidal thoughts was referred to public mental health service for assessment and management. Following an assessment, she was offered information about public

and private mental health care. The patient subsequently made an appointment with a private psychiatrist who suggested an admission to private hospital after an initial assessment. After a stay of one week, the patient discharged herself against medical advice from the private hospital on a weekend. The staff at hospital followed the appropriate policy for discharge against medical advice. The patient was not found to have met criteria for assessment under the *Mental Health Act 2014* and was discharged. She went home with a friend. The patient died by hanging herself later that day in her house.

The Coroner referred the case to the Coroners Prevention Unit for a review. The Coroners Prevention Unit identified a number of issues -

- Should the private psychiatrist have spoken to the patient directly, either in person or by telephone, to persuade her to continue treatment as an inpatient?
- Should a follow-up appointment with the psychiatrist have been scheduled soon after discharge?
- Did the clinical file correctly reflect discussions with the next of kin about strategies to reduce the risk of suicide?

The private hospital and the psychiatrist provided further responses about steps taken to address the above queries before the patient was discharged.

The Coroner concluded that the risk of suicide is dynamic in nature. The Coroner identified the importance of good clinical follow up post discharge in reducing that risk. The Coroner also noted the importance of education to next of kin about risks associated with discharge and the safety measures such as follow up appointments and access to psychiatric triage and crisis teams.

There was no recommendation from the coroner, concluding that the patient's suicide may not have been preventable even with onward referral to appropriate community services.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the Coroner's comments. Discharge against medical advice occurs infrequently in public mental health services as well. Services are reminded to have policies and procedures in place to address these issues. Staff should have access to senior staff including Psychiatrists for any patient who is requesting discharge against medical advice. This is particularly important during afterhours and on weekends. Appropriate steps must be taken to ensure ongoing follow up after discharge.

5. Safety checks in residential facilities

A young man with a long history of multiple diagnoses including Borderline Personality Disorder, PTSD and substance abuse was living at a residential program managed by a Mental Health Community Support Service. He had regular reviews with his GP. He was not a current patient of the local mental health service although he had previous involvement with them. A few days prior to his death, he was feeling physically unwell and spoke to his mother. He felt better the next day but did not respond to further telephone calls from her. When she was unable to contact him the next day, she spoke to staff who told her that he had been sighted going out. On the third day, she rang the facility again after failing to reach him by phone. Staff checked his room (but not the ensuite) and found no sign of him. On fourth day, the mother travelled to the facility and asked staff to check his room. He was found dead in the ensuite. The cause of death could not be ascertained.

The Coroner asked a Mental Health Investigator from Coroners Prevention Unit to review the adequacy of the care provided at the facility. It was evident that the facility was not a clinical facility and tracking of residents was not expected. There were no staff on site after 8 pm but patients were provided information about an on call after-hours service for any ill health.

The Mental Health Community Support Service also conducted an internal review of the incident and identified four recommendations –

- Resident safety is to be checked every 24 hours at a minimum.
- Staff rosters are to be reviewed to reduce the hours without staff onsite on weekends.
- A safe is to be placed in each resident's room for storage of medications.
- All staff are to receive first aid training.

The Mental Health Investigator commented that the recommendations will specifically reduce the likelihood of the circumstances of a resident not being located for a number of days. The Coroner also commented that it was not known whether an earlier search of the ensuite would have prevented the death. There was no recommendation from the Coroner.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the initiatives to ensure resident safety in residential facilities, clinical as well as non-clinical. Mental health service providers should ensure that there are systems in place to check residents' whereabouts and that staff know what procedures to follow when residents cannot be located within a reasonable timeframe. This also applies to Community Care Units and Prevention And Recovery Care units.

6. Varenicline (Champix) and suicide

A young man received treatment for a brief psychotic episode. He had a good recovery from the episode and returned back to work. Under the guidance of his treating psychiatrist, he gradually reduced and stopped his medications. He stayed well for more than a year and then had another psychotic episode, which responded well to treatment. Subsequently, the patient was prescribed Varenicline to help quit smoking. Although he was not observed to be unwell or depressed, he died by suicide eight days later. Toxicological analysis revealed the presence of Varenicline. The patient's family wrote to the Coroner concerned that Varenicline may have been a significant contributing factor to the death.

The Coroner stated that "*while the investigation was unable to identify any definitive link between the prescription of Varenicline and patient's death, I note that Victorian coroners have observed an increasing number of deaths by suicide where Varenicline is present in the results of the toxicological analysis performed on the deceased*".

The Coroner also commented that the evidence base for Varenicline's association with suicide is still very limited[1].

Chief Psychiatrist's comments

Mental health patients have high rates of smoking and psychiatrists may prescribe Varenicline as part of a smoking cessation plan. Although Varenicline is mostly prescribed by GPs, it is important that staff are aware of this association and discuss this with the patients and carers where appropriate.

1. Wu, Q., Gilbody, S., Peckham, E., Brabyn, S., and Parrott, S. (2016) Varenicline for smoking cessation and reduction in people with severe mental illnesses: systematic review and meta-analysis. Addiction, 111: 1554–1567. doi:10.1111/add.13415.

7. Patients leaving from Emergency Departments

A number of instances have been reported to the Chief Psychiatrist of patients leaving from an emergency department and subsequently meeting with an adverse outcome.

It is suggested that services take steps to prevent absconding by patients on Assessment Orders who are awaiting admission to an inpatient unit, as well as patients brought to the emergency department by police under section 351 of the *Mental Health Act 2014*. These steps include -

- Conducting a prompt mental health assessment, including an assessment of absconding risk.

  Locating the patient's bed in a safe location within the department.
- Providing 1:1 nursing.
- Calling a Code if the person tries to leave the department.

8. Deteriorating patients

Issues about escalation of care were identified in services' internal reviews of a number of deaths notified to the Chief Psychiatrist. These issues included the availability of senior staff and psychiatrists for discussion about patients who were deteriorating or difficult to engage. In many instances, junior staff were uncertain when to escalate concerns. Most of these incidents related to patients receiving care in community.

Recognition that a patient is deteriorating is critical. Besides changes in mental state, other indicators that a patient is deteriorating include repeated cancelled appointments or 'no shows' and repeated presentations to emergency departments or crisis teams. In such circumstances it is vital that staff are encouraged to discuss these issues with senior staff or in other forums like clinical reviews or handovers.

From the internal reviews, it was recommended that -

- Guidelines should be provided to staff about when and how to escalate concerns, deal with cancelled appointments and when to consider a home visit.
- Home visits must sometimes be preferred to phone contacts to help clarify clinical urgency.
- Information should be sought from a nominated person, family member, next of kin or carer to help clarify the reasons for deterioration and facilitate early assessment, including a home visit.

- There should be clarity about the frequency of face to face reviews with medical staff and other clinicians.
- For those who present repeatedly to emergency departments in a short time frame, further discussion should be undertaken with senior staff to identify more effective solutions.

9. Clinical handover

Clinical handover, information sharing and documentation standards continue to be highlighted as major issues in some Coronial investigations and many services' internal reviews. Although not necessarily identified as direct causative factors in the incidents, they remain issues of significant concern. A number of reviews recommended review of clinical handover procedures and information sharing between –

- Inpatient and community teams during admission and prior to discharge
- The emergency department and community teams after patient attendance at emergency department
- Area mental health service and primary care providers including GPs, psychiatrists and psychologists especially during transition from one level of care to another, e.g. discharge or refusal to accept care.
- The recommendations also include timely and appropriate documentation of clinical handover process.

In situations where a referral is not accepted, clear communication is critical with the parties who initiated the referral, for example family members or the police. These discussions must be recorded in the clinical record.

10. Clozapine and constipation

A patient who had been on Clozapine for several years was admitted to hospital with a relapse due to non-adherence. He was recommenced on Clozapine with good response. Complaints of constipation were treated appropriately but unsuccessfully. The medical team suspected that worsening abdominal pain was due to faecal impaction but their treatments also failed to help. Rapidly progressive abdominal distension culminated in a Code Blue a few hours later. Bowel obstruction was suspected and an exploratory laparotomy was undertaken, but the patient died during the procedure. The Forensic pathologist conducted an autopsy and identified cause of death as "complications of large bowel pseudo-obstruction" due to faecal impaction. The Coroner concluded that his medical care and management was reasonable and appropriate. There was no recommendation from the coroner.

The service, following a review of its own care, undertook to maintain bowel charts for all patients prescribed Clozapine in an inpatient setting, and to educate staff in the management of constipation. Community clinicians should also regularly enquire about bowel function for people taking Clozapine.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NC- 9

This is the attachment marked 'Your Experience of Service (YES) survey' referred to in the witness statement of "Dr Neil Coventry" dated 28 June 2019.

sure that all wording and images are reproduced to

Your Experience of Service (YES) Questionnaire

Survey Period: 1 March – 1 June 2018

We would like to invite you to tell us about your **experience** of care at this mental health service.

The information gathered from this questionnaire will help your mental health service work with you and other consumers to build better services.

Ipsos Australia, an independent research company, is conducting this survey on behalf of the Victorian Department of Health and Human Services.

Taking part in the survey is **voluntary and anonymous**. If you do not want to answer a particular question or questions you do not have to. The questionnaire will take you about 10 minutes to complete.

There are two ways to complete this questionnaire:

Pen and paper: simply fill in the survey, remove the cover page, and return it to Ipsos Australia in the **Reply Paid envelope provided**. You can either mail it yourself or put it in the questionnaire return box located in the reception area of your service.

OR

Online: visit survey link [insert link] and enter this password when prompted: [INSERT PASSWORD]. Alternatively, scan the QR code at the bottom of this letter using your tablet or smartphone and enter this password when prompted.

If you have misplaced the Reply Paid envelope, please use a plain envelope (no stamp is necessary) and address to:

Ipsos Australia
Your Experience of Service
Reply Paid 90162
Hawthorn VIC 3122

Please be reassured that there are many safeguards in place to protect your privacy. However, if you do not want to participate, simply disregard this letter.

Further information and instructions about the questionnaire are on the next page. If you have any questions regarding this survey, please contact Ipsos Australia's toll-free Survey Helpline on 1800 559 104, Monday to Friday, 4pm – 8pm.

Thank you for taking the time to participate.

Yours sincerely

Jodie Geissler
Director, Mental Health Branch
Department of Health and Human Services

Pink = Overprint Red = TBA

Clinical Health Survey_2018_V3.indd 1 PMS 7683 Black 7/02/2018 11:46 AM

sure that all wording and images are reproduced to your expectations.

Date:

What is the Your Experience of Service (YES) questionnaire?

The **Your Experience of Service** questionnaire is a nationally developed survey which seeks to understand the **experience** of people who use public mental health services.

The YES questionnaire will be undertaken every year over March – June.

How is my privacy protected?

Completing the YES questionnaire is **voluntary** and **anonymous**.

The YES questionnaire does **not** record your name, date of birth or any other personal information that may identify you. Your answers to the questionnaire will **not** be used to identify you.

Your mental health service will receive combined anonymous feedback only. Details such as your age, gender and cultural background will **not** be attached to this information.

What happens to my survey responses?

Your feedback on this mental health service will be **anonymous**. Your feedback will be combined with other people's feedback in a report that will identify common **experiences** and themes. This report will help your mental health service **understand what they do well** and **what they could do better** so that they can build better services.

The results from this survey will be publically reported in the Annual Report on Victoria's mental health services.

The information collected through the survey will also be used by the Victorian Department of Health and Human Services to monitor how well your mental health service is enacting service system change consistent with the mental health principles in the *Mental Health Act 2014* and other important policies, as well as identify areas that require new investment, redesign or improvement.

Completing the questionnaire

You can complete the questionnaire yourself, or ask a friend, family member, carer or staff member to help you complete the questionnaire. If someone helps you to complete this questionnaire, please ensure the answers given are from your point of view, and not the opinion of the person helping you.

The closing day for mailing your completed questionnaire, placing it in the questionnaire return box, or doing it online, is the **1 June 2018**.

How do I get more information about the survey?

Please contact the Ipsos Australia Helpline on **1800 559 104**, Monday to Friday, 4pm – 8pm, excluding public holidays or email **yes-info@ipsos-research.com** If you are hearing impaired you can contact Ipsos Australia via the National Relay Service on 1300 555 727.

More information about the Your Experience of Service questionnaire can be found at the Victorian Department of Health and Human Services website:
www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers

Clinical Health Survey_2018_V3.indd 2 PMS 7633 Black 7/02/2018 11:46 AM

sure that all wording and images are reproduced to your expectations.

Date:

Your Experience of Service (Clinical Mental Health Services)

Your feedback is important. This questionnaire was developed with mental health consumers. It is based on the Recovery Principles of the Australian National Standards for Mental Health Services. It aims to help mental health services and consumers work together to build better services.

Completion of the survey is voluntary. All information collected in this questionnaire is anonymous. None of the information collected will be used to identify you. It would be helpful if you could answer all questions, but please leave any question blank if you don't want to answer it.

Please put a cross in just one box for each question, like this...

Never	Rarely	Sometimes	Usually	Always	Not applicable
☐	☐	☐	☒	☐	☐

These questions ask **how often** we did the following things...

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	Never	Rarely	Sometimes	Usually	Always	Not applicable
1. You felt welcome at this service	☐	☐	☐	☐	☐	
2. Staff showed respect for how you were feeling	☐	☐	☐	☐	☐	
3. You felt safe using this service	☐	☐	☐	☐	☐	
4. Your privacy was respected	☐	☐	☐	☐	☐	
5. Staff showed hopefulness for your future	☐	☐	☐	☐	☐	
6. Your individuality and values were respected (such as your culture, faith or gender identity, etc.)	☐	☐	☐	☐	☐	
7. Staff made an effort to see you when you wanted	☐	☐	☐	☐	☐	☐
8. You had access to your treating doctor or psychiatrist when you needed	☐	☐	☐	☐	☐	☐
9. You believe that you would receive fair treatment if you made a complaint	☐	☐	☐	☐	☐	☐
10. Your opinions about the involvement of family or friends in your care were respected	☐	☐	☐	☐	☐	☐
11. The facilities and environment met your needs (such as cleanliness, private space, reception area, furniture, common areas, etc.)	☐	☐	☐	☐	☐	

Clinical Health Survey_2018_V3.indd 3 PMS 7633 Black 7/02/2018 11:46 AM

sure that all wording and images are reproduced to your expectations.

These questions ask **how often** we did the following things...

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	Never	Rarely	Sometimes	Usually	Always	Not applicable
12. You were listened to in all aspects of your care and treatment	☐	☐	☐	☐	☐	
13. Staff worked as a team in your care and treatment (for example, you got consistent information and didn't have to repeat yourself to different staff)	☐	☐	☐	☐	☐	
14. Staff discussed the effects of your medication and other treatments with you	☐	☐	☐	☐	☐	
15. You had opportunities to discuss your progress with the staff caring for you	☐	☐	☐	☐	☐	
16. There were activities you could do that suited you	☐	☐	☐	☐	☐	☐
17. You had opportunities for your family and carers to be involved in your treatment and care if you wanted	☐	☐	☐	☐	☐	☐

These questions ask **how well** we did the following things...

Thinking about the care you have received from this service within the last 3 months or less, what was your experience in the following areas:	Poor	Fair	Good	Very Good	Excellent	Not applicable
18. Information available to you about this service (such as how the service works, which staff will be working with you, how to make a complaint, etc.)	☐	☐	☐	☐	☐	
19. Explanation of your rights and responsibilities	☐	☐	☐	☐	☐	
20. Access to peer support (such as information about peer workers, referral to consumer programs, advocates, etc.)	☐	☐	☐	☐	☐	☐
21. Development of a care plan with you that considered all of your needs (such as health, living situation, age, etc.)	☐	☐	☐	☐	☐	
22. Convenience of the location for you (such as close to family and friends, transport, parking, community services you use, etc.)	☐	☐	☐	☐	☐	

Clinical Health Survey_2018_V3.indd 4 PMS 7633 Black 7/02/2018 11:46 AM

As a result of your experience with the service in the last 3 months or less please rate the following:	Poor	Fair	Good	Very Good	Excellent
23. The effect the service had on your hopefulness for the future	☐	☐	☐	☐	☐
24. The effect the service had on your ability to manage your day to day life	☐	☐	☐	☐	☐
25. The effect the service had on your overall well-being	☐	☐	☐	☐	☐
26. Overall, how would you rate your experience of care with this service in the last 3 months?	☐	☐	☐	☐	☐

Please provide any extra comments

27. My experience would have been better if...

sure that all wording and images are reproduced to your expectations.

28. The best things about this service were...

The information in this section helps us to know if we are missing out on feedback from some groups of people. It also tells us if some groups of people have a better or worse experience than others. Knowing this helps us focus our efforts to improve services. No information collected in this section will be used to identify you.

What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other

What is the main language you speak at home?

- ☐ English
- ☐ Other

Are you of Aboriginal or Torres Strait Island origin?

- ☐ No
- ☐ Yes - Aboriginal
- ☐ Yes - Torres Strait Islander
- ☐ Yes - Aboriginal and Torres Strait Islander

What is your age?

- ☐ Under 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 years and over

Clinical Health Survey_2018_V3.indd 6 PMS 7633 Black 7/02/2018 11:46 AM

sure that all wording and images are reproduced to your expectations.

Date:

How long have you been receiving care from this service on this occasion?	☐ Less than 24 hours ☐ 1 day to 2 weeks ☐ 3 to 4 weeks ☐ 1 to 3 months ☐ 4 to 6 months ☐ More than 6 months
At any point during the last 3 months were you receiving involuntary treatment (such as an involuntary patient or on a community treatment order) under Mental Health Legislation?	☐ Yes, involuntary patient/on a community treatment order ☐ No, I was always a voluntary patient ☐ Not sure
Did someone help you complete this survey?	☐ No ☐ Yes - family or friend ☐ Yes - language or cultural interpreter ☐ Yes - consumer worker or peer worker ☐ Yes - another staff member from the service ☐ Yes - someone else

Clinical Health Survey_2018_V3.indd 7 PMS 7633 Black 7/02/2018 11:46 AM

sure that all wording and images are reproduced to your expectations.

Date:_____

Clinical Health Survey_2018_V3.indd 8 7/02/2018 11:46 AM