Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF MR PETER FRANCIS KELLY

I, Mr Peter Francis Kelly, Director Operations of NorthWestern Mental Health, Melbourne Health, of Level 1 North, Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050, say as follows:

1 I am authorised by NorthWestern Mental Health (**NWMH**), Melbourne Health to make this statement on its behalf.

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

BACKGROUND

Qualifications and experience

3 I have the following qualifications:

(a) Registered Nurse in the State of Victoria 1992; and

(b) Professional Certificate in Health Systems Management, University of Melbourne, 2011.

4 Attached to this statement and marked 'PFK-1' is a copy of my curriculum vitae.

Current role

5 My role is Director Operations NWMH and I have held this position since March 2005. I am based at the Royal Melbourne Hospital, Grattan Street, Parkville, 3050. I manage the service in partnership with the NWMH Medical Director, Dr David Fenn, and we both report to the Melbourne Health Chief Operating Officer and Deputy Chief Executive.

6 NWMH is Victoria's largest publicly funded mental health service that provides services to approximately 1.4 million people in the northern and western suburbs of Melbourne. Funding for the 2019-20 Financial Year is approximately $240m.

7 Melbourne Health has a total workforce of 8,400 staff. NWMH employs approximately 1,450 equivalent fulltime (**FTE**) staff (including administrative staff) which translates to approximately 1,900 headcount, from the disciplines of medicine, occupational therapy, social work, psychology and nursing.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

8 NWMH operates 503 beds across a number of health services and across a number of campuses (please see paragraph 9 below) as well as a number of community mental health clinics. NWMH is a unique entity in the state of Victoria in that it provides specialist mental health services to Melbourne Health, Western Health and Northern Health (i.e. it provides these services to not only Melbourne Health but also other health services).

9 NWMH delivers a comprehensive range of clinical mental health services for youth, adults and older people who are experiencing or are at risk of developing a serious mental illness. Our services are delivered from a range of locations, including Western, Sunshine, The Royal Melbourne and the Northern hospitals, and various community-based mental health clinics based in Coburg, Broadmeadows, Preston, Epping, Sunshine, Melton, Mill Park, Wyndham and Moonee Ponds.

10 Our services are organised into 6 local Area Mental Health Services (**AMHS**) and Programs, spanning 32 sites across the north and west of Melbourne. The Area Mental Health Services and Programs managed by NWMH are:

(a) Inner West Area Mental Health Service (**IWAMHS**);

(b) Mid West Area Mental Health Service (**MWAMHS**);

(c) North West Area Mental Health Service (**NWAMHS**);

(d) Northern Area Mental Health Service (**NAMHS**);

(e) Aged Persons Mental Health Program (**APMHP**); and

(f) Orygen Youth Health Program (**OYH**).

11 Apart from the usual suite of services provided by the area based or youth or aged services, NWMH provides a number of sub-specialist services, namely;

(a) Inpatient and outpatient Eating Disorder services;

(b) Inpatient and outpatient Neuropsychiatry services;

(c) 24/7 Telephone Triage Service;

(d) Substance Use Mental Illness Treatment Team (**SUMITT**);

(e) Centre of Excellence in Eating Disorders (**CEED**);

(f) Mental Health – Forensic Interface Team (**MH-FIT**);

(g) Mental Health Training and Development Unit (**MHTDU**); and

(h) Centre for Mental Health Learning (**CMHL**).

12 In conjunction with the Medical Director NWMH, I am responsible for the operational and financial management of this division. This encompasses a number of areas of responsibility including:

(a) strategic planning;

(b) budget setting;

(c) coronial matters;

(d) recruitment;

(e) emergency planning, eg bushfire and COVID-19 response;

(f) access and flow;

(g) staff disciplinary / performance matters;

(h) Department of Health and Human Service (**DHHS**) expert reference group memberships, i.e. mortality and morbidity, activity based funding (**ABF**);

(i) NWMH Triage Service;

(j) Centre of Excellence for Eating Disorders

(k) facilities management; and

(l) acting as a key interface with the DHHS Mental Health Branch.

PANEL QUESTIONS

Designing a graduated system of mental health services and supports for different levels of need.

The following questions are directed to the design of the future community mental health system. In your responses, please identify any examples of best practice in other jurisdictions.

Question 1: What is needed to support people to self-manage their mental illness (where appropriate) in the community?

13 NWMH reformed its model of care 5 years ago to change our focus from an exclusive case management approach (which has only been shown to improve connection with services, but has not been shown to reduce relapse rates or improve quality of life) to the use of evidence-based psychosocial treatments across six practice domains to provide more psychosocial-focused and holistic care.

14 The six practice domains for evidence-based psychosocial treatments are

(a) psychological Interventions;

(b) family and carer work;

(c) health and wellbeing;

(d) vocation,

(e) lived experience; and

(f) overcoming hurdles.

15 Each practice domain has both core and specific interventions.

16 The following are examples of how these interventions work:

(a) **Psychological Interventions:** The Early Warning Signs Relapse Prevention Program is a brief individual program (six sessions) to help consumers self-manage their mental health by identifying the very first warning signs of relapse. There is strong evidence that this program significantly reduces relapse admission rates (from 65% in the 18 months prior to the program to 18% in the 18 months following the introduction of the program).

(b) **Family and Carer Work:** The core intervention involves the Community Team getting in contact with the consumer's family within the first 6 weeks of contact with the consumer. During that family contact, they offer a Single Session Family Consultation to the family. Other, specific interventions may be introduced. Such interventions have resulted in a significant reduction in relapse rates and help to reduce the stress on family and carers. For example, the Multiple Family Group treatment is delivered to up to 7 families including the consumer on a fortnightly basis over 9 months, providing psychoeducation, social support and collaborative problem solving.

(c) **Health and wellbeing**: There is generally premature morbidity and mortality among consumers. We have a large range of activities and health related groups (for example, the walking group and the swim/gym group) to promote physical health along with mental wellbeing. These have proven to be very popular with consumers and provide social connection opportunities. I have covered off in more detail the morbidity and mortality data for NWMH consumers later in this statement.

(d) **Vocation:** It was identified that the IWAMHS, for example, has very low employment rates (12%) amongst its consumers. We recruited an employment consultant who has been able to assist 30 consumers to find paid employment and another 25 enrol in volunteer or training programs — which are pathways to paid employment. There has been good feedback from consumers (many of whom would not have considered employment otherwise).

(e) **Lived experience:** Consumers in the acute inpatient unit are able to engage with a peer support worker. There are also programs such as Peer Zone, a

peer-support and recovery education initiative which provides a series of up to 20 three hour peer-led workshops, and Kick Butt, a peer-led support program for people wishing to stop smoking.

(f) **Overcoming Hurdles:** NWMH has also significantly developed group programs in the service to support skill-building programs such as navigating and using public transport, budgeting, meal planning and shopping etc.

17 All consumers coming into the service are expected to have the opportunity of exposure to the core interventions in each practice domain within the first 3 months of treatment, following which specific interventions are offered that are relevant to their specific needs.

18 NWMH has employed different staff types to support the practice domains (for example, employment consultant, exercise physiologist, dietician, yoga instructor and music therapist). The IWAMHS, for example has recently recruited an Aboriginal mental health clinician.

19 While evidence-based psychosocial treatments are effective, it is a struggle to deliver the treatments during episodes of care of 6 to 12 months as these are generally insufficient for lasting recovery. That is, we utilise the episodic care model versus the continuing care model.

20 People experiencing mental illness need access to a range of supports and services that go beyond just clinical mental health expertise. This includes providing:

(a) adequate housing;

(b) vocational training;

(c) budgeting advice;

(d) assistance with accessing and receiving Centrelink entitlements;

(e) social connectedness. Beyond the supports offered by the AMHS, being part of the community is integral to having good mental health and people experiencing mental illness are often not well connected with society;

(f) advocacy on their behalf and to destigmatise mental illness;

(g) assistance with accessing and navigation of the mental health system;

(h) assistance with attending skilled specialist mental health service follow-up appointments, and to receive proper diagnosis, treatment and management of issues such as medication management, the need for adherence and monitoring and management of side-effects from medication;

(i) training for living skills such as cooking, shopping, travel training and doing laundry;

(j) referrals to other agencies for physical health. Consumers have very poor physical health outcomes. Physical health issues are often diagnosed too late in an individual's episode of illness, and consumers often then receive sub-optimal treatment (discussed further at paragraphs 172 to 178 below); and

(k) referrals to other social services and supports. For example, this could be linking consumers who have children with schools and parenting groups.

21 This wide range of supports was provided by our clinical staff in the early 1990s when we worked in a "continuing care" model. As the name implies, a continuing care model recognised that consumers with a serious and enduring mental illness, most commonly a psychotic or mood disorder, required prolonged, and often, life-long care.

22 However, now that the mental health sector has moved to an "episodic care" approach, out of necessity due to the lack of resources, it is not possible to offer the same level of support. This means that someone with a serious and enduring mental illness enters and leaves the service on a "relapse – recovery – stability" cycle.

Question 2: What is needed to make specialist mental health expertise available to general practitioners and other service providers?

23 General practitioners (**GPs**) need ready access to expert mental health advice. GPs are extremely busy and often see many patients a day. Providing this ready access is therefore very difficult.

24 While the mental health system is intended to provide care to 3% of people with a serious mental illness, it currently only provides care to 0.9%-1.1%. The mental health system needs to be adequately resourced so that GPs can easily access assistance from mental health specialists over the phone. This requires that more psychiatrists, registrars and other mental health clinicians are available to assist GPs. GPs also need to be able to facilitate quick re-entry of a patient into the mental health system if this is required.

25 What is needed more broadly is the level of resourcing required to return to the kind of care provided by the mental health system in the early 1990s. At that time, the system was adequately funded and our community services provided "continuing care teams". These teams provided consumers with care for life — or as long as they required it, rather than episodic care which only treats consumers when their mental health issues reach a certain level of severity.

26 The current episodic care model is not consistent with the broader health system. For example, we would not wait to treat a person with diabetes until they required limb amputation.

Question 3: The Commission's Interim Report defines community-based clinical mental health services as 'services that are made available to people outside hospital settings—often in their own homes, in community facilities or by phone'. These include specialist mental health services and psychosocial supports.

a. Considering a future mental health system (10 years into the future), what types of care, treatment and support should most appropriately occur:

i. in hospitals?

27 The care, treatment and support that should occur in hospitals should be guided by the purpose of a hospital admission.

28 The purposes of admission include:

(a) observation of a consumer so a diagnosis can be obtained and treatment commenced;

(b) containment of the person as a means to managing risk;

(c) resolution of a diagnostic dilemma which is more difficult to do in the community where a person is observed cross-sectionally, i.e. during the course of a 30 minute consultation or review as compared to the quality of observation and history taking that can occur over a 9 day admission. Also, in the hospital context, all manner of diagnostic tests can be undertaken to assist with diagnosis;

(d) commencement, or recommencement of treatment which may not be possible in a community setting;

(e) provision of treatment such as electro-convulsive therapy (**ECT**) which may not be able to be provided as an outpatient; and

(f) "social admissions" in circumstances where an individual's supports or housing have been disrupted.

29 Hospital care should be focused on treating people in the acute phase of illness where it is not possible to do so in the community.

ii. in the community?

30 During the early 1990s, the Victorian mental health system was the benchmark of the Western world. This model included providing hospital-level care and support to

consumers in the community. For example, previously, crisis assessment and treatment teams (**CATT**) were able to provide home based assessment and treatment. Significant population growth in Victoria since the 1990s has meant we can no longer sustain that service.

31 Hospital in the Home (**HITH**) type care is very palatable to consumers and their families as it puts the consumer back in control of their care and care delivery is much less disruptive to people's lives. It has significantly better outcomes in terms of consumer engagement and thus longer term acceptance of treatment. HITH type care however is limited by the level of risk which can be acceptably managed in the community. At times, the risk of deliberate self-harm, suicide, disorganised behaviour, substance use or family violence may preclude HITH as an option.

32 In the 1990s, Victoria also operated mobile support treatment teams (**MSTT**). These teams essentially provided intensive support to consumers who typically experienced five admissions per year in the preceding two years. MST clinicians operated with reduced caseloads of 10 consumers compared to a caseload of 25-30 for a general community clinician. As a result of those lower caseloads, those patients were seen more frequently and more intensively. The MSTT focused on support such as medication management (adherence), vocational skills, living skills, stabilisation of accommodation and integration into the community, as discussed in paragraph 20 above. Typically, MSTTs provided treatment and care to consumers with a long-standing psychotic disorder who had prominent negative symptoms such as amotivation, poor self-care, disinterest, lack of spontaneity and initiative and blunted affect.

STREAMING

Question 4: Considering how the mental health system might be designed around streams of care for people with different types of strengths, needs and characteristics:

a. Should there be different streams of care (e.g. for age, severity, diagnostic group, stage of care, gender)?'

33 For mental health, streaming for diagnostic groups and vulnerabilities can be effective and efficient for diagnosis, treatment and follow-up. This was achieved for example with the MSTT which had a focus on treating consumers with schizophrenia as alluded to in paragraph 32. These teams developed a lot of expertise in this area and the work was rewarding and consequently these were not difficult teams to recruit to and, in fact, staff turnover was low. Consumers and carers also appreciated highly skilled, highly motivated and consistently available clinicians over the longer term. Similarly, in a future state, it would be desirable to have teams that sub-specialise in mood disorders or psychotic disorders, for example.

34 In the delivery of physical health, the advantages of streaming generally are that expertise is concentrated where it is needed and it reduces the use of resources when they are not required. The downside to a streaming model is that clinicians become highly specialised. In this regard, public mental health services and acute health services are at opposite ends of the spectrum. For the most part, apart from age streaming, mental health services are generalist in nature and acute health services are highly specialised. OYH is the exception to this general rule where community services at least are streamed by mood disorders, first episode psychosis, borderline personality disorder and continuing care. In so doing, the service has been able to attract and retain highly skilled clinicians who have niche expertise and research interests in each of these sub-speciality areas.

35 The possible advantages of streaming in the mental health system are obscured by budgetary constraints. The reality of the current mental health system is that every consumer is placed in a large pool. Inpatient units where all consumers with different diagnoses and different vulnerabilities are physically together is unhelpful for recovery. Mixed wards are often inappropriate for women, LGBTIQA+ people, people who have experienced trauma and people with an intellectual disability or an autistic spectrum disorder. In my view, it would be better to have flexible modules that could be used to cohort people with similar vulnerabilities. For example, it is not helpful to cohabit a male consumer who is agitated, aggressive, sexually disinhibited, impulsive and withdrawing from drugs and alcohol in the same space as a female consumer who is depressed, vulnerable and who has a history of trauma.

36 Consumers also need adequate circulation, buffer and recreation spaces so they do not feel hemmed in by these environments (discussed further at paragraphs 242 to 249 below).

i. along what criteria and why?

37 We currently do not have the required resourcing or flexibility for proper streaming. A significant challenge that needs to be addressed is how to respond to both short and long-term acute and chronic needs in bed-based care. That said, it would be helpful to have flexible, adaptable modules within acute inpatient units where different treatment approaches and interventions are required for different disorders such as a relapse of a psychotic disorder, or the resolution of an adjustment disorder / situational crisis, or the treatment of a drug induced psychosis compounded by an acute withdrawal from illicit drugs — to give 3 examples.

38 Inpatient units should be designed to allow the flexibility to place consumers with similar needs together, and separate from other patients who may be a risk to them. For example, a risk of sexual assault can arise if a young woman is placed in proximity to an

aggressive male patient who has been recently released from custody and has been convicted of rape. This scenario is not uncommon.

39 DHHS has taken a great deal of interest in examining the impact of the design of mental health facilities and how the design can assist or impede recovery. Stefano Scalzo, Architect and Director, Planning and Development at the Victorian Health and Human Services Building Authority (**VHHSBA**) was awarded a Churchill Fellowship to research mental health facilities overseas. He identified best practice examples of building design in Scandinavia, Germany, France, Spain, USA and Canada that were designed to be soothing and therapeutic and can be changed for use. Salutogenesis is a design approach focusing on factors that support human health and well-being, rather than on factors that cause or perpetuate disease. These factors include the totality of the design however individual elements include artificial lighting, access to fresh air and circulation space, the use of natural materials, access to natural light, etc. The design challenges include attending to safety, security, amenity, privacy and dignity when designing new facilities. None of these elements are mutually exclusive. Using this approach we could be confident that new mental health inpatient units will look (and feel) very different to the current NWMH inpatient units which are 20+ years old.

b. What are the alternatives to streaming (e.g. individualised packages)?

40 Individualised packages are an appropriate means to deliver assistance to community patients as an adjunct to specialised mental health care. These packages can be tailored to a consumer's particular needs and circumstances, such as a relationship breakdown, family violence, homelessness, poverty or ongoing court proceedings. The effectiveness of these packages, however, relies on adequate funding to ensure the consumer receives the appropriate expertise in care.

c. What are the strengths and weaknesses of these alternatives?

41 The strength of individual packages is that the package can be customised to a particular consumer's needs. For example, 'Consumer A' might benefit from a package that deals predominantly with finding stable housing, medication management and vocational training whereas 'Consumer B' might benefit from a package that deals with income support, family violence, drug addiction and physical health. The challenge in a 'capped or rationed' system is that great care would need to be taken to ensure a fair and equitable allocation of packages.

CATCHMENTS

Question 5: Should mental health services in Victoria continue to be delivered on a geographic catchment basis?

42 Catchment areas for mental health services are desirable, but consideration needs to be given to their size — both in terms of the geographical area of the catchment and also the size and demography of the population it serves, and how they link with other public health services in the area or overlapping areas. Area Mental Health Services ought to be adequately resourced to service the population that resides within its catchment area with loadings applied to off-set factors such as culturally and linguistically diverse (**CALD**) populations, unemployment rates, rates of homelessness, rates of dependency on social welfare, incarceration rates and other forms of involvement with the criminal justice system.

43 Catchment areas ought not be absolute, in other words, consumers should be able to choose where they access services from, noting that the vast majority of consumers will access services close to where they live however others may choose to access services close to where they work or for other reasons and this should be accommodated. This in fact already occurs, and a NWMH example is at NAMHS, where consumers from Goulburn Valley Mental Health Service who reside at the southern end of that catchment, choose to access services at NAMHS because the service is closer and more convenient for them.

a. What are the advantages and disadvantages of catchments?

44 The advantages of catchments include:

(a) continuity of care for the consumer;

(b) predictable funding for a defined population and thus a predictable workload for the Area Mental Health Service;

(c) 'networked' and coordinated care between the Area Mental Health Service and Community Managed Mental Health Services, Community Health Centres and Primary Care Physicians (GPs); and

(d) encourages population based planning and funding arrangements which recognise the particular, and perhaps unique, features of a catchment in terms of population size, demography and a number of social determinants directly related to the mental health or mental illness of its community.

45 Disadvantages of catchments include:

(a) under the current model, there is an inequitable distribution of funding and a maldistribution of resources. This is largely due to outdated and historically based funding models which have not kept pace with population growth or other changes in demography;

(b) in years past, services have perhaps stuck rigidly to the catchment areas and may have at times shown insufficient flexibility in servicing the needs of consumers who live marginally outside of a designated catchment area. This may include a reluctance for clinicians to travel outside their own catchment area for assessment or home visiting purposes. It may also include a resistance to provision of clinic-based services to a consumer who resides outside of a designated catchment area but who may find it more convenient to access those services from the consumer's place of residence or work.

46 On its face, this may seem like a 'thin edge of the wedge' justification; however, the disadvantage referred to in paragraph 45(b) ought to be viewed in the context of services being under extreme pressure and being resourced to service about 0.9-1.0% of the seriously mentally ill despite an expectation that 3% of the seriously mentally ill are seen in public mental health services. In recent years, DHHS has encouraged Area Mental Health Services to adopt a more flexible approach to servicing the needs of consumers who reside outside a given catchment area and NWMH has certainly responded positively to this.

b. Could these advantages be achieved through alternatives to catchments?

47 In my view there is no obvious alternative to the catchment system, though no doubt changes to catchment area boundaries and the size of populations they serve could be changed to effect a more equitable system and one which recognises the demography, geography and particular challenges of a defined area

c. What are the risks of abolishing catchments for mental health services?

48 The risks of abolishing catchment areas would be to lose or undercut the advantages of catchment areas as described in paragraph 44.

49 Where an aggregation of catchment areas exists, such as occurs at NWMH, an abolition of catchment areas would result in the loss of all of the sub-speciality programs as detailed in paragraph 11. Furthermore, a service such as NWMH, which has been highly successful in terms of recruiting and retaining a skilled workforce, would become far less attractive from a recruitment perspective because it would no longer be able to offer the range of specialist and sub-specialist training opportunities. NWMH has been

able to provide these programs as a consequence of its size and scale and an abolition of catchment areas would result in a cessation of most, if not all of these programs.

Question 6: If catchments are to remain an element of the mental health system, how should they be configured?

50 A catchment should service approximately 500,000 people. Catchments need to be defined according to a rational system based on population and the equitable distribution of resources. This is not the approach of the existing catchment system which is based on historical funding models which take very little account of the geography or demography of the population in each catchment area.

51 When I talk about geography in the NWMH context, and if we focus on the Mid West Area Mental Health Service, its catchment area spans from Melton to Sunbury. Accordingly, this can lead to gross inequities when you factor in travel time for clinicians conducting home visits compared to a much more compact but more densely populated area like that served by the IWAMHS, which covers the area from Moonee Ponds up to, and including, the CBD.

52 The reality is that the current system is not equitable. Patients in areas with a lower socioeconomic demographic are not receiving the same level of access to treatment and care as those patients in areas with a higher socio-economic demographic. This might seem obvious but there is great disparity between St Albans and Toorak for example and there are a number of contributors to this disparity including;

(a) employment levels;

(b) workforce skill levels;

(c) mean household income;

(d) English proficiency;

(e) levels of home ownership housing stability;

(f) levels of private health insurance cover;

(g) crime rates;

(h) population density;

(i) number of GPs per 10,000 population;

(j) number of private psychiatrists per 10,000 population;

(k) amount of “green space” and other publicly accessible leisure facilities such as sports grounds and clubs, walking and biking tracks, swimming pools, tennis courts;

(l) background of population in terms of forced migration, subject to trauma through war or persecution, exposure to violent crime, family violence etc; and

(m) access to psychosocial supports in the catchment area such as vocational services, disability services, community managed mental health services and other services that foster social connectedness.

53 Catchments should also be flexible and should not require services to rigidly adhere to their boundaries. For example, the Royal Melbourne Hospital has a notional catchment area but it does not prevent people coming from Gippsland or Geelong for example if they want to access its highly specialised services. Similarly, people at the southern end of the Goulburn Valley often attend the Northern Hospital, which is their closest service, despite not being in its catchment area. The same level of flexibility does not occur in all catchment areas.

54 Ultimately, people should have choice about where they receive mental health services, as long as there is not wholesale migration from one service to another due to perceptions or reality based beliefs that one service is better resourced, more convenient, more accessible, or provides better care than another. Unfettered migration could cause disadvantage to consumers and to services in the short to medium term. For example, if one service experiences a significant net increase of consumers self-selecting from a neighbouring service this might lead to increased staff turnover and increased caseloads in the service receiving these consumers.

55 An answer or remedy to this of course is an ABF model which pays the service a defined rate for a defined range of services provided to a consumer. An ABF model is currently under development by DHHS, in fact I am a member of an expert reference group working on this. The ABF, if implemented would be a very significant departure from the current “block funding” model. In short, it would be good to move to a system whereby the service provider is paid for the work that it does and is incentivised to provide services to a defined standard for example by only paying services when they demonstrate they have delivered on the six domains of care in a community setting as described in paragraph 14.

56 Six years ago, I was consulted about the possible restructure of mental health service catchments. I recommended that catchments should align to local government areas, police service districts and other health services including Primary Health Networks as is done in the United Kingdom. This would greatly enhance coordination of services, streamline communications, assist cooperative arrangements between services, and set expectations for consumers and indeed for Area Mental Health Services in terms of the range of services provided within the catchment. I continue to hold this view for the reasons above. However, there was no appetite for change of this magnitude in Victoria

so we are stuck with a system, using the broadest possible definition, in which the system elements do not have good alignment and this translates at times to dis-jointed service planning, sub-optimal communication and coordination of service delivery.

a. What are the risks and benefits associated with larger regional catchments such as the Primary Health Network (PHN) catchments?

57 One of the issues of the PHN catchments is that they have changed in name and area size over the last 15 years. This creates a risk of discontinuity of care and disjointed service planning.

58 The PHN system can work more effectively in places like the United Kingdom and New Zealand where there is better alignment across the different tiers of healthcare. A key difference between those countries and Australia is that in the United Kingdom and New Zealand, is that people are expected to register with particular GPs or practices to receive treatment. Communication is therefore streamlined through one GP or practice where possible. This concept has considerable merit but is unlikely to gain traction in the Australian context where, for the most part, consumers make a co-payment for the service they receive and would therefore resist being directed to a particular practitioner. I have worked in Australia, New Zealand and the United Kingdom and there are strengths and weaknesses in each model.

59 Recent initiatives in Victoria such as “Safe Script” which deals to an extent with the issue of “Doctor Shopping” and in particular, patients attending multiple general practitioners for prescriptions of opiates, benzodiazepines, hypnotics and sedatives, has and will continue to save lives. This is an example of a systems approach to deal with a specific issue or risk however this initiative took over a decade to implement and was subject to a number of coronial recommendations before it was finally implemented. In the absence of a system like New Zealand or the United Kingdom, GPs in Australia could be incentivised to provide a higher level of care to people with a severe and enduring mental illness. The incentivisation would recognise the complex interplay between physical and mental health and provide different MBS item numbers which account for the additional time required to attend to this cohort. In an ideal world this may involve the employment of mental health clinicians (nurses or allied health) who could undertake a number of the care coordination, care planning, system navigation and consumer engagement tasks.

b. What are the risks and benefits associated with only using catchments for planning and resources allocation (i.e. similar to the broader health system), rather than for determining consumer eligibility for services?

60 Using catchments only for resource planning could allow for flexibility and consumer choice when accessing mental health services. In other words, the services could be appropriately funded to service the population within the relevant catchment areas, with an acknowledgement (and an expectation from DHHS) that services must respond flexibly to 'out of area' consumer requests for service provision. Such requests might arise for reasons of convenience, transport or logistics or indeed dissatisfaction with the consumer's usual service. A risk, albeit a relatively small risk, of this approach is that consumers from one catchment area may wholly migrate to another catchment area and place a strain on its resources. A benefit would be that each catchment area is looked at in totality, as discussed in paragraph 50, and resourced in an equitable way to meet the needs of the population it serves. Certainly, you would not like to see a situation whereby a perverse incentive existed for a service to encourage consumers to migrate to a neighbouring service and, in so doing, retain the funding without having to do the work. If it became evident that significant numbers of consumers were migrating from a particular service, this may demand a closer examination to understand why this is the case.

61 It is inevitable that Victoria's mental health system will move to an ABF model at some point. This had been planned to be implemented as a 'shadowed' system in the 2021-22 FY to run in parallel with the current block funding model, with a full implementation in the 2022-23 Financial Year (please also see paragraph 55 above). However, the implementation of this new funding model has been deferred for a year due to the COVID-19 pandemic. This is highly relevant to the issue of equitable funding because services will, in the future, be funded based on measurable outputs.

SERVICE PROVIDERS AND DELIVERY MODELS

Question 7: In service 'hubs' a range of services are co-located in the same geographical area. What are the strengths and limitations of service 'hubs'?

62 Service hubs have a number of strengths. They can:

(a) develop extremely co-operative relationships between mental health services and other complementary services to ensure that each consumer attending that service receives a holistic service which attends to the consumers' physical and mental health needs;

(b) create streamlined referral pathways; and

(c) help to decrease stigma and discrimination against mental illness by adopting the philosophy that mental health be mainstreamed into the broader health system.

63 An ideal hub would include services beyond health services. Hubs should include the broad range of supports and services integral to good mental health discussed at paragraph 20, such as the Office of Housing and Centrelink, vocational services, legal drop in centres, etc.

64 An example of an existing service hub which combines a broad range of services is the Melton Health and Community Services hub. It combines mental health, podiatry, dentistry, alcohol and drug, and allied health services. I have not observed any limitations in the Melton hub so far. However, it has been open for 12 months and seems to have already reached capacity. This indicates that service hubs will need to be futureproofed to account for further rapid population growth.

65 However, even in areas that are not in growth corridors, hubs may be perceived as the best, i.e. fastest, way to access a multitude of services and therefore may be swamped by those already living in the area and who may be "sub-threshold". It is therefore necessary to place limits or thresholds on access to care. Mechanisms to achieve this include means testing, restrict access to pension or healthcare card holders or set thresholds based on diagnosis, severity of illness and/or co-morbidity for example.

Question 8. How should services within the mental health system be coordinated?

a. To what extent should consumer choice determine the nature and volume of care received?

66 It is necessary to balance the nature and amount of care or services a consumer thinks they need against what can reasonably be provided in the rationed system that we currently have.

67 While I am in favour of consumer choice, there may be times where consumer choice is perhaps contraindicated. For example, if we look to the particular diagnostic group of people with borderline personality disorder (**BLPD**), this cohort often want more services than they need or that can reasonably be provided. People with BLPD experience high levels of morbidity and are well represented in mortality data. There are evidence based models of care available, such as dialectical behaviour therapy (**DBT**), however, this therapy is labour intensive and thus expensive, and there are significant restrictions on the availability of DBT in the public mental health system. The person with BLPD benefits from consistent, well-coordinated and well communicated care and will therefore, not be assisted by a system that promotes and/or encourages freedom of choice at the expense of these goals.

68 Another example is the person with a severe and enduring mental illness, say schizophrenia, who has limited insight, who actively avoids treatment and who requires treatment mostly as an involuntary patient. This consumer will not be assisted by a system which encourages and promotes freedom of choice at the expense of continuity of care and assertive and active engagement. This can be counterproductive for a system as a whole. While respecting consumer choice, we cannot disadvantage other consumers who have equally meritorious needs.

b. What are the merits and challenges of a 'single care plan' approach to coordinating services?

69 There are significant merits to individualised or single care plans. The main challenge of this approach, however, is that the mental health system is not currently resourced to provide the full range of services we consider as best meeting the consumer's needs.

70 As discussed at paragraphs 25 and 26 above, services have shifted from a model of continuing care to episodic care, where people have to relapse, or meet a threshold of risk, before being able to re-enter the system. Essentially, services have to achieve "balanced books" in the sense that an equal number of consumers have to be exited from the service each week, month or year to off-set new consumers accepted into the service. If this balance is not achieved the inevitable result is either (a) a wait list or (b) an increased threshold for entry.

71 This model is causing harm, it is well understood that a person with a long term psychotic disorder with a cyclical pattern of maintenance ->relapse -> recovery -> maintenance -> relapse; experiences a minor cognitive decline with each relapse and these cognitive declines build on each other with each successive relapse. This harm is preventable yet we subject consumers to this process via the episodic care model. I reiterate that not every consumer who is referred to an Area Mental Health Service will need or indeed benefit from a continuing care model however a sub-set most definitely do. It is also harmful to those who will not gain access to the system at all due to what is effectively a capped or rationed service.

72 We are also often discharging people who cannot be properly managed in the primary care system and, for some, co-ordination of services is not effective. For example, the workload of GPs often means they will not have the capacity to assertively follow-up or have their practice staff remind consumers to attend appointments.

73 Consumers may miss appointments with GPs for a variety of reasons including:

(a) use of heavily sedating or amotivating medications;

(b) disorganised thinking due to a psychotic or mood disorder;

(c) lack of insight;

(d) ambivalence;

(e) co-morbid physical or mobility issues

(f) the impact of substance abuse; or

(g) practical impediments such as lack of funds, no means of transport etc .

INDIVIDUAL QUESTIONS

A FUTURE COMMUNITY-BASED MENTAL HEALTH SYSTEM

Core component services in a future community-based mental health system

74 As discussed at paragraph 20 above, there is a need for community-based mental health services to provide a broad range of supports and services beyond clinical expertise. Essential to enjoying good mental health is social connectedness, employment and a reasonable standard of living — which includes income and stable, affordable housing.

75 I think the question is not so much about what services should be provided by mental health services but perhaps how best the relevant services such as housing, Centrelink and vocational services, could be co-located or better connected to ensure improved access for consumers who experience a number of hurdles in terms of their capacity to engage with these services. I have described some of these issues in paragraph 54 but in addition there are often problems with literacy or English proficiency.

Reducing the gap between the need for community mental health services and the available supply

76 The primary care sector could be better supported to manage consumers with mental illness who can be treated in that sector. This would require giving the primary care sector easier access to psychiatry specialists for a second opinion, for a discussion about prescribing or management of side effects for example and to assist with developing a treatment plan. This access would also allow for a streamlined referral back to the mental health system if this was needed. In addition, GP practices would be greatly assisted by having experienced mental health nurses or allied health clinicians to support their roles as per paragraph 62.

77 Secondly, psychiatrists in private practice also require better support to access the public health system when their patients are acutely unwell or when the patient's needs can no longer be met in the private system. This comment acknowledges the symbiotic relationship that exists between private psychiatrists and the public system.

78 Finally, there is also a need to further address the maldistribution of private consulting psychiatrists in Victoria. NWMH has established two private consulting suites, one each in Sunshine and Coburg due to a lack of private psychiatry in these areas. NWMH established these (subsidised) practices about 15 years ago at a time when there was only 6 psychiatrists in private practice west of the Maribyrnong River and at a time when large numbers of public sector psychiatrists were exiting the public system due largely to workload.

79 This initiative has been very successful in terms of:

(a) retaining psychiatrists in the public sector, often via a public / private mix of work; and

(b) providing better access to private psychiatrists for consumers residing in the north and west of Melbourne which in turn supports throughput from the public system.

80 These psychiatrists now see 8,000 patients who would otherwise have been seen in the public system. The consulting psychiatrists have links to the public system, so if their patients deteriorate they can easily be referred back to the public mental health system. Notwithstanding the above, cost and waiting lists still represent significant barriers for consumers to access private psychiatry.

Reducing the number of missed appointments

81 It must be recognised that many people with serious mental illnesses have chronic disorders where disorganisation is a feature. These consumers will often need prompting and assistance to get to their mental health appointments.

82 NWMH sends out text reminders and makes phone calls to prompt consumers to attend their appointments. We also recognise the needs of particular consumers and schedule their appointments accordingly. For example, we will not book morning appointments for patients who are taking highly sedating medication as the effect of this treatment often means they will not be awake until later in the day.

83 Interestingly, the COVID-19 pandemic has necessitated the fast tracking of telehealth initiatives for NWMH which have been shown to be safe, effective and efficient as a means to maintaining contact with and engaging with consumers. The biggest barrier to implementing telehealth for consumers has been their access to a mobile phone or data packages. NWMH has taken the initiative with this and has purchased a number of pre-paid mobile phones for this purpose.

84 Another way to improve attendance would be to establish community mental health clinics in places that are easily accessible via public transport. Clinics are often not

located near public transport hubs/routes. A good example of this is the consumer living in Melton and accessing a specialist mental health clinic in Sunshine. This was a logistical and financial challenge if the consumer was dependent on public transport. In recent months, we have established a clinic in Melton and this has dramatically improved access and attendance.

Benefits and risks of centralising screening and triage services

85 A strength of centralised screening and triage services is that it is easier to establish and maintain the skill level of those performing the screening, maintain adequate training and ensure fidelity to the Statewide Screening tool across the system. Triage is highly skilled work and suitably skilled and experienced clinicians are required to conduct a thorough assessment in a one dimensional way, namely they can only hear what the person is saying in response to the triage clinicians questions. This allows the clinician to take note of answers to specific mental state examination questions and attend to the volume, tone, content and rate of speech of the consumer. A skilled clinician can elicit symptomatology via a well-structured interview format.

86 However, this is very different to a face to face assessment in a consumer's house for example where so much more information can be gathered for example:

(a) how the person is dressed – neatly kempt, dressed appropriate to weather etc;

(b) their level of eye contact;

(c) facial expression – affect;

(d) their level of self-care;

(e) how they are interacting with others in the house;

(f) whether any dependent children are being adequately cared for or neglected.

87 NWMH currently provides about 20% of Victoria's public mental health care and provides Triage to a very significant geographical area. A triage service of this size operates with about 23 FTE staff. A team of that size enables economies of scale and efficient rosters based on call volumes and call patterns. It is much more efficient to have a large centralised service, rather than 6 smaller services as we did previously. Conceivably, it would be possible to have a triage service for the whole state so long as the team was appropriately orientated to the service system as a whole, properly inducted into the service and skills and training maintained over time.

88 A risk is that if these centralised services cover larger geographic areas they may not have sufficient familiarity with local services however this could be addressed as described above.

89 In a limited, but highly important way, NWMH undertakes 5 Statewide Triage functions on behalf of the State. It accepts triage calls from:

(a) the Victoria Police Critical Incident Response Team (**CIRT**). Triage is able to interrogate the Statewide Mental Health database, the Client Management Interface (**CMI**) and the NWMH or local Area Mental Health Service database and alert the CIRT to any mental health history or alerts as CIRT is deployed to a critical incident. This confidential information sharing partnership has demonstrably improved safety for consumers, for CIRT and for the general community. A data matching project conducted prior to this arrangement indicated that approximately 80% of CIRT deployments involve people with a mental illness.

(b) the Victoria Police/Forensicare partnership — Victorian Fixated Threat Assessment Centre (**VFTAC**). This partnership deals with radicalised persons or those engaging in grievance fuelled violence. About 60% of the persons coming to the attention of VFTAC have a mental illness, diagnosed or not. History has demonstrated that engaging this cohort in treatment greatly reduces the risk to them and to the wider community.

(c) returning travellers who have been quarantined in CBD or airport hotels for 14 days as part of the COVID-19 response. NWMH was asked by DHHS to activate this service at the end of March 2020 in response to the COVID-19 pandemic. It was apparent to officials receiving these passengers at the airport that a significant number were experiencing psychological distress.

(d) consumers and carers who are aggrieved or distressed by COVID-19 restrictions and who have been contacting the Department of Premier and Cabinet and intimating self-harm or suicidal ideation. This became particularly prevalent in the lead up to mother's day.

(e) people in the community at large who have been directed to self-isolate for 14 days and who are not coping with isolation and are contacting the office of the Minister for Mental Health and intimating self-harm or suicidal ideation.

90 These five examples demonstrate that the service can be scaled up with relative ease and in fact all five examples deal with persons from across the state of Victoria, rather than restricted to the NWMH catchment.

Strengths and limitations of telephone and online screening and triage services

91 The strengths of performing screening and triage over the telephone include:

(a) people develop and refine the skill of eliciting key information over the phone without using normal visual cues as per paragraph 86; and

(b) these services can be run 24/7 which enables better accessibility for consumers, and also creates an economy of scale. Telephony systems are now very sophisticated and allow for good data collection, call queuing and call prioritisation with priority call taking options available for GPs, Private Psychiatrists and Police.

92 An example of existing online centralised screening is a state-wide neuropsychiatry specialist health care service run by NWMH. This screening and diagnostic service is conducted remotely using iPads or desktop PCs to assess people for signs of neurological conditions, such as early onset dementia, Huntington's disease or indeed very rare disorders such as Niemann-Pick Type-C disease. This service has found that assessing a person through video can be just is affective as assessing them in person. It can certainly be more effective and less onerous for consumers and carers to access this highly specialised service at the Royal Melbourne Hospital from Mildura or Shepparton for example. Previously these consumers, who often had mobility or cognitive problems would have driven to Melbourne one day, stayed overnight in a motel, had their appointment the following day and then driven back to the regional centre afterwards. Consumers and carers have been surveyed by the service and it has received high levels of satisfaction and acceptability.

93 NWMH has not previously used online platforms for screening and triage functions, but the COVID-19 outbreak has required a rapid adoption of these technologies and utilisation of Webex, Zoom, Microsoft Teams, Skype etc as a means to staying connected and engaged with consumers. This has required a rapid up-skilling of staff, attendance to privacy, confidentiality and record keeping and indeed an up-skilling of consumers, many of whom are using these technologies for the first time.

94 There are obvious limitations with these technologies. Firstly, if the consumer does not wish to engage s/he will simply not accept the call or will prematurely terminate the call if the conversation strays into difficult territory. Secondly, it is very difficult to undertake some interventions such as medication supervision via telehealth. Thirdly, you will only see what the consumer wants you to see, and as described in paragraph 86, the clinician will miss many of the elements one would see in a face to face visit.

a. Mitigating risks of telephone or online screening

95 The risks of telephone and online screening can be mitigated to an extent by exercising good clinical judgement and after considering the consumers psychiatric history in terms of medication adherence, attendance at follow-up appointments, and other risk issues as relevant.

b. Benefits and risks of running screening and triage functions separately from on-the-ground providers

96 The benefits of running screening and triage functions separately from on the ground providers are twofold:

(a) the larger the service, the greater the economies of scale and the greater the efficiency in terms of roster numbers, roster patterns etc; and

(b) if fidelity to the Statewide triage guidelines is maintained, then the Triage service simply conducts its screen and then refers on as necessary utilising the appropriate Triage disposition category.

97 In other words, it is not concerned about the level of resourcing in the clinical service. It simply triages the call and refers on. The threshold for acceptance by the relevant community team does not 'float up or down' based on available resources.

COMPULSORY TREATMENT

Benefits of compulsory treatment:

a. Benefits for people living with mental illness

98 Compulsory treatment orders can benefit people living with mental illness because they place an obligation and a responsibility on the system to provide care to that person, even if that person has no insight, is rejecting of help, is minimising their illness or is threatening towards mental health service staff.

99 Over my career, I have also observed instances where compulsory treatment is the only thing that will work for a person with mental illness because they do not have any insight into the fact that they are unwell and therefore do not believe that they require treatment and therefore they resist treatment at every opportunity. Ultimately, a compulsory treatment order is just a piece of paper, but it can carry powerful symbolic weight for the consumer and engender their engagement in treatment, albeit, often resentfully.

100 Despite these benefits, it is important to ensure that communication and engagement with a consumer regarding compulsory treatment is done in a way that does not come across as controlling, abusive, coercive or traumatic. Successful engagement depends on the development of rapport, trust and a therapeutic relationship with the consumer. Necessarily, the conversations between the clinician and the consumer, in the context of a compulsory treatment order, are highly nuanced to keep the consumer engaged in treatment and, over time, work with the consumer to ensure that treatment can be provided voluntarily.

101 Compulsory treatment is a serious imposition on an individual's freedom of choice and should only be used in the smallest number of cases and for the shortest period of time. Whether compulsory treatment is utilised or not will always be about balancing the consumer's rights and choice against the risk to themselves and to the community at large. It is accepted that, sometimes, it is not always possible to provide the benefits of compulsory treatment without it being perceived as traumatic by the consumer. It is true that some consumers experience deep shame and resentment about being subjected to a compulsory treatment order and view it as akin to a criminal record or an intervention order.

b. Benefits for families and carers of consumers

102 In some cases a consumers' behaviour may be seriously impacting their family or carers. For example, a person diagnosed with bipolar disorder may spend large amounts of money on things they are unable to afford, which ultimately may render their family homeless. Another example is that a person might engage in other risky behaviours whilst their mood is elevated which may place at risk their employment, their reputation, their supportive relationships or otherwise bring them into contact with the criminal justice system.

103 In these circumstances, it may be appropriate to engage compulsory treatment to protect that consumer and indeed their family from further hardship, but again, a weighing up of the considerations discussed above must occur.

c. Benefits for the community

104 I have seen many examples of people committing horrendous acts beyond their control when a mental illness relapses and no compulsory treatment order was in place. Compulsory treatment therefore can have the benefit of protecting the wider community from these risks of harm. These acts range from an unintentional neglect of dependent children to homicide.

Alternatives to compulsory treatment

105 For the reasons discussed above, compulsory treatment is always engaged in reluctantly, but appropriately by a clinician.

106 One way to engage people without compulsory treatment is to foreshadow that it may be a possibility further down the track, but to offer the consumer an opportunity to pursue other treatment options. A skilled, experienced and empathic practitioner will, as far as possible, place the choice and the locus of control back with the consumer until such a time when that is no longer possible due to individual or community safety concerns.

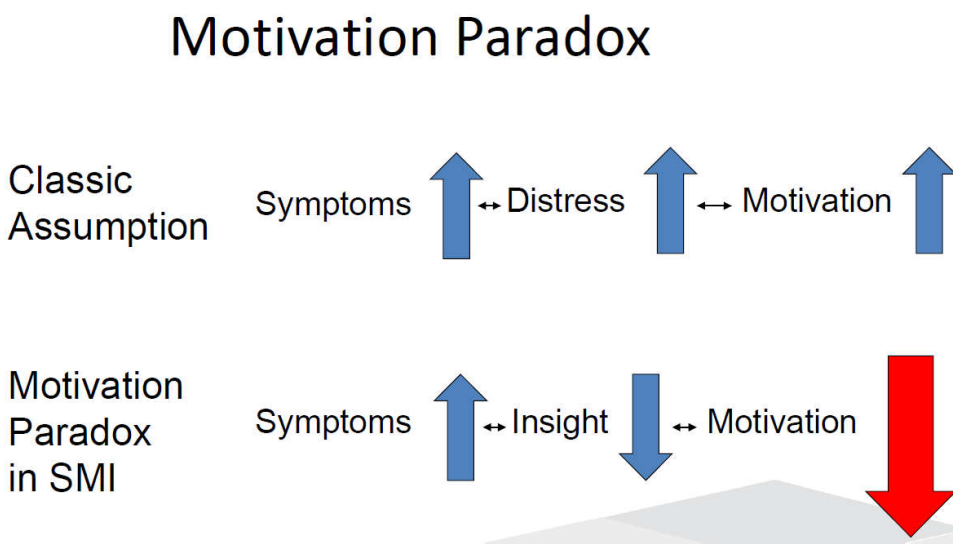
107 A good example of this is a consumer who holds delusional beliefs that he has supernatural powers and is impervious to harm. The individual takes risks driving his car by speeding through traffic and running red lights thinking his super powers will protect him. The skilled practitioner will attempt to get the consumer to surrender voluntarily his driver's licence and accept treatment. If this is refused, the practitioner can consider proceeding to the next step and make a notification to VicRoads and implement the *Mental Health Act 2014* (Vic) (**Mental Health Act**) to compel treatment during this acute phase of the illness. When the consumer has moved into a recovery/stability phase it may be appropriate for the practitioner to write a letter of support to VicRoads to re-implement the drivers licence and it may be appropriate to revert back to voluntary treatment.

108 This accords with the principle of "dignity of risk" upon which the Mental Health Act was devised. This involves allowing a person to make their own decisions which may well be against the practitioner's better judgment. Withholding the decision to make an order immediately is one way to work with a consumer and gain their respect, co-operation and engagement.

109 The rates of use of Community Treatment Orders (**CTOs**) have been driven down over the past two decades. This has occurred for a number of reasons, including an increased focus on consumer rights, increased advocacy on behalf of consumers and, more recently, the amended Mental Health Act with a focus on consumer autonomy and the dignity of risk. For some consumers, as described above in paragraph 105, a CTO can be used as a relatively brief intervention to manage periods of extreme risk and to prevent further deterioration. For other individuals, who lack insight into their illness, CTOs and involuntary inpatient care are an almost constant feature of their illness management.

110 Insight is an interesting concept and can be viewed as a double edged sword. On the one hand you want the consumer to view their experiences as abnormal and as symptoms of a serious and enduring mental illness and therefore s/he will be motivated to accept treatment. On the other hand, it can be terribly confronting to an individual experiencing their first psychotic breakdown and who is admitted involuntarily to hospital who then looks around at the other consumers in the ward and thinks "is this what my future holds? Is this what I have become? Is this how people view me?" Of course, the second example is somewhat skewed because none of the other consumers in the ward were in hospital two weeks earlier. People do recover, they do lead productive lives however in that confronting moment in which there is a flash of insight — hopelessness and despair can enter one's mind and the risk of self-harm and suicide can increase.

111 A Dutch psychiatrist, Professor C L Mulder described a concept he referred to as the "Motivation Paradox". This concept describes the different ways that individuals respond to physical illness vs mental illness and this is also tied to the issue of insight and explains, to an extent, why compulsory treatment orders are sometimes required. The graphic below portrays that someone with a physical illness will experience pain, discomfort, mobility issues or other symptoms and, over time, as these symptoms increase in pain or severity, the person will experience increased distress which will motivate him/her to seek treatment. In other words; more symptoms = more distress = more motivation to seek help.



112 For the person with a serious mental illness however, those symptoms might start off as sleep disturbance, auditory hallucinations, delusions. However, as those symptoms progress they might include social withdrawal, paranoia and feelings of persecution — accompanied by decreasing self-awareness and insight and therefore become less motivated to seek help. In other words; more symptoms leads to less insight which leads to a decreased motivation to seek help.

113 In order for alternative methods to work, at a systemic level services should be sufficiently resourced to optimise a consumer's recovery and maintenance of a baseline level of functioning. As indicated previously, these are time consuming, labour intensive interventions which are dependent on a skilled workforce to deliver. Services also need robust governance systems in place for ease of escalation to discuss and resolve risk issues, seek second opinions, and discuss alternate strategies to the use of restrictive interventions. Good data collection systems will also alert the Executive to different patterns of usage in respect to CTOs. A departure from the norm might point to a cultural, skill, experience or supervisory issue, or it might simply point to a statistical

maldistribution of high risk consumers. In any event, that data enables the Executive to explore this with the relevant service.

114 The engagement strategy described above is used more commonly by skilled and experienced practitioners, so there is scope to increase its use in more junior practitioners.

Reducing rates of compulsory treatment use

115 A study conducted about 15 years ago showed that people from non-English speaking backgrounds are more likely to be placed on a compulsory treatment order. It is important to understand why this occurs and how this could be addressed.

116 At a broader level, the Mental Health Act and its "dignity of risk" philosophy were only introduced in 2014. It is to be expected that the paternal aspects of the pre-2014 mental health system and compulsory treatment will take some time to be dispelled.

117 Associate Professor Ruth Vine, previous Executive Director of NWMH, has recently written a paper on the outcomes of the introduction of the Mental Health Act and found that there were no appreciable changes in rates of homicide or suicide. This suggests that "dignity of risk" approach in the Mental Health Act has not increased the risks to the wider community.

118 I think the rates of compulsory treatment, both the numbers of orders and the duration of orders is steadily being driven down. Also, the Mental Health Tribunal has been setting a high threshold for the continuation of orders and is thus modelling expectations to clinical services.

119 Data about rates of involuntary treatment orders and also the provision of feedback to services comparing rates between services is helpful in driving change. We have seen this work very effectively in regard to the use of restrictive interventions where transparent data, comparative data, trend pattern data and outlier data is available. There is also a discussion about restrictive interventions at the quarterly DHHS performance meetings as a rights based discussion and a patient experience discussion.

FORENSIC MENTAL HEALTH

Development of the Community Forensic Youth Mental Health Service and the Custodial Forensic Youth Mental Health Service (FYMHS)

120 Workforce training was a problem when establishing the Community Forensic Youth Mental Health Service (**FYMHS**). The absence of a youth-forensic sub-speciality in Victoria meant that there are simply very few individuals appropriately trained in the

area. We have worked with Swinburne University of Technology to develop a 4 day course for mental health clinicians to improve workforce knowledge and skill. A further, more in-depth course will be devised (for example a one year Certificate/Diploma). However future service provision needs to take into account training schedules for new staff. For example, as with nurse practitioners, new FYMHS clinicians may need protected time in contracts for training/education/supervision.

121 The other issue in expanding the FYMHS service to half of the state (with The Alfred serving the other half) has been responding to existing demand. The whole FYMHS team is occupied by servicing Orygen clients with forensic issues. Evidently the psychiatry and clinician FTE needs to be increased to deliver a state-wide service.

122 It has been very productive and rewarding to start to knit together existing services: e.g. holding joint clinical reviews with the Youth Justice Mental Health clinicians and members of the custodial team. Through this we have seen the beginnings of a more joined-up multi-systemic approach to complex young people which has yielded some excellent results. For example, young people seeing Orygen clinicians in custody, who then refer to Orygen community FYMHS, enabling engagement between the young person and Orygen community clinicians *prior* to release, in addition to linking-up with community Youth Justice workers. This is the kind of model that needs to be delivered to all young people in custody, rather than the few.

123 **Positives**: highly motivated, skilled team. The take-over of custodial services was largely uneventful and service delivery is now stable. We are providing a high level of mental health care to a large number of young people in custody (I would state that we are significantly outperforming what we are funded/expected to provide). Also as noted a huge positive, for only a few clients, is the ability to join-up their custodial and community mental health input.

124 **Negatives:** these are all related to the (dis)organisation of youth justice custodial services generally. The vast majority of the Armytage-Ogloff (2017) recommendations remain untouched.

125 The most concerning matters include:

(a) the safety of staff in youth justice

(b) no appropriate places to see young people for mental health reviews;

(c) lack of staff and environments to safely administer medication;

(d) lack of training/extreme negative counter-transferences of frontline youth justice staff; and

(e) an inability to easily see young people due to the security/escorting issues implemented in youth justice centres in recent years.

126 In short: there is little point having a world class mental health service in youth custody if you cannot actually obtain the time and space to see clients.

Community FYMHS

127 The Community FYMHS provides advice, secondary consultations and primary consultations (the age group seen spans 10 years to 25 years). The consultations are documented formally in a forensic report which is supervised by a forensic psychiatrist and sent to the referrer. Our triage scale (level or urgency of cases) is still being developed. From the point of acceptance of the referral, we aim to have a report furnished within two weeks.

128 Given the gap between young people with forensic issues and the mental health treatment they typically require, we aim to be as inclusive and pro-active as possible. Therefore our inclusion criteria is less strict. We accept referrals for Orygen clients (15 to 25) with forensic issues or where the team has medico-legal questions or need the support.

129 The Community FYMHS has also begun accepting referrals from the Royal Children's Hospital and Austin Child and Adolescent Mental Health Services (**CAMHS**). In 2020 we aim to visit other CAMHS, headspaces, VFTAC and other sources of referrals to provide education and to open FYMHS referrals to their services.

Custodial FYMHS:

130 The Custodial FYMHS sees people 10 to 21 years old; those aged 18 to 21 years can be "dual tracked" — which means sent from adult to youth custody at the point of sentencing if deemed to be vulnerable.

131 In my opinion the current funding approach was aimed at offering a 'point and shoot' style of mental health service provision. That is, see clients, diagnose, medicate / offer a course of individual therapy. This is the exact opposite of what is required for this complex cohort; evidence points towards early intervention-MST models of care; with the mental health service a fulcrum at the centre to provide nuanced formulations and co-ordinate multi-service involvement.

132 Therefore we are currently adapting/transitioning our model of care to better suit the needs of the custodial youth justice cohort. We have been taking far more of an active role in "Care Team Meetings" (multiagency/family complex care meetings), discharge planning and joining-up custodial and community mental health services and developing

plans to help support young people during their incarceration. However this kind of case management and co-ordination takes time and does not necessarily provide easily accessible 'KPI/contact' data. In other words, it is difficult to demonstrate the "value add" via traditional metrics.

Engaging with Youth Justice and other agencies

Community FYMHS

133 We have youth justice mental health clinicians (**YJMHCs**) in our teams who work closely with community youth justice and often see clients at the youth justice offices. One youth justice clinician (the co-ordinator) is based at Forensicare but works closely with Orygen and supervises our YJMHCs and is responsible for in-reaching into custody to support youth justice on the shopfloor on units with supervision, reflective practice and a modest 4 hours of induction is provided during their 6-week induction for new staff.

134 My perception is that youth justice staff are largely not overly responsive to the mental health input, given the negative counter-transferences in action, the tendency to frame maladaptive behaviours as purposeful/malicious, and the perspective that access to mental health for the young person is something of a "bonus" which staff do not have time to facilitate nor believe the young person deserves.

Custodial FYMHS

135 As noted above, although not a clear mandate of the originally funded model of care, from inside custody the FYMHS clinicians try hard to liaise with community youth justice to join-up plans and improve information flow. This can be hard as the computer systems used in youth justice are sub-optimal and the relevant staff can be difficult to reach via telephone. Multi-agency care team meetings arranged for consumers in custody are usually organised by community youth justice and we try to attend, however they can be anything from poorly attended to attended by a confusingly large number of services.

Demand for services

136 The demand for the FYMHS services has been enormous. I strongly suspect that the figures quotes in the Armytage-Ogloff report, which I believe were referenced from Youth Health and Rehabilitation Service and Youth Parole Board data, hugely under-represented the prevalence of mental disorder, intellectual disability /neurodevelopmental issues in the youth justice custodial and community cohort. This was because — paradoxically — there was not sufficient service to diagnose the issues. As previously noted there is vast demand in the community too, such that it has been

difficult to start the state-wide FYMHS service, because there are so many forensic issues within the existing Orygen case management cohort.

Changing needs of the youth justice cohort over the past 10-15 years

137 The Armytage-Ogloff (2017) report talks about the changing needs of the youth justice cohort to some degree. My summary is that there are the two following issues:

(a) Cultural issues: Aboriginal and Torres Strait Islander (**ATSI**) young people have always been about 20% of the youth justice population; however other demographics have changed. There used to be more Vietnamese background young people in youth justices (this reportedly tailed-off), followed by Pacific Islander and Maori young people. The current youth justice migrant group of increasing overrepresentation is African, specifically South Sudanese.

(b) "Concentration effect". In the last 10 years there have been less convictions of young people (aged 10-21 years), due to increased community diversion options post implementation of the *Child Youth and Families Act 2005 (Vic)*. The result of this is that the most complex young people were grouped together in custody (with "complex" as a proxy for those with untreated mental illness, intellectual disability, significant substance use disorders, major social care issues and subsequent violence/offending). However custodial services were not robust enough to manage this level of complexity. Arguably this occurred at a time of a decrease in service provision, certainly from a mental health perspective. What has been seen is a custodially/institutionally created ` sub-population of very violent individuals (some forming into gangs) committing vast numbers of offences. The 2017 report noted that approximately 180 individuals were responsible for 25% of all youth crime in Victoria. This has propagated a myth in youth justice and in the community that young people are becoming more violent/dangerous; which is not really the case. However there is certainly more violence (and mental illness) in youth custody than ever before.

Effectiveness of the Community FYMHS & Custodial FYMHS

138 When we are able to co-ordinate assessment and multi-service delivery for young people, which is seamless across age groups and different environments (secure welfare, inpatient units, custody and community), the service we offer through the Community FYMHS & Custodial FYMHS is extremely effective. At this time we only have single-case studies to draw-on to back this up. Unfortunately being able to offer this level of input is not currently possible for all FYMHS clients, but it should be the rule not the exception.

Recommended changes

139 We need to extend the reach of FYMHS; both in-reach into custody and also community outreach to see young people with forensic issues and mental health issues prior to them deteriorating and coming into contact with justice services.

140 In the custodial team; we need:

(a) increased clinician and doctor time in custody to do more in-depth assessment and multi-agency co-ordination, including discharge planning (i.e. moving away from "point and shoot" psychiatry);

(b) funding for OYH drug and alcohol service provision (approximately 80% of clients) currently being managed by Correct Care Australia (**CCA**) GPs only in custody with some sporadic input from Youth Support and Advocacy Services/Western Drug Services; neither of whom prescribe Opiate Substitution Therapy Program or other withdrawal medications. This should be joined-up with the same service as the mental health issues to be true dual-diagnosis (as well as being simpler for young people to access);

(c) the ability to offer or be involved in vastly increased training for youth justice staff, in the community and especially in custody. This should be 6 weeks of mental health training and 4 hours of security/administrative training processes, not the reverse of this, 4 weeks and 6 hours respectively as currently exists;

(d) environmental change. The custodial environment is not conducive to most mental health focused work;

(e) an enhanced computer system, to communicate better with other services such as youth justice, school in custody (known as Parkville College) and external providers; and

(f) appropriate and safe ways of administering medication to young people. Currently there are approximately 100 young people to one CCA registered nurse/registered practical nurse for medication administration and medications dispensed in non-clinical environments. Ideally I think OYH should take over registered practical nurse duties in youth justice centres. It makes little sense that these functions are performed by another health service.

141 In the community team; we need:

(a) increased clinicians and funding as discussed in paragraphs 140(a) and (b) above;

(b) to extend the FYMHS team formally into community youth justice settings, secure welfare settings and schools;

(c) to take over services offered at the Children's Court Clinic. Currently a separate provider with private clinicians working there: again this makes little sense and often leads to a doubling-up of work. For example, young people are assessed there, then come to custody and get assessed again by OYH;

(d) to develop formal links with CALD and ATSI services;

(e) to develop formal links with work providers willing to take-on forensic young people as a means to reducing recidivism;

(f) need to form a robust community FYMHS network in Victoria capable of lobbying for significant change, for example changing the mean age of criminal responsibility; and

(g) the biggest thing we need is a forensic youth secure unit. Somewhere to treat young people with forensic mental health issues and gradually transition them to the community. The United Kingdom has a number of low and medium beds, as does New Zealand. New South Wales have seven. It is the missing part of the system in Victoria at the present time. I can provide data on the estimated number of beds based on the United Kingdom, New Zealand and New South Wales service systems.

Good practice models of forensic mental health services

142 The Forensic Youth Mental Health in-reach services at the Melbourne and Malmsbury Youth Justice Centres is a very good practice model of services which have identified young people in the justice system who are very mentally unwell. This model has demonstrated the incredible value of forensic mental health services engaging with the youth justice system.

143 As a result, DHHS has funded $6.3m for the establishment of three youth justice inpatient beds at the Orygen Inpatient Unit at Footscray (which is a component of NWMH's youth service). These inpatient beds will enable people in the youth justice system with acute mental health problems to be transferred to and treated at the OYH service. These beds are currently under construction and will be completed as expected around 30 June 2020.

Key changes and/or reforms to effectively support young people to better manage or resolve mental illness and engagement with the justice system

144 The youth justice in-reach model is a concept that has demonstrated its worth. The task is to now significantly expand it. To that end, it would be helpful to properly evaluate this model.

145 Prior to the implementation of this model, it was difficult to ascertain what the incidence of mental health issues was in the youth justice population. We are now finding that it is alarmingly high. Young people with mental health issues are often discharged from the youth justice system without having received any mental health treatment. We should be aiming to provide treatment, where possible, to these young people while they are within youth justice centres and transfer them to specialist mental health services if their problems are acute. When they are discharged from the youth justice system, we also need to determine what is required for them in terms of ongoing care for their mental health issues.

146 I looked at community homicides involving NWMH consumers over the period 2005 to 2012 and found that, out of 10 homicides, 5 had been committed by current OYH consumers or relatively recent graduates of OYH. Of the 10 perpetrators, 8 were aged 29 years old or younger. This highlights the critical need for engaging these consumers as early as possible.

Released offenders requiring emergency department treatment

147 There are two problems associated with offenders being released from prison that Melbourne Health has observed.

148 Firstly, there is a maldistribution of prisoners into the mental health system. The Royal Melbourne Hospital and Sunshine Hospital receive a disproportionate number of forensic patients because of the location of the Magistrates' Courts, custodial centres and prisons such as Ravenhall Correctional Centre and the Dame Phyllis Frost Centre. The majority of these facilities are located in the CBD or in the western suburbs of Melbourne. In the case of prisoners who are acutely unwell, they should, in my view, be allocated to emergency departments on an equitable rotational basis, so as to reduce the burden on The Royal Melbourne Hospital and Sunshine Hospital. For example, the three city hospitals, The Royal Melbourne Hospital, St Vincent's and The Alfred could accept these released prisoners on a rotational basis.

149 Secondly, and relatedly, there appears to be an apparent practice policy of police and ambulance services to convey persons released from custody to the emergency department closest to where they have been released. This means that patients who live in regional locations are not taken by police and ambulance services back to where they have familial and community connections. For example, quite recently I was aware that a forensic patient with connections in Bendigo was being released from the Melbourne Assessment Prison. I contacted a colleague in Bendigo to arrange for the patient to be referred there and accordingly I secured a mental health bed for this consumer at Bendigo Hospital. Despite this, the patient was taken to The Royal Melbourne Hospital Emergency Department and remained in the emergency

department there for roughly 72 hours before finally being transferred to Bendigo. The emergency department is a high stimulus area. This was not a good outcome for the consumer, it was not good for other patients in the emergency department. In the end, this appears to be the result of a decision by Ambulance Victoria and Victoria Police about not transferring a consumer across their service boundaries. However, in the end, both agencies were required to effect the transfer anyway and thus their resistance and time delay served no purpose.

150 The trend that emerges from these two problems is that people are often released on assessment orders, and it becomes the responsibility of the nearest emergency department and mental health service to assess the patient and determine whether they require ongoing care. About 50% of treatment orders are not upheld when the person is assessed by a psychiatrist. This seems to imply either that the criteria for utilising the Mental Health Act is poorly understood or that the Assessment Orders are being used as a mechanism of convenience to pass on responsibility of treatment from the justice system to the mental health system regardless of whether the consumer needs that level of care. What we find most commonly is that the released person is homeless and has no funds, and under these circumstances the mental health service is left to sort out these issues often in the highly inappropriate setting of a busy emergency department.

151 Consumers are also released to us at different points in the justice system process, with a mixture of people being released on bail and also after 'time served'. We often have very little warning that these people are going to be released and consumers often arrive at the emergency department in a state that is unmanageable, for example a consumer who is floridly psychotic and in restraints. This is generally because the consumer has refused treatment for the entire time they were in custody and in fact s/he cannot be compelled to accept treatment while in custody. In other words, unless the person consents to treatment in custody, s/he will be released un-treated or under treated.

Forensic clinical specialists at Melbourne Health

152 The four key responsibilities of forensic clinical specialists (**FCS**) are:

(a) clinical consultancy, including primary consultation through risk assessments and secondary consultations, reporting on domains of violence, sexual offending, stalking behaviour and general offending;

(b) partnerships and networking as a key contact and referral point for mental health services, the justice system and support to agencies within the local area;

(c) education and training to AMHSs, Community Managed Mental Health Services and justice agencies workforce on forensic mental health topics; and

(d) service development related to policy and quality improvement of forensic mental health services.

153 FCSs do not carry an active caseload of clients and do not provide crisis intervention.

a. Effectiveness of the role

154 The FCSs are effective in supporting clinicians with their work with consumers. They provide support to consumers indirectly through primary and secondary consultation and conduct a violence risk assessment. FCSs are effective in applying a theoretical framework to client presentations and developing a robust formulation to inform treatment and intervention. They are also effective in liaison/interface with the justice system and hold knowledge and skills in this area over and above 'standard' mental health clinicians.

b. Barriers or challenges associated with effective performance

155 Barriers to effective performance by FCSs include inadequate resourcing. The FCSs are spread very thinly across services. This diminishes their ability to educate staff through modelling and lends itself to a situation whereby recommendations may be made but which staff may or may not be able to implement. Violence risk assessments take time to conduct and write up, and the challenge is to provide one for every consumer that requires one.

156 A challenge exists to maintain a presence across emergency department, inpatient, residential and community services and also to provide consistent in-reach to prisons. The role does not allow for a caseload of high risk consumers to be held by the FCS.

157 At times the AMHS relationship with justice services may lead to a variable response to collaboration. This usually occurs in the context of staff turnover at justice services or at periods of increased demand for services. Key challenges are a differing legal framework, different organisational cultures, competing priorities, and minimal understanding of service systems, which may occur in justice services.

c. Improving effective performance

158 Effective performance by FCS could be improved by increased resourcing and/or establishment of forensic assertive community treatment teams to assist regular treating teams to work with and implement recommendations made by FCSs. Establishment of justice liaison positions to sit alongside FCSs to be the main point of contact, to resolve

conflict, agree on priorities and resolve problems would also improve the effectiveness of FCSs.

159 It would greatly assist if there was a one stop shop post release from prison for individuals with a mental illness to sort out Centrelink payments, source emergency housing and link the person with an AMHS for ongoing mental health care. Attending to these three basic issues would greatly reduce recidivism. This could be achieved via the development of a 'Transition Centre' adjacent to the custodial centres at Ravenhall / Deer Park.

160 The effectiveness of FCSs could also be improved by providing compulsory care for prisoners under the same conditions that apply to consumers in the broader community. This will require amending the Mental Health Act with oversight by the Mental Health Tribunal. Further, increasing the number of forensic clinical specialist positions; providing more appropriate inpatient bed options and more appropriate accommodation services for people exiting prison with serious mental illness, would also improve the effectiveness of FCSs.

COMPLEX NEEDS RESPONSES AND SECURE EXTENDED CARE

Current role and function of Secure Extended Care Units

161 The role of Secure Extended Care Units (**SECUs**) has changed substantially over the past 25 years. I am most familiar with the Sunshine SECU and when this first opened 20 or so years ago its main focus was on refractory (treatment resistant) psychosis and in fact the first tranche of consumers at Sunshine were transferred from the big institutions such as Larundel, Mont Park and Royal Park Psychiatric Hospitals, many of whom had been hospitalised for years if not decades. In the intervening years the patient demographic has changed significantly. Now, apart from a primary diagnosis of psychosis, we also commonly see these consumers with co-morbid physical problems plus substance use dependency plus a forensic history. Increasingly, we are having consumers referred who have come to the attention of the VFTAC because they have been radicalised or harbour ideas of grievance fuelled violence in the context, most commonly, of a delusional disorder.

162 The term SECU is somewhat misleading because the facilities are not very secure at all and this can lead to unrealistic expectations in terms of what sort of clinical presentations can be safely managed in this environment. At the present time, security at the Sunshine SECU is being upgraded via a $750,000 capital grant we received confirmation about on 22 May 2020, in response to the number of VFTAC referrals we have been receiving. We have received four referrals for inpatient treatment from VFTAC/MH-FIT. These referrals are all for patients with psychotic (delusional) disorders and each admission will require a minimum of 9 months inpatient care in a secure

environment. The $750,000 capital grant will enable an 'up-spec' of a number of infrastructure items including glazing, locking systems, CCTV cameras and the like.

Effectiveness of the current SECU model

163 There are insufficient SECU beds across the state. Simply, demand exceeds supply and turnover of beds is slow. A consumer entering the SECU at Sunshine will typically require a 9 month admission. Up until recently there were 3 consumers at SECU who had been in the unit longer than a decade and 'long stayers' further degrade bed turnover performance.

164 The Sunshine SECU is highly specialised. It is a professorial unit headed up by Professor Christos Pantelis who enjoys an international reputation in the area of treatment resistant psychosis. By definition, many of the consumers admitted to SECU will already have been tried on a number of medications and combinations of medications without success. Part of the standard approach at Sunshine is to undertake a "washout" of antipsychotic medications, ensure the person is not able to access or use illicit drugs, undertake a full organic work-up and then start afresh in terms of diagnosis and treatment. Necessarily, this also involves a historical file review which will detail both the consumer's illness and treatment history. It is not uncommon at the conclusion of this process for the consumer to be de-diagnosed or re-diagnosed.

Required changes to the SECU model of care

165 The model of care in SECU is sound and responds well to the needs of this consumer group. However there are insufficient beds in this growing area of need. In a future state it may be beneficial to stream according to diagnosis such as:

(a) treatment resistant psychosis;

(b) autistic spectrum disorder;

(c) acquired brain injury; and

(d) VFTAC/Forensic cohorts.

166 The common denominator for these sub-groups will be a psychotic disorder however it is unhelpful to have these consumers — with quite different needs — all occupying the same space.

Strengths and weaknesses of current SECU governance and service delivery arrangements

167 There are pros and cons to having SECUs located on general acute hospital campuses.

168 The pros include:

(a) access to very sophisticated investigative tools such as CT, MRI or PET scanning;

(b) easy access to medical and allied health specialists to diagnose and treat the myriad physical co-morbidities experienced by these consumers;

(c) access to second opinions from colleagues in general acute psychiatry;

(d) access to acute psychiatry treatment and care if a consumer cannot be safely managed in the SECU environment;

(e) access to ECT treatment at Sunshine Hospital; and

(f) opportunities for teaching, training and education in regard to this sub-specialty area of psychiatry

169 The cons include:

(a) insufficient circulation space or leisure space for consumers in an acute hospital setting; and

(b) generally speaking, rehabilitation tasks such as shopping, travel planning and linking with psychosocial supports, is more difficult to undertake from a hospital setting.

Best practice examples

170 I think the Sunshine SECU represents best practice not just in terms of diagnosis, treatment and clinical care but also in regard to the use of least restrictive practices and research undertaken with this consumer cohort. The success of this program has been in the recruitment of an excellent calibre of medical, nursing and allied health staff who are passionate about improving the quality of life of this cohort.

Managing the needs of very complex clients

171 Managing the needs of very complex clients is a challenge because, as alluded to above, demand for SECU beds exceeds supply and bed turnover is low. Unfortunately, this means that consumers waiting to access a SECU bed are often "held" in an acute psychiatry bed, sometimes for many months, which further compounds the pressures on that part of the service system. This in turn means that consumers awaiting an acute psychiatry bed are often "held" in the community, at great risk, while waiting for an acute bed to become available.

INTERSECTION BETWEEN MENTAL HEALTH AND PHYSICAL HEALTH

Potential improvements to ensure that both physical health needs and mental health needs are understood and treated

172 People with a serious and enduring mental illness often do not get access to adequate primary health care. As an example, when people in Australia turn 50 they receive a letter from the government saying that they are entitled to a longer consultation with their GP for a general health check. This includes screening for bowel, prostate and breast cancers. It is often at this check-up that age related health issues such as undiagnosed hypertension, heart disease, prostate cancer, bowel cancer and diabetes are diagnosed for the first time and treated. Those who have an existing general practitioner will make an appointment, and then follow the advice of their GP, attend follow-up appointments and take any prescribed medication. However, mentally ill people face a couple of hurdles:

(a) only those who have stable housing will actually receive this letter; and

(b) only those who are not suspicious of communication from the government will open and read it.

Many consumers with mental health needs do not even receive this letter, let alone open it and make an appointment, or follow through with their GPs advice if they do make an appointment.

173 People with mental health issues often present too late for physical health problems to be addressed. Over the past 12 years, 165 NWMH consumers have died of natural causes. The average age at death of those consumers is 50.8 years. Mostly, the consumers died of preventable and treatable physical causes, such as cardio-vascular disease, respiratory disease and (treatable) cancers. A disproportionate number of those consumers' cause of death is also "unascertained" after autopsy, which we would not expect to see to the same extent in the general population. Many of the cardiac related deaths are due to undiagnosed and untreated hypertension.

174 To improve physical health outcomes for people with mental health issues, we need to make the system easier to access and navigate. This involves embedding physical health practitioners in mental health services. At NWMH, we have a physical health nurse working in our clinics and have tried to set up the expectation that consumers should have their physical health (height, weight, BMI, blood pressure, blood glucose and blood lipids) checked at a baseline level and then be referred if they need further treatment. It is an uphill battle as a result of the numbers of consumers we care for.

175 People with a severe and enduring mental illness face a number of challenges:

(a) the overwhelming majority are dependent on welfare payments and therefore struggle to buy and prepare healthy food;

(b) mentally ill people smoke cigarettes at a greater rate than the general population;

(c) psychotropic medications can reduce energy and motivation at the same time that they stimulate appetite which can lead to profound weight gain and eventually lead to metabolic syndrome; and

(d) people with a mental illness generally have poor access to dental care.

176 In my view there is still significant stigma and discrimination against people with a mental illness in society in general but in the acute health system more specifically. All of these factors conspire to deliver poorer health outcomes and increased mortality — with significantly reduced life expectancy for the mentally ill.

177 As discussed above, hubs would also make the system easier to navigate. Ideally you would have GPs located in these hubs and other community mental health services as well as proximity to other local government and community managed mental health service supports as described in paragraph 20.

178 Given the complexity of problems often faced by mentally ill consumers, I would also suggest that different Medicare item numbers be developed for GPs so that they are able to spend more time with these consumers and perhaps use telehealth as an alternative to face to face appointments.

Best practice models

179 A GP has been embedded in the Waratah Clinic at the Inner West Area Mental Health Service in Moonee Ponds for 10 years. This has been a very successful example of integration of primary care in mental health services.

180 I also managed a mental health service in New Zealand for two years in the late 1990s. Under that system, every patient was registered with a GP. Each time a patient attended a mental health clinic, typed notes were sent to the GP they were registered with. This ensured consistent and timely communication and information flow between the health systems. It also meant that the GP had direct telephone access to the treating psychiatrist or case manager and could easily refer the consumer back into the specialist mental health service if the need arose. In New Zealand, every person has a single unique identifier, a National Health Index number which applies wherever the person accesses healthcare in New Zealand and across the primary and tertiary health systems. By comparison, in Victoria every person has at least two and often more Unit

Record (**UR**) or Client Management Interface (**CMI**) numbers. The CMI is a universal UR number in the state-wide mental health system however in every health network in Victoria runs a separate UR number system. Accordingly, NWMH could find itself dealing with a person who has multiple UR numbers (and therefore multiple histories and medical records). This can introduce risk and inconsistency of care.

FAMILIES AND CARERS

Practice models to develop family/carer

181 NWMH as a whole, and local areas, have developed many examples of practice models to develop family/carer engagement;

(a) Working with Families and Carers Procedure;

(b) Families as Partners in Care (**FaPIC**);

(c) Single Session Family Consultation (**SSFC**);

(d) Best Practice Guidelines for Sharing Information with Families and Carers; and

(e) Engaging families/carers — best practice for NWMH Clinicians: poster and brochure.

182 The model to encourage family and carer engagement is multi-layered and multi-pronged as no one intervention can cover all that is needed in this space. The NWMH Working with Families and Carers Procedure outlines our definition of family and carers to be as broad as any one consumer sees it; outlines our understanding that consumers, clinicians and carers form a tripartite treatment team; and outlines our obligations under legislation and departmental guidelines. The Procedure also outlines our role in working with our consumers who are parents, their children, and the role we play in ensuring the health, wellbeing and safety of their children.

183 FaPIC is an evidenced based model developed by Tandem (Victorian peak body representing family and friends with mental health issues) and was rolled out to all clinical staff in all areas by social work and lived experience staff from within NWMH. This modularised training formed the foundation level of supporting clinicians to understand why it is important to work with family/carers and how to undertake that work. An abridged version is still used as the basis for orientating new staff to working with families/carers

184 SSFC is an evidence based intervention that has been developed and supported by Bouverie Family Centre. This model sees clinicians work with the family/carer and consumer before the session to ensure that the needs of all present are taken into account, and are equally prioritised. Families are told that their needs are also important to the treating team. The training around SSFC is quite extensive, requiring 2 days of

face to face training and then ongoing support. Mostly, this training has been delivered by Bouverie staff. NWMH staff have adapted this training to be delivered within teams as a 1 day training.

185 APMHP have successfully implemented SSFC as a model for intervention with all families in the inpatient units with sessions run together by the social worker and the consultant psychiatrist.

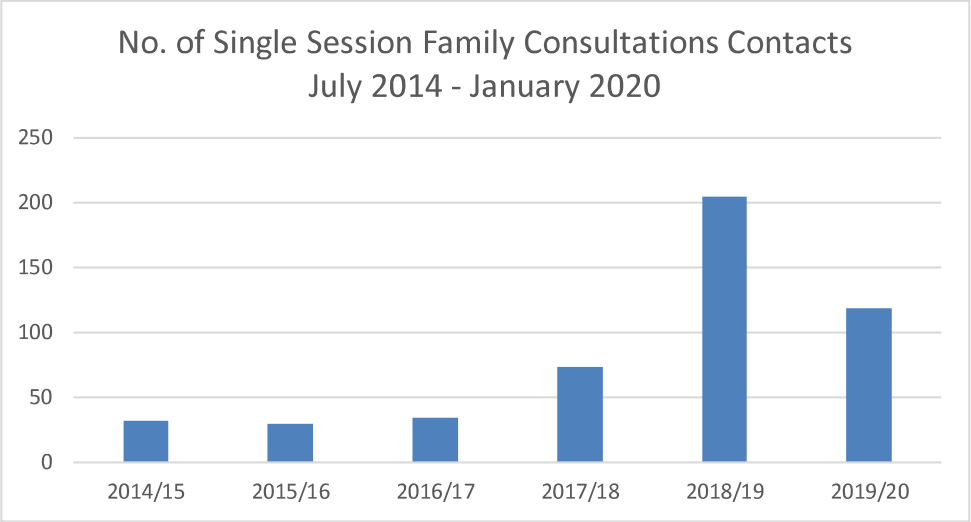
186 Other services have opted for either a "specialist" SSFC clinician to run the single session with the key clinician in a mentoring role or a process of support for clinicians who run SSFC sessions for feedback/support after the sessions.

187 NAMHS have developed a more intensive SSFC Therapy model that involves a more intensive pre-session process, at least three sessions with the family and a formal ending process including the writing of a therapeutic letter. NAMHS also have a Primary Care led partnership employing a dedicated SSFC clinician who provides SSFC to consumers who are having their care shared with GP and NAMHS.

188 The Best Practice Guidelines for Sharing Information with Families and Carers outline the why, when, how and what of working with families and carers, particularly around the tricky space of sharing information when the consumer may be reluctant to do so. It is incumbent on clinicians to explore the reasons there might be issues with sharing information and to try to improve those relationships. This is supported by the Engaging Families/Carers poster and brochure resources which have a clear visual representation about the ways clinicians can engage with families/carers at the various points in the treatment journey, including discharge.

Effectiveness of family/carer engagement models

189 The effectiveness of these family/carer engagement models is difficult to assess objectively as there are no outcome measures for family and/carers. With that in mind we have evidence of increased contact with families and increased offering of specific interventions to families/carers across our programs and areas, as shown in the diagram below. There is also an increase in the positive rating around working with families/carers in the various surveys (both the YES Survey and final evaluation of the NWMH Adult Community Service Redesign).



**Data from CMI – only shows 3 Program Areas. Data for 19/20 is for only half the year.*

Challenges in establishing these models

190 The challenges to establishing family/carer engagement models are both theoretical and practical. Some clinicians still have the view that client confidentiality precludes reaching out to family and carers while some clinicians feel that working with families/carers is specialist work that they are not skilled in.

191 Whole of workforce practice change is difficult and time consuming. There needs to be a five year commitment to implementing and sustaining the change. This is hard when there are many competing needs for clinicians working with consumers and their family/carers who present with multiple and complex needs. Finding ways to ensure all staff are included in training/induction around how to engage with family/carers is challenging with a workforce that includes a large part-time contingent, many who work rostered hours, and having people who work in different settings (bed-based and community) and at different sites (geographically distant).

Initiating and embedding these models

192 The initiation of family/carer engagement models within NWMH was assisted by having agreement from the NWMH Executive down to the staff on the ground that working with Families and Carers is core business, was essential to ensuring the initiative was successful. Additionally, having Family Work identified as one of the 7 priority Practice Areas for workforce training and development, with a clear rationale and expected activities outlined as part of the Practice Guide also enabled its success.

193 As with all translation efforts, having a multi-pronged, multi-layered approach is needed. Talking about working with families/carers (and actually do the work) is embedded within the local clinical team, with training, education and reflective practice conducted

at the team level. This provides a solid base for embedding the model within team practice. Having clinicians from one team working together on a change of practice also increases the uptake of the model.

194 NWMH services that have most effectively embedded SSFC have dedicated FTE (as little as 0.1 FTE) for staff to coordinate, support and "champion" the work and/or had ongoing support from Bouverie in terms of regular supervision and reflective space. The success of FaPIC was helped by the ongoing partnership we had with Tandem, whose Chair is a member of our NWMH Family Work Steering Committee. These partnerships with external experts add weight to the practice area and help our busy clinicians have ready access to an expert. Having the consultant psychiatrist and social worker work together on APMHP inpatient units has meant that all consumers have a SSFC during the admission.

195 In essence, having an identified NWMH wide agreement that Family Work, working with Family/Carers is a priority, NWMH allowed for resources to be dedicated to the implementation of FaPIC and SSFC over the past several years. This prioritisation has been supported through the Safety and Inclusion Committee, with the Carer Advisor and Social Work Advisor working closely together and with the support of the Senior Social Work leadership group and Consumer Carer Advisory Groups.

WORKFORCE

Organising workforces to provide multidisciplinary and consumer- focused practice in community settings

a. Helping professional teams to work in multidisciplinary teams

196 Over the past 5 years NWMH has moved away from a "case management" system to one in which practitioners from the disciplines of medicine, psychology, nursing, occupational therapy and social work are more able to use their specialist skills to attend to the six domains of care utilised in community settings. Practitioners do this work in the context of a multidisciplinary team in which the skills that each person brings to the table is equally valued and respected. In short, the work needs to be stimulating and rewarding and clinicians need to be able to use their specialist skills.

b. Challenges to achieving collaborative, cross-disciplinary professional practice

197 NWMH has maintained the multidisciplinary team model across all clinical settings. Each team or unit is governed by a Lead Consultant and a (Clinician) Manager. This delivers a positive culture in which clinicians feel valued and supported.

198 NWMH has Discipline Seniors in the fields of nursing, social work, psychology and occupational therapy. These roles have representation on NWMH Executive

committees and direct access to the Executive via monthly meetings. The roles are crucial in terms of advocating for their respective disciplines, recruitment and retention strategic planning, workforce planning and training and education. These roles also support undergraduate training and postgraduate placements. Nursing is by far the biggest segment of the NWMH workforce and despite nursing shortages in other Victorian mental health services, NWMH is fully recruited in terms of nurses, largely due to a very successful and long standing program of overseas recruitment. NWMH has a well-established policy that nurses must have a specialist mental health qualification or be working towards one via the post graduate diploma program. This recognition of the specialist skills of the mental health nursing workforce has given NWMH a competitive advantage when compared against peer organisations.

Difficulties in recruiting and retaining skilled mental health professionals in nursing, psychiatry, social work and psychology

199 NWMH does not have difficulties recruiting clinical staff. It is very well regarded as an employer with an excellent reputation for training all disciplines. Also, NWMH enjoys a positive relationship with the unions. We work very proactively in this space and take our responsibilities very seriously in regard to occupational health and safety. Also, we fully understand our responsibilities under the industrial award(s) to consult with the unions in regard to workplace change. Our approach is to maintain open, honest, transparent and respectful relationships with the unions. We view that relationship as crucial to our success.

Workforce supply, composition, or capability challenges as a result of streaming services

200 There will be more significant workforce challenges in rural, regional and remote areas where highly specialised roles such as neuropsychologists for example are in short supply and hard to recruit to. Rural, regional and remote services sometimes struggle to recruit to even less highly specialised roles such as general adult psychiatrists, or child and adolescent psychiatrists.

201 In the NWMH context, however, it has not been difficult to recruit to sub-specialist teams such as triage, neuropsychiatry, eating disorders and VFTAC. In fact, I would say that having highly specialised teams is one is one of the factors that makes NWMH an attractive employer.

202 NWMH is currently preparing for the 'Pathway to 135' new beds (P135 Project) initiative arising from the recommendation in the RCVMHS Interim Report. New beds will be built at the Royal Melbourne, Sunshine and Northern Hospitals with a completion date of late 2021 / early 2022. Ordinarily, this would place our recruitment processes under some

duress however in the context of COVID-19, with international borders closed, with the NHS and the Republic of Ireland imploring their citizens to 'remain in service' and with a dramatic slowdown of AHPRA processes, we envisage recruitment to these new units being a very real challenge.

Improving the safety and wellbeing of staff and service users

203 In relation to improving the safety, I agree with the observations made about consumer and staff safety in the NWMH submission to the Royal Commission in to Victoria's Mental Health System (**NWMH Submission**). In particular, I consider that:

(a) there is increasing concern regarding workload and safety issues, including occupational violence, especially in the provision of after-hours cover to our wards and the emergency departments; and

(b) occupational violence is the most significant issue confronting NWMH as an organisation and in particular the health, safety and wellbeing of our staff and consumers.

204 To improve consumer and staff safety it is necessary to recognise the problem of occupational violence, understand the contributors and understand the impact of this violence on consumers and staff. Services should then engage with their staff, consumers, unions, security and police, as we have done in NWMH, and develop an action plan to deal with modifiable factors. This may include:

(a) introduce gender segregation or modularised units to better attend to the needs of vulnerable consumers;

(b) creation of additional acute beds stock- across all care types;

(c) additional allied health staff to support the functioning of in patient units, particularly in regard to therapeutic group activities and diversional activities;

(d) increasing the medical and nursing staff in inpatient units to reflect the 7 day nature of the work;

(e) embarking on a process of refurbishment of existing bed-based programs to bring them up to contemporary standards;

(f) making provision for security staff on all inpatient units 24/7; and

(g) investing more in the physical security of inpatient units and intensive care areas in particular.

205 These issues need to be talked about openly, measured in terms of incident reporting and there needs to be a whole of government led approach to dealing with this. The

Emergency Services legislation should also be amended for example to include assaults on healthcare workers.

206 NWMH has undertaken a number of initiatives to improve the safety of staff and consumers. As outlined in the NWMH Submission at page 44, NWMH formed an occupational violence Steering Committee at the end of 2016 which was comprised of clinical staff, managers, OH&S specialists, representatives from People and Culture and representatives from the ANMF and HACSU. A number of strategies to improve safety in inpatient units were identified and implemented by the Steering Committee, including the:

(a) implementation of a campaign to increase reporting of occupational violence incidents;

(b) development of a protocol for the reporting of occupational violence incidents to Victoria Police;

(c) introduction of CCTV cameras;

(d) introduction of a drug detector dog program;

(e) purchase of sand filled 'Norix' brand furniture;

(f) installation of 'custody suite doors' between the intensive care area and the staff base in inpatient units;

(g) introduction of saliva drug detection kits;

(h) introduction of a Security Officer at Broadmeadows Health Centre on an evening shift, 7 days per week. This service is supplemented by the Security Officers at Broadmeadows Health Service;

(i) introduction of hand-held metal detectors used by nursing staff to screen for weapons or contraband. We seek to do this with the consumer's consent wherever possible;

(j) introduction of rubberised toothbrushes to prevent the making of 'shivs' (homemade, knife-like weapons);

(k) introduction of specialised 'custodial style' paper cutlery for use with consumers known to use cutlery as weapons or who have a propensity for swallowing cutlery;

(l) introduction of a Nurse Practitioner Candidate to Northern Inpatient Unit to model de-escalation techniques, be a champion for the Safe Wards program, provide teaching, training and education and run simulations for the use of least restrictive interventions and

(m) redevelopment of the Management of Clinical Aggression training syllabus.

207 As described in the NWMH Submission at page 22, NWMH also adopts a number of strategies to improving the sexual safety of consumers in inpatient units and intensive care areas including:

(a) grouping of consumers into cohorts;

(b) more frequent visual observations;

(c) 1:1 Nurse 'specialling';

(d) allocation of a female consumers bedroom proximal to the staff base;

(e) use of the women's own corridor;

(f) reinforcement of *SafeWards* principles at Inpatient Unit community meetings; and

(g) use of prominent signage indicating use of CCTV cameras in public areas of the inpatient units.

208 NWMH has undertaken a number of initiatives to reduce the risk of deliberate self-harm or suicide in Inpatient units. These initiatives include;

(a) development of policies and procedure in relation to risk assessment, drug and alcohol assessment, clinical observation and consumer engagement.

(b) Introduction of ward environmental checks during which staff check each consumer's bedroom and en-suite bathroom for contraband or prohibited items. These checks are supplementary to the checks done of consumer property on admission and recognises that, despite our best endeavours, potentially harmful objects may be introduced to the ward by carers / family. Such objects include; charging cables, scarves, plastic bags, razors etc.

(c) investing heavily in a ligature safety program to remove potential ligature attachment points in bedrooms and en-suite bathrooms. This investment has been circa $750,000 however despite all of these initiatives bedrooms and en-suite bathrooms in particular continue to represent a risk to consumers' intent on self-harm or suicide. The P135 Project sets up an opportunity for architects to design en-suite bathrooms without doors, but which still afford the consumer dignity and privacy. En-suite doors, hinges and other fittings represent the most significant risk in terms of providing a weigh bearing attachment point for a ligature.

RESTRICTIVE PRACTICES

Psychological and physical impacts of restrictive practices on consumers

209 It is important to understand that restrictive practices can have a profoundly negative effect. As a result, we avoid them at all costs. At NWMH, we have reduced the use of physical restraint, and have developed peer reviewed 'acute arousal guidelines' to ensure that pharmacological management is now used in a much more judicious way such that it does not result in people being overly sedated, as may have occurred in years past. In other words there is a much greater emphasis on achieving symptomatic control over distressing symptoms such as command type auditory hallucinations which may be inciting suicide, without causing undesirable side effects such as over sedation, drooling or movement disorders.

210 Psychological factors during the use of restrictive practices can include feelings such as fear, isolation, anger/hatred, mistrust, confusion and despair. Consumers often report feeling anxious and unsure why they have been placed in a seclusion room.

211 Re-traumatisation during a restrictive event is very likely. A large number of consumers report a history of trauma, neglect, physical/sexual abuse, and or persecution. Many consumers have histories of institutionalised care, either as children, or in previous mental health inpatient care, refugee/asylum seeking backgrounds, or forensic services. These have inherent systems of custodial management which can be perceived as punitive and controlling rather than therapeutic and people will often have trauma carried from their time within these services.

212 An unfortunate side effect of environmental design within an inpatient setting means that consumers often enter the ward through the seclusion suite because of its proximity to the vehicle airlock (this is often the only private, safe place to enter somebody into the unit). For someone who has previously experienced an episode of seclusion they are already forced to experience fear and distrust at having been reminded immediately on entry that this practice exists and it may happen to them. One of the first statements our staff often hear is "You're not going to lock me in here, are you?". The person immediately interprets the environment as threatening — which is completely understandable.

213 "The Power Threat Meaning Framework" (Johnstone and Boyle, 2018) can be used to understand the interaction between the themes. According to that framework, participants may experience seclusion as a trauma that is interpreted as threatening.

214 Physical impacts include the increased risk of medical deterioration due to reduced capacity to monitor and asses the individual. Consumers placed in seclusion are often simultaneously receiving large doses of antipsychotic medications which pose

significant risks of respiratory depression. Consumers, when left alone in seclusion rooms are at risk of either accidental or intentional self-harm, falls, head strike or other self-harming behaviours, head banging, scratching, using bedding as ligatures to attempt hanging or asphyxiation. Whilst there are close monitoring requirements, these behaviours and subsequent deterioration can be unwitnessed, leading to potentially life threatening medical compromise.

215 There is no doubt that, with compulsory treatment, it can be traumatising to have your liberty taken away or medication administered against your will. Restrictive practices should therefore be used as a last resort, for the shortest period of time and done in the least restrictive way possible. Ultimately, we are trying to engage people in a therapeutic way and work with consumers collaboratively.

Psychological and physical impact of restrictive practices on workers

216 Consumers often relate to the experience of being in the intensive care area as being "locked up". I spoke to a colleague from the lived experience workforce, who gave me his insight. He describes his experience with seclusion as so traumatic that it is this fear that ensures he takes his medication every day. Whilst he believes it was necessary at the time, he maintains it was distressing and traumatic, and never wants it to happen to him again, he feels the best way to avoid that is to take his medication. Obviously everyone will articulate this fear or trauma in different ways but I think this message is very powerful.

217 While acknowledging the traumatic effect that restrictive practices have on consumers, it must also be acknowledged that occupational violence for mental health service workers is a very significant issue. At NWMH over a 90 day period during mid 2019 we recorded 350 incidents of occupational violence, with 84 of these incidents resulting in physical harm to staff. Restrictive practices may sometimes be necessary to protect the safety of workers.

218 Staff often feel defeated when seclusion events occur, sometimes the amount of effort and work that goes into developing a rapport with the consumer, developing plans, utilising de-escalation strategies, exploring alternative treatment options can be both emotionally and physically taxing. It often leaves staff feeling disheartened and others with feelings of failure if after all that effort a seclusion episode occurs. The incidents of physical injuries to staff can and do occur around the point of physical restraint in the lead up to seclusion or during seclusion breaks. Commonly occurring injuries are caused by banging in to doors, falls, trips and strains or from assaultive behaviours from consumers. These assaults take the form of spitting, scratching, punching, kicking or choking of staff. It is not uncommon for these staff injuries to be career changing or career ending in nature. It must be said that consumer aggression may be in response

to psychotic phenomena such as delusions or hallucinations however the aggression may also be goal directed and purposeful.

Use of restrictive interventions and patients with specific characteristics

219 What is obvious is that seclusion rates in a given inpatient unit can be affected greatly by just one consumer experiencing multiple, though brief periods of seclusion. There can be some months of sustained, consistent reduced episodes of seclusion only to have an up-tick due to one persons repeated episodes.

220 There are certain demographics which are over represented in regard to the use of seclusion. If I had to pick a prototypical consumer it would be a male, recently released from a custodial setting, recent polysubstance misuse, antisocial personality traits and who has a mild intellectual disability or a dull normal IQ and/or an acquired brain injury. Typically, someone like this has an extremely low frustration tolerance and poor impulse control both of which are portents for occupational violence.

Impact of service leadership, operating models and physical environments on the use of restrictive practices

221 Leadership plays a significant role in team culture in relation to the use of restrictive practices, particularly around the motivation to maintain reductions in restrictive practices in a system of relentless pressure, of high acuity and high turnover of consumers. This is done in many ways but positive role modelling, coaching and mentoring and understanding the barriers are key.

222 The operating model within current inpatient units does not allow for the 24 hour, 7 days a week nature of the work. In other words, the acute inpatient units are staffed on a Monday-Friday (9 am to 5 pm) model which is supplemented afterhours by the use of on-call medical staff and managers. Rates of seclusion increase during afterhours and weekends when staff are not as supported by a complete multidisciplinary team. Social work, nursing leadership, occupational therapy and medical leadership all play a significant role in the management of the most acute incidents and currently the business week modelling leaves staff and consumers vulnerable during after-hours periods. To be clear, staffing numbers, as well as skill-mix and leadership roles are significantly reduced outside of normal business hours.

223 Striking the balance between safety and therapy in the acute environment is a challenge but nevertheless one that is incredibly important to get right. Through innovation and creative thinking, listening to feedback and suggestions from people actually working and using the service, there can often be very small things that can be achieved to have a positive impact of the environment. For three simple examples, installing noise baffles or acoustic shielding in intensive care areas has had a big impact in these noisy,

echoing spaces. Also, installing drinking fountains in the intensive care area has been helpful in ensuring that consumers can have their most basic needs met without having to ask for permission. We also disabled voice paging in the intensive care area because 95% of the announcements were not relevant to staff and consumers in that area. As a result the intensive care area is calmer and quieter.

224 Some items however, need continuous upgrade and investment, which we have seen little of over the last 15 years. The current environment not only has little therapeutic benefit but can in fact cause harm and trauma. The built environment can instil a sense of dread, hopelessness and despair, a general feeling of not being cared about. Whilst orientating consumers to the ward upon admission, staff often feel the need to apologise for the quality of the facilities or lack thereof, we reassure consumers that areas are cleaned regularly as appliances and surfaces are so worn that they look dirty and there are also difficulties in maintaining a high standard of infection prevention. Soft furnishings such as lounge furniture is replaced very infrequently due to budget constraints. NWMH used to receive approximately $1.1m per year to attend to infrastructure and minor capital works however over the past decade this grant has been incrementally reduced to zero.

Responses to challenging consumer behaviour in mental health wards, emergency departments and other areas of a health service

225 When a consumer displays challenging behaviours, the principles and policies that are consistent across Melbourne Health (mental health, general wards and the emergency department) will apply but the response may vary depending on where the person is and the contributing factors. For example, a person who regularly attends the emergency department may have a frequent attender plan, a person with a hypoxic brain injury in a trauma ward may have a plan developed based on changes to their cognition and their stage of rehabilitation and a consumer cared by the mental health team may have an enhanced treatment plan. Staff working in all areas do Management of Clinical Aggression (**MOCA**) training that is based on the model for prevention of aggression produced by Professor Joy Duxbury (UK) who has researched the environmental factors, staff/situational factors and patient factors which can prevent aggression. In training, these factors are relevant for all clinical situations in all settings.

226 When a code grey is called the same response team attend and the same data is collected across all of Melbourne Health. One to one nursing or specialling is used across Melbourne Health as a means to managing risk and to provide additional support to the consumer. Melbourne Health Nurse Bank have employed a group of Health Assistants in Nursing who are 2nd year undergraduate student nurses who have training in providing one to one observation. We also use enrolled nurses and Division 1 nurses to undertake this function.

227 In general acute wards, a consultation-liaison psychiatry nurse will respond to most code grey events and consult with the relevant treating team(s) on management and risk reduction strategies and work to reduce restrictive interventions though policy, consultation and improved reporting via Riskman.

228 There is also a Behaviour of Concern working group with both acute and mental health representation. It is chaired by the NWMH Director of Nursing.

Barriers to reducing restrictive interventions

229 We are aware that seclusion of patients is more likely to be used during night shifts, when we have only a quarter of the staff that we have during the day. As a result, there is less management oversight, less scrutiny of practice, less immediate availability of senior medical staff and actually, less staff period. Further, during night shifts, we are also usually relying on junior medical staff and registrars to respond to the unit and there are no senior medical staff on 'stand-up' duty.

230 One barrier to reducing restrictive interventions is therefore a lack of expertise and experience being available afterhours, compounded by greatly reduced staffing numbers. As alluded to earlier, acute psychiatry units are running a 7 day service on a 5 day, Monday to Friday (9 am to 5 pm) staffing model. This is in contrast to Intensive Care Units or Emergency Departments for example, which always have senior staff managing the unit at all times of the day, and every day. So, whilst it might be tempting to characterise this as a cultural issue, it is also a staff and consumer safety issue. There is no doubt that staff on night duty and weekends face a greater risk of occupational violence and have less resources at their disposal to manage that risk.

Factors enabling professionals to employ alternative strategies

231 It is a paradox that, in general terms, we have the most junior and inexperienced staff looking after the most acutely unwell consumers in our inpatient units. Alternative strategies can be employed by having more senior and experienced staff on hand, but also the skill mix is important. Experienced staff bring exactly that — "clinical experience, life experience, knowledge and wisdom" to the table and offer coaching, mentoring, problem solving and conflict resolution skills to bear when considering what strategies may be employed to reduce the incidence of occupational violence and the use of restrictive interventions. However, retaining experienced staff is difficult as inpatient unit staff are constantly lured to roles in the community by promotional opportunities, regular hours and the reduced risk (in relative terms) of occupational violence.

232 Having excellent communication skills cannot be over-emphasised. A clinician with excellent verbal and non-verbal communication skills is able to convey that they are

actively listening, that they understand what the consumer is saying, they can convey empathy, respect, concern and compassion and they can often de-escalate a situation that is rapidly escalating. Conversely, a poor communicator can convey disrespect, disdain, disinterest and a lack of compassion which can quickly escalate a situation.

QUALITY AND SAFETY MONITORING BY MENTAL HEALTH SERVICES

Quality and safety incidents information provided by Melbourne Health

Chief Psychiatrist

233 Melbourne Health notifies the Office of the Chief Psychiatrist of:

(a) all reportable deaths (that is, deaths of mental health consumers which were unnatural, unexpected or violent, or where the consumer was subject to an order under the Mental Health Act);

(b) the number of consumers receiving restrictive interventions (seclusion and restraint);

(c) the number of consumers receiving ECT;

(d) all orders under the Mental Health Act; and

(e) any other major adverse event

Mental Health Complaints Commissioner

234 In accordance with the Mental Health Complaints Commissioner's (**MHCC**) function under section 267 of the Mental Health Act, Melbourne Health sends biannual reports about the complaints received directly.

Department of Health and Human Services:

235 Melbourne Health notifies the Department of Health and Human Services of:

(a) total contact service hours;

(b) 28 day readmission rate;

(c) 7 day post discharge follow up;

(d) number of seclusion events per 1000 bed days;

(e) pre-admission contact;

(f) inpatient bed occupancy;

(g) inpatient length of stay;

(h) community new case rate; and

(i) inpatient and community health of the nation outcome scales (**HoNOS**).

Safer Care Victoria

236 Melbourne Health notifies sentinel events and provides root cause analysis reports to Safer Care Victoria.

Feedback received

237 Melbourne Health receives periodic bulletins and forums including the *Inspire* report and the annual report from the Chief Psychiatrist. Melbourne Health also frequently receives feedback in response to the lodgement of a MHA125 (Notification of Death) report. The Chief Psychiatrist also contributes to feedback provided by Safer Care Victoria on root cause analysis reports. Melbourne Health receives also feedback from Safer Care Victoria on root cause analyses following a Sentinel Event.

238 Melbourne Health receives the annual report and the outcomes of reviews into complaints from the MHCC.

239 Melbourne Health also receives data from the Department of Health and Human Services for all mental health services on the following key performance indicators:

(a) average length of case;

(b) average treatment days;

(c) bed occupancy rates;

(d) casual referral rate;

(e) changes in mean number of clinically significant HoNOS items;

(f) transfers from emergency departments to mental health beds within 8 hours;

(g) inpatient local access;

(h) inpatient readmission rates;

(i) long stay bed occupancy;

(j) mean HoNOS at Community case start;

(k) multiple seclusion episodes;

(l) new case rates;

(m) percent of community cases with client on CTO;

(n) post discharge follow up;

(o) preadmission contact rate;

(p) preadmission contact rate (ongoing);

(q) proportion cases with significant improvement;

(r) seclusions per occupied bed days;

(s) self-rating measures completion rate;

(t) trimmed average length of stay;

(u) valid HoNOS compliance community; and

(v) valid HoNOS compliance.

Strengthening existing regulatory to improve the quality and safety of mental health services

240 Existing regulatory mechanisms focus on safety and are generally appropriate. Quality is more difficult to measure; outcome measures are affected by many variables, and inter-rater reliability is not measured. The content of services provided may be recorded in PRISM but quality is not routinely measured or analysed. For example, engagement with families, provision of psychoeducation, psychological therapies, drug and alcohol referral and treatment. Benchmarking on these elements of service provision, and inclusion in performance meetings, would be useful additions. Self-report measures in consumer and carer surveys could easily be included in performance reports.

Gaps, duplication and overlap in the functions of regulatory bodies

241 There are gaps, duplication and overlap in the functions of regulatory bodies. There is overlap between the safety and quality functions of the Office of the Chief Psychiatrist and Safer Care Victoria, but these bodies have worked to limit the impact of the overlap on services.

PHYSICAL INFRASTRUCTURE

Factors contributing towards a healing, restorative, respectful and safe physical environment

242 We are currently working with the Victorian Health Services Building Authority (**VHSBA**) in regard to the design and procurement of new beds following one of the recommendations arising out of the Royal Commission in to Victoria's Mental Health Service's Interim Report. Current ward environments can be perceived as harsh and un-welcoming, and are subject to significant destruction. The theory guiding the design of the new beds and spaces is that, if you create nice spaces for consumers, consumers will respect them.

243 It is important to recognise that in creating these restorative and respectful spaces, a one-size-fits-all approach does not meet anyone's needs. Different needs exist in different parts of our service system. For example, at Broadmeadows Hospital the large Muslim population requires a separate space is needed for Muslim women. Similarly, the Royal Melbourne Hospital sees a large number of university students who would benefit from youth friendly spaces. At Northern Hospital in Epping, culturally safe spaces are needed for the higher number of Aboriginal consumers.

Aspects of physical environments which do not create healing, restorative, respectful and safe spaces

244 Utilitarian spaces which are designed for the lowest common denominator are not conducive to healing and recovery. That is, spaces designed for the consumer who is self-harming, actively suicidal or aggressive towards others or who destroys infrastructure. Designing rooms and spaces for these types of behaviours result in spaces that are "stripped down" in the sense that all ligature attachment points are removed, there are no proper wardrobes, nor bedside cabinets for consumers to store and safeguard personal belongings, the bathroom doors are "topped and tailed" (i.e. opened at the top and bottom) and all of the fittings and fixtures are "ligature safe" approved items for use in custodial or mental health settings. Lack of fresh air, direct sunlight and outdoor circulation spaces compound these perceptions.

Designing physical infrastructure to assist de-escalating situations and reducing the use of restrictive practices

245 The risk of occupational violence and the use of restrictive practices may be reduced if physical infrastructure is designed to create a calm, quiet and peaceful environment. Spaces that are noisy, loud and echoing are not conducive to reducing these risks.

Enablers and challenges associated with modernising mental health facilities

246 Given the risk of suicide that exists for patients in mental health services, the infrastructure of inpatient units are designed around removing ligature risks. Avoiding these risks entirely is almost impossible. As alluded to earlier, NWMH has spent $750,000 to remove ligature risks located above waist-height from our units, but people still find alternatives ways to harm themselves or to effect death by suicide.

247 Removal of these risks is also a challenge to creating therapeutic and healing spaces, as it results in a stark and hostile environment. This environment can, in turn, reduce hope amongst inpatients and increase suicidal ideation.

248 A further challenge is that when acute mental health services are built in dense urban settings, you lose the circulation space that would have been available in more

traditional institutions outside urban centres. I recently visited a Tasmanian institution established in the 1890s that had one acre of circulation space adjacent to the 'female ward'. In modern units, nine patients may share only a small room as their circulation space.

249 A final challenge is that, given that our beds are always full, it is difficult to have the time and space to maintain, upgrade or modernise mental health facilities. We currently have $1 million available in funding to refurbish one of our units, but have not had the time or space without patients to do so.

COVID-19

Emerging changes in mental health service delivery as a consequence of COVID-19

250 The COVID-19 pandemic has highlighted the vulnerabilities of people with a serious mental illness. Three cohorts are extremely vulnerable:

(a) the elderly;

(b) people with eating disorders; and

(c) people with multiple comorbidities – cardiovascular disease, obesity, asthma, chronic obstructive airways disease, diabetes etc.

251 In general terms, viral outbreaks are poorly contained in mental health inpatient units. We see evidence of this each year in regard to influenza and norovirus outbreaks. The poor containment does not occur as a consequence of staff inattention to infection control procedures but rather, it is a consequence of facility design and consumer behaviour. Consequently, NWMH was very concerned about the potential impact of COVID-19 in an inpatient setting.

252 We have seen reports from Europe and the United Kingdom detailing horrendous conditions in inpatient settings after the COVID-19 virus was spread in an un-contained manner. Similarly, a report of an outbreak at Western State Hospital, Washington State, USA, eloquently describes the challenge of managing a viral outbreak in a mental health inpatient setting compared to a medical or surgical inpatient setting.[1]

253 The imminent capital development of new inpatient bed stock at Sunshine Hospital, The Royal Melbourne Hospital and Northern Hospital, arising from an interim recommendation from the Royal Commission in to Victoria's Mental Health System (**RCVMHS**), sets up an opportunity to incorporate pandemic planning into the design of inpatient units for the first time. Certainly, the outbreak of COVID-19 at the Albert Road

[1] https://www.nbcnews.com/health/mental-health/coronavirus-psychiatric-hospital-it-s-worst-all-worlds-n1184266

Clinic in April 2020 demonstrated the potential for the virus to be transmitted across staff, consumer and direct contacts of consumers post discharge and potentially spread into the public system via consumer transfers and due to the number of clinicians who work in the public system and who also do sessional work in the private system. In short, there is an inter-dependency between the public and private mental health systems that make both systems vulnerable in a pandemic. NWMH was forced to quarantine a total of eleven staff for two weeks following the Albert Road Clinic outbreak due to their dual appointments at both NWMH and the Albert Road Clinic.

254 The COVID-19 pandemic has also highlighted challenges for mental health services in terms of the density of the workforce per m^2 in community clinic settings. Early on in the course of this pandemic, NWMH took steps to achieve appropriate social distancing in community based clinics. This involved splitting teams or workgroups into smaller groups and having them alternate from working from home or working from the clinic. This was done for two reasons:

(a) to limit the risk of transmission of the virus; and

(b) as a business continuity strategy.

255 As we contemplate a return to 'Business as Usual', the issue of social distancing and hygiene remains a challenge.

256 In support of this, NWMH rapidly adopted telehealth as a means to maintaining engagement with consumers and carers. A variety of telehealth platforms were used during the first two weeks of the pandemic including Skype, Webex and Zoom however in recent weeks we have settled on Webex due to the enhanced security that this platform provides. Telehealth was introduced very rapidly indeed and there were a number of challenges associated with this including:

(a) clinician proficiency;

(b) availability of camera enabled devices for clinicians and consumers;

(c) consumers limited by unavailability of smart phones or data packs;

(d) many consumers do not have access to the internet in their residence;

(e) clinical limitations of telehealth interventions; and

(f) establishing some business rules for our interactions with other entities, for example the Mental Health Tribunal.

257 The adoption of telehealth introduces some real efficiencies for NWMH in terms of a reduction in non-productive 'travel time'. Telehealth also enables NWMH to get better

use out of Psychiatric Registrars and Consultant Psychiatrists as we are better able to organise their time by scheduling sequential Telehealth sessions.

258 Also, there are improvements to safety in terms of being able to conduct some Mental Health Tribunal functions via telehealth. I have previously alerted the RCVMHS to a number of serious injuries incurred by clinical and legal staff at Mental Health Tribunal hearings, particularly in circumstances in which the consumer was being delivered unwelcome news such as the continuation of an involuntary treatment order.

Longer term opportunities for new approaches to service delivery

259 NWMH is of the view that it can do more good, for more people, by utilising telehealth initiatives in the future though the challenge will be to define under what circumstances telehealth will be used instead of a face to face intervention. For example, it may be most appropriate to use face to face appointments for the initial assessment, for a review of legal status, for a medication review and for a 91 day review and it may be appropriate to have some or all of the in-between appointments conducted via telehealth. Telehealth also becomes a much more accessible medium for consumers and carers who may have transport constraints, or for whom public transport is not appropriate because of cognitive or mobility or indeed for convenience reasons.

260 It is inevitable that significant investment will be necessary for services to be able to fully realise the potential of telehealth. This will include investment in devices, data packages and an upgrade to fibre optic connections for services.

261 Zoom and Webex capability has also introduced significant efficiencies in the way that staff meet, consult and coordinate care, particularly if clinical staff work across multiple sites or campuses.

262 The feedback from consumers and carers has been mostly positive in regard to telehealth. We have found that consumers and carers have been quick to embrace the technology and the concerns we held that consumers and carers would not do so have been ill founded.

sign here ►

print name PETER FRANCIS KELLY

date 29 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT PFK-1

This is the attachment marked 'PFK-1' referred to in the witness statement of Mr Peter Francis Kelly dated 29 May 2020

Peter Kelly

Summary of qualifications

1990 - 1992	Muriel Yarrington School of Psychiatric Nursing (Royal Park and Footscray Psychiatric Hospital	Melbourne, Victoria
2011	Professional Certificate in Health Systems Management. Melbourne Business School, University of Melbourne	

Employment History

Dec 1991 Mar 1992	Graduate Registered Psychiatric Nurse Footscray Psychiatric Hospital
Mar 1992	Associate Nurse Unit Manager, High Dependency Unit, Footscray Psychiatric Hospital December 1992
Dec 1992 Mar 1995	Registered Psychiatric Nurse, Grade 3, Crisis Assessment and Treatment Team, Mid West Area Mental Health Service
Mar 1995 Apr 1997	Registered Psychiatric Nurse, Grade 4, Crisis Assessment and Treatment Team, Mid West Area Mental Health Service
Apr 1997 Nov 1999	Nurse Unit Manager, St Albans Community Care Units, Mid West Area Mental Health Service
Nov 1999 Nov 2001	Manager, Huntly / Hamilton Integrated Community Mental Health, Waikato District Health Board, Hamilton, New Zealand
Nov 2001 Apr 2003	Registered Nurse, Grade 4, Crisis Assessment and Treatment Team, Mid West Area Mental Health Service
Apr 2003 Mar 2005	Area Manager, Mid West Area Mental Health Service 230 staff, budget $21m, located across 7 sites
Mar 2005 Sep 2005	Seconded to support Professor Bruce Singh, Executive Director NorthWestern Mental Health, Melbourne Health. This was on a 0.5 EFT basis while maintaining my substantive role as Area Manager
Sept 2005 to present	Director Operations North Western Mental Health, Melbourne Health. A recent restructure of this service has resulted in the this role up-graded to a co-director role and reporting through to the Deputy Chief Executive / Chief Operating Officer, Melbourne Health.

NorthWestern Mental Health (NWMH)

NWMH is a $240 million (2019-20fy) per annum, publicly-funded mental health service for people living in northern and western metropolitan Melbourne. A division of Melbourne Health, NWMH is the largest publicly-funded mental health service in Victoria.

NWMH provides clinical mental health services across a catchment area with a population of over 1.5 million people. The catchments covered by NWMH services include 4 of the largest and fastest growth corridors for metropolitan Melbourne, incorporating the cities of Moreland, Hume, Melton, Brimbank, Moonee Valley, Melbourne, Darebin and Whittlesea.

NWMH delivers a comprehensive range of clinical mental health services for youth, adults and older people who are experiencing or are at risk of developing a serious mental illness. Our services are delivered from a range of locations, including most major hospitals within the north and west of Melbourne, and various community-based mental health clinics based in Coburg, Broadmeadows, Preston, Epping, Sunshine, Melton, Mill Park, Wyndham and Moonee Ponds.

Our services are organised into local Area Mental Health Services and Programs, spanning 32 sites across the north and west of Melbourne. The Area Mental Health Services and Programs managed by NWMH are:

- Inner West Area Mental Health Service (IWAMHS)
- Mid West Area Mental Health Service (MWAMHS)
- North West Area Mental Health Service (NWAMHS)
- Northern Area Mental Health Service (NAMHS)
- Aged Persons Mental Health Program (APMHP)
- Orygen Youth Health Program (OYH)

NWMH manages a range of core and specialist services, some of which have a state-wide or regional focus (see nwmh.org.au for full range of services). Table 1 below summarises the range of services we provide across age ranges, spanning acute, subacute, specialist, residential, community and inpatient unit services.

NWMH employs 1344 equivalent full time staff (approximately 1900 headcount). The total headcount of clinical staff is 1370, and is primarily comprised of the disciplines of medicine, nursing, occupational therapy, clinical psychology and social work. In addition, there is a Lived Experience workforce of approximately 38 staff, comprised of Consumer and Carer Advisors, Consultants and Peer Support Workers (total 22 Consumer and 16 Carer workers). NWMH also employs over 500 staff in administration and support roles. Multidisciplinary teams work in all areas of the service.

NWMH, as a clinical division of Melbourne Health, is a unique entity in the statewide mental health system in that it provides specialist mental health services to Western Health and Northern Health on campuses at Footscray, Sunshine, Broadmeadows, Epping and Bundoora as well as a number of locations in the community.

Current Role

- Responsible for the operational and financial management of NWMH – reporting through to the Deputy Chief Executive Melbourne Health. This is a large, complex and dispersed program operating across 3 health services – Melbourne Health, Western Health and Northern Health – and across 32 separate sites.

- 15 Direct Reports
  - 6 x Area and Program Managers
  - Director of Nursing
  - 2 x Facilities Managers
  - Manager, NWMH Centralised Triage Service
  - Manager, Centre of Excellence in Eating Disorders (CEED) (statewide service, NWMH is the auspice agency)
  - Manager, Access and Flow
  - Manager, Mental Health Training and Development Unit (MHTDU)
  - Manager, Centre for Mental Health Learning (statewide service, NWMH is the auspice agency)
  - Director, Finance and Business

- Responsible for access and flow across 502 acute, sub-acute, rehabilitation and specialist youth, adult and aged mental health beds.

- Responsible for oversight of NWMH capital projects. This involves participation in project scoping, tender submissions, tender evaluations, tender selections, chairing of Project Control Groups. Examples of recent projects
  - $2.5m Noogal Community Mental Health Clinic – completed March 2005
  - $11.2m 20 bed Youth Prevention and Recovery Care Service (YPARC) – under development
  - $6.3m Youth Justice Beds / High Dependency Unit upgrade of the Orygen Inpatient Unit – under development
  - $1m fitout, Level 6 Waratah Clinic – scoping underway

- Responsible for service performance and reporting of same to Chief Executive and to the Department of Human Services via regular performance meetings.

- Management of coronial matters for NWMH. This includes the establishment of coronial files, maintenance of a database, liaison with Victoria Police and the Coroner's Court, preparation of witness statements, liaison with insurers and legal counsel, and, on occasion, attendance at Court.

- Preparation of Executive Briefs, Board Papers and other documents as required. This includes a recent formal submission to the Royal Commission into Victoria's Mental Health System.

- Responsible for development of Service Level Agreements (SLAs) with Western Health and Northern Health with a combined value of $4.2m.

- In conjunction with the NWMH Director of Finance, negotiate a number of commercial leases pertaining to community mental health clinics and office accommodation.

- Responsible for the health, safety and welfare of the NWMH workforce.

- Responsible for the health, safety and wellbeing of consumers receiving care from NWMH.

- Development of finance and sustainability plans and, in conjunction with the NWMH Director Finance, set annual budgets.

- Responsible for maintaining productive relationships with the unions and associations representing the NWMH clinical and non-clinical workforce.

- Responsible for maintaining productive collegial relationships with a range of organisations including Victoria Police, Primary Health Networks, Community Managed Mental Health Organisations etc

- Responsible for workforce development strategies broadly, including the management of NWMH Training entities – the Mental Health Training and Development Unit and the Centre for Mental Health Learning as well as overseas nursing recruitment.

- Oversea the use of contracted private mental health beds at three private hospitals. These beds are funded by DHS as an interim strategy pending the development of new bedstock.

- Act as an employer representative on the Victorian Hospitals Industry Association (VHIA) for the negotiation of enterprise bargaining agreements for nurses.

- Oversee operational investigations for critical incidents and develop and implement improvement plans as necessary.

- Manage high risk infrastructure in terms of ligature safety. NWMH has a comprehensive ligature safety program and I have overseen a $0.6m program to mitigate ligature risks.

- Oversee a $0.7m Priority Discharge Fund – which is a discretionary fund used to expedite discharges or prevent admissions or re-admissions. I am one of two approvers for this fund.

- Have responsibility for, and have delegated authority to determine staff disciplinary outcomes.

- Sit on a number of DHS Committees including;

  - Office of the Chief Psychiatrist, Root Cause Analysis Review Panel
  - Expert Reference Group, Activity Based Funding
  - Victorian Fixated Threat Assessment Steering Committee
  - Critical Incident Response Team (CIRT) Information Sharing Project – Evaluation Committee

Key Achievements

- Developed a sophisticated access and bed management system supported by an agreed set of principles, twice daily telephone conference calls, and clear escalation procedures. The system is predicated on equity of load sharing, and transparency of data.

- Developed an information sharing protocol between the Security Services Division, Victoria Police, specifically the Critical Incident Response Team (CIRT) and NWMH. This resolved an issue that has not been resolvable for decades due to legitimate concerns about privacy and confidentiality of clinical information. The protocol was developed as a pilot project and has now become business as usual. Essentially, we have set up a dedicated telephone line at our Triage Service. On deployment to a job, CIRT contact Triage with relevant information and Triage then interrogate the CMI (statewide mental health database) and contact clinical services as necessary and revert to CIRT with relevant clinical information that may prove helpful in resolving a siege or other high risk situation in which an individual may be threatening self-harm, or harm to others. This system has demonstrably improved safety for consumers, for CIRT operatives and for the general community. This project was a joint winner in the Statewide HealthCare Awards in 2018.

- Consistent with government policy, I oversaw the closure of three aged residential care facilities. All consumers were found suitable alternative accommodation and all staff were successfully redeployed. No staff were made redundant.

- Implemented a major project regarding Occupational Violence. NWMH partnered with Victoria Police to develop a reporting regime and following a broad consultation with staff I implemented a number of strategies to counter occupational violence. These strategies included;

  - Rollout of CCTV cameras
  - Introduction of a drug detection dog program
  - Purchase of specialized sand filled furniture
  - Strengthening of staff base glazing
  - Use of hand held metal detectors for screening of contraband
  - Implementation of acute arousal prescribing guidelines etc etc

- Introduced a sick leave donation scheme whereby staff can donate amounts of sick leave to a colleague. This is very carefully managed and used infrequently, perhaps once a year however it creates enormous goodwill when used for a staff member who has no personal leave entitlements and who is experiencing severe financial hardship and facing a serious illness.

- Have overseen a number of significant savings strategies including a review of the NWMH vehicle fleet which resulted in a fleet reduction by 124 vehicles. Other strategies have included;

  - Reduction of a medication co-payment $800K
  - Reduction in the use of Agency Nursing
  - Reduction of Accrued Days Off and Annual Leave balances etc

- Implemented one of the Clinical Enhancement programs (the other is operated by Monash Health) that works in conjunction with the Victorian Fixated Threat Assessment Centre (VFTAC). I sit as a member of the VFTAC Steering Committee.

- Provided a mental health crisis response to the communities of King Lake and Whittlesea during the 2009 Victorian Bushfires. NWMH deployed 80 clinical staff to King Lake, working out of campervans for 8 weeks to support community members and first responders directly affected by this tragedy.

- Receiving the Melbourne Health Chief Executive's Award in 2015 for Clinical Leadership.

- Lead reviewer of a three person team which conducted an external review of the Australian Capital Territory Mental Health Service. The review was conducted to a high standard and the report was tabled in parliament.

- Have provided an external perspective to a number of health service reviews in regard to Sentinel Events.

- Have participated in many successful accreditation cycles during my 14 years in this role.

- The NWMH Aged Person's Mental Health Program is the most regulated part of NWMH and the four Residential Care Facilities are all fully accredited and no sanctions have been applied by the Aged Care Standards Agency.

- Have overseen the introduction of *SafeWards* and this program has delivered significant improvements in regard to the use of restrictive interventions

- Have delivered significant improvements in terms of the levels of occupational violence by driving up reporting rates and introducing a number of strategies to improve safety. The culmination of this is a projected reduction in the Workcover levy circa $0.3m.

Referees Provided on request