Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR TRICIA SZIROM

I, Tricia Szirom, Chief Executive Officer of VMIAC, of Building 1, 22 Aintree Street, Brunswick East, VIC, 3057 say as follows:

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

Background and experience

2 I am the Chief Executive Officer of VMIAC. I was appointed to this position in February this year. VMIAC represents consumers who have lived experience of mental health challenges. Prior to this role I was the Chair of VMIAC. As CEO, I represent the consumer voice in a number of forums and have a major role in building the capacity of VMIAC to effectively advocate for and with consumers.

3 I have experience working in government, the community not for profit sector and in small business as a consultant. I held positions such as the Director of the Drug Strategy, Senior Advisor in the Office of Women's Policy and developed the framework for the Commonwealth Office of Consumer Affairs. I also worked on the Prime Minister's Youth Strategy.

4 In the community sector, I was the Chief Executive Officer of the YWCA of Victoria, Director of Family Planning Association and Manager of Family and Children's Services at the Brotherhood of St Laurence.

5 As a consultant I evaluated various programs including Partnerships Against Domestic Violence, Supported Accommodation Assistance Program, School Focused Youth Service, Victorian Palliative Care program and the Alcohol and other Drugs intervention.

6 I am a Churchill Fellow and a Life Member of the Centre for Excellence in Child and Family Welfare and the YWCA of Australia. I have previously been on the boards of ACOSS, Windermere Family Services, Drummond St and Melbourne City Mission.

7 Attached to this statement and marked '**TS-1**' is a copy of my curriculum vitae.

The VMIAC Declaration

8 VMIAC launched the VMIAC Declaration (**Declaration**) on 1 November 2019. It was born from a concern that we were only identifying things that were wrong with the system. The purpose of the Declaration is to identify what the mental health system would look like if it was working brilliantly. The Declaration is a collective consumer statement about the future. It is a living vision. It will keep evolving as long as we all keep articulating what works, and what can be better. Attached to this statement and marked '**TS-2**' is a copy of the Declaration.

9 The process for developing the Declaration occurred over a number of months. VMIAC consulted with over 200 people and heard of many peoples' expectations of what the system would look like if it could be replaced with something wonderful. VMIAC heard from people through online surveys, face-to-face workshops, conversations and a private online group for merging ideas, to ensure accessibility and wide scope. It was important to VMIAC to ensure we obtained geographical, cultural and experiential diversity in responses. Consumers were asked to dream their biggest dreams.

10 The responses we received were grouped into eight main themes:

(a) **Our experiences**. Respondents described the diverse ways of understanding the experiences that are often called 'mental illness'. For example, less than 20 per cent of responses thought that the term 'mental illness' was a helpful or accurate term. The most preferred words included 'people with lived experience', 'emotional distress', 'trauma', 'mental health challenges' and 'neurodiversity'. This understanding is key to addressing discrimination and marginalisation.

(b) **Social change**. This looked at how respondents wanted society to change. The responses focused on housing, real and supportive social security, connection with others (human rights, equity and respect). Respondents wanted society to be understanding, to stop pathologising their beliefs, thoughts and emotions. Respondents wanted to live in a society where they felt safe.

(c) **Concepts**. This response focused on concepts that would shape a wonderful mental health system. Responses included compassion and love. They also focused on the social determinants of health, trauma informed care and a holistic approach. According to respondents, a wonderful mental health system would also address climate change, be accessible, and be responsive to traumatic events and natural disasters.

(d) **People and values**. Responses focused on the people and values needed for support. The two disciplines that the Declaration identified as being most valued were peer workers and therapists (which I believe happen to be the least funded in the sector). Occupational therapists were mentioned a lot.

(e) **Places and services.** The places most people spoke about as safe and comforting included peer respites, recovery houses, crisis centres, peer support groups, recovery colleges and retreats. Respondents also wanted nature, gardens, trees, lawns, flowerbeds, light and windows. Respondents spoke of respite services including drop-in services, community spaces, learning spaces. Others only wanted their own home. A minority of responses stated that the hospital was the best place for them in a crisis, but they wanted nicer, cleaner environments with more light and unlocked doors.

(f) **Actions and supports**. Respondents told of the things that they needed to do or receive for support. Respondents noted that large community support programs with groups and classes had been cancelled due to the National Disability Insurance Scheme. Respondents wished for support and therapy groups, creating groups, peer support groups, nature activity groups, life skills and recovery classes. Some explicitly requested individual supports. Therapy is inaccessible for many due to cost, yet it is dearly wanted. The ten free sessions offered with a mental health plan is not nearly enough, and there are too few bulk billed options. Others stated that they wanted music, art, political action, consumer activism, and for social issues to be addressed. Conversations and listening were also strong themes, including the deep need to be heard by another person. Animals and pet therapy were popular responses.

(g) **Access**. This focused on the things we need access to. Walk in access was a dominant theme, as was streamlined support and less bureaucracy. Respondents said they wanted help, when they asked for it. If they said they were in crisis, they want to be believed, not assessed and sent away. They wanted affordable services that were open when they need them.

(h) **Our life outcomes**. This involved asking respondents how their lives would be different. Respondents said they would be happier, feel accepted and feel cared for. They would have employment, justice and human rights. They would feel connected to others.

11 This consultation process shows that we are a diverse population. In my view, a key reason why the current mental health system does not work is because it tries to have a one size fits all approach. When I think of the range of challenges that people face around mental health, they do not fit easily together. The closest we get to a common name is 'people with lived experience'. That is something really important that has come out of the Declaration.

12 We see different treatment models depending on our experience of what mental health challenge we are facing. The Declaration reflects this by saying that we need options and choices. It also says that we know more about what we need than a professional that has never met us before. Many of the responses showed that people not only dream for more choice. There is the expectation that there is choice.

13 There are many ways the system should change to meet the aspirations and expectations of the Declaration. I discuss these throughout my statement.

14 There should be supportive and compassionate communities, with access to counselling, therapy and peer support. Services should be recovery oriented, trauma informed and community led. There should be a move away from treatment that is overly focused on medication with little consideration of broader needs or social determinants.

15 Services should be designed and delivered by people with lived experience. There should be investment in and support for career development and progression of the lived experience workforces (including both consumer and carer workforces).

16 Services should create and uphold a truly human rights driven and co-designed mental health service at all levels, particularly for acute service provision with strong and effective external oversight. There should be community based alternatives that are affordable, available, flexible in choice of supports and located throughout Victoria that respect the self-determination of people with mental health challenges, emotional distress or neurodiversity.

17 The system should also recognise the social determinants that contribute to people experiencing acute crises.

Involving people with lived experience

The contribution of people with lived experience in development of policy, practice and research

18 Listening to people with lived experience of mental health challenges is essential in considering the many and complex issues of responsive mental health service provision, and a way to filter and assess the many options for reform. It is also the best way to uphold and safeguard human rights, prevent serious harms, learn about the social determinants that led to mental health crisis and further develop community led responses.

19 The voice of lived experience needs to be embedded in every aspect of the system including rethinking the system's main activities and intended outcomes, workforce composition and skill requirements, accountability and oversight, and service types.

20 Placing the consumer voice of lived experience at the forefront of policy, practice and research is the best way to ensure that mental health treatment is no longer in danger of being cruel, degrading or inhumane.

21 In my experience, and from decades of VMIAC's advocating with and for the consumer community, many people live with a lifetime of traumatic memories of seclusion and other restrictive practices. As a result, some consumers decide that it is not safe to ever ask for help again, leaving them isolated and at risk during future periods of distress.

22 There is a greater need for peer workers. We would like to see them in the system working full time. There should be more support and training for peer workers. VMIAC are looking at how we might play a role in that. I discuss peer workers further below.

Mechanisms and structures required to ensure people with lived experience have a meaningful and enduring voice in decision-making at all levels of system design, policy planning and setting, and service delivery

23 VMIAC supports people within the mental health system in three main ways:

(a) **Maintaining a register of people with lived experience**. VMIAC receives funding from the Department of Health and Human Services (**DHHS**) to manage a register of people with lived experience. VMIAC is often asked to recommend people to speak at events about their lived experience and there is money in the register to pay people to do that. Many of the people on our register are unemployed so it is good that we can pay them.

(b) **Assisting people with lived experience to be appointed to meaningful positions within the system**. VMIAC are often asked to nominate people for governance positions.

(c) **Supporting and training people with lived experience.** We are increasing our training work for people with lived experience. We provide training on what it means to represent lived experience. We also provide training for those people who want to take up governance positions within the system. We provide training to make sure that their voice is heard on whatever board or committee they are appointed to. We know how important it is to have people with lived experience in decision making positions and we want them to attend those meetings feeling confident and empowered. These are the mechanisms and structures that are important to ensure that people with lived experience have a meaningful and enduring voice in decision making at all levels.

The role of mental health advocacy groups in the future of the mental health system

24 Advocacy should be individual and systemic as well as independent, like the Independent Mental Health Advocacy. Individual advocacy will feed through to systemic advocacy and will identify and address service gaps. Advocacy will be dynamic and responsive to the population it serves and to workforce delivery improvement.

25 Advocacy should be a blueprint for supporting mental health services as they develop. However, advocacy currently attempts to ‘fill the gaps’ missing in mental health service. In the future advocacy will identify and direct mental health services to address their own service gaps in a more timely and effective manner.

26 Advocacy should be independent in funding and governance and hold services accountable. It will continue to be a voice for consumers and help identify what is and isn’t working, and beyond the mental health system itself to social determinants. Advocacy will actively engage with and respond to minority groups.

Opportunities for mental health advocacy groups to work with other representative and peak bodies from across mental health to support mental health reform into the future

27 VMIAC liaises with LEAG (the Lived Experience Advisory Group of the Department of Health and Human Services Victoria), MAC (the Ministerial Advisory Committee on Mental Health in Victoria) and other bodies such as the Victorian Council of Social Services (VCOSS) to address the social determinants of mental health.

28 VMIAC has a critical role in the broad mental health system as our individual advocacy informs trends and themes which then informs our systemic advocacy. VMIAC can work with other advocacy and representative groups such as LGBTIQ+, CALD, Women’s Mental Health Victoria and TANDEM.

29 We also collaborate with state government and look forward to liaising with local government for more community-based mental health services. As a peak body, VMIAC has formed a national alliance with other peak bodies interstate.

Community-based services: effectiveness and experiences

30 Community can mean a lot of things. It can refer to:

(a) the group of people who may or may not have any knowledge of mental illness who have felt down for a short amount of time and say *I’m depressed* and think that’s what it feels like to have clinical depression, and their attitude may be *just pull yourself out of it* or *grab your boot straps pull them up*;

(b) the community around people with lived experience, the people next door who have been affected by mental illness in some way;

(c) the organisations that identify as community based organisations.

31 When I refer to community based services, I refer to the community health centres as they existed under the late Victorian Premier John Cain in the late 1980s and 1990s. They were governed by a mix of people professionally and by people with lived experience who lived locally who had the best interests of consumers in mind. These organisations were born out of the social movements from the 1970s and 1980s regarding equality and civil rights – this influenced a lot of thinking at that time.

32 People in the sector at that time were influenced by the work of psychologists and sociologists like Ronald David Laing, Erving Goffman and Travis Scott. A number of places were emerging with these ideas in mind. The key players that were working at this time now sit on the Mental Health Tribunal. However, the people who are now working in the system do not have the same experience – they have an experience that is much more cut and dried. Debates about rights or the social determinants of health are not going on as they were around that time. This impacts the attitude of service providers and the quality of services consumers receive. Services are now siloed away from a sense of community. Mental health clinicians treat a 'diagnosis' rather than as a whole person with a life and a history.

Governance and a trans disciplinary approach to services

33 As stated above, there should be strong consumer representation within the governance of any community based service. All services should have a flat governance structure, with people with lived experience in decision making roles.

34 At the core of any service should be a trans disciplinary team of staff which includes people with lived experience. This core group would acknowledge their own experience and place the consumer experience at the centre of their work. There should be a commitment to co-design and co-production at the individual, program and organisational level.

35 The services should not be hierarchical, and should not be run by psychiatrists. The hospital based system that psychiatry has developed does not work for many people living with mental illness. For example, for people in inpatient units, the six month psychiatry rotation through those units means that they have a new doctor every six months. This lack of continuity can be damaging to recovery. It also compounds reliance on the medical model as, in my view, medication is administered in the absence of a people based approach.

36 A trans disciplinary approach to governance would mean that people with lived experience were involved in the process, which would provide a better service,

particularly for people in crisis. This is because when you bring people with diverse backgrounds together, you can solve complex problems, particularly as you are able to bounce your ideas off one another and you all bring with yourself a different perspective.

37 There should also be a range of treatment or therapeutic interventions offered that are broader than the current medical model. There should be a range of different therapists able to provide support including psychologists, occupational therapists, physiotherapy services, pharmacy and dental services. In my experience, one of the issues for people living with mental illness is that they need to feel relaxed and in control, so there needs to be services that encourage this. Psychiatrists should still work in the service but as advisors or consultants.

38 If a trans disciplinary approach was taken, it means we would be talking the language that consumers would understand. It would mean we wouldn't be asking consumers to fill out the same form or asking people to answer the same question six times. If you are unwell, it is stressful to tell the same story over and over again. In a trans disciplinary model, workers are sharing files, critiquing each other, and sharing their approaches. This results in better outcomes for consumers.

39 An example of an organisation that used a trans disciplinary approach was a community health service that existed in Collingwood around thirty years ago. As I recall, there were two psychiatrists, a couple of psychologists and social workers. There was a flat governance structure that worked with people across disciplines. The organisation was run by a multidisciplinary governance group, who were settled in their community and wanted the service to have an approach that really addressed the public health needs of the community of Collingwood. It was a model that was looked to as one of the best approaches. It was extremely powerful. When community health was taken over by the hospital system in the 1990s, it totally changed the dynamic and meant that the services were less local and less responsive to local communities. Other examples include the Response Assessment Discharge (RAD) team of Peninsula Health Allied Health at Frankston Emergency Department, and The Hunter Brain Injury Service (HBIS) rehabilitation approach.

40 Community based services need to be set in a place where there is beauty and nature, where people can sit inside and put their feet in water. If you have a service that is built with beautiful spaces, has a flat governance structure; people are going to feel safer in those services; and they will be stronger services. There are some beautiful services in our current system but, in my view, they do not have the sense that *we are part of your community*.

41 In order to have a different system, we need to train staff as leaders not as managers. You *manage* while the system is working well, and you *lead* between the paradigms when it is not working well.

42 The governance of the system needs to change such that it is consumer driven, co-designed, co-produced and collaborative. Everyone needs to feel that their voice is equal to others, and people do not feel that at the moment. To achieve a system that is co-designed, you need to involve people with lived experience at the start. People with lived experience also need to hold senior positions within organisations. They need to have effectively the same level as the senior clinician and also with other parts of the system. Organisations with people with lived experience in the senior levels are able to be consumer focused because the consumer is at the highest level.

43 Our system is currently based on the medical model around the operation of hospitals. Changing this governance model is critical if you are to have meaningful change in the system. The lived experience workforce is mainly within the hospital system, but I do not know of one hospital that has a chief consumer. This needs to change.

44 One way of addressing complex social issues is through the collaborative approach known as 'Collective Impact'. Collective Impact is a framework for engaging with different sectors and groups who share a vested interest in a common outcome. It works by bringing all the people vested in the outcome together. For example, one community may have higher rates of women getting pregnant prior to leaving school than any other town. A Collective Impact approach to this issue may involve bringing together the school principal, the school welfare advisor, parents, the lady who runs the local milk bar (as she would know what is happening with young people more than others), youth workers and family planners. They would get together and answer the question: '*what is it that we specifically want to achieve at the end of the project?*' Once the shared vision is decided on, in this case young women not getting pregnant until they finish high school, each party agrees on what they will contribute to reach that outcome. The parties also agree that what they will do will be measured. All parties are reliant on others doing their part. This also results in outcomes (not simply inputs or outputs) being measured. In other jurisdictions that have introduced a Collective Impact approach, there may also be a *back bone organisation* that takes responsibility for coordinating the process. The back bone organisation may meet every few weeks and hold each party to account. This is collaboration in action. Toronto has two million people and a huge multicultural community – they are using Collective Impact and getting amazing results.[1]

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[1] Further information about Collective Impact can be found at: https://www.homelesshub.ca/toolkit/conditions-collective-impact-success

45 Another way of obtaining social change is to undertake an *appreciative inquiry*. This starts with people within an organisation reflecting on and considering what is going well in the organisation and in the community rather than what is going wrong. In my view, it is a great tool for getting everyone on the same page. In every organisation there is something working well. According to this approach, if you build on things working well, more often you get a better outcome than if you focus on the problem. This goes back to why we prepared the Declaration. It is important focus on asking the question of what is being done well and how do we do more of that.

46 It is also important to consider the social determinants of health and mental health. For many, obtaining support on how to manage their budget or their anxiety about not having a job or dealing with family issues, would (for many) prevent them from reaching the acute phase of any illness. We should be focusing on early intervention. If we had a community based model, we would need less acute beds and we would be focusing on intervening early to prevent crisis and hospital admissions.

Best practice governance model – Piri Pono (New Zealand)

47 Piri Pono is led by a lived experience workforce and offers acute residential care. It is small in scale and responsive to the needs of its community. The leadership of the Waitematā District Health Board (DHB) decided against replacing the sub-acute beds with hospital beds and opted to look at alternative, community-based options instead. In my view, it represents best practice regarding community based mental health services.

48 I believe that when the service was announced, Jacinda Arden said that something like *not a brick should be laid down without consumer input*. People with lived experience were involved from the get go, and this has contributed to the success of that service, in my view.

49 Piri Pono has a great model of governance which is based on Intentional Peer Support (IPS). Piri Pono also evaluates its service, and guest experiences, every step of the way to ensure continuous improvement.

50 In 2019, the Centre for Public Impact published a case study on Piri Pono. According to an interview with the Centre for Public Impact and Darryl Bishop (Group Chief Executive Officer at Ember – Korowai Takitini), the formation of Piri Pono was based on “the desire for more community beds away from hospital, and the desire for more peer services, kind of crunched together to create Piri Pono”. Mr Bishop is quoted as saying: “to ensure that Piri Pono’s peer support aspect was understood by all those who managed it, lived experience was represented throughout the different management structures, such as staff on the ground, the team managers and the board”. In relation to the IPS model, Mr Bishop stated: “It’s all about keeping people in the [IPS] model. So, the model’s based on

mutuality. So if somebody's stuck and they're working with somebody, then we're constantly reminding them what the model says and bringing them back to the model."[2]

Supporting people in the community

51 People with lived experience in the community should have access to a peer worker, support groups and neighbourhood houses to tackle loneliness. Depending on the social determinants of health, if required there should also be available assistance with housing, employment, social connections and family relationships. Therapy can't work if the social determinants aren't there to support it.

52 Community care is effective when people with lived experience are the co-producers of the service, where governance is consumer driven, and where staff are caring and compassionate. Community care is ineffective when a person does not feel safe. It can also arise from services that do not measure or monitor outcomes, and who are not achieving outcomes. This is true of all services not just those that are community based. It is important that there is consistent and ongoing evaluation and review of quality standards. Ongoing reviews are not common in mental health services and this needs to change.

Improving navigation of mental health services

53 There should be a centralised information system. Until the mental health system becomes more user-friendly to access, consumers will need navigation advocacy.

54 There should be a simpler funding structure, moving away from the current structures in place and directed by people with lived experience.

Digital services

55 Digital services are great as a space that can create community. However, in my view, they are not able to replace services by any means. For the most part, digital services should be a supplementary service, and supplementary at a different level. Digital services can be about information, education and connection.

56 Digital services have the potential to be a good service, particularly by allowing consumers to remain in contact with professionals when face to face therapy is not possible. For example, I have heard of people with very strong relationships with their psychologist, using Skype to connect with their psychologist while they were on holiday.

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[2] See interview with Darryl Bishop, Group CEO at Ember – Korowai Takitini, 24 August 2019 referenced in Linnea Larson 'Piri Pono – a peer-led acute residential service in New Zealand', 20 December 2019, accessed on 1 April 2020 at: https://www.centreforpublicimpact.org/case-study/piri-pono-peer-led-acute-residential-service-new-zealand/

Technology provided a way of continuing the working relationship when the face to face contact was not possible. There are obvious benefits to this service. There are also benefits for people living in remote areas who may not otherwise be able to access support.

57 Digital services can connect people in groups. For example, if there are a few people living in a town or living nearby, they may be able to join together to have a group conversation, and that can be useful too.

58 Digital services should not replace face to face personal contact between consumers and the system. They should certainly not short change people particularly in rural areas. We need to value the face to face therapeutic relationship. Telehealth is a good service, but it is not sufficient. It should not be seen as a substitute for face to face contact and should not be relied upon to shirk away from workforce investment in rural areas.

59 It is worth noting that digital services have to some extent been corrupted as the platforms (including social media) can sometimes be used for abuse. We need to be really careful about these platforms.

Service safety

60 From a service safety perspective, it is critical that there are women only wards with staff that are women. This is for a number of reasons. We have received various reports from women being sexually abused by staff. In this respect it is a safety issue, as described by the Right to be Safe Sexual Safety Project Report published by the Mental Health Complaints Commissioner in March 2018. We also know that women's treatment may involve addiction treatment and that there may be particular reasons (including a history of trauma) as to why women may be self-medicating. Once VMIAC identified this, we started to achieve better treatment outcomes for women. It is also about choice – there needs to be the choice available to women. I acknowledge that there are challenges and complexities regarding the LGBTIQ+ community that would come from women only wards, but in my view there should be the choice available to women to ensure they feel safe. We also acknowledge the unique and challenging experiences of the LGBTIQ+ people within the mental health system who are often discriminated against by staff and fellow consumers based on their gender.

Workforce

61 The values, behaviours and practices that should underpin multi-disciplinary, consumer focused and recovery oriented care are reflected in the Declaration. In terms of collaboration and co-production, it's not just with other professionals but with the consumer. It is very important that consumers have choices and options.

62 Consumer focused and recovery oriented care are based on person centred care. They are based on the understanding that the person receiving care is a complex human being, not just a sum of their symptoms. The therapeutic relationship, human to human is core for any recovery oriented and consumer focused care to be successful. Compassion and warmth is also important.

63 Services should ensure that there is cultural respect and safety for all people, that gender diversity and sexual identity are appropriately acknowledged as needed, there is adaptable language, an understanding of how disabilities and health related issues intersect and impact a person collectively and the ability to listen and give the consumer agency and space to express their needs and expectations.

64 There should be a choice of treatment options at every point. We know that when people feel they have had legitimate control of their care options, recovery is much more likely and successful.

65 One of the benefits of the National Disability Insurance Scheme is that it gives individual consumers choice and control. As I understand it, the worker that does your plan tells you what your options are, so the starting point for the consumer is ‘oh, I have choices!’ This can be very empowering.

66 Multidisciplinary care needs to place all parties on equal footing in terms of being heard. There needs to an inclusive array of practitioners that will foster a recovery focus, not just alleviate particular symptoms. Psychologists, dieticians and exercise physiologists must be included as needed, and made accessible in the public system.

67 The current system has lack of services, lack of treatment options and an ever-increasing rotation of staff. Further, there is an overreliance on the medical model (which I have described in other parts of my statement) which means that most of the mental health system is not set up to be recovery oriented and consumer focused. In my view, symptom management cannot continue to be the gold standard and exit point, as experienced by many Victorians engaging the mental health system.

68 The role of consumer workers is critical to consumer focused and recovery oriented care. The power dynamics are equalised between a consumer worker and a care recipient if set up properly. Self-empowerment is harnessed through this, as is a space for connection and understanding by well-trained consumer workers. However, many consumer workers do not have full time roles which undermines their ability to use their knowledge base of recovery and consumer focused care. There are many incredible workers who provide care and support, but the system cannot and does not allow for this to be the consistent standard of care.

69 In my view, all staff in the system need to be trained or re trained, particular in the area of human rights. There are rights you have when you are an inpatient, and there are rights that are taken away from you when you are an involuntary patient. When staff are unsure of what rights apply, that can be a really confusing space, and that's when breaches of human rights can happen. Our seclusion report gives a good picture of how different services stand. There are some stars but some health services have appalling results. Attached to this statement and marked '**TS-3**' is a copy of VMIAC's seclusion report dated April 2019.

70 In my view, at the heart of the variation between services is a difference in philosophical approach; in organisational culture. Our next seclusion report will be prepared in conjunction with the DHHS. We are hoping to release them on a regular basis.

Helping and enabling people with lived experience to feel supported and empowered

71 Each consumer is the expert of their life and their needs. They need to be listened to. Service providers and staff should not assume that their truth is the consumer's truth. As consumers, we know what we need; we just need to be listened to.

72 Staff need to use critical reflection and question everything they do to ensure it is recovery oriented and consumer focused. It is important that staff know the history of their discipline and work setting. They should not settle for damaging work practices. The best system needs this.

73 In my view, agency and self-empowerment are key to recovery. Consumers should be given the right to inform decisions, options and choices. Feeling disempowered is the opposite of the recovery process. It is important to acknowledge that not all consumers want the same things.

74 There should be engagement in training. Co-design and co-production can ensure that meaningful, appropriate training is created and rolled out. All staff should be re trained where needed in order to shift the culture of mental health care to be recovery oriented and consumer focused.

Lived experience workforce

75 There are two levels of lived experience in the mental health system, peer workers and consumer consultants:

(a) **peer workers** work directly with those who deliver services. They work directly with consumers to support recovery.

(b) **consumer consultants** work at a slightly different level to peer workers as they work around change. For example, consumers consultants may work within a health service as an advocate for systemic change.

76 The experience of the consumer and the peer support worker can influence and guide the consumer consultant, particularly with their work with clinical governance through participation at meetings regarding system improvement at a health service. We need both peer workers and consumer consultants.

77 Peer workers bring lived experience. When a peer worker sits down and talks with me, they know what's happening to me. They've been through it. The introduction of peer workers into the system has made a huge difference to people's experience and in some cases it has made a difference to the teams of staff.

78 Having someone on the team at a service with lived experience means that clinicians are reminded that they are dealing with a person when they provide their services. People with lived experience aren't necessarily looking at data, treatment or results with a clinical lens. They are looking at the treatment with person focused lens. It's a reminder of a different perspective that needs to be taken into account. The sooner you get peer workers into the service, the better the culture is, and the less ingrained any clinical attitudes are.

79 The lived experience workforce needs to be valued and elevated to equal footing with other mental health disciplines within the mental health system. We need to acknowledge the long history of lived experience work in mental health within Victoria. We should also assess the current state of working conditions for lived experience workers and develop and support the lived experience workforce for career progression in line with other mental health disciplines.

80 There should be a deeper recognition of training programs such as Intentional Peer Support and Emotional CPR. Emotional CPR (eCPR) is a public health education program designed to teach people to assist others through an emotional crisis by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing. People who have been through the training consistently report that the skills they learned have helped them communicate better in all their relationships. They tell us that eCPR is a way of life. There should be the establishment of consumer advisory groups. These groups should be seen as essential to best practice in mental health.

81 The number of lived experience staff across services needs to be bolstered to prevent feelings of isolation and 'peer drift'. Peer Drift occurs when the peer support providers do not feel comfortable in their recovery-oriented role, and they begin to shift to a more medical treatment role.

82 There needs to be suitable working hours for peer workers (as in the consumer lived experience workforce), with a living wage, appropriate supervision from a lived experience mentor and pathways for promotion and career progression within the field of lived experience as a profession and discipline. Such measures would sustain a workplace culture that values the voice of lived experience in delivering best practice and upholding human rights for consumers from access, to care and above all, treatment.

Great experiences of professionals or teams providing holistic care and support

83 There are great teams that provide holistic care and support and successfully understand the importance of therapeutic relationships. They use their wisdom and navigate the human side of being with someone in crisis. They empower the consumer, listen and are guided by what the consumer needs. They let go of having to be the expert with all the answers, all the time. They know to question and critically reflect on their work. They are open to new ideas and are flexible. They are trauma informed and see the whole person, not just their symptoms. They understand that their role has an impact and take responsibility for their behaviour. They work together as a team and listen to each other. They also understand cultural difference and cultural safety.

84 This work is exemplary when service providers do not assume to be the expert. Where they can understand that each person is unique, and that agency is the key to recovery. When they can see strength in each person and empower them through this. They give time and listen and are well trained in recovery-oriented practice. Prevention and Recovery Centres offer a good example of this.

Stigma amongst professionals living with mental illness

85 The consumer movement holds incredibly bright, intelligent, thoughtful people including heads of departments and judges who are afraid to speak out because they feel it may affect their career. I was a senior executive in the health department and I didn’t tell people about my mental illness for ten years. I felt that if people knew if I had depression and contemplated suicide I would never have been promoted. There is a real issue of stigma.

86 If we can overcome this and encourage successful people in the industry to speak out, that would be a very powerful perspective to obtain system change. We have started to see this in the sporting industry, but it needs to be more widespread.

87 It comes down to bravery and leadership. What we need now are a cohort of leaders, not just good managers. We need a cohort of strong leaders who are willing to say I know how to do this, I know how to change things, I know the processes, and I’m willing to say I have had mental health challenges.

88 VMIAC has some of these people on our register, and we know who the people are who are willing to be part of that body (and those who are not).

89 When VMIAC advertises a position we always note that lived experience is important to the role and respondents are always so relived and happy to apply for a job and are relieved to be able to disclose their mental health challenges. In my view, it would be great if other professional workforces (for example, psychiatry) could do this.

90 It would be great if we could reach the position where people are able to say *I have had a mental health challenge and it doesn't matter*.

91 It is worth noting that employing people with lived experience can sometimes be a challenge for an organisation. If you have people with lived experience involved, you cannot rush the process because what you do is build anxiety and stress which may trigger a person's episode. We have people in our team who some weeks only work two hours a day, and we have to make sure we can deal with that. However, having people with lived experience can positively change the culture of an organisation.

sign here ►

print name Tricia Szirom

date 12 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TS-1

This is the attachment marked 'TS-1' referred to in the witness statement of Tricia Szirom dated 12 May 2020.

Tricia Szirom is currently the CEO of Victorian Mental Illness Awareness Council (VMIC) and previously was on the Committee of Management.

Prior to working with VMIAC Tricia was Senior Manager of Children and Families at the Brotherhood of St Laurence where she oversaw the development of three new program areas: Service Hubs in growth corridors, the BSL Community Engagement program and a program to bring preschool children and their mothers out of poverty called Growing Learners. She also developed the BSL position on partnering and collective impact.

From 1990 – 2008 Tricia was the Managing Director of Success Works a highly successful consultancy company which specialised in planning and evaluation of community sector innovative projects most of which were funded by government. Some of the programs the team worked with were:

- Meta Evaluation of Partnerships Against Domestic Violence, a four year program with the Commonwealth, States and Territories to address the issues of the impact of Domestic Violence across the country.
- Evaluation of the Supported Accommodation Assistance Program which looked at the structure, funding, and outcomes of the SAAP program over a two year period.
- Consideration of Integrated governance for the Commonwealth Government
- Evaluation of Bring Them Home national initiative
- Two year establishment and Implementation of a Rural Mentoring Program for the Department of Health and Human Services
- Evaluation of the School Focused Youth Service over three years

In addition, Success Works used Appreciative Inquiry to assist community sector organisations to develop strategic directions, planning and inhouse evaluation. A key part of their work was developing agency skills in Income Generation.

Prior to the establishment of Success Works, Tricia spent ten years in the public service in the Department of Premier and Cabinet, Office of Youth Affairs, Victorian Drug Strategy and the Department of Health.

Other key roles that Tricia has taken include State Director YWCA, Education Director Family Planning Association, Senior Policy Advisor YMCA Australia.

Tricia has been Chair Youth Affairs Council Victoria, Chair National Your Affairs Council, Member ACOSS Board, establishment committee WIRE, Women's Heath Victoria, National President YWCA Australia. She is a Life Member of the Centre for Excellence Child and Family Welfare and the YWCA Australia and a Churchill Fellow.

Having left school at fourteen to work in the National Bank, Tricia studied Youth and Community Work, undertook a BA with a major in Urban Planning, studied Group Work at the University of Wales (Swansea) and completed a PhD in Education at Monash.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TS-2

This is the attachment marked 'TS-2' referred to in the witness statement of Tricia Szirom dated 12 May 2020.

OUR COLLECTIVE VISION

of a future when we replace the mental health system with something **WONDERFUL**

This vision is a DECLARATION of our dreams for the future.

It was co-created by people with lived experience of:

- Emotional distress
- Trauma
- Neurodiversity
- Mental health challenges

This is a living document.

We call for mental health policy that acts on our vision.

[redacted]

Like Physical Illness
MADNESS
Social & Emotional Distress
Mental Illness Not An Illness Mental Health Problems
SOCIAL DETERMINANTS
Neurodiversity Diversity
Disability
Mental, Emotional & Social Distress Emotional
Altered States
TRAUMA distress
Mental Health Issues An Illness Psychosocial Disability
Trauma Response EXPERIENCES Mental & Emotional Problems
Emotional Distress
ADVERSITY Spiritual Emergence
Mental Health Challenges
Mental & Emotional Challenges Mental Ill Health
Mental & Emotional Issues Natural Response

SOCIETY

The social change we need

EDUCATION HOUSING KINDNESS
EQUITY WE ARE SAFE Love Kind To Strangers Food
Psychiatry Apology
No Family Violence Connection Stop Pathologising Us End Capitalism We Are Valued
Nonjudgmental Stigma Free Positive Attitudes Respected
Understanding
Supportive Rights Based Law Flexible Work Caring
Real Social Security
Climate Action Prevent Violence Social Determinants
No Stigma Human Rights Accepting
Police Alternatives

CONCEPTS

The concepts that will define & shape the system

Acknowledge Injustice
CLIMATE
Holistic
Accessible
Supportive LOVE
Acceptance Consumer Leaders
Open Trauma Informed
Political Action Our Diversity Valued
Social Determinants
Social Security Therapeutic
Informal support COMPASSION No DSM
Choice

VMIAC
by and for consumers

OUR DREAM IS FOR MORE CHOICE

ACCESS

The ways we need to access support

SELF-REFERRAL
24/7
Phone
GP Referrals
Walk In Access
LOCAL
Help When We Ask
Support to get support
WELCOMED
Short Wait Time

PLACES

The places & services we need

Recovery house
Support cafes
Drop In
Windows
RETREATS
Holistic centres
Home
Community spaces
More PARCs
Peer support groups
gardens
Not Institutional
Nature
Day trips
Peer-Run
LIGHT
Hospital
Small places
Tranquil
RESPITE
Quiet
Open doors
Therapeutic communities
Choices
Recovery Colleges
Learning spaces

ACTIONS

The actions, supports & processes we need

Individualised
Critical Theory
Trauma Therapy
No Medication
Informed
Medication
Political Action
Options
CLASSES
GROUPS
First Nation Culture
FREE
Reflection
Day Trips
Critical Psychiatry
Connection
Collaboration
Understanding
Learning
Social
therapy
QUIET
Music Therapy
YOGA
NATURE
Validation
Nonjudgmental
ART
LISTENING
Meditation
No Pathologisation
Art Therapy
Friends
Mutual Support
Nutrition
NonClinical
Dance
Animals
Relaxation
Conversations
Share Stories
choices
HUMAN RIGHTS
Safety
BEING WITH
Exercise
Peer Support
MUSIC
Solidarity

PEOPLE

The people, staff & values we need

Facilitators
Expertise
Knowledge
EMPATHY
Respectful
LISTENERS
Friendly
Understanding
Psychiatrists
OTs
Lived Experience
Positivity
Yoga Instructors
Professionals
Rights Based
Spiritual Support
Empowering
Nonjudgemental
Honest
Therapy Animals
HUMANE
Peer Workers
Meditation Instructors
NURSES
Teachers
GPs
Compassionate
Diversity
Multidisciplinary
REFLECTIVE
Kind
THERAPISTS
Caring
Helpful
Psychologists
Trauma Experts
Social Workers
Consumer Leaders

OUTCOMES

How our lives will be different when these changes happen

JUSTICE
Connectedness
Meaningful
Accepted
Caring
HAPPIER
Employment
Human Rights

www.vmiac.org.au/declaration

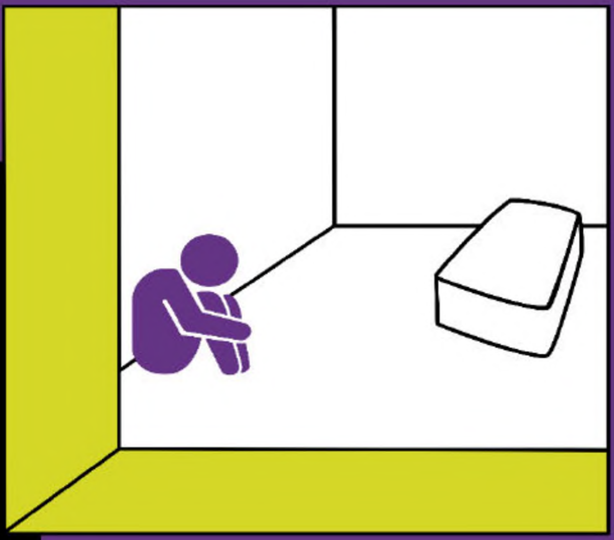
Royal Commission into
Victoria's Mental Health System

ATTACHMENT TS-3

This is the attachment marked 'TS-3' referred to in the witness statement of Tricia Szirom dated 12 May 2020.

HOW SAFE IS MY HOSPITAL?

SECLUSION REPORT



Accessible information on seclusion in Victorian mental health services

VMIAC
by and for consumers

This report was produced by VMIAC, the peak body for mental health consumers across Victoria.

April 2019

www.vmiac.org.au

WHAT IS SECLUSION?

Seclusion is a type of 'restrictive' practice used in mental health services that aims to control a person's behaviour. The Mental Health Act (Vic) defines seclusion as:

> **The sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.** [1]

Mental health services are supposed to use seclusion only as a 'last resort' and 'to prevent serious and imminent harm to the person or another person'. [1]

In plain language, seclusion means being locked in a room by yourself.

Image source: abc.net.au

Accessibility and accountability: Why we've written this report

We wrote this report to make information about seclusion more accessible. We believe people have a right to know how safe or traumatising their local hospital might be.

The information in this report is freely available on various government websites, however it is often difficult to find and understand. For example, some reports use the name of catchment areas (e.g., 'Inner Urban East') instead of hospital names (e.g., 'St Vincent's Hospital').

We also wrote this report because we don't think that Victorian public hospitals are held accountable enough for their use of seclusion. We hope making this information more accessible will create additional pressure for change.

Seclusion and all forms of restraint are inherently harmful.

Seclusion has no place in a safe, therapeutic mental health service.

Our position is that Victoria must:

1. Set a deadline to eliminate all seclusion and restraint in mental health services
2. Take serious action to reduce these harmful practices until they are eliminated
3. Hold mental health services publicly accountable for their use of these practices
4. Respond to damaging impacts for individuals, including human rights breaches, physical and emotional harm

SECLUSION RATES

Victorian Adult Mental Health Inpatient Units

VMIAC
by and for consumers

QUARTERLY RATINGS: OCTOBER–DECEMBER 2018

			THIS QUARTER		LAST QUARTER		
Rank	**Change**	**Hospital**	**Seclusion rate**	**Within KPI**	**Seclusion rate**	**Rank**	**Within KPI**
Best to worst	*Since last quarter*		*This quarter Oct-Dec 18*		*Previous quarter Jul-Sep 18*		
1	▼	Casey Hospital	1.9	✓	7.5	12	✓
2	▼	Latrobe Regional Hospital	2.0	✓	5.0	7	✓
3	▲	Frankston Hospital	2.5	✓	0.7	1	✓
4	▼	Alfred Hospital	3.0	✓	3.8	4	✓
5	▲	St Vincents Hospital	3.5	✓	2.6	2	✓
6	▼	Broadmeadows Hospital	3.6	✓	6.2	8	✓
7	▼	Northern Hospital	4.2	✓	14.8	17	✓
8	▼	Royal Melbourne Hospital	4.6	✓	10.5	14	✓
9	▼	Sunshine Hospital	5.0	✓	7.0	10	✓
10	▲	Austin Hospital	5.9	✓	2.7	3	✓
11	▼	Warrnambool Base Hospital	6.4	✓	18.4	21	×
12	▼	Goulburn Valley Hospital	6.9	✓	11.4	16	✓
13	▲	Orygen Youth	8.7	✓	4.4	6	✓
14	▼	Bendigo Hospital	9.1	✓	9.3	13	✓
15	▼	Werribee Mercy Hospital	10.3	✓	10.7	15	✓
16	▲	Dandenong Hospital	11.4	✓	7.4	11	✓
17	▲	Maroondah Hospital	12.4	✓	6.3	9	✓
18	▲	Monash Medical Centre	13.0	✓	4.3	5	✓
19	▲	Ballarat Base Hospital	20.1	×	15.3	19	✓
20	▲	Mildura Base Hospital	22.6	×	18.2	20	×
21	▲	Box Hill Hospital	23.8	×	15.2	18	✓
22	▲	Wangaratta District Base Hospital	32.5	×	20.8	22	×
23	▲	University Hospital Geelong	36.5	×	23.9	23	×

Source: Victorian Agency for Health Information
https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports. [2]

Legend:

▼	Reducing: a positive result
▲	Increasing: a negative result
✓	Within key performance indicator (seclusion rate of less than, or equal to,15)
×	Exceeded key performance indicator

Note: This section includes 22 adult services and 1 youth service.

VICTORIAN AVERAGE

9.4

Average seclusion rate this quarter across all adult units

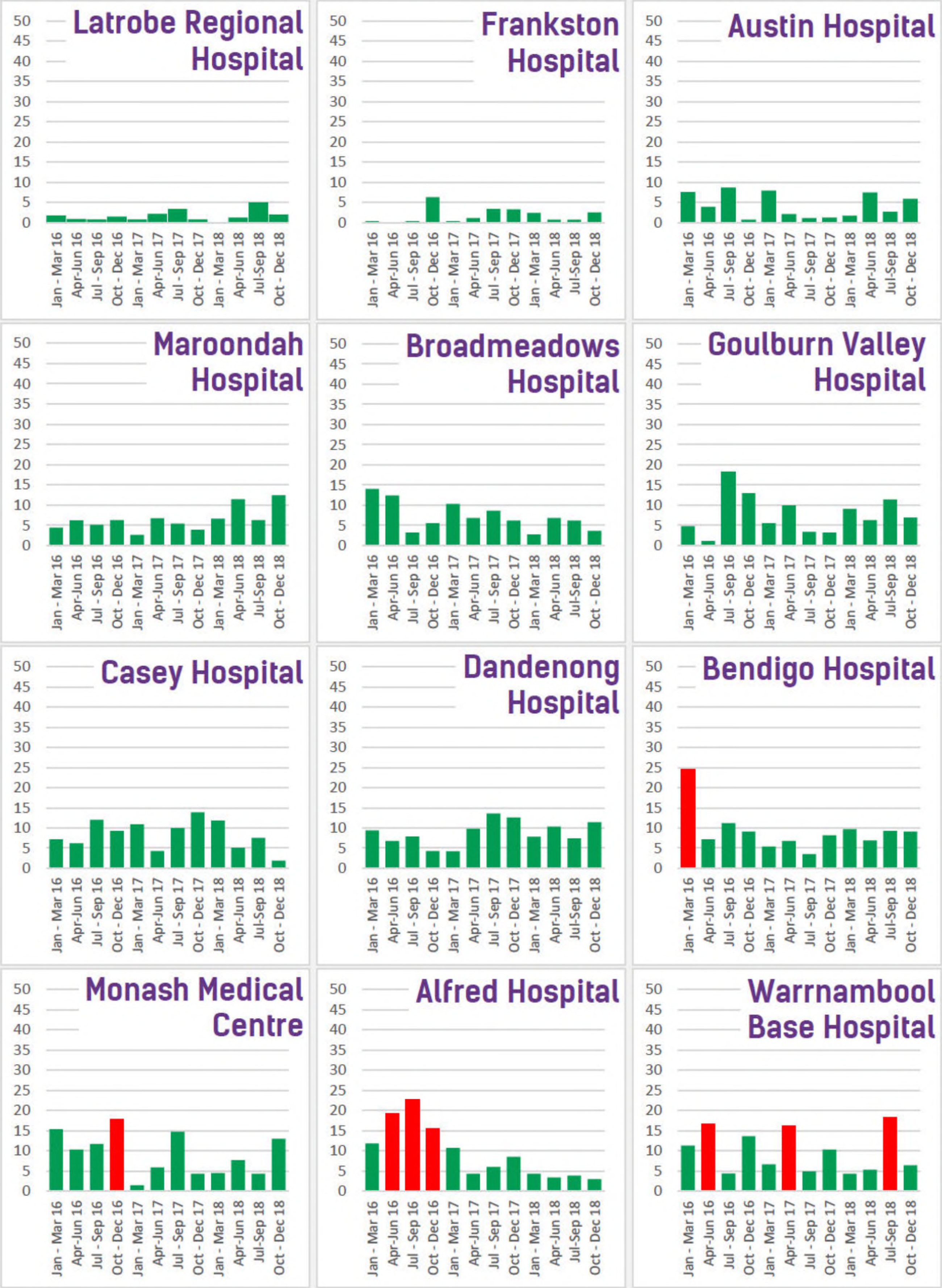
▲ from 8.9 last quarter

SECLUSION RATES

Victorian Adult Mental Health Inpatient Units

VMIAC
by and for consumers

HOSPITAL PERFORMANCE OVER THREE YEARS



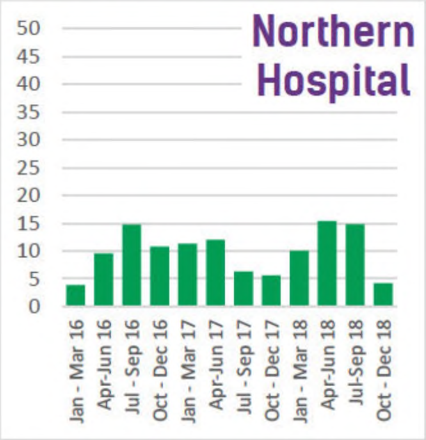
Source: Victorian Agency for Health Information , March 2019
https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports. [2]

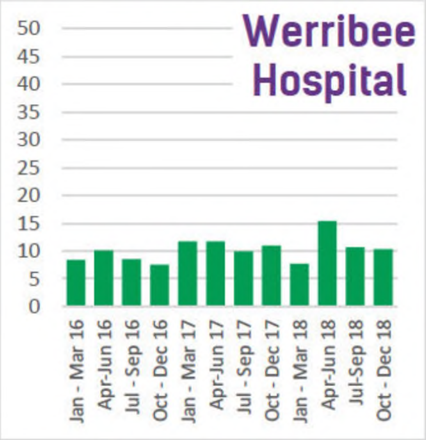
🟩 within
🟥 exceeds

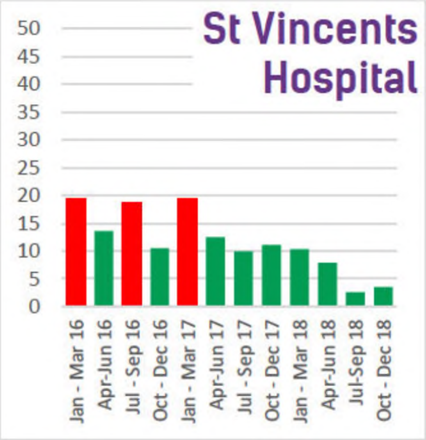
SECLUSION RATES

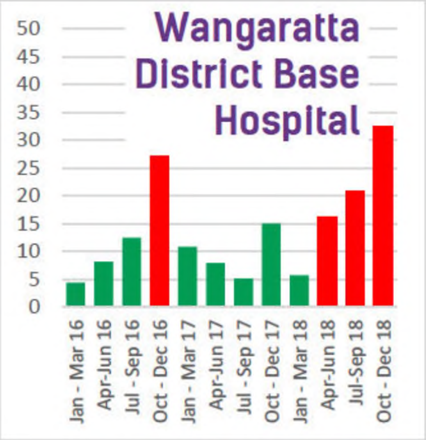
Victorian Adult Mental Health Inpatient Units

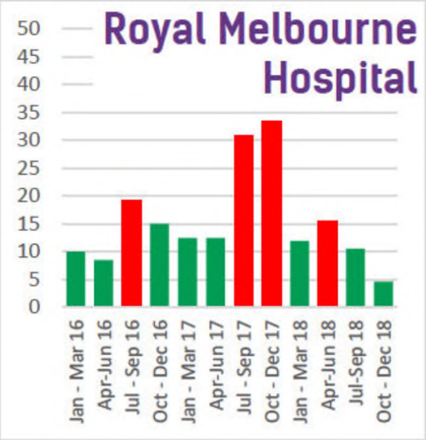
HOSPITAL PERFORMANCE OVER THREE YEARS

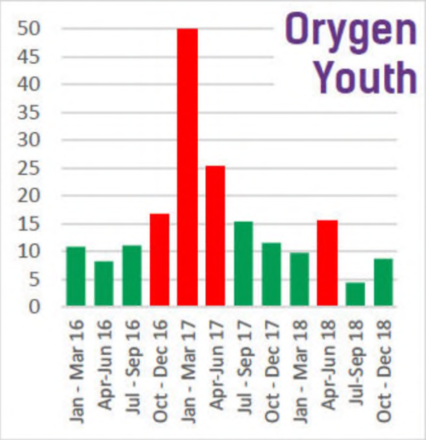


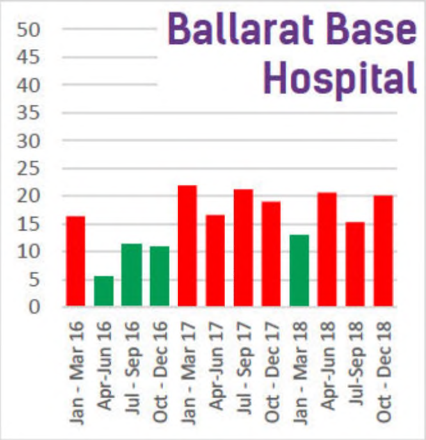


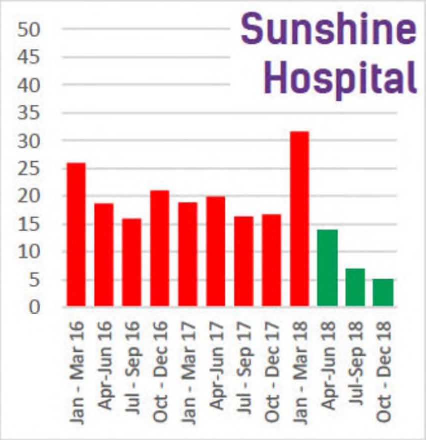


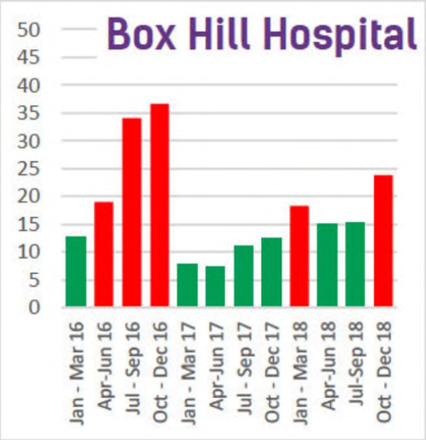


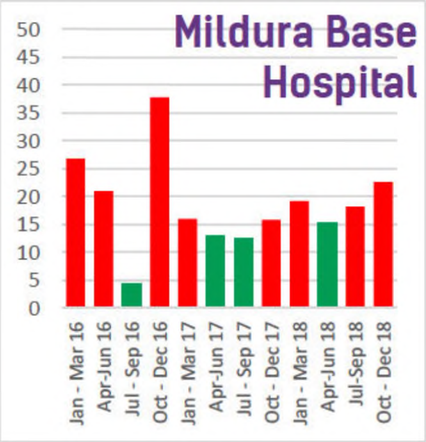


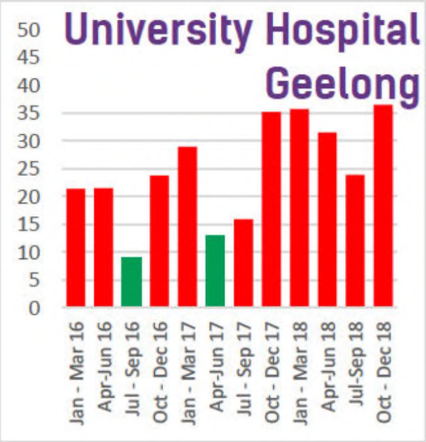








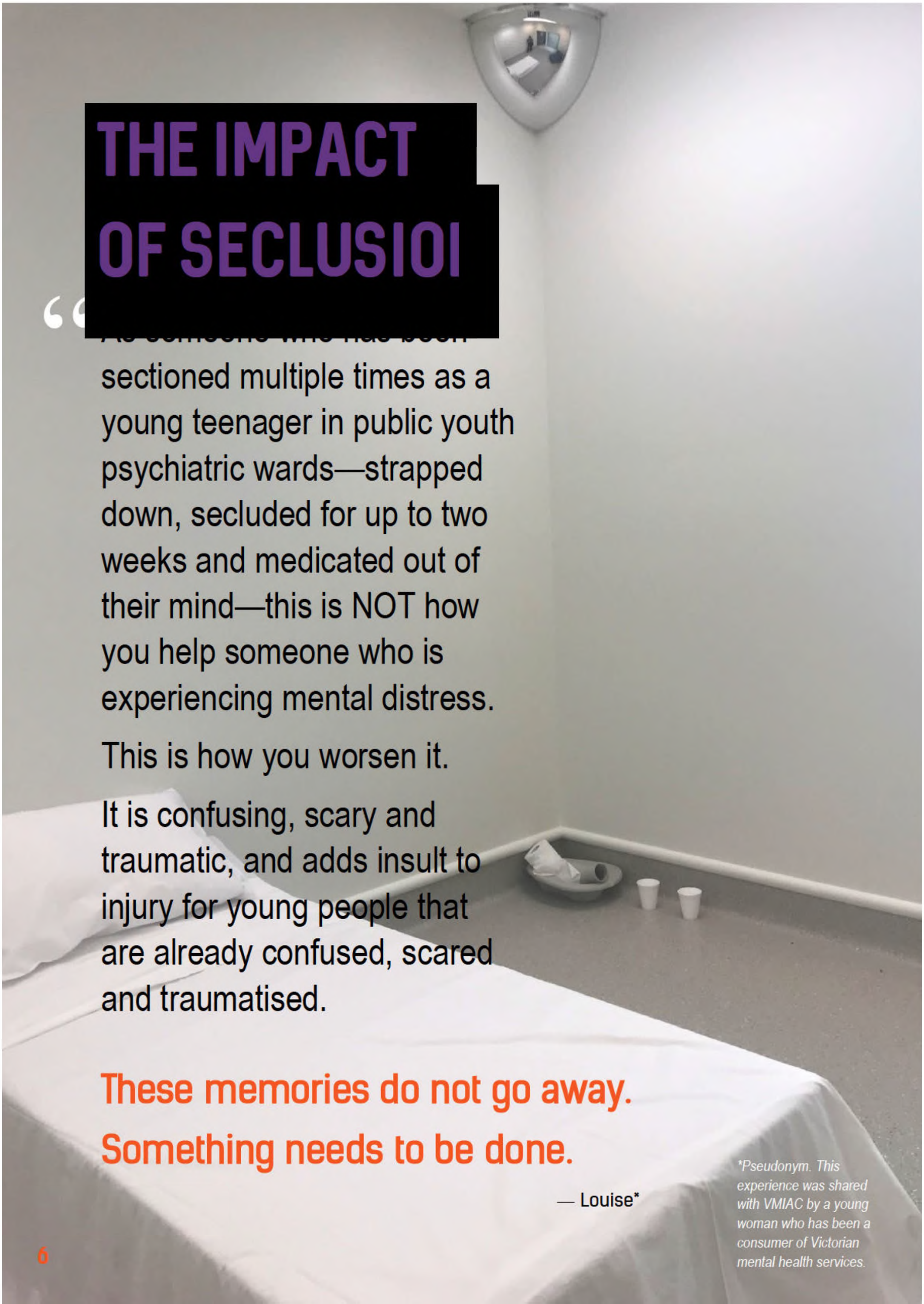




🟩 Seclusion rate within key performance indicator

🟥 Seclusion rate exceeds key performance indicator

Source: Victorian Agency for Health Information, March 2019 https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports [2]



THE IMPACT OF SECLUSIO

[redacted]

“ sectioned multiple times as a young teenager in public youth psychiatric wards—strapped down, secluded for up to two weeks and medicated out of their mind—this is NOT how you help someone who is experiencing mental distress.

This is how you worsen it.

It is confusing, scary and traumatic, and adds insult to injury for young people that are already confused, scared and traumatised.

These memories do not go away. Something needs to be done.

— Louise*

**Pseudonym. This experience was shared with VMIAC by a young woman who has been a consumer of Victorian mental health services.*

WHY IS SECLUSION A PROBLEM?

SHAME
HUMILIATION
FEAR
DISEMPOWERMENT
LONELINESS
LOSS OF TRUST

Seclusion hurts people.

The psychological impacts of seclusion can include feelings of disempowerment, fear, vulnerability, anger, loneliness, humiliation, dependence, impaired trust, sadness and shame.[3,4]

Seclusion can lead to serious physical injuries, with a prominent example being the tragic death of Miriam Merten in NSW during 2014, which led to a major inquiry.

Australian policy aims to 'move towards eliminating' restrictive interventions, like seclusion.[5] However, in recent years, seclusion in Victoria has been growing instead.

Seclusion affects all consumers.

Only a minority of consumers are secluded, and these people usually experience distress and ongoing trauma.

But most consumers will witness other people being secluded, which is often loud and distressing. Many people speak about the fear of wondering if or when it may happen to them.

Seclusion rooms are typically small, bright and bare, with a big locked security door and a plastic mattress on the floor.

Seclusion room from a regional Victorian hospital
Image supplied under the condition the source remains anonymous

Some seclusion rooms have toilet facilities. Many do not, instead they provide a cardboard bedpan on the floor.

MONITORING PEOPLE IN SECLUSION
While in seclusion, the hospital must provide a medical examination at least every 4 hours, and a clinical review or observation by a registered nurse or doctor every 15 minutes.[1,6]

SECLUSION ACROSS AGE GROUPS

Comparing seclusion across adult, adolescent and aged services

Types of services

Victoria's mental health system has inpatient units for different age groups, shown in the table to the right.

Seclusion occurs in all types of inpatient mental health services. This report focuses on adult and youth services.

Type of service	Client group	No. of inpatient services
Adult	16 to 64 years	**23**
Youth	16 to 24 years	**1**
Adolescents	12-13 to 17-18 years (varies)	**4**
Aged	65 years+	**17**

Note: Some services include multiple units/wards. Victoria also has a range of specialist inpatient services, 7 secure extended care services and a forensic service, which are not included in this report.

Seclusion rates across age-based service types

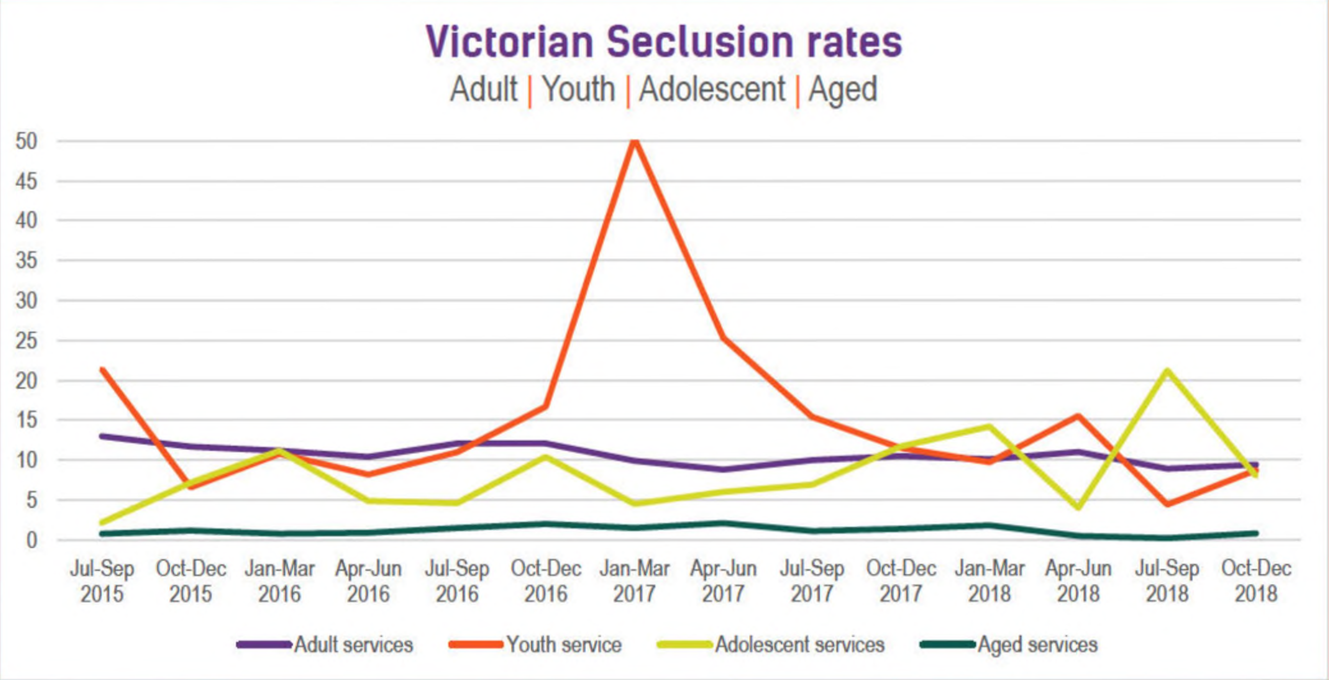
Rank	Change	Service type	Average seclusion rate		No. of services
Best to worst	*since last quarter*		*this quarter Oct-Dec 18*	*previous quarter Jul-Sep 18*	*(state wide)*
1	▲	Aged services	**0.8**	**0.2**	17
2	▼	Adolescent services	**8.0**	**21.2**	4
3	▼	Youth service	**8.7**	**15.5**	1
4	▲	Adult services	**9.4**	**8.9**	23

Source: https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports. [2]

26,098

Total people admitted to inpatient mental health services in 2017/18. [7]

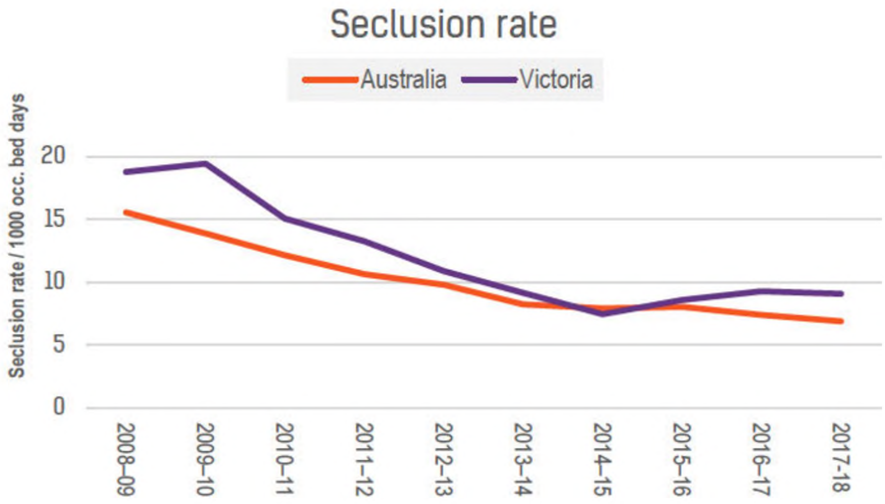
Seclusion rates vary between different types of service. Seclusion of adolescents has been on an upwards trend since January 2017, despite improvements this quarter and in April-June 2018. Aged services have very low rates of seclusion, adult services have shown little change in the last three years.



Source: https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports [Adult reports (total state-wide), CAMHS reports (total metro) and Aged reports (total state-wide), 2015/16 Q1 – 2018/19 Q2]. [2]

NATIONAL SECLUSION DATA

More information about seclusion is found in national datasets. The graphs below show data sent by each state government to the federal government, and reported by the Australian Institute of Health and Welfare (AIHW).

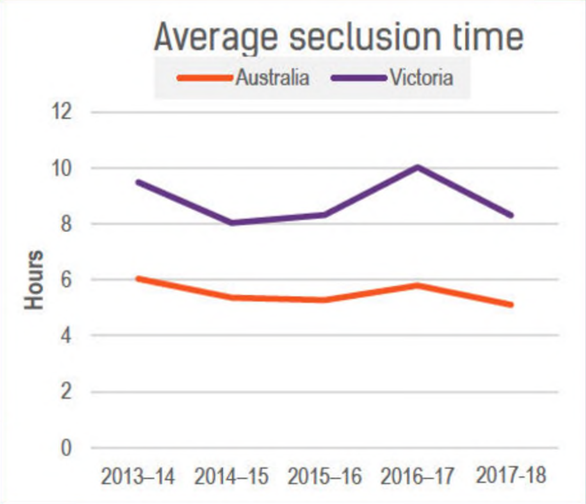


Victoria secludes people at higher rates than Australia as a whole.

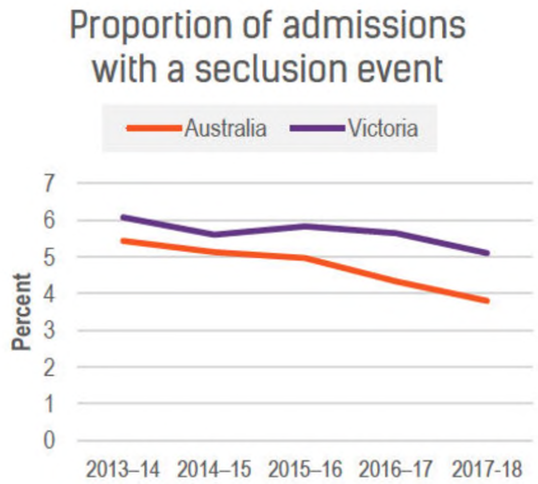
Seclusion is decreasing across Australia—but it has been increasing in Victoria since 2014/15.

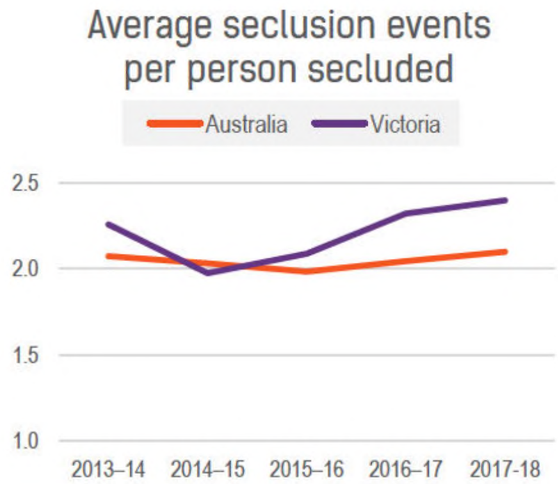
Victorian hospitals lock people in seclusion for longer than any other state, with an average of 8.3 hours* last year

*excluding forensic services



* This data excludes seclusion in forensic services. The average length of seclusion in Victorian hospitals increases to 16.7 hours for 2017/18 when all units are included.[7]



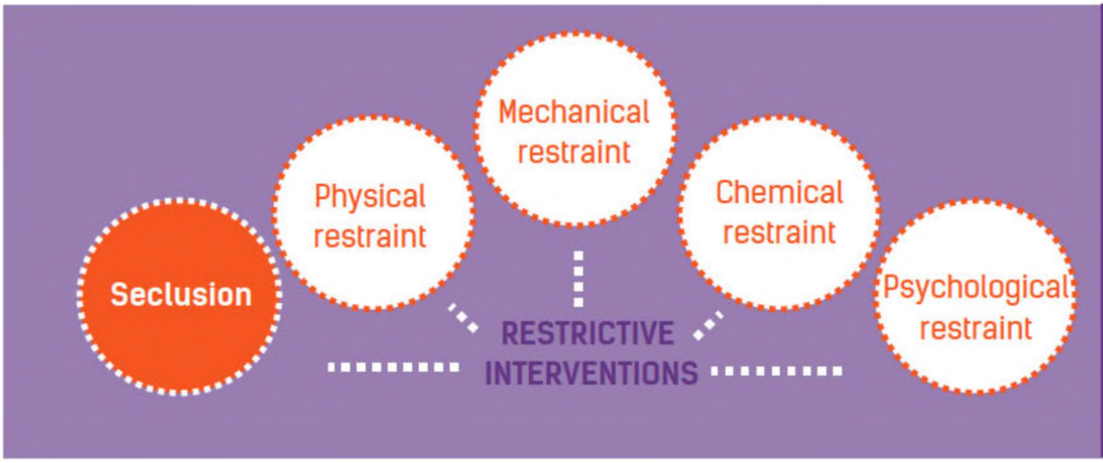


Source: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices [8]

ABOUT RESTRICTIVE INTERVENTIONS

Different, harmful practices used to control people in mental health services

Seclusion is one of several different practices used to control people in mental health services. All of these practices can be extremely harmful. Sometimes these are called restrictive 'interventions' or 'practices'.

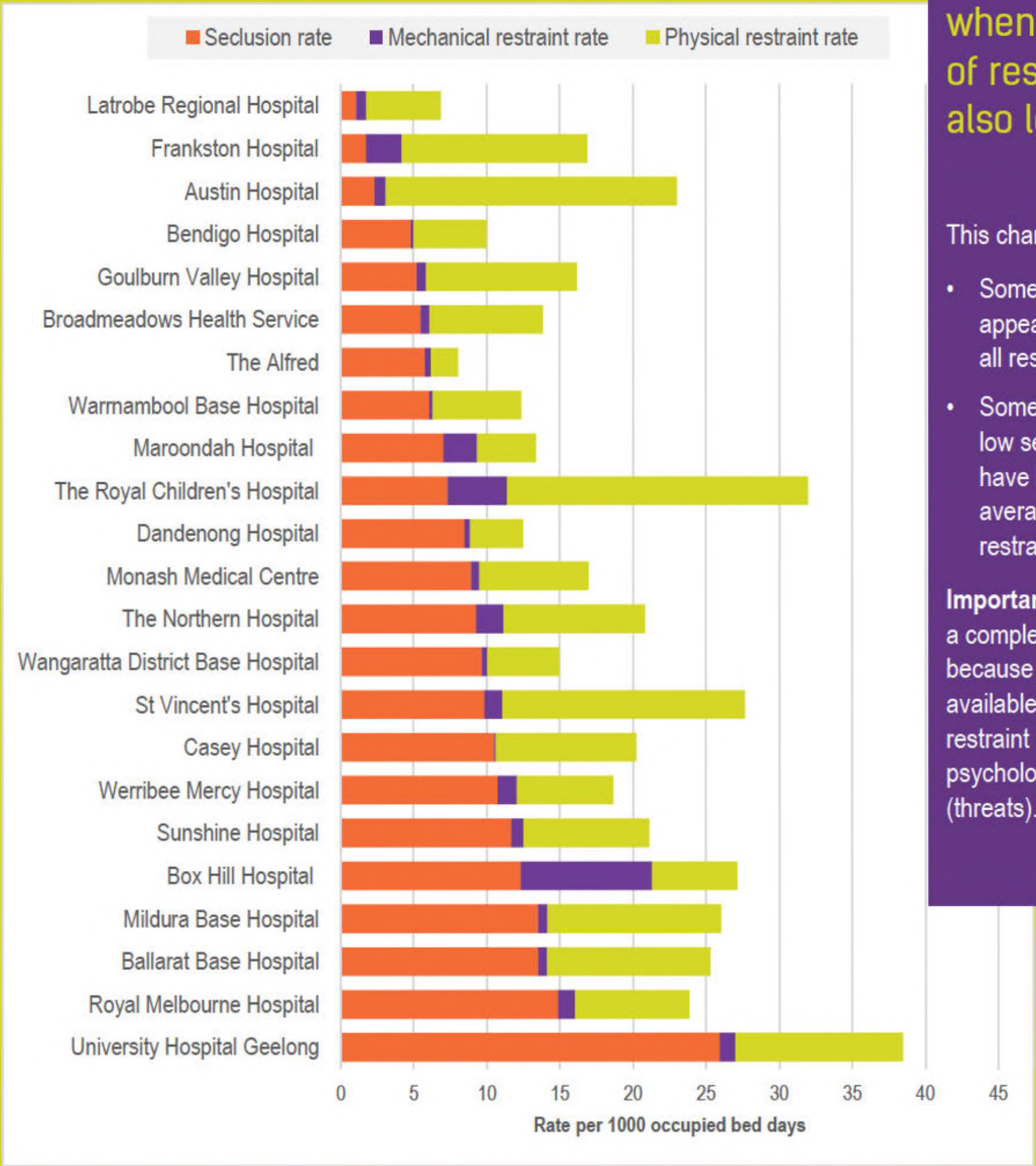


Seclusion is one of many 'restrictive' practices designed to control people.

All are harmful.

Restrictive intervention	What it means	Is data collected?	Is data reported publicly?	Transparency and accountability
Seclusion	Locked alone in an area	✓ Yes	× Some	Victorian government reports seclusion rates by service, and amalgamates some other state-wide information about seclusion. Many aspects of seclusion are not reported.
Physical restraint	Forcibly held down by people (e.g., 5 staff)	✓ Yes	× Minimal	Victorian government reports combine these two forms of restraint, and reports them together under 'bodily restraint'. Separate data for each type of restraint can be found for Victoria in AIHW reports. Victorian government only reports bodily restraint data by individual hospital for aged services, the rest of Victorian restraint data is amalgamated. However, from March this year, data by restraint type has been reported through AIHW for some hospital services.
Mechanical restraint	Tied down with straps	✓ Yes	× Minimal	
Chemical restraint	Controlled with sedating drugs	× No	× No	No reports provided by Victorian Government.
Psychological restraint	Controlled with threats or emotional control	× No	× No	No reports provided by Victorian Government.

Is seclusion being replaced with other forms of control?



Source: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices [8]

Low seclusion rates are only meaningful when all types of restraint are also low.

This chart shows how:

- Some hospitals appear to be reducing all restrictive practices
- Some hospitals with low seclusion rates have higher than average rates of restraint.

Important: This is not a complete picture because there is no data available for chemical restraint (drugs) or psychological restraint (threats).

Notes about this data:

The data in this chart includes rates for the whole of 2017/18, reported by hospital. The data is sourced from the latest AIHW report on restrictive practices released in March 2019. It is the first public report which specifies restraint rates in Victoria by hospital.

Variance from Victorian Government Performance Indicator Reports: Some of the seclusion rates included in this AIHW report vary from the Year-To-Date totals in Victorian reports. The AIHW report does not clarify reasons for this variance. A possible explanation may be that some hospitals are reporting combined seclusion rates across different unit types (e.g., adult, aged, child and adolescent).

Exclusions and inclusions: The dataset does not explicitly include Orygen Youth, however this data might be included as part of the Royal Melbourne Hospital. The dataset includes the Royal Children's Hospital. Identified aged services in the AIHW report were excluded from this chart as the list was incomplete.

WHAT IS A GOOD RESULT?

This depends. We suggest there are different ways to think about seclusion rates:

Have we stopped hurting people?	Seclusion always has a serious risk of harm, so the only good result is: '0'
Is seclusion just being replaced with another harmful form of control?	Zero seclusion is only a success if there is also zero restraint. This means we can't draw full conclusions until all forms of seclusion and restraint are reported.
Are services meeting their Key Performance Indicators?	The Victorian Government sets a Key Performance Indicator (KPI) for mental health services about seclusion, which is a rate of '15' or less.[9] It is clear that a lower rate is better. Any hospital with seclusion rates above 15 is failing to perform to expected standards of quality and safety.
Are services improving, getting worse?	We think it's important that hospitals can demonstrate they are improving over time. It is concerning to see that some hospitals report increasing seclusion rates, and others are very inconsistent.

MAKING SENSE OF THE SECLUSION RATE

Understanding seclusion information in this report

Victorian Government reports don't say how many people are secluded, or what percentage of people are secluded. Instead, they report on a 'seclusion rate'. The seclusion rate means:

> 'The number of seclusion episodes for every 1000 occupied bed days'.

The seclusion rate is confusing, and it doesn't make a lot of sense in the real world. But it's helpful for comparing hospitals with each other.

What does '1000 occupied bed days' mean?

This is a measurement that's helpful for statisticians, but not so helpful for the rest of us.

It combines the number of people admitted to hospital AND how long they stay. So, 1000 occupied bed days can mean:

- 1000 people who stay in hospital for 1 day **OR**
- 100 people who stay in hospital for 10 days **OR**
- 10 people who stay in hospital for 100 days **OR**
- 1 person who stays in hospital for 1000 days

Why are Victorian seclusion rates so much higher than Australia as a whole?

In reports from the Australian Institute of Health and Welfare (AIHW)[8], the Victorian Government provides two possible explanations for why seclusion rates are higher in Victoria than other states and territories:

1. **'Victoria's service delivery model produces a higher threshold for acute admission'**

   This argument says that people admitted to Victorian mental health inpatient units are more unwell than in other states. We assume this relates to the fact that Victoria funds less hospital beds per capita than other states.

2. **'The seclusion and restraint metrics may be inflated compared to other jurisdictions'**

   We understand this point suggests that Victoria may use stricter definitions of seclusion, so things that count as seclusion in Victoria might not be counted in other states. If this is correct, then Victoria is doing a good job of collecting data. We support strict definitions which ensure all instances of restriction are counted.

Does this justify high rates and lengths of seclusion in Victoria?

No. Neither of these points explain the enormous variations in seclusion (or restraint) between different Victorian hospitals.

It does not explain why someone in Barwon last quarter was 18 times more likely to secluded than someone in Traralgon.

Or why someone in Box Hill was 12 times more likely to be secluded than someone in Cranbourne.

These large variations point to serious problems in the culture and practice of particular hospitals.

SECLUSION AND HUMAN RIGHTS

Seclusion is a serious breach of multiple human rights in United Nations conventions ratified by Australia.

Seclusion impacts:

- The right to liberty
- The right to bodily integrity
- The right to freedom from torture, cruel, inhuman and degrading treatment

Even though Victoria has a Charter of Human Rights and Responsibilities (2006), under Victorian law seclusion is not always a breach of legal rights—because of limitations to rights in the Mental Health Act (2014).

In a report on Australia's compliance with the Convention on the Rights of Persons with Disabilities, the United Nations said:

> The Committee is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals (2013).[10]

GAPS IN SECLUSION REPORTING

Given the seriousness of seclusion, as a major human rights issue and a cause of psychological injury, we believe that much more information should be made available to the public. However, none of the following information is reported publicly:

Basic, accessible data

- How many people are secluded?
- What percentage of consumers are secluded?
- Length of seclusion by hospital
- Average seclusion episodes per person, by hospital

Seclusion room facilities

- Cleanliness of seclusion rooms
- Access to toilets in seclusion rooms
- Access to sunlight for people secluded
- Access to sensory stimulation VS sensory deprivation
- Independent inspections of seclusion facilities

Seclusion practices

- Reasons provided by services for seclusion
- Reasons provided by consumers for seclusion
- Service compliance with Mental Health Act seclusion requirements

Seclusion impacts

- Physical injuries as a result of seclusion
- Psychological injuries as a result of seclusion
- Provision of counselling to people secluded, by independent party

Sector & government accountability

- Consequences for services who fail to meet their KPIs
- Funding and initiatives to reduce, then eliminate, seclusion

Seclusion oversight & governance

The Chief Psychiatrist of Victoria has a statutory responsibility for seclusion and undertakes these oversight and governance activities:

- Requires hospitals to provide monthly reports on seclusion
- Analyses seclusion data and looks at variance
- Provides clinical leadership and promotes continuous improvement in the quality and safety to the sector
- A statutory committee meets 2-3 times each year to review data and recommend improvements. VMIAC is an invited member of this committee.

Perhaps the most important gap is that not all forms of 'restrictive interventions' are reported on a hospital-by-hospital basis.

So, while it's good that a hospital has lower seclusion rates, there is no way to tell if they are just replacing seclusion with other harmful practices instead. New national reports on mechanical and physical restraint begin to tell this story. Now we need this data reported quarterly, and reports on chemical and psychological restraint as well.

Seclusion causes mental, emotional and physical injuries—it has no place in a modern healthcare setting.

Every seclusion is a failure of care.

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[10] United Nations. (2013). Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (2-13 September 2013), s35. https://www.refworld.org/docid/5280b5cb4.html

Further information is available from:

Office of the Chief Psychiatrist, DHHS: Annual report: https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrist-annual-report-2016-17

Victorian Agency for Health Information (VAHI): https://performance.health.vic.gov.au/Home.aspx

www.vmiac.org.au

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