Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR RUTH GERALDINE VINE

I, Dr Ruth Geraldine Vine, Director, of Yarra Bend Road, Fairfield VIC 3078, say as follows:

1. I make this statement in my personal capacity and, to the extent relevant, I am also authorised by the Victorian Institute of Forensic Mental Health (**Forensicare**) 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

3. My full name and title, together with postnominals, are as follows: Dr Ruth Geraldine Vine, MB BS, FRANZCP, LLB, Dip Crim, DPM.

Relevant changes to background since my last witness statement dated 27 June 2019

4. I have ceased employment with Melbourne Health. I have been working part-time as a consultant at the Commonwealth Department of Health, briefly with the Department of Health and Human Services (**DHHS**), and the Eastern Melbourne Primary Health Network (**PHN**). This means I have had added exposure to other parts of the mental health system, including those funded through the PHN. I have also joined the Board of MIND.

5. Attached to this statement and marked 'RGV-1' is a copy of my Curriculum Vitae.

QUESTIONS FOR PANEL MEMBERS

6. Please note that in my opinion many aspects of public mental health care in Victoria has been distorted to some extent from the original expectation because of resource and funding constraints.

COMPULSORY TREATMENT

Question 1: How and why does the approach to compulsory treatment in mental healthcare differ to other areas of healthcare where greater agency is provided to individuals?

7. Every country has specific legislation on mental health because of the particular impact of mental illness. The course of a mental illness fluctuates and can result in a sudden, temporary or prolonged disturbance of behaviour. Some mental illnesses are evidenced by symptoms that include disorder of thought, mood, perception and behaviour, with

resultant negative impact on judgement. These are often referred to as psychoses. In particular, these mental illnesses are associated with misattribution such that the person does not recognise their experience and behaviour as being part of an illness that will respond to treatment. As the person considers the cause of their experience and behaviour to be external, they will not seek, or will evade, treatment. The impact of the illness can result in that person's inability to care for themselves and/or their family, and the misattribution can also result in behaviour that causes direct harm to that person and to others in the community.

8. While a person may lose capacity to consent to treatment because of acute trauma or other medical conditions, or may never have capacity to consent because of intellectual disability, these are not generally associated with disturbance of behaviour occasioning harm to self and/or the community.

9. Unless there are legal means for compulsory treatment, people living with mental illness would be tormented with untreated psychosis – this would be cruel and untenable in a humane society. Compulsory treatment is different from other forms of coercion, as the compulsion is linked to treatment which will mitigate the reason for compulsion. Even though the treatment may not be perfect in that it does not always result in complete resolution of symptoms or lead to cure, it will lessen:

    (a) the risk these people will be unable to care for themselves;

    (b) the risk of harm to these people and to others in the community; and

    (c) the distress experienced by these people.

Question 2: From your perspective, in what ways, if any, does compulsory treatment provide benefit to:

a. people living with mental illness, including children and young people

10. There are absolutely benefits of compulsory treatment for people living with mental illness when they will not accept treatment without such compulsion. Compulsory treatment can be life-saving – not just by reducing the risk of suicide but also by reducing the risk of dangerous behaviour. It can also avert loss of family, employment, housing and finances, and can reduce the risk of criminal offending.

b. family and carers

11. Seeing a loved one go through the torment, loss and confusion associated with psychotic illness is heart-breaking and terrifying, and can result in loss of family and friends. There

are very moving descriptions of mental illness and its impact on the person and their family and friends by Allan Fels,[1] Anne Deveson,[2] and Sandy Jeffs.[3]

12. While the compulsory treatment regime is directed at, and serves to protect, people living with mental illness, it also benefits and protects the nearest and dearest of such people.

c. the community

13. Members of the general public do not like seeing a person in distress and in general find a person who is mentally unwell and acting strangely frightening. Random acts of apparently senseless violence are most often related to untreated mental illness (noting that this worsens the stigma associated with, and discrimination of, people living with mental illness). As such, compulsory treatment also benefits and protects the broader community.

d. diverting demand for more acute mental health services, such as admission to an acute mental health inpatient unit?

14. Mental illness which is untreated is a common reason for admission to public mental health units. Keeping a person well, or minimising the risk and impact of relapse, through compulsory care in the community can reduce demand on acute units. As most mental illnesses have a high risk of relapse and recurrence without treatment, it is difficult to determine how long compulsory care should last. Relevantly, the *Mental Health Act 2014* (Vic) (**Mental Health Act**) seeks to reduce the duration of community treatment orders (**CTOs**). There has been a lot of research on CTOs but views on their effectiveness or appropriateness are polarised.

Question 3: Are there other alternative methods to compulsory treatment to engage people in treatment?

15. I do not believe a civilised society can wholly avoid compulsory treatment until we know how to prevent or cure psychosis and other severe mental illnesses.

16. It may be possible to have layered levels of compulsion, where there could be early intervention to institute compulsory treatment if a person is living with a severe mental illness that has a risk of serious harm (for example, schizophrenia). Currently, there is a single set of criteria for compulsory treatment (whether for inpatient or community care), and the treatment is immediate. There is no subset of criteria with a lower threshold for people with particular characteristics. The issue with that is that if people have to be very

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1 Allan Fels, *Tough Customer: Chasing a better deal for battlers* (Melbourne University Publishing, 2019).

2 Anne Deveson, *Tell me I'm here* (Penguin Books Australia, 1998).

3 Sandy Jeffs, *Flying with Paper Wings: Reflections on Living With Madness* (Vulgar Press, 2009).

unwell before they can be treated to get better, they end up having to be treated in high-dependency inpatient units or be in seclusion. Conversely, the problem with having a different threshold or set of criteria for particular subgroups is the difficulty of prediction – that is, knowing which people are most at risk of harm to self and others if treatment is ceased.

17. Some Canadian legislation only allows compulsory treatment in the community if a person has relapsed a few times following compulsory treatment as an inpatient (for example, 'three strikes' before they are eligible for compulsory treatment in the community) – their CTO is a sequential measure as opposed to a parallel measure.

If so:

a. what are they?

18. The need for compulsory treatment can be reduced by:

    (a) improving the accessibility and intensity of treatment in both bed-based and community (clinic-based and outreach) services, and improving the amenity of these services such that they feel safe and welcoming;

    (b) having better engagement and consistency of care such that there is a stronger therapeutic alliance between individual clinicians at the health service and the person living with mental illness; and

    (c) the person having an intact and caring family or social support group,

    such that the person may be able to be persuaded to accept treatment and care without compulsion.

19. With the above measures, the state of some people's mental health can improve without compulsory treatment. For others, there is no viable alternative; the alternatives for them include homelessness, prison and suicide.

b. what factors needs to be present in an individual for these methods to work?

20. The measures set out in paragraph 18 are likely to be aided by the person living with mental illness having had good pre-morbid functioning, such as being resilient, having good coping skills and a strong sense of self. Nevertheless, possessing such qualities does not of itself mean that the person will understand and accept that they have an illness.

21. In addition, in my opinion being able to access private care improves the likelihood of such person obtaining consistent and expert care.

c. what features or circumstances need to be present at a systemic level for these methods to work?

22. There needs to be accessible mental health services of good quality that have staff who can convey empathy, work with the person and their family across a range of interventions that go beyond solely pharmacological interventions. The place of treatment (whether it be in, for example, the community, inpatient units and community care units), needs to be a place where people feel that they are safe, occupied and valued. The infrastructure in many of Victoria's mental health services leaves a lot to be desired, and this seems to reflect the low value placed on mental health services.

d. to what extent could these methods be replicated or used more widely in Victoria?

23. The measures set out in paragraph 18 can be replicated or used more widely in Victoria to a great extent, but would require considerable investment with longer term planning for regular upkeep, renewal and workforce development.

Question 4: In Victoria, the Mental Health 2014 (Vic) states that compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or to another person.

a. Are there other factors that influence how clinicians may seek to use compulsory treatment? Please consider the impacts, if any, of resource constraints within the current mental health system.

24. There is misapprehension in some parts of the community that clinicians seek or want to use compulsory treatment orders. I disagree with that view. More so under the Mental Health Act (as compared to the previous *Mental Health Act 1986* (Vic)), clinicians tend to take people off treatment orders (both inpatient treatment orders (**ITOs**) and CTOs) earlier and at lower thresholds than before. The Mental Health Tribunal (**MHT**) also tends to be more stringent in making treatment orders and there is more frequent legal representation at MHT hearings. All these support the minimisation of the use and duration of compulsory treatment.

25. In addition, in my experience resource constraints are more likely to mean that people are discharged from inpatient and community mental health services earlier, and not that more compulsory treatment in the community is used. Relevantly, the lack of accessible services means that people living with a severe mental illness are likely to present late and so compulsory treatment is more likely to be imposed on such people.

26. In relation to the view that people are placed on compulsory treatment orders to get into services, I have not seen that happen and I do not believe that happens often. I am aware, however, that magistrates have granted bail with conditions that the person must be

admitted to an inpatient unit to receive mental health treatment. In my view, this is inappropriate and untenable but this does illustrate the extent to which other service sectors will go to seek access to mental health services.

27. It should be noted that 'immediate' and 'serious' are capable of different interpretations. For example, a person can be quite stable on treatment and relapse may not occur for months after ceasing long-acting treatment, but a CTO still provides for immediate treatment because there is a high risk of the person relapsing without 'immediate treatment'.

Question 5: To what extent are the existing safeguards contained in the Mental Health Act (including advance statements, nominated persons and the second opinion scheme) as well as current non-legal advocacy and legal representation arrangements:

28. Please note that, unless I have specified otherwise, my answers to the sub-questions relate to the safeguards in both the Mental Health Act and non-legal advocacy and legal representation agreements.

a. reflective of contemporary practice and evidence?

29. The existing safeguards are reflective of contemporary practice and evidence. The Mental Health Act, which was adapted from the *Mental Health (Care and Treatment) (Scotland) Act 2003*, is consistent with mental health legislation in other jurisdictions.

b. compatible with international conventions on human rights?

30. The existing safeguards are compatible with international conventions on human rights. In relation to the United Nations' Convention on the Rights of Persons with Disabilities, Australia had ratified this convention but declared limitations on its ratification (including on its understanding of when a nation can impose compulsion). In my view, leaving a person untreated, tormented by auditory hallucinations and delusions and at great risk of harm, is not compatible with international conventions on human rights.

c. operating as intended?

31. The existing safeguards are operating as intended, although the take up of advance directions and nominated persons is probably lower than anticipated.

32. I am uncertain if the degree of investment in safeguards has been compared against that in service provision. I question whether there has been disproportionally greater investment in oversight and other safeguards as compared to investment in service delivery.

d. currently taken up by consumers?

33. The safeguards contained in the Mental Health Act have been used to a greater extent as compared to those under the *Mental Health Act 1986* (Vic), as there is now more public funding for legal representation of consumers and a funded advocacy service through the Independent Mental Health Advocacy (IMHA) service. In some cases, having legal representation alters the outcomes of the MHT hearings.

34. Nevertheless, the safeguards in the Mental Health Act are probably not taken up by consumers as much as they could be. This may relate to a perception that they are not needed or will not make a difference. In addition, it is likely that publicly funded legal assistance will be rationed to those cases where representation is most likely to make a difference. A related problem is that the safeguards in the Mental Health Act provide a sense of security rather than necessarily resulting in change. The second psychiatric opinion scheme and the processes involving the MHT result in a change to a consumer's status under the Mental Health Act in a very small proportion of cases. If mental health services were under less pressure in terms of demand, the consumer's experience of interacting with the treating psychiatrist providing the first opinion would be improved and a second opinion less likely to be requested. It should be noted that mechanisms such as advance statements should really be part of all good health care, and not merely legal mechanisms, as they involve, for example, planning for early warning signs and considering what works best for a particular consumer.

e. currently taken up by families and carers?

35. I am not aware of the extent to which the existing safeguards are currently taken up by families and carers.

f. currently considered in practice by clinicians when determining assessment and temporary treatment orders?

36. I am not the best person to comment on whether the existing safeguards are currently considered in practice by clinicians when determining assessment and temporary treatment order. I note, however, that this is probably variable. When I have sat on the MHT, clinicians mostly did not refer to these safeguards. I note that there has been research on the use of supported decision-making which may better inform how this option can be utilised.

g. currently considered by the Mental Health Tribunal when determining treatment orders?

37. The existing safeguards are all regularly considered by the MHT. The uptake of advance statements and the nominated persons under the Mental Health Act has, however, been

low. The MHT is primarily focussed on whether a person meets the criteria for compulsory treatment.

Question 6: Do current independent oversight mechanisms governing the use of compulsory treatment need to be improved?

38. In my opinion, the current independent oversight mechanisms governing the use of compulsory treatment generally do not need to be improved, as they are already multi-layered, available and have received considerable investment. It will, however, be interesting to consider the impact of COVID-19 on these oversight mechanisms.

39. The main independent oversight mechanism is the MHT. Other mechanisms include the Mental Health Complaints Commission and the second psychiatric opinion scheme. Relevantly, while the Mental Health Complaints Commissioner has issued valuable reports (for example, *The right to be safe* report on ensuring sexual safety in acute mental health inpatient units), such reports will only result in real change if there is appropriate investment in mental health services.

a. If so, how?

40. In my opinion, the oversight of the MHT is very effective. An area where change could be contemplated is that of Electroconvulsive Therapy (**ECT**). ECT is an evidence-based and effective treatment. It should be a clinically-determined treatment and in my view should not require approval by a tribunal. It is discriminatory that ECT, but not any other clinically-determined treatment in other health care areas, requires such consent. The determination of the MHT can also be arbitrary, as the determination is dependent on who is sitting on the MHT for a particular case.

b. What is required to ensure any changes are successfully implemented?

41. As with other areas of mental health service delivery, having good reporting supports good practice. In my view, mental health services and relevant agencies should be required to report the numbers and outcomes of MHT hearings, and to report on subsequent service utilisation and need for treatment under the Mental Health Act.

Question 7: To what extent, if any, should compulsory treatment be used in Victoria's future mental health system?

42. As noted in paragraph 15 above, until we are able to prevent or cure psychosis, compulsory treatment should be used in Victoria's future mental health system, with plenty of protective measures in place.

a. Why or why not should compulsory treatment be used in Victoria's future mental health system?

43. Please see paragraphs 9 and 15 above. Even if Victoria has the best and most accessible mental health services, until we can prevent or cure psychosis we will need to have a system of compulsory care (with all the necessary caveats and criteria, protections and oversight mechanisms so that compulsory treatment is not used punitively or arbitrarily) if we are to be a humane and civilised society. A lack of availability of services and compulsory care will result in an increase in people living with mental illness who are homeless, socially isolated and disenfranchised, or in a justice/correctional setting.

b. From your perspective, if compulsory treatment is to continue, which services and settings should be permitted to use compulsory treatment?

44. Compulsory treatment does involve limitation of rights. It does need to be regulated and monitored, and there needs to be independent review mechanisms in place. Nevertheless, the limitation of rights is linked to treatment.

45. Compulsory treatment most often relates to pharmacological treatment or ECT. Compulsory treatment therefore needs to involve medical and nursing staff, but this could be in a service provided by a community or primary care agency. In other countries and jurisdictions, compulsory care is able to be provided in parts of the private system. In my view, this is appropriate provided there is still independent oversight, and there is no financial incentive for a person to be detained as a compulsory patient. It has been argued that compulsory treatment should not be in the community as the degree of oversight in the community is lower than that in a hospital. There cannot, however, be large numbers of people undergoing compulsory treatment in hospitals, unless Victoria returns to having big bed-based services providing institutional care. Thus, there is a need to maintain the use of compulsory treatment in the community, with the necessary oversights. In addition, until there is sufficient capacity in the forensic mental health system, there needs to be a way to provide more intensive mental health care (including the use of compulsory treatment) in prisons; it is untenable that we provide 19th century treatment to people living with mental illness in prisons in the 21st century. Ideally, there should be greater investment in the amenities and capacity of the forensic mental health system, so that there is a reduced number of prisoners living with untreated mental illness.

46. There are also other settings where persons living with mental illness, and who are under compulsory treatment orders, can be supported to access other services. In my opinion, it is important that despite the emphasis on personal choice in relation to funding under the National Disability Insurance Scheme (**NDIS**), Victoria ensures that people living with severe mental illness (who may be under compulsory orders) are not excluded from eligibility for NDIS support.

Question 8: Other than legislation, what are the other ways that could be used to reduce rates of compulsory treatment use? Please consider policy, data collection and dissemination, funding and operational levers.

47. As a starting point, compulsory care should only be used for the right reasons – that is, to provide treatment and to lessen the morbidity and negative impact of mental illness. It should not be used to detain and/or provide treatment to a person when the person does have capacity to consent or refuse, but is not agreeing to proposed treatment. The use of compulsory treatment should be publicly reported and benchmarked between and within health services, as this would contribute towards reducing the rates of compulsory treatment use.

48. Funding levers can be used to reduce rates of compulsory treatment use. Mental health services should ideally be adequately funded in line with population growth and the consumer price index. The services should be able to demonstrate to the Victorian government the level of funding that allows them to provide the necessary services – in other words, funding on a per capita basis (whether activity-based or block-funded) that provides for a level of service provision. This funding should correlate to episodes of care, experience of care, and patient outcomes, including follow up arrangements. For example, if the requirement for throughput means that a person is discharged to a General Practitioner (**GP**) without the area mental health service providing support to the GP and maintaining some contact with the person, it may be more likely that the person will drop out of treatment and relapse, re-present as being very unwell, and be again subject to a compulsory treatment order under the Mental Health Act. The Victorian government should also disseminate information on the per capita funding or Equivalent Full-Time positions (**EFT**) per capita dollar of area mental health services.

49. As noted in paragraph 22 above, having good and accessible services with caring, skilled and empathetic staff is important in minimising the use of compulsory treatment. By and large, there is a consistency as to how compulsory treatment is used by clinicians. This is demonstrated by how rarely a decision is changed by the MHT. Nevertheless, more confident and experienced staff, as compared to inexperienced staff, are more likely to make consistent decisions about the use of compulsory treatment orders – that is, decisions regarding when they should be retained and when a person will be able to manage without that oversight and protection. Experienced staff are also better able to pre-empt and diffuse aggression, and to engage therapeutically with consumers.

50. Having appropriate facilities in mental health services to support earlier access to services would be helpful in reducing the rate of compulsory treatment use. In addition, if there is sufficient space and amenity, mental health services would have greater capacity to manage risk and lessen the use of compulsory treatment.

51. Notwithstanding the above levers to reduce the rates of compulsory treatment use, it should not be assumed that such reduction is the only or most important aim.

a. How could they be deployed in Victoria and by whom?

52. The benefits of space and improved design should be considered for future facilities (please see paragraph 50 above). There are models of CTOs which are linked to other benefits (for example, housing and financial support contingent upon accepting treatment) but these also have their problems.

b. What is required to ensure the use of these levers are successfully implemented?

53. A whole raft of social policy improvements across human services, justice and health are required to ensure that the use of the levers discussed in paragraphs 47 to 50 are successfully implemented. These would include accessible and appropriate housing with support and a range of justice dispositions linked to treatment (with similar provisions in relation to child protection and youth justice).

COMPULSORY TREATMENT

Key objectives of CTOs

54. The key objectives of CTOs are to enable people living with severe mental illness, who would otherwise refuse treatment and become unwell, to live in the community and to participate in the community to the greatest extent possible through the provision of appropriate treatment.

55. The current practice in the application of CTOs meets these objectives reasonably well. The legislative framework of CTOs is, however, still very clunky and has an 'all or nothing' approach. If a person comes off a CTO and subsequently becomes unwell, they need to have a full-blown relapse to get back on a CTO.

Therapeutic relationship between a consumer and a clinician

56. A good therapeutic relationship between a consumer and a clinician can influence decisions around the use of compulsory treatment in both ways. It may mean that there is earlier recognition of relapse as the consumer and family are more likely to talk about the symptoms, and this can result in referral to settings with more intense care (for example, inpatient units). This may include early use of compulsory treatment. A good therapeutic relationship between a consumer and a clinician may also mean that the person will be more likely to accept increased intensity of, or change in, the treatment, without the need for a CTO. In any case, the best possible therapeutic relationship will not remove the need for compulsory treatment because of the consumers' misattribution or failure to recognise that their behaviour or mood has changed as a result of their mental

illness. This is particularly an issue for people living with brittle Bipolar Affective Disorder who, while in a manic phase, will see no reason for treatment or for restriction on their activities.

57. Clinicians can establish and maintain an effective therapeutic relationship with consumers who are on CTOs by being good in their role. Mental health services can also ensure that they provide consistent care by having fewer changes of clinicians. There have been very positive therapeutic relationships in forensic settings where a consumer is kept well for prolonged periods. There are also many positive relationships in public mental health settings where the person has a long term community clinician, and is treated with respect and empathy.

58. It is also important to note that a person receiving treatment under the Mental Health Act has rights and protections under that Act that are not available to people who are not receiving such treatment (for example, the right to an external review and a second psychiatric opinion).

MHT

59. I sit on the MHT. I believe it does a good job and takes its role very seriously.

60. The additional burden of MHT hearings on mental health services is considerable in terms of documentation, logistics and staff time. The number of MHT hearings has been increasing. The MHT changes a compulsory treatment order (that is, by ceasing it) in about 5% of cases. Thus, there is a lot of investment of resources in a mechanism that changes the decision in a small percentage of cases and it should be considered whether the balance is set right in this regard. I understand that in New South Wales, the process of reviewing compulsory orders is more administrative (paper-based rather than via a tribunal sitting), but this may diminish procedural fairness. It may be possible to conduct more MHT hearings by way of video conference to reduce the administrative burden. Clearly, the COVID-19 experience will influence this.

61. In relation to the MHT's jurisdiction over security patients, the current oversight mechanisms do not need to be improved. There are small numbers of security patients and often these patients would prefer to be in hospital. We do have a major problem with access to treatment in prisons but that is not directly related to the MHT. If CTOs were able to be used in prison then there would need to be very close oversight by an independent body.

Minimising the impacts of mental illness

62. In my opinion, the State should provide adequate health and social services (including better accommodation and support options) to enable accessible treatment for those

living with mental illness who are not able to afford or access treatment in other settings. As discussed in paragraph 43 above, these will not negate the need for compulsory treatment. People have a right to receive treatment for an illness with major complications and increased mortality, even if this has to be compulsory. It is important to understand that people with a severe psychotic illness are often unable to receive appropriate treatment in other settings.

63. State-funded mental health services can only provide what is possible within their budgets and infrastructure (including buildings, information technology, and workforce development and support). They should be supported to attract and retain the best staff and to ensure there are experienced staff who work in all settings, but this is hard if budgets are tight, the facilities unattractive and they face negative discrimination and stigma. The services should also have a responsibility to have students and trainees so it is inevitable that junior staff will rotate through different work experiences.

64. In relation to support services, in my view Victoria was short-sighted to break up the very functional community support services that were in place when the NDIS began. It will take years for these services to be as functional under the NDIS as they were previously for those living with severe mental illness. Individual choice may not be the most effective way to provide support in the community to people living with severe mental illness.

Reducing the rates of compulsory treatment use

65. The rates of compulsory treatment can be reduced, but any reduction should be because people can access treatment and care earlier during the onset or relapse of mental illness and for longer periods, and not because reduction per se is seen as a good thing.

66. To reduce the rates of compulsory treatment use, there needs to be many more beds – maybe double – in the mental health system, greater community mental health service capacity, and probably changes to the primary care sector as well. Every clinician and MHT member will have seen people who were receiving good treatment and support, had improved and were then discharged to a primary care sector that is not well set up to provide assertive and responsive care. These people then ceased treatment and some months later experienced a relapse that results in placement under a CTO or an ITO. The growth of the mental health system needs to keep pace with population growth, and the system should have welcoming facilities and a range of community options. The institution of long-term services for people who have experienced major trauma would also help to reduce the rates of compulsory treatment use.

Target populations and proportion of mental health consumers subject to compulsory treatment

67. I am not aware of the current proportion of persons seeking support from area mental health services who are, or are at risk of being, under compulsory treatment orders. A rough estimate is about 60-70% of consumers on admission to inpatient units and 40% of current inpatients. I am also not aware of the current proportion of case-managed mental health consumers who are on a CTO.

68. In my view, Victoria should aim for at least 2% of the population to receive treatment in public settings (the current percentage is about half that percentage now). The rate of compulsory treatment would be much less, but I am not aware if there is an agreed rate of compulsory treatment. I think it is important, however, to note that if there is an intention to expand the target group receiving treatment in public settings, there also needs to be a way to ensure that those living with severe mental illness are not unintentionally provided with less services.

69. Unless the access to inpatient units is increased to support earlier admission and longer length of stays for consumers, and community services are able to provide ongoing treatment and support, the number of consumers on a CTO will remain comparatively high (compared to other States and other jurisdictions).

Role of collection and publication of data around the use of compulsory treatment

70. The collection and publication of data around the use of compulsory treatment can play a role in reducing the use of compulsory treatment, but this is not simple. Compulsory care occurs in a context, and there is clinician variation. For example, at NorthWestern Mental Health (**NWMH**) some units had very experienced and stable staff, while other units had more junior and risk averse staff or had a greater turnover of staff. This is very hard to change with the levers currently available (for example, lack of funding, unattractive infrastructure and the inability to direct staff to move within a service). In addition, the data on rates of CTO use is influenced by not only the population growth but also social and patient factors such as rates of homelessness or use of illicit substances; these factors need to be considered.

71. The Victorian government should collect and publish demographic and service data (including data on population, EFT, profile of staff including years of experience and bed numbers and range) from mental health services. While this data is currently reported at a State level by the Australian Institute of Health and Welfare, it is not reported at a health service level in Victoria. As such, the data from area mental health services cannot be easily compared to enable better understanding of why there is variance in the use of compulsory orders.

72. Benchmarking between mental health services is complicated because of the reluctance to have service level detail in the public domain, but demographic and service data could be shared among mental health services at least at the Chief Executive and Director of Clinical Services levels.

Governance and accountability arrangements required for compulsory treatment use if catchments were removed in Victoria

73. While mental health services are rationed and block-funded, in my opinion mental health services in Victoria should continue to be delivered on a geographic catchment basis, especially in relation to compulsory patients. If funding was more nuanced to activity and the complexity of activity, and there was a base level of funding to ensure sustainability, then perhaps services would not need to be delivered on a geographic catchment basis.

74. I am not aware of an alternative to having catchments in Victoria for compulsory patients. I note, however, that people can go to any service in the primary care sector or private sector regardless of their place of residence. It then follows that they may have less continuity of care or a reduced range of options if the service they seek is at some distance from their place of residence.

75. As discussed in paragraphs 18(b) and 57 above, consistency of care is important. If catchments were removed in Victoria, some people who are likely to be made subject to compulsory care will try to evade services by moving and trying different services. Similarly, in respect of people with particularly complex needs, mental health services may directly or indirectly seek not to provide treatment. In addition, a person who needs intensive community treatment will not be able to have that provided to them if they seek treatment at a service some distance from their place of abode.

76. I accept that there is a tension between having services of a viable size in rural areas, and having locally available services in the outer metropolitan growth areas. This means that catchments should not be rigidly adhered to. If a person presents to, and is admitted to an out-of-area service, I do not think they should necessarily be repatriated as an inpatient, but they should be referred back to their local area upon discharge.

77. The responsibilities imposed on health services as a result of catchments provide a level of consistency and a guarantee of service delivery. If there were no catchments, then wherever a person presents or is brought for treatment to a service, that service must be obliged to accept and provide treatment to that person. Where this is impractical (for example, if the person presents at the Alfred Hospital but lives in Ballarat), the service must be obliged to arrange for transfer and the receiving service must be obliged to accept unless it is manifestly unreasonable.

78. Services should be rewarded for providing consistent care, and the level of complexity of consumers' needs should be reflected in additional funding to the services – this would be an incentive for the service to provide treatment regardless of a person's place of abode.

COMMUNITY BASED MENTAL HEALTH SERVICES

Ideal long-term role of the community-based mental health system in providing support

79. I do not consider it realistic for clinical community-based mental health services to provide support to people at risk of developing mental illness (unless there is some way of defining this group), but it is reasonable for services to be available to provide assessment and advice to other community services, including primary care services.

80. Community-based mental health services have a role in providing support to the following groups of people:

(a) **People experiencing signs of mental illness**: Services should be able to provide assessment and initiation of treatment if indicated. Services should also be available to primary care services, and be funded to provide Primary Mental Health Teams or some equivalent service to provide ready access to support and consultation to primary care practitioners. The COVID-19 situation may have enabled better digital platforms of support for primary care services for this cohort of patients.

(b) **People experiencing suicidal ideation or following a suicide** attempt: Services should provide assessment and support, as well as more intensive care if indicated (for example, admission to inpatient units, treatment and ongoing care). Crisis intervention is a useful model that can be relied on for a short duration but requires a very skilled input. The Hospital Outreach Post-suicidal Engagement (**HOPE**) trials seem sensible but they should be able to be flexibly incorporated into mental health services (with reporting requirements) rather than having to be a stand-alone team – more integration (rather than fragmented and siloed services) is needed in this area.

(c) **People experiencing mild and moderate illnesses**: An adequately resourced and multi-disciplinary mental health system should provide treatment and related support to this group in conjunction with primary care and private services. The Better Access scheme has seen enormous uptake, but I am not sure that it is the most effective way of reaching this group. My concern is that if the public mental health sector broadens its eligibility criteria to cater for this population, the ability of the sector to meet the needs of those living with chronic and severe illness, who have nowhere else to go, will be diminished.

(d) **People experiencing severe mental illness**: This is the non-discretionary population. People who cannot, or will not, access mental health services in the primary care or private sector must be able to access the State-funded system in both bed based and community settings. At issue, however, is whether this population should be separately provided in the same manner as in pre-mainstream days. There are arguments for and against this. One reason why people experiencing mild to moderate mental illnesses should not be supported by the State-funded system is that mixing these people with those experiencing most severe mental illnesses can be confronting and traumatising. Also, a focus on severe mental illness may limit the options available for different treatment modalities.

(e) **Families and carers**: The mental health system has a major role to play in listening to, supporting, and responding to the needs of family and carers – this can be done through information provision, involvement in treatments and being responsive to calls for greater support.

Exemplar community-based mental health care

81. There is no doubt that some community-based mental health services are better and more functional than others. Community-based mental health services should:

(a) be fit-for-purpose and have appropriate amenities;

(b) be locally accessible, welcoming and safe;

(c) be able to deliver treatment and care across a range of modalities;

(d) have multi-disciplinary staff with clear leadership and oversight; and

(e) have outreach services and extended hours of operation.

82. There are not many services in Victoria that achieve these standards, but many do provide very good care and have keen and dedicated staff. Some of the current services have grim infrastructure and are neglected and overcrowded. Newer facilities are mostly much better fit for purpose.

83. In my view, the services should be clinically led but this does not have to be so. There are some models delivered by community organisations which employ clinical staff.

84. I think it is relevant to note that Commonwealth funding has been announced for a trial of adult community mental health centres. I understand that the intent is to combine aspects of Commonwealth-funded health care (for example, primary care services and a broader scope of Medicare Benefits Scheme (**MBS**) items) and aspects of State-funded health

care (for example, immediate assessment, short term intervention, and the ability to provide outreach services). In relation to young people, headspace is doing well with providing community-based mental health services but there are limitations. Most of these community-based mental health services are not sufficiently integrated with State-based services, and are limited in their ability to respond to more severe or acute presentations. Also, the dependence on MBS income limits the range of clinicians available or willing to work at the services.

Reducing the gap between service need and supply

85. It is difficult to reduce the gap in community-based mental health services between service need and supply without more funding somewhere in the mental health system. There could perhaps be diversion to the private sector or through MBS items. Using a cheaper workforce is one way to reduce the gap but I believe it is wrong to consider that people living with mental illness should be expected to receive less skilled or expert treatment than other areas of health. Having a lived experience workforce may be economically attractive and their provision of support is welcomed by consumers and carers. Nevertheless, support does not replace evidence-based and effective treatments for people living with mental illness; such treatments should not be disregarded.

86. The costs of delivery of community-based mental health services can be reduced by having fewer clinicians (especially fewer medical staff), higher caseloads, more junior staff, shorter episodes of care and less outreach services. That is, however, how the mental health system got to where it is today. Costs could also be reduced by reducing the fragmentation, duplication and inefficiencies of having both State-funded and Commonwealth-funded systems. Consideration of fund pooling as suggested by the Productivity Commission, even to a limited extent, would be worthwhile.

87. There are improvements in, for example, data collection, record-keeping, making sure appointments are kept, using more telehealth and having more secondary consultation to primary care. For those living with severe mental illness or complex needs, more investment in care coordination that supports information sharing between providers, and minimises duplication, is needed to further improve outcomes.

Coordination of services within the mental health system

88. In my view, the extent of the multi-provider landscape should be reduced as much as possible. I think there would be greater efficiency and effectiveness if relevant parts of the Commonwealth's PHN funding could come through to State-funded organisations, including headspace, adult mental health centres, and probably even schemes such as Better Access and the Access To Allied Psychological Services program.

89. There may be different issues for different States but the problems with the current divide between the States and the Commonwealth in relation to health services include major duplication, confusion as to their respective roles, and poor use of the available workforce across private and public sectors (including under the Medicare scheme). I think there are also inefficiencies because of the multi-provider landscape. For example, there are currently multiple different providers of Prevention and Recovery Care services – this represents a lost opportunity to develop a skilled workforce and governance mechanisms for these services.

90. The common view is that there should be better coordination of services in delivering care, and this has worked well where people are receiving services from several different agencies or funding streams (such as those under the Multiple and Complex Needs Initiative, which has legislated information sharing provisions).

91. The challenge of a 'single care plan' approach to coordinating services is the risk of having all coordination and no care – that is, there may be many meetings among the services but little actual treatment. Each of these services will have their own information systems, clinical governance systems and competing priorities. There has been work in this area by, for example, the Eastern Melbourne PHN and the Brisbane North PHN in line with the Fifth National Mental Health and Suicide Prevention Plan, but it is unclear whether this work will be fruitful in the absence of an agreement between the States and the Commonwealth about shared funding.

Role of consumer choice

92. The role of consumer choice in determining what level and type of service and care they should receive is a difficult issue, as there is a tension between consumer choice and publicly funded service rationing. Consumer choice should be tempered by what has been shown to be effective and is accepted practice. I do not believe that an individual should be able to receive whatever intervention they want, regardless of its effectiveness or otherwise, if that intervention is publicly funded. Again, it is concerning if mental illness is viewed differently from other parts of the health sector. In other areas of health, while a consumer may choose whether or not to accept what is offered, what is offered is relatively standard across the public and private (MBS-covered) sectors.

93. Within accepted parameters, however, consumer choice should be supported and respected.

Whether mental health services in Victoria should continue to be delivered on a geographic catchment basis

94. Please also see paragraphs 73 to 78 above.

95. In the absence of catchments, there needs to be tighter regulation and greater consistency in clinical recording. The Client Management Interface/Operational Data Store (**CMS/ODS**) is great, but also cumbersome. If people are more likely to move between services, a shared clinical record would be advantageous.

96. The risk of abolishing catchments for mental health services is that some services will be perceived as less attractive, especially rural services that have outer metropolitan areas in their current catchment areas. Conversely, the inner metropolitan services may be more highly sought after and local residents may be squeezed out by patients who are itinerant or concentrated in the Central Business District. As a result, the risk for some patients is a loss of continuity of care and even greater rejection – this carries a risk for both those patients and the community. I accept that most people will seek treatment from their local health service. This works well for rural services, but less well for both outer and inner metropolitan services. Consumer choice in this matter is also more complex for people who may benefit from in-home services or who need compulsory care. Catchments are more important for those living with severe mental illness and those subject to treatment orders under the Mental Health Act, than for those living with mild to moderate mental illness.

97. If catchments are to be retained, it is difficult to re-configure them in the absence of change across the health system. There was considerable work in 2011 to consider different options to revise catchments and it was eventually considered to be too difficult. The current arrangement, while not perfect, does:

    (a) align mental health services with the local hospital networks (but not with the PHN catchments), which results in greater synergy between mental and physical health services;

    (b) provide adult, aged, and child and adolescent/youth mental health services that are of sustainable critical mass (noting that the shift to youth services has complicated this in some areas (as experienced by the Royal Children's Hospital, Orygen and Melbourne Health's adult services) but not in others) – for example, I understand that, while Alfred Health and Monash Health share the same child and adolescent mental health service (**CAMHS**) catchment, Alfred Health has been able to develop a youth community mental health service with sensible integration between adult and child catchments; and

    (c) result in clear governance by the health services. NWMH is an exception to this, as Melbourne Health has governance over mental health services provided in facilities managed by Northern Health and Western Health; at the time of their creation, the smaller outer metropolitan services were probably not ready to run an area mental health service. This position has changed and now the limiting

factor as to whether Northern Health and Western Health should manage their own mental health service is not the lack of corporate capability to do so, but rather the lack of capacity to manage their local demand.

98. In my view, the PHN catchments are not mature or established enough yet to be the organising principle for mental health services. In particular, unlike in other States, the PHN catchments in the metropolitan area of Victoria are quite complex. For example, the Eastern Melbourne PHN covers most of the catchment areas of Eastern Health, and parts of the catchment areas of Austin Health, Northern Health, Monash Health and St Vincent's Hospital Melbourne. Another example is that the North Western Melbourne PHN covers a large area which extends out to Bacchus Marsh, and so covers the catchments of Melbourne Health and Western Health.

99. If catchments are used for planning and resources allocation (similar to the broader health system) and are not tied to consumer eligibility for services, there would need to be some mechanism to link episodes of service and complexity of care to resource allocation, and to have a base funding level that ensures ongoing availability and acceptable standards of services. Planning should be linked to population growth even if consumer choice is promoted.

TRIAGE

100. My views on triage services are based on my experience with NWMH's triage services. I do not know much about other health services' triage services.

Centralising screening and triage services over large geographic areas

101. The benefit of centralising screening and triage services over large geographic areas is that there is more streamlined access for consumers (for example, those who can dial in through a single telephone number). The risks are the large and fluctuating demand for screening and triage services, and demand that is so great that there are long waits or high drop-outs. For example, there is great demand for NWMH's triage services and people may have to wait for about 45 minutes to get through a call.

102. Centralised triage services are particularly useful for emergencies/critical incident responses. If these services are over larger geographic areas, better systems can be put in place to support warm referral. This means that a person would be supported in getting an appointment rather than just being provided with the contact numbers etc. It should be noted that a more assertive approach would be getting the appointment for the person and then ensuring that the person attends the appointment.

Screening and triage functions being performed over the telephone or online

103. The main advantage of screening and triage services being provided over the telephone or online is that the services can be accessed from anywhere by patients, families, community members and emergency services. It is also possible to provide facilitated access to these services for GPs and the police. In addition, it is more likely that a standardised system is provided by using, for example, drop down-menus so that consistent responses can be provided.

104. The limitations of screening and triage services being provided over the telephone or online are:

(a) the degree of urgency is not assessed until the person gets through to a triage worker, unless there is a layered system whereby there is preliminary assessment;

(b) the services are dependent on technology – this may be a greater problem with the National Broadband Network as phones are less reliable; and

(c) the assessment will always be limited by not being able to see the clients and their social settings.

105. These limitations can be mitigated by having standardised training, good staff selection and the best possible technology. I also believe that having the input of a consultant psychiatrist (to review calls that were not referred for further support and to discuss complex or repeat callers) has been very useful at NWMH in making sure that there is clinical review and audit. It is, however, impossible to predict suicide and other adverse events.

Screening and triage services from on-the-ground providers

106. There has been some experience in Victoria with running separate screening and triage services from on-the-ground providers (which can refer people for assessment). It may be useful for the Royal Commission to check with services which have used different models, such as Goulburn Valley Health.

107. This approach does not work if there is effectively an added layer of assessment and the provider does not have great familiarity with local service personnel and local services. While there should be maximum integration and coordination of the different services, a degree of local and personal triage should be retained. The use of technology in providing triage services is helpful, but the role of these services is to provide not only information but also access to treatment and care. We need to avoid having all coordination and no

care. In addition, outsourcing services to another provider can be expensive and requires contract management.

CRISIS OUTREACH TEAMS

Role of crisis outreach teams

108. The role that crisis outreach teams should play in the mental health system of the future is dependent on their expected functions. If a crisis outreach team is expected to be experienced, capable of making autonomous decisions in high risk situations, responsive for 24 hours, 7 days a week, and equipped to provide services safely, it will be very expensive. We do not provide similar services in any other area of health (other than ambulance and first responder services) so it could be questioned why the mental health system should provide this level of service.

109. The Crisis Assessment and Treatment Team (**CATT**) described in the 1990s frameworks were part of reassuring the community and families that if large numbers of people living with mental illness were to live in the community, a service would be available to see them in their homes, provide short term treatment and avoid, or lessen the need for, hospitalisation. This is a different from a roving support role (providing intensive home-based support) that is usually provided by Non-Governmental Organisations (**NGOs**) rather than the clinical sector. In the 1990s, Victoria's population was much smaller, the spread of metropolitan Victoria was less, and traffic was better. The community and the social compact has changed since then. Having a larger population over a much larger area makes accessibility problematic and it would be too resource-intensive to have a mobile workforce to provide a timely assessment function.

110. The idea of CATT is still attractive but issues such as cost, workforce availability and social change mean that it is probably not realistic to return to having CATT as described in the 1990s frameworks. The move to the Hospital In The Home is not entirely the answer to these issues, as it is unclear whether this is to provide monitoring, ongoing treatment and a current assessment function (which is the function of a Mobile Support and Treatment Team (**MSTT**)) or a more acute crisis intervention and short-term treatment function (which is the function of the CATT). Health services have reduced the scope of CATT services by reducing their hours and days of operation and changing the staffing profile to have fewer doctors and experienced staff.

Location of crisis outreach function

111. The crisis outreach function could be located in emergency departments (**EDs**) and/or community-based mental health services. I believe it makes sense to have strong mental health teams in the EDs that have the capability to provide some outreach. The HOPE program has a degree of outreach capability and is often linked to EDs (noting that the

HOPE program is rationed and it is not ideal that a suicide attempt has to occur before services are provided). Likewise, the Police, Ambulance and Clinical Early Response (**PACER**) program allows clinicians in the EDs to perform an outreach function with the police or ambulance services. I agree that there should be ways of supporting these services, but I am not sure that the PACER program is the best model. Outreach is limited in both the HOPE and PACER programs, as the demand for clinicians in the EDs will always trump the demand for outreach. Thus, it may be more effective to link the crisis outreach function to community-based mental health services.

112. The crisis outreach function can also be linked to inpatient units to support early discharge, including to community clinics. Relevantly, it is important to remember that the crisis outreach function is different from the MSTT function which is more about maintaining stability than responding to urgent deterioration or crisis situations.

STREAMING

Streams of care for people with different types of needs and characteristics

113. Streaming is an attractive idea but it is very dependent on service size and critical mass. There needs to be critical mass to provide appropriate staffing and cost efficiencies. For example, some of the early CAMHS in patient units only had 2 beds. This number is too small to allow for appropriate treatment or age-appropriate activity, such that streaming may end up as more isolating and anti-therapeutic.

114. It is most appropriate to have different age-based services with some greyness at the overlapping ages (for example, age groups comprising 13 to 18, 16 to 25, 18 to 65, and 65 and above years). It would also be good to have an ability to segregate consumers based on:

    (a) gender (but this seems increasingly complex with gender fluidity); and

    (b) degree of behavioural disturbance that is matched with the appropriate staffing and environment.

115. Victoria has done relatively well with providing separate and specialised services for particular groups, such as people living with eating disorders and mothers/babies.

Purposes of streaming

116. The purposes of streaming are to provide:

    (a) appropriate amenities (for example, amenities for elderly consumers)

    (b) appropriate treatment modalities for both individuals and groups; and

(c) a safe and therapeutic milieu.

Alternatives to streaming

117. Streaming is more relevant in inpatient or residential services. Individualised packages may be relevant to other less acute presentations or phases of care. It may be that individualised packages can be used as a sort of voucher for care in the private sector, but this would need to be very carefully considered.

118. As discussed in paragraph 113, streaming requires critical mass. As such, streaming may work better than individualised packages where there is moderate to high demand for a stream of care. There is also opportunity to use services across other sectors such as community support services and primary care services.

ALCOHOL AND OTHER DRUGS

Best practice service response and consumer experience

119. Alcohol and other drugs (**AOD**) is not my area of expertise, but it seems to me that the services that Victoria has for adults and young people with co-occurring mental illness and problematic AOD use are very limited. New South Wales has done a better job than Victoria, as they kept a strong oversight of AOD services within the health sector. My main experience of working in this area in Victoria was in the late 1980s, which was a long time ago, but I remember that there was a dedicated and very skilled staff group (including doctors, nurses and social workers) in this area. There was also a service setting, such as the Pleasant View centre, that provided bed-based detoxification and clinic-based treatment, and longer term rehabilitation services. Up until the 1990s, the AOD services were designed to provide a coordinated range of outpatient services, short detoxification treatments and longer term rehabilitation services. I know much has changed, including the drugs which are prominently used by consumers, but in my view the current AOD service system is too separate from the clinical system.

120. Where a person presents with co-occurring mental illness and problematic AOD use, it should be routine that there is integrated care in that both aspects are part of the treatment plan and the person has access to people skilled in both areas. This would require major workforce development. There is also a need to have further debate and discussion about whether there should be legal compulsion to engage with drug treatment that is not linked to correctional orders, and when this legal compulsion should take place. This is a complicated area.

121. It is relevant to note that, unlike the Mental Health Act which can compel inpatient admission if CTOs are not complied with, there is no legal health consequence if a person does not undertake treatment in relation to AOD use. The *Severe Substance Dependence*

Treatment Act 2010 (Vic) sets a high threshold and only considers about 11 people a year. It is a legislative framework that is a last resort.

Greater integrated care

122. Please see paragraph 120 on integrated care for people with co-occurring mental illness and problematic AOD use. I believe that integrated care can entail shared treatment planning, good communication and shared clinical records between the mental health and AOD service providers. Alternatively, integrated care can be provided by a single provider which is able to support different streams of treatment. In my view, the latter is more likely to have good clinical governance.

123. In my opinion, the key way to achieve greater integrated care is to bring AOD services back into the clinical sector. In particular, given the preponderance of people with co-occurring mental illness and problematic AOD use, AOD services should fall within the mental health system. If AOD services remain in the NGO and private sectors, then whether or not a person has financial resources makes a lot of difference to the treatment and care available to that person. Alternatively, the NGO sector could be required to develop a workforce that has greater treatment skills, or the private sector could be regulated to ensure that they are providing relevant services (especially the rehabilitation providers that sometimes demand high cost payments). There should also be AOD/mental health clinical teams integrated into the general health care linked to the Consultant-Liaison Psychiatry teams.

GOVERNANCE

Integrating governance arrangements of mental health services and acute health services

124. The merits of integrating the governance arrangements of mental health services and acute health services are related to efficiencies associated with the health service size and the service's corporate and clinical supports (for example, ED, Information Technology, Human Resources, and capital). Such integration works well where the Chief Executive and Board have an interest in mental health and work to ensure that there is recognition of, and support for, mental health services.

125. The limitation is that the above merits do not always eventuate. There is 'soft' discrimination like limited access to recovery for consumers receiving ECT, grumbles when demand by mental health consumers for the ED services is high, and less support for Consultant-Liaison Psychiatry. The segregation of mental health from the rest of the health service is much greater than the segregation of medicine and surgery in terms of outliers. Mental Health tends to be an 'add-on' with the building at the back of a health service. The lack of space and amenity is a real limitation in health services where the needs of ambulant mental health patients are hard to recognise.

126. The alternative of separating the governance arrangements of mental health services and acute health services is also difficult unless there is the establishment of separate Boards which would need to cover large geographic areas.

Ideal objectives of performance monitoring with regard to Victoria's mental health system

127. The ideal objectives of performance monitoring for consumers, families and carers are that mental health services:

(a) demonstrate that services are available and are used;

(b) accord with services provided in like jurisdictions;

(c) are safe and effective; and

(d) particular aspects are closely regulated and monitored (for example, length of stay in high-dependency inpatient units, use of seclusion and restraint, and verbal/physical violence).

128. The ideal objectives of performance monitoring for service providers are:

(a) the objectives set out in paragraph 127 above;

(b) access to, and throughput of, services;

(c) length of stay in ED, inpatient units, community-based mental health services;

(d) use of the Mental Health Act;

(e) experience of care measure;

(f) workforce data including retention, turnover, and occupational health and safety; and

(g) budget (including, for example, leave/Information Technology investment),

so as to allow consideration of the pressures on the service's system, system effectiveness and acceptability and workforce requirements.

129. The ideal objectives of performance monitoring for the system manager are (noting that these objectives should be at a high level):

(a) the objectives set out in paragraphs 127 and 127 above;

(b) critical incidents, reviews and recommendations;

(c) key workforce data including vacancy rates, graduate programs;

(d) use of restrictive interventions; and

(e) population and infrastructure reporting,

so as to enable planning and system adjustment to meet emerging areas of concern and to provide benchmarking across the sector.

Changes to current performance monitoring arrangements to meet ideal objectives

130. I believe that performance monitoring arrangements have improved considerably in recent years. Nevertheless, there is a need to:

(a) include more data with denominators (for example, beds per capita, EFT per capita and length of stay in ED per inpatient unit capacity); and

(b) have more public reporting of issues such as staff assaults and absenteeism.

Statement of Priorities

131. I believe that the Statement of Priorities is limited in utility in enabling performance oversight of mental health services and accountability for mental health outcomes. The Statement of Priorities can be improved by:

(a) adding in more measures, such as those relating to finances, infrastructure and experience of care, that are specific to mental health services (for example, there is far greater attention on occupational violence in the ED rather than the psychiatric inpatient units, when occupational violence in the latter tend to be much more serious); and

(b) in relation to the measure on length of stay in the ED, separating mental health services from other areas.

132. Relevantly, mental health priorities and indicators are not comparable to broader health priorities and indicators because of different funding and service attributes.

COMMISSIONING

Support of new care models

133. My view is that commissions add a layer of bureaucracy to provide oversight but do not necessarily improve the system in terms of minimising duplication, improving coordination and improving access to services. More commissioning appears to result in more

providers rather than fewer providers. I also do not believe that commissions are the answer to addressing the underfunding of the mental health system.

134. In relation to how commissioning approaches can support new care models, there needs to be much better articulation of what is intended to be provided, what funding is available, and the target population. I have not been active in this area for a while, but I understand that the commissioning of the 'mental health and AOD Hubs' has been through many changes in expectation. There probably needs to be local flexibility unless the funding is clear about whether infrastructure and other start-up costs are included. The funding should be adequate for commissions to perform their roles, but the commissions should be accountable to DHHS.

Responding to and valuing the preferences and needs of consumers

135. Good policy and service development will have taken into account consumer preferences and needs along the way. It is important that commissioning approaches consider the needs of the consumers who are most likely to need or use the service and not simply adopt the views of a general lived experience representative.

Incentivising early intervention approaches

136. Early intervention may be incentivised through commissioning approaches by funding new referrals in preference to repeat callers, but there is a risk arising from this. My view is that since the mental health system has not provided good care to people already living with established mental illness, a focus on early intervention is problematic unless it is accompanied by a similar focus on established illness, and on the provision of ongoing treatment and care.

Encourage the provision of treatment, care and support to people with complex needs

137. Commissioning approaches can encourage the provision of treatment, care and support to people with complex needs by using funding incentives to encourage multi-agency or multi-stream plans, regular multi-agency and multi-disciplinary clinical review and regular reporting of adverse incidents and positive outcomes.

Local, national or international examples where commissioning has worked particularly well

138. While I am sure there are examples where commissioning has worked particularly well, I am most familiar with commissioning by the PHNs. The success of the process has varied considerably.

139. Models of commissioning which have worked particularly well:

(a) allow information sharing and encourage mutual respect;

(b) are not constrained by the divide between the States and the Commonwealth in relation to funding or responsibilities (for example, Alfred Health's headspace)

(c) have some workforce rotation or co-location;

(d) a single system of recording;

(e) strong clinical leadership with authority to make decisions and have these supported; and

(f) require the Chief Executive or the Board to sign off on shared critical incident reviews across the members of the consortia (if it exists).

SECURE EXTENDED CARE UNIT (SECU)

Role of SECU services in the Victorian system

140. When SECU services were first provided, they were intended to be a long-stay and secure clinical service. This role has changed since then because:

(a) SECU services are not attached to large open spaces so it is difficult for consumers to have space and time to settle in a separate area;

(b) drug use patterns have changed so it is harder to monitor substance use;

(c) there is a need for throughput so people with very long projections for rehabilitation may not be accepted – this means that people living with dual disabilities or have very severe substance may not be accepted, or are given a trial of 6 months before being required to leave despite them not having fully recovered;

(d) as a result of the factors in paragraphs 140(a) to (c), the environment in SECU services is often more complex and acute than intended; and

(e) the limited number of beds in SECUs mean that a single SECU has to manage consumers who may be both young and old, vulnerable and predatory, male and female, for an extended period of time.

141. If the role of SECU services is to be a place of moderate containment that provides treatment to people with complex treatment and support needs, then in my opinion services have largely achieved this.

Responding to consumers with very complex treatment and support needs

142. The SECU model is not consistently applied in Victoria. Some SECUs do amazing work (for example, the SECU in Sunshine Hospital) with people with complex needs and provide treatment and care as safely as possible, but the effectiveness of SECUs is variable. The limited amenity of SECUs does limit the good work some SECUs can undertake. Staffing is also very limited. For example, I was told recently that a SECU did not have access to a psychologist.

143. In order to ensure effective treatment and support consistent with the principle of least restriction in the Mental Health Act, changes are required to the design, staffing and funding of SECUs and these changes may then allow a change to the model of care. SECUs are funded even less than acute inpatient units.

144. It should be remembered that SECU services are for people living with the most severe and treatment-resistant mental illnesses and often with major physical co-morbidity. I believe the SECU model could be improved by having greater integration with the NGO sector, but to best comply with the Mental Health Act there needs to be more space and greater flexibility about placement. This includes being able to support people in various accommodation options.

145. The Thomas Embling Hospital (a forensic mental health hospital, not a SECU) has a large area with a secure perimeter, and the ability to allow consumers to 'step down' (in relation to the intensity of care) and access that area within the secure perimeter. No SECU has this.

FORENSIC MENTAL HEALTH

Provision and oversight of prisoner health services

146. The responsibility for the health of prisoners moves between the Justice and Health sectors in a number of jurisdictions. In Victoria, responsibility for the health of prisoners transferred from DHHS to the Department of Justice and Community Safety (**DJCS**) in the context of privatisation of some prisons. My view is that the DHHS is better placed to manage the clinical governance, intersections and workforce requirements than the DJCS. Regardless of which Department has carriage, there needs to be clear areas of responsibility, reporting requirements, and processes for escalation and external review.

147. In my opinion, it is problematic that St Vincent's Hospital Melbourne provides physical health services to prisoners but is unable to admit prisoners who are detained under the Mental Health Act, and that patients of Thomas Embling Hospital have to go to the Austin Hospital for physical health needs (with all the risks and expense of individual escorts and

not receiving treatment in a secure environment). Please also see paragraph 45 above on the need to provide more intensive mental health care in prisons.

Forensic mental health service delivery to young people

148. In relation to forensic mental health service delivery to young people in contact with the justice system, Victoria has not done well in this area until very recently. A service for young people in the justice system has recently been developed by Orygen at its Footscray location, and I understand this is progressing and is going well. Like any service, this service needs to have options for escalating the intensity of care; as such, it needs to have outpatient clinics in custody areas to provide greater support and clinical input, as well as inpatient clinical beds. There are also plans for a dedicated mental health space in Youth Justice's facilities.

149. Given the high prevalence of mental illness and comorbidities like substance use in young offenders, it should be the norm of treatment, not the exception, to provide support to them to better manage or address co-occurring mental illness and engagement with the justice system. They are a highly vulnerable population.

Responding to the needs of very complex clients

150. In relation to very complex clients in both community and inpatient settings, responding to their needs is a very difficult area and there are a couple of current cases that demonstrate the complexity of it. Inpatient settings are not necessarily the most appropriate for young offenders with very complex needs and self-harming behaviours. I do not have an answer as to the most appropriate response to their needs, but I believe that DHHS and Corrections Victoria need to work very closely together with input from a senior level.

Information sharing to facilitate consumer treatment

151. Clinical information is only held by mental health services, while correctional information is only held by Corrections Victoria. While I agree that it is not appropriate for officers from Corrections Victoria to have access to consumers' clinical files, there needs to be good communication between mental health services and Corrections Victoria in certain circumstances (for example, where consumers have very high risks of self-harm and suicide or are living with very severe mental illnesses). Information sharing between prisons may be even more problematic as each prison tends to have their own management systems, but I am not the best person to address this issue.

152. Information sharing between Forensicare and Corrections Victoria is managed as well as possible. I believe the addition of the Forensic Clinical Specialist program has greatly improved information sharing and treatment planning for persons who are entering or

exiting the criminal justice system. While it would be ideal if mental health services and Corrections Victoria are all on the same health record system, the CMI/ODS has been very helpful in this area and it should be upgraded, maintained and retained).

153. There are also restrictions on the sharing of health information, but in general I believe that mental health providers are willing to share relevant health information with the clinical providers of forensic health. A bigger issue is perhaps the limits of sharing that information with courts and prisons. In my view, such sharing of information needs to stay tight given that information about mental illness can be misused and misconstrued.

RESTRICTIVE PRACTICES

Changes that have influenced when and how frequently restrictive practices are used within mental health services

154. The following changes are likely to have influenced when and how frequently restrictive practices are used within mental health services:

(a) **Changes to legislative and policy settings**: I believe that the national effort (through national policies) to reduce the use of restrictive practices was very effective in both adult and aged care settings. The comparison between mental health services within Victoria in relation to the use of restrictive practices also led to practice change, but there is still enormous variation between services. I am not so sure that the legislative change to the Mental Health Act resulted in changes to the use of restrictive practices, but this was confounded by the demands on services and a general shift to a more acute patient mix.

(b) **Changes to service environments**: The changes to policy settings has led to changes to service environments. Clinicians do think more about how and when to use restrictive interventions, but the high demand for mental health services, the mix of consumers, and the need for safety for all, makes this tough. I believe that services are doing well in terms of oversight and review (including at the leadership level) of the use of restrictive interventions.

(c) **Changes to patient characteristics**: The increased use of methamphetamine has been a major issue in relation to the use of restrictive practices, but the demographic of consumers who are more likely to be subject to these practices is similar – that is, young men with impulsive behaviour who are at risk of assaulting staff and others because of misinterpretation of the environment and the impact of mental illness and substance abuse. Increased homelessness may have worsened this issue.

(d) **Changes to acuity**: Changes to consumers' acuity (with delayed access to help) has absolutely influenced how frequently restrictive practices are used within mental health services. There will always be people who evade services and present late, but in the face of service constraints (in addition to a frenetic service environment), I worry that the mental health system may have been complicit in waiting for people to become more unwell before admission. The reforms to legislation do not help this. Relevantly, forensic mental health services tend to use seclusion more than area mental health services partly because consumers present to these services late and are living with very severe mental illnesses. They are therefore at a higher risk and seclusion is more likely to be required.

Actions that service providers can take to reduce the use of restrictive interventions?

155. The actions service providers can take to reduce the use of restrictive interventions (including by using alternative strategies and only using restrictive interventions as a last resort) are limited by their amenities. Having small units with limited outdoor and contained spaces means that providers cannot allow a person space and time to settle in a separate area. Also, it would be helpful if consumers can be admitted to the services earlier.

Support that staff need so that they can reduce the use of restrictive interventions

156. Often, inpatient areas are seen by staff as more stressful and less attractive as workplaces. Where staff are less experienced and more likely to be anxious, there will tend to be more use of restrictive interventions. Relevantly, the key staff members are the Nurse Unit Manager, the lead consultant, and the nurses in charge of the shift. If service providers have experienced and confident people in these roles, there will likely be less use of restrictive interventions. These staff members should be rewarded for working in these high pressure areas.

WORKFORCE

Digital and community-based services

157. The COVID-19 situation is teaching us a lot about how much clinical work can be done in virtual settings. Previously, I would have said that only a limited amount of the mental health services currently funded by the Victoria could be delivered online or in different settings. Nevertheless, it remains the case that mental health services depend on interpersonal relationships more than most other areas of health, and these relationships are not easily replaced by online technology. I believe that some community services could be aided by online work, but in my view it is not possible to do a thorough mental state assessment of an acutely disturbed person online. I also think that, where a person

may be detained and placed under compulsory treatment under the Mental Health Act, the assessment should be face-to-face.

158. I agree that a contemporary workforce should have a variety of skills, including digital technology skills, but it needs to retain a solid base of professional skills and there needs to be face-to-face treatment for interpersonal relationships to be established. People who are seeking support and information, or are willing to invest time and energy to get their own treatment, may be amenable to digital services. We have to, however, consider the key population which the mental health workforce currently services, being those with acute needs for mental health treatment. That population needs a mobile workforce that can provide services face-to-face (including outreach services).

Changes in workforce roles and identities

159. I assume there will need to be more supervision and support of a less qualified and experienced workforce across a range of disciplines and settings to keep up with the changing needs and expectations of consumers. I believe, however, that the core needs of good mental state assessment and instigation and monitoring of treatment by a professional workforce will remain important. As discussed in paragraph 85, I do not believe that those who experience mental illness should expect to receive treatment from a less qualified workforce than those with physical illness. The use of a lived experienced workforce may be helpful in relation to the support of people who are receiving treatment in a mental health service, but does not replace the need for clinical treatment. A professional workforce is needed for more severe mental illnesses such as major depression or personality disorders.

Preparing and support for workforces to take part in significant changes to the way they work, and the environments they work in

160. People who work in the mental health system will need to be equipped with great information technology support to enable remote access and entry into the medical records system. They need to be trained and supported to work across providers (including State, PHN, NGO providers) while staying within the parameters of confidentiality.

161. Over time over multi-year reforms, I assume that there will be ever greater improvements in how we record, store and access clinical information. I sincerely hope that there will also be advances in diagnosis and treatment that will enable earlier intervention and more acceptable treatments.

Organisation of workforces

162. I believe there needs to be clinical leadership and oversight in relation to the provision of multi-disciplinary and consumer-focussed professional practice across community-based services. Such practice needs to be medical, with the main component of treatment being medication and/or treatment under the Mental Health Act. The public mental health system has been de-medicalised to a significant extent; there has been too much focus on pharmacological treatment instead of the importance of more holistic input. Mental health services have a long tradition of having a more horizontal and multi-disciplinary workforce, and in my view this is a strength.

163. There should be changes to how the workforce is organised in relation to the Medicare scheme. In my view, the most effective use of the workforce would be to enable those working as private and public providers to work across the systems with as few barriers in relation to client information as possible.

sign here ►

print name RUTH GERALDINE VINE

date 29 April 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RGV-1

This is the attachment marked 'RGV-1' referred to in the witness statement of Dr Ruth Geraldine Vine dated 29 April 2020.

CURRICULUM VITAE

RUTH GERALDINE VINE
MB BS, FRANZCP, LLB, Dip Crim, DPM
Associate Professor, University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences
CITIZENSHIP: Australian

QUALIFICATIONS

1980 MB BS University of Melbourne.
1983 FRACS (Part 1)
1990 Diploma of Psychological Medicine (University of Melbourne)
1990 Fellow of the Royal Australian and New Zealand College of Psychiatry
1994 Graduate Diploma of Criminology (University of Melbourne)
2000 Bachelor of Laws (Latrobe University)
2011 Graduate of the Australian Institute of Company Directors

APPOINTMENTS

July 2013 - 2019 Executive Director, NorthWestern Mental Health, Melbourne Health

November 2012 – July 2013.
Director of Clinical Services, Inner West Area Mental Health Service, Melbourne Health.

May 2009 - November 2012.
Chief Psychiatrist, Department of Human Services. Since August 2009 this was within the Department of Health.

March 2010 - March 2011.
Director, Bushfire Psychosocial Recovery team, Department of Health.

September 2010 - July 2011
A/Director Operations, Mental Health Drugs and Regions, Department of Health.

May 2008 – May 2009.
During a period of leave without pay from the Department, I worked as a consultant psychiatrist in the Western Region Community Health Centre part time and as a project officer with the Mental Health branch of the Department of Health and Aging in the Commonwealth government.

March 2007 – Oct 2007
Acting Executive Director, Mental Health and Drugs division, Department of Human Services.

Jan 2004 – Feb 2008
Director, Mental Health Branch, Department of Human Services.

1999 - 2004 Deputy Chief Psychiatrist, Department of Human Services.
1991 – 1999 Consultant Psychiatrist, Forensic Psychiatric Services.
1991 –1993 Lecturer, University of Melbourne, Department of Psychological Medicine, Austin Hospital.

1990 – 1991 Fellow in Geriatric Psychiatry, Baycrest Centre for Geriatric Care, University of Toronto, Canada.
1986 – 1990 Psychiatry registrar

PUBLICATIONS

- Vine R.G., Judd F.K. Anxiety Disorders and Panic States. **The Disease Index**. 1991/92. 51-55.
- Vine R.G. Benzodiazepine use by women prisoners: association with personality disorder and behavioural dyscontrol. **Psychiatry, Psychology and Law**. 1994 1 53-58.
- Vine R.G, Steingart A. Personality disorder in the elderly depressed. **Canadian Journal of Psychiatry** 39 392-398
- Burrows G, Vine R.G. Anxiety Disorders. In **Foundations of Clinical Psychiatry.** Edited by Sidney Bloch and Bruce Singh. Melbourne University Press 1994.
- Vine R.G. 'Decision making by psychiatrists about involuntary detention'. In: **Involuntary Detention and Civil Commitment: International Perspectives**. Edited by Ian Freckleton and Kate Diesfeld. 2003
- Vine R.G. Modernising the Mental Health Act: proposed areas for reform. **Newparadigm,** the Australian Journal on Psychosocial Rehabilitation, Summer 2009/10, pp 14-17.
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- O'Donoghue B, Brophy L, Owens N, Rasic M, McCullough B, Huang B, Vine R and McKenna B. Rate of community treatment orders and readmission orders following reconfiguration of community mental health services. **Australasian Psychiatry** June 2016
- Vine Ruth, Turner Suzanne, Pirkis Jan, Judd Fiona, Spittal Matthew. 2016. Mental health service utilisation after a Community Treatment Order: a comparison between three modes of termination. **ANZJP**. 50(4) 363-370
- Vine Ruth, Tibble Holly, Pirkis Jan, Judd Fiona, Spittal Matthew. 2018. Does legislative change affect the use and duration of compulsory treatment orders? **ANZJP**.
- Vine Ruth, Judd Fiona. 2018. Contextual issues in the implementation of mental health legislation. **International Journal of Law and Psychiatry**
- Vine Ruth, Tibble Holly, Pirkis Jane, Judd Fiona, Spittal Matthew. 2019 The impact of substance use on treatment as a compulsory patient. **Australasian Psychiatry**

PROFESSIONAL ACTIVITIES

1992 – 1994	Member, Victorian Branch Committee, RANZCP
1992 -	Reviewer for Australian and New Zealand Journal of Psychiatry, Medical Journal of Australia and Australasian Psychiatry
1996 - 2002	Member of Committee for Examinations, RANZCP
2005 – 2008	Chair, National Mental Health Workforce Advisory Committee
2005 - 2008	Chair, Mental Health Standing Committee
2005 – 2012	Member, Forensic Leave Panel
2008 – 2009	Member, Mental Health Review Board
2008 – 2009	Board member, Australian Community Support Organisation
2009 -	Surveyor/Assessor, Australian Council of Healthcare Standards (ACHS)
2010- 2012	Chair Safety and Quality Partnership subcommittee
2011	Member, Reference Committee for review of Guardianship, VLRC
2012 – 2014	Board member, Western Region Health Centre. I was a member of the Board during the amalgamation with Doutta Galla and North Yarra Community Health centres to form CoHealth.
2013 - 2018	Board member, The Haven Foundation
2014 -	Member, Mental Health Tribunal
2014 -	Member, Clinical Advisory Council, IHPA
2012 -	Member, Mental Health Working Group, IHPA
2015 -	Board member, Victorian Institute of Forensic Mental Health (Forensicare)
2018 -	Member, Medical Board of Australia (Victorian Board)
2019 -	Board member, MIND

During the period of my employment in the Department of Human Services, and the Department of Health, I contributed to a number of Departmental, Inter-Departmental and external committees. Examples include membership of the Disability Legislative Review steering committee, Corrections Health Board, reference group for the Complex Clients project, Inter-departmental liaison committee on women in prison, advisory committees for the Law Reform Commission in regard to People with an Intellectual Disability at Risk, Defences to Homicide, and review of the Guardianship and Administration Act. From 1999 to 2007 I was appointed the Principle Medical Officer under the Corrections Act. This ended when the responsibility for prisoner health moved to the Department of Justice.

On the National level I was Chair of the Forensic Mental Health reference group, which developed the National Forensic Mental Health Principles, and was on the drafting committee for the Third National Mental Health Plan. I was co-chair of the Co-morbidity taskforce, a subcommittee of the NMHWG during 2004. I was involved in the development of the National Action Plan for Mental Health 2006 – 2011 developed under the COAG. As noted above, I chaired two National committees relating to Mental Health from their inception. I was also involved in the drafting of the revised National Mental Health Policy. During my time working with the Department of Health and Aging, I worked on the development of the 4th National Mental Health Plan and the revision of the National Standards for Mental Health

Services. I have been involved in a number of invited service reviews and critical incident inquiries relating to individual and service standards.

In 2013 I commenced a PhD which I hope to complete in 2020. The thesis concerns service utilisation after a Community Treatment Order and considers the context of service delivery under both the Mental Health Act (1986) and the Mental Health Act (2014).

In 2019 I was requested to make a statement and to be a witness before the Royal Commission into Victoria's mental health services.