Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR STUART LEWENA

I, Dr Stuart Kirk Lewena BMedSci, MBBS (Hon), FRACP, Director of Emergency Medicine, of 50 Flemington Rd Parkville Victoria 3052, say as follows:

1 I make this statement in my personal capacity but with authorisation from my employer The Royal Children's Hospital (**RCH**).

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.

Qualifications and experience

3 I qualified as a paediatrician and paediatric emergency physician in 2003 and have worked across several roles since then, as per below:

(a) As Clinical Director, Emergency Medicine, RCH, I provided leadership to deliver a high standard of emergency care in an environment of continual and significant increased demand. I managed Emergency Department operational change initiatives including, developing the Emergency Department Observation Ward, implementing Criteria Led Discharge and redesigning Fast Track emergency care.

(b) As Acting Deputy Director, Emergency Medicine, RCH, I helped redesign emergency models of care utilising dedicated clinical teams, while maintaining a united and cohesive department through a period of significant departmental and organisational change.

(c) As Consultant, Emergency Department, RCH, I lead a team with the aim of improving patient safety and risk management, acted as the medical lead for the Emergency Nurse Practitioner program, was a member of the Patient Safety Committee and supervised the University of Melbourne medicine and medical research students.

(d) As Director and Instructor, Advanced Paediatric Life Support, a not-for-profit organisation delivering Australia's most respected training course in paediatric resuscitation, I provided strategic leadership through a period of improvement and significant change, and instructed courses to improve the organisation's

ability to deliver mandated courses to specialist medical colleges and to help translate evidence into clinical practice.

(e) As representative, Australian Resuscitation Council, I helped to interpret research evidence and translate that into resuscitation guidelines and education.

(f) As Australian representative, Advanced Life Support Group International Working Party, I helped translate research and best practice evidence into a standardised international curriculum for paediatric resuscitation training and education.

4 As the Head of Emergency Medicine at RCH, I provide strategic leadership to foster excellence in clinical care, research and education which is recognised nationally and internationally. I build staff capabilities and our relationships with campus partners, Murdoch Children's Research Institute and the University of Melbourne, to deliver world class research, education and clinical care within the field of paediatric emergency medicine both within my department and beyond the RCH campus.

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

MODELS OF CARE IN EMERGENCY DEPARTMENTS

Responding to children and young people with mental health related needs and their families and carers

6 Children and young people present at the RCH emergency department with mental health related needs ranging from acute mental health conditions to underlying mental health concerns coexisting with other reasons for seeking health care. While the majority of attendances occur through the teenage years, with RCH treating young people up to the age of 18, children as young as 6 years are attending with mental health related conditions. This younger cohort often manifest through pathologically dysregulated behaviour of a severity to cause significant personal, family and social disruption.

7 When they present for treatment, the emergency department at RCH responds to those children, young people, their families and their carers by:

(a) flagging that that child or young person has mental health related needs;

(b) ensuring that senior RCH staff provide oversight over the service delivered to that child or young person;

(c) reviewing that child or young person's RCH mental health records and behavioural management plans through RCH's Electronic Medical Record (**RCH EMR**) (see paragraphs 70 to 72);

(d) reviewing any patient care plans for that child or young person, a limited number of which contain shared content from other hospitals, mental health services and the Department of Health and Human Services;

(e) responding to families' and carers' concerns about that child or young person's mental health condition, including by organising for a behaviour management plan, identifying the key characteristics of that child or young person's mental health condition, any behaviours to avoid and the potential triggers that exacerbate their condition; and

(f) where necessary, ensuring that that child or young person may access safer environments and reduced environmental stimuli through streaming into private, quieter waiting spaces while awaiting clinical attention (see paragraphs 8 to 13).

Streaming of RCH emergency department patients

8 Children and young people presenting with mental health related needs are generally streamed to quieter, more private and higher dependence spaces within the emergency department. In contrast to the general emergency department, the spaces available to children and young people presenting with mental health related needs include:

(a) quieter rooms in which to wait;

(b) rooms retrofitted to reduce environmental stimuli and reduce the risk of self-harm; and

(c) for the most serious presentations, a room previously built for seclusion purposes. This room is therapeutically counter-productive and no longer fit for purpose as a seclusion room (see paragraph 29), and has since been repurposed into a quiet low stimulus room separated from the rest of the emergency department. Whilst in this room the child or young person must be accompanied by their family, carer or RCH staff.

9 Streaming is necessary to separately cater for children and young people who present with mental health related needs, to ensure that those particularly vulnerable patients' mental and physical health conditions are not compromised or exacerbated.

10 Paediatric mental health presentations in the RCH emergency department are streamed on the basis of an assessment of their need for reduced:

(a) environmental stimuli;

(b) freedom of movement;

(c) opportunities to self-harm; and

(d) opportunities to harm staff, other patients, their families, their carers and other members of the public.

11 Streaming of this type requires appropriate and, ideally, purpose-built physical spaces catered to children and young people presenting with mental health related needs. While some existing facilities are available to RCH (see paragraph 8), emergency departments with a large paediatric case-mix would generally benefit from purpose-built 'behavioural paediatric assessment units', which would:

(a) facilitate smoother streaming for children and young people who present with mental health related needs;

(b) provide a hub to facilitate a coordinated approach to clinical care, in which staff from multiple disciplines could support children and young people who may present with mental and physical health related needs simultaneously;

(c) operate at 24 hour capacity; and

(d) have the capability to deal with both acute presentations, and provide follow-up care and support to access community mental health services once the child or young person stabilises and is discharged.

12 The RCH emergency department streams patients according to the particular child or young person's underlying presentation and behaviour at that time. Streaming allows RCH to treat patients presenting with mental health related needs within the general model of emergency management, while recognising that the ideal physical environment for, and clinicians attending to, patients who present with mental health related needs differs from one another, as well as from those with physical health related needs.

13 Paediatric emergency mental health presentations encompass a wide range of ages from young children to adolescents and young adults. Rather than streaming on the basis of age, it is more appropriate to stream on the basis of need and the nature of the presentation. A 6 year old and a 17 year old may present with very similar mental health and behavioural challenges. Whilst their care will be individualised and need to be age appropriate, the environment in which to deliver that care within a paediatric emergency department is not significantly influenced by age. The situation in a mixed adult and paediatric emergency department may well be different and in this environment age based streaming will be more relevant.

Support for children and young people from diverse backgrounds

14 RCH makes all of its services available to support children and young people from diverse backgrounds and from the LGBTIQ+ community according to their individual need. Access to services is facilitated through use of on-site and telephone interpreter services,

Wadja to support aboriginal and Torres Strait Islander communities, and an adolescent service with a high profile and engagement with gender diversity.

15 The RCH Gender Service is a global leader in gender dysphoria in children and young people. RCH staff are familiar with those gender dysphoric individuals who also have known mental health conditions. Care of these young people is delivered in collaboration with staff and / or care plans from the Gender Service to ensure the complexity of their care is appreciated.

THE CHANGING NATURE OF MENTAL HEALTH NEEDS

Changes in emergency department presentations

16 Ten years ago, RCH saw comparatively few paediatric mental health presentations in the emergency department. This made mental health a relatively low priority for paediatric emergency departments. Facility design, processes and staffing models paid less attention to this patient population than is currently required.

17 Since then, and particularly in the past five years, RCH, along with other paediatric emergency departments in Australia, has seen a very significant increase in children and young people presenting with mental health crises. Presently, about 7% of all emergency department presentations in the 7-17 year old cohort at RCH relate to acute mental health concerns. Underlying conditions more commonly seen in the adolescent cohort include anxiety and depression, borderline personality disorder, and less frequently psychotic disorders. Common presentations include acute behavioural disturbance, violence, self-harm, risk taking behaviour, attempted suicide and social withdrawal. These patients contribute to our more than 200 mental health presentations per month. This represents a 400% increase in mental health presentations at RCH in the past five years, a number which continues to increase. Children with significant mental health comorbidities presenting for other reasons are not captured in this data.

18 The sources of that marked increase in mental health presentations are not clear. However, RCH have seen an increase in particular themes, including:

(a) Social overlays are associated with the mental health conditions of many of the children and young people at the RCH emergency department. These children and young people come from very troubled backgrounds, have experienced past engagement and disengagement at other mental health services and may present with behavioural issues or substance abuse.

(b) Families and carers turn to the RCH emergency department as a ‘last resort’, frustrated with their inability to gain timely access to community mental health services, or to obtain treatment at all due to the de-escalation of the child or young person’s mental health condition by the time of the next available appointment.

(c) Other hospitals, police and paramedics have increasingly diverted children and young people to RCH, due to the geographical segregation and fragmentation of mental health service provision and the false perception that RCH is the 'centre of excellence' for paediatric mental health.

(d) Children and young people cared for by the Department of Health and Human Services may experience unnecessary or prolonged hospital admissions before they can be safely placed into appropriate accommodation supported by a community mental health service.

(e) Community mental health services have been decreasingly able or willing to provide mental health services to certain individuals who are considered 'challenging', or may lack a traditional psychiatric diagnosis.

19 There have also been significant increases in children and young people who present with behavioural issues in the emergency department. Often, these patients do not have well defined mental health conditions, but may be on the autism spectrum, or have other neurocognitive disability, violent or exhibit behaviour management issues (which are often examples of poor impulse control or dysregulated, but 'normal' childhood behaviour). Generally, those individuals are admitted to the emergency department by families or carers who:

(a) are frustrated with their inability to access community mental health services in a timely manner and turn to the emergency department as a 'last resort'; or

(b) struggle to manage that child or young person's behaviour at home or in residential care and request the assistance of police, paramedics and/or RCH to manage it.

20 There continue to be many children and young people presenting with underlying issues with alcohol abuse, misuse of prescription medication and use of illicit drugs, especially amongst the adolescent cohort. Relatively few children and young people present with conditions solely attributable to drugs and alcohol abuse. Substance use and abuse more frequently coexists and complicates the underlying behavioural or mental health disorder versus being the primary determinant of that behaviour.

Changes in the model of care

21 To respond to the sustained increase in paediatric mental health presentations, the model of care at RCH has had to drastically adapt to provide a greater focus on mental health presentations in the emergency department.

22 The aim of the majority of these changes to RCH's model of care is to manage mental health related needs in the emergency department just as capably as physical health related needs. Changes which have been implemented include:

(a) children or young people that have mental health related needs are flagged at the time of triage;

(b) referral information to community mental health services when appropriate is provided to every patient's family or carer prior to discharge;

(c) mental health specialists, comprising senior mental health nurses or psychologists, are embedded in the emergency department during evening shifts;

(d) rooms for patients presenting with mental health conditions have been retrofitted to reduce environmental stimuli and to reduce the risk of self-harm and harm to others;

(e) more detailed mental health care plans, detailing what works and what doesn't for particular patients, and communicating these plans to all clinicians and triage nurses and

(f) additional training has been provided to RCH emergency department staff to reduce usage of restrictive practices and to improve their ability to manage children and young people presenting with underlying behavioural conditions, autism and mental health conditions.

Supports required by emergency departments

23 Emergency departments are generally not the ideal environment to support children and young people presenting with acute mental health presentations (see paragraph 54).

24 The RCH emergency department lacks the capability or the capacity to manage follow-up with patients after discharge, being limited to providing treatment for acute mental health conditions in the relatively short term. The RCH emergency department therefore necessarily relies on referrals to community mental health services upon discharge.

25 The key supports which emergency departments require to prepare and respond to the significant growth in paediatric emergency mental health presentations are as follows:

(a) The mental health system, of which emergency departments only represents a small part, should be better coordinated. Mental health system navigation is the primary issue facing many patients, as referral pathways are limited and often untimely. Once children and young people are discharged from hospital, they encounter the access issues that caused them to present to the emergency department in the first place. Community mental health services need to be more

accessible both immediately following emergency department discharge and ongoing to prevent the need for crisis re-presentation.

(b) The geographical barriers to mental health care, through zoning and catchments, should be reduced. For instance, as the RCH emergency department's catchment covers the densely populated city and inner city, RCH gets a disproportionately large number of children and young people presenting with mental health related needs. Equally, children from areas outside the RCH mental health catchment often present to RCH but their ongoing care is required to be delivered in their residential catchment which can further fragment their care. Quality mental healthcare must be made available to children and young people irrespective of their locality.

(c) Ongoing and specific medical training by tertiary institutions and hospital training programs should specifically address paediatric emergency mental health, to fill the existing skill gap. Currently, even the mental health training received by paediatric physicians is most often provided in the context of the hospital's general mental health department, rather than specifically for paediatric emergency mental health. While RCH provides internal paediatric mental health training to its emergency department physicians, access to contextually appropriate external training is extremely limited (see paragraphs 47 to 49).

(d) Health services which are capable of managing paediatric mental health conditions must be incentivised to manage them themselves, rather than referring them to another health service. For instance, RCH accepts many paediatric mental health referrals, adding to RCH's already stretched capacity, as a result of:

(1) the inaccurate perception that RCH is the 'centre of excellence' for paediatric emergency mental health;

(2) other services feeling ill-equipped to deal with, or no longer wanting to manage, a particular mental health concern or particular behaviours; or

(3) other services feeling like they cannot assist children or young people who 'fall between the cracks' because they have no diagnosable mental health condition, but instead may present with difficult to manage, risk-taking behaviour.

(e) The conflict between providers within the mental health system must be reduced. Mandating coordination between services on some basic level would support each provider's ability to provide effective and timely treatment.

INTERSECTION BETWEEN MENTAL HEALTH AND PHYSICAL HEALTH

26 The RCH emergency department and short stay units are not well-suited to mental health presentations. This is particularly relevant for children or young people with sensory processing impairment such as those with autism and related disorders. The emergency department is often a chaotic and highly stimulating environment which risks exacerbating mental health conditions.

27 At present, children and young people with underlying mental health concerns cannot stay in the RCH short stay unit due to its lack of a safe physical environment.

28 Children and young people who present with both mental and physical health concerns are admitted to other, physical health focused parts of RCH, which often struggle to manage them. Due to capacity issues, mental health staff only work in the mental health ward. While management of a patient's acute physical health risk may take priority, it is important that mental health concerns are coordinated and treated in parallel.

29 While the seclusion room in the emergency department was originally built less than 10 years ago for the purpose of safely managing the acutely disturbed child or adolescent, it is no longer fit for purpose. The room is austere and designed to be used as a locked room to severely restrict the young person's freedom of movement and autonomy. Best practice for paediatric mental health has moved on quickly in the years since it was built. Furthermore, its isolation from the rest of the emergency department makes it difficult to maintain oversight over patients in that space. As a result, it is no longer used to isolate children and young people who present with mental health conditions, but rather as a space in which families, carers and staff are encouraged to accompany acute or at-risk children or young people in a safe, quiet environment.

30 One improvement that could be made to improve service models is to construct emergency departments and hospital wards which support health professionals with relevant physical and mental health expertise to work together to cater for children and young people with joint mental and physical health concerns. The current dichotomy between physical and mental health, an example being the requirement for "medical clearance" to occur before mental health needs are specifically addressed, compromises the holistic care of the patient.

31 RCH has proposed a purpose-built 'behavioural paediatric assessment unit', which would help to achieve that goal. This would offer a coordinated approach to clinical care by creating a hub in which a combination of staff from multiple disciplines could provide assistance and support to children and young people who present with complex needs. It would be a stand-alone unit accessible from the emergency department and provide acute assessment, de-escalation and coordination of community based care across a

range of disciplines including mental health, adolescent health, child development and disability and emergency medicine.

32 I am not aware of any best practice models used in other jurisdictions.

RESTRICTIVE PRACTICES

The use of restrictive practices

33 Restrictive practices as defined in the Mental Health Act include seclusion, whereby a person is solely confined in a room without the freedom to leave that room, and bodily restraint incorporating any form of physical or mechanical restraint preventing freedom of movement. Whilst involuntary sedative medication is not included within this definition, it is included in our practical consideration of restrictive practice if the intent is to effectively chemically restrain an individual by administering a drug at a dose which prevents the individual's freedom of movement.

34 RCH only uses restrictive practices where:

(a) all other avenues have failed, including verbal de-escalation, and situating the child or young person in a low stimulus environment; and

(b) when the child is a risk to themselves, to staff or to the public.

(c) the treatments and alternatives have been explained to the child / young person

35 Restrictive practices used include physical restraint, such as holding down or mechanically restraining a child, and chemical restraint, namely involuntary medication. Seclusion of a child by their sole confinement in a room is almost never used. Use of our Emergency Behavioural Assessment Room almost always involves a parent / carer / staff member present in the room with the child, rather than their sole confinement. There may be rare instances where for the immediate safety of staff, a young person is briefly contained alone within this room while additional resources are recruited to allow safe management.

36 RCH also regularly admits children and young people who have been subject to physical and/or chemical restraint by police and paramedics prior to their admission to the RCH emergency department. These young people are generally transported to the emergency department on a section 351.

37 In some cases, children or young people who frequently attend the RCH emergency department may voluntarily accept medications to help them calm down when an RCH staff member alerts them that their behaviour is escalating.

Factors contributing to the use of restrictive practices

38 Restrictive practices are used as an avenue of last resort, after de-escalation and manipulation of the environment have been tried and failed. Use of restrictive practices depends solely on an assessment of need for that child or young person, on the basis of their presentation at that time.

39 Factors which do not contribute to the use of restrictive practices include mental health diagnosis, previous usage of restrictive practices on that individual and age.

Changes in the use of restrictive practices over the last five years

40 There has been a marked decrease in the use of restrictive practices in the RCH emergency department in the past five years. That marked decrease may be attributable to the following changes:

(a) RCH provides training to emergency department staff to engage in techniques to de-escalate situations without needing to resort to restrictive practices.

(b) RCH promotes to staff an understanding that, in the long run, it is better to allow patients to calm down themselves without restrictive practices, compared to the unsustainable, short term gain (and potential detriment to long term care) afforded by restrictive practices.

(c) RCH utilises past knowledge about particular patients to understand what assists de-escalation, and the social overlays fuelling certain behaviours (eg, extreme neglect, physical or sexual abuse, sexual violence, abandonment, custodial care and drug and alcohol abuse).

(d) Locked seclusion environments in emergency departments have been banned for use by the Chief Psychiatrist and, accordingly, RCH's emergency department seclusion room has been deemed no longer fit for purpose (see paragraph 29).

Supporting staff to minimise the use of restrictive practices

41 Emergency department staff can be supported in minimising the use of restrictive practices when treating children and young people with mental health related needs in the following ways:

(a) Providing training to emergency department staff, as well as paramedics and police officers who tend to be the first point of contact, to:

(1) better understand the less intrusive alternatives to restrictive practices and the risks of using restrictive practices unless absolutely necessary;

(2) better understand what motivates the behaviour of 'disruptive' children and young people, who may not have a traditional mental health

diagnosis, including social overlays (eg, experiences of sexual violence, drug and alcohol abuse and/or family violence) and potential triggers; and

(3) effectively talk to the patient to de-escalate the situation (eg, RCH has had success using de-escalation techniques over the phone with well-known patients in the community, without resorting to restrictive practices felt necessary by attending members of Victoria Police or Ambulance Victoria).

(b) Offering physical environments within emergency departments which are well adapted to streaming children and young people with mental health presentations.

(c) Allocating more resources to IT systems to record the needs of high risk, frequent attenders with mental health related concerns. Improved background knowledge and patient care plans may reduce the number of negative interactions with those children and young people, reduce the number of harmful incidents, reduce the need for restrictive practices and improve consistency for those patients. RCH has made successful progress, but there is scope for more work to be done in this space.

WORKFORCE

42 Occasionally, harmful incidents do affect the RCH workforce, including violence, attempted violence, threats of harm and damage to property. Examples include kicking, punching, biting, spitting, use of secreted weapons or use of other objects such as chairs as weapons. RCH minimises the occurrence of harmful incidents by:

(a) using de-escalation techniques to prevent behaviour from escalating to a point where harmful incidents are likely to occur;

(b) conducting physical searches of high-risk children and young people upon admission;

(c) accessing any existing and current behaviour management plan to gain an understanding of what triggers the child or young person;

(d) manipulating facility design, using physical environments to provide some degree of decreased stimuli, increased control and containment without being secluded;

(e) retrofitting rooms to remove equipment which may be used as weapons, and increase safety; and

(f) if harm is imminent, utilising restrictive practices as a last resort. Anticipating this situation and activation of a Code Grey response summons additional staff and resources to manage the situation safely.

43 If harmful incidents do occur which impact on staff or patients, these will be recorded in the hospital's incident management system (**VHIMS**). Incidents are thus investigated, debriefed and feedback provided to those impacted with the aim of minimising any consequential harm and reducing the risk of future recurrence.

Improving the safety of children, young people, families and staff in emergency departments

44 Paragraphs 41 and 42 outline the key processes emergency departments can implement to improve the safety of children, young people, families, carers and staff in emergency departments.

45 The key to improving the safety of provision of care is building adaptable physical environments, both in and out of emergency departments, which provide:

(a) some level of containment without applying restrictive practices;

(b) areas where patients, staff, parents and carers feel safe; and

(c) spaces for de-escalation and compassion, as opposed to punishment.

Training gaps and priorities

46 Health professionals working in paediatric emergency departments have been required to become highly skilled in delivering acute mental health care, alongside their traditional skills in delivering physical health care. This has been a challenge, particularly to meet the significant increase in mental health presentations in recent years. It is important to communicate to emergency department staff that the children and young people that present with mental health related needs are some of the most at-risk patients in the hospital, with complex and different needs.

47 The key difficulty in training emergency department staff in the specific space of paediatric emergency mental health is the lack of any external training providers. Many paediatric services are therefore struggling to meet that training gap.

48 RCH has attempted to meet the needs of the quickly increasing number of children and young people presenting with mental health conditions by providing internal training to emergency department staff alongside other stakeholders at RCH, such as adolescent health specialists and mental health professionals. Training is currently provided in areas such as patient management and de-escalation of difficult situations, but RCH is also trying to develop additional training to further improve the quality of paediatric emergency mental health care.

Skill development, training and support required

49 Paediatric emergency mental health training is still in early stages of development internationally, so I am limited in my ability to provide an exhaustive list of proposed areas of training. However, RCH sees more scope to develop the skills of emergency department staff through external training in:

(a) understanding how to manage children and young people with mental health related needs without resorting to restrictive practices;

(b) understanding the differences between adult mental health care and paediatric mental health care, including understanding the social overlays that accompany the mental health conditions of many children and young people (eg, experiences of sexual violence, drug and alcohol abuse and/or family violence);

(c) simultaneously managing mental and physical health concerns through a co-ordinated, team based approach (see paragraph 11, and 51 to 53); and

(d) identifying mental health related needs as opposed to behavioural control needs.

50 RCH has an opportunity to be a global research leader in this space by utilising the data it has gathered on the interface between emergency departments and paediatric mental health to perform research on the underlying causes of the increase in mental health presentations by children and young people.

51 Mental health presentations are often multifaceted, involving mental health, physical health and social elements. Collaboration between health professionals with complementary expertise is essential to providing quality health care to children and young people who present at emergency departments with mental health related needs.

52 The result is a model of care which provides timely treatment and is focused on the behavioural presentation of the child or young person, rather than siloing each health professional to focus independently and concurrently on discrete elements of that patient's presentation. That model of care facilitates the formation of teams around the patient, instead of deciding which individual health professional is responsible for managing them.

53 RCH's proposed purpose-built 'behavioural paediatric assessment unit' would facilitate that model of care, fostering collaboration between the multidisciplinary practitioners who would support and work within that unit (see paragraph 11).

DIVERSION AND ALTERNATIVE SETTINGS

Best treatment setting for children and young people experiencing a mental health crisis

54 There are limited circumstances in which children and young people experiencing mental health crises are 'best' treated in an emergency department. Chiefly, mental health crises which are acute, urgent and which are at risk of serious deterioration are best treated in an emergency department. In these cases there may be no reasonably accessible and timely alternatives in the community mental health system. In addition, mental health crises with significant coexistent acute physical healthcare needs are appropriately managed in an emergency department.

55 Otherwise, children and young people experiencing mental health crises are ideally treated in alternative settings, such as community mental health services and by health specialists with specific skills in this area such as psychiatrists, psychologists and social workers. Emergency departments are not well adapted to most mental health presentations because:

(a) Emergency departments are not engaged in the community based ongoing and follow-up care that many patients need. We see them solely during their periods of crisis which further contributes to their fragmentation of care. Given the chronic nature of most mental health conditions, continuity of service provider for both periods of stability and emerging crisis would be ideal. The lack of "out-of-hours" access to these providers results in much of the crisis care being delivered in an emergency department.

(b) Mental health conditions may escalate in the loud, chaotic and fast-paced space that is a hospital emergency department. This is especially the case if the child or young person is on the autism spectrum. Most individuals would benefit far more from timely treatment in the community, in a non-hospital based environment.

56 Unfortunately, many of the children and young people that present at the RCH emergency department do so despite not needing or wanting to attend an emergency department. There are a number of key reasons for this:

(a) Many children and young people attend the emergency department as a last resort. Often, they, their families or their carers have been unable to access community mental health services in a timely fashion despite being at crisis point, such as threatening suicide or being violent in the community. On these occasions, if the mental health system were functional, emergency departments would not need to intervene.

(b) Many children or young people who attend the RCH emergency department — often with great frequency — may not present with acute mental health issues, but may exhibit dysregulated behaviour in the community and get brought in by police or paramedics utilising physical or chemical seclusion. Often, these children and young people lack access to alternative supports and exhibit behaviour perceived as 'clinical' while the reality is that medical care has nothing to do with the drivers or approach to these behaviours.

(c) Children and young people may attend the emergency department because they 'fall through the cracks' of the community mental health system as:

(1) general paediatricians may not be able to assist or know how to manage those individuals' behaviour despite it being an integral component of the child's underlying diagnosis; and

(2) paediatric mental health professionals may say that those individuals' presentation is not a recognised mental health condition and therefore not amenable to further treatment.

57 I am not aware of any best practice for paediatric emergency mental health operating in other health jurisdictions.

The ideal role of the community-based mental health system

58 Children and young people would benefit from:

(a) Greater availability of paediatric community mental health services which they may attend, or be attended by. This may constitute face-to-face services, but also telehealth outreach targeted at children and young people.

(b) Better education for police and paramedics in assessing and de-escalating situations, including embedding mental health professionals in response teams. For instance, RCH has sometimes been successful in de-escalating mental health crises over the phone because they know that particular child or young person well and are able to provide familiarity and outreach.

(c) A 24 hour accessible community mental health service which is both reactive to crises and provides ongoing clinical support to children and young people, and takes ownership of their mental health treatment over time. Such a service should be complementary to interactions with the hospital system. Implementation of a community model, supported by a hospital hub, would be preferable. Any community model must be cognisant of the barriers imposed by geographic catchment zones and be available to support children regardless of their residential address at times of crisis, and a capacity to share information across the services.

59 Any model of care delivered to the child or young person should be designed with family centred care as a cornerstone. The support and therapeutic intervention will rarely be limited towards the child but should address the need of the "family" unit as a whole.

ROLE OF CRISIS OUTREACH TEAMS

The ideal role of crisis outreach teams

60 There is a clear gap in the availability of an outreach service targeting children and young people with mental health related needs. Police, Ambulance and Clinical Early Response (**PACER**) teams, which play a role in mental health crisis outreach for adults, will not attend children and young people. While there are paediatric mental health professionals, the lack of community based outreach risks failing to provide support until behaviour escalates.

61 The ideal model for a crisis outreach team focused on paediatric mental health care would offer:

(a) access to telehealth for children, young people, their parents and their carers;

(b) referral to community mental health services;

(c) a scope and scale big enough to circumvent geographical limitations;

(d) an ability to respond to and de-escalate mental health crises in children and young people, who would otherwise be attended to by police and paramedics, who may be less well-equipped to deal with those difficult situations;

(e) embedded mental health professionals within police and paramedic response teams, to assist with mental health crises then and there without ending up in an emergency department;

(f) access to on-call support for police and paramedics to reduce the need for restrictive practices;

(g) access to a central mental health record containing individuals' needs and characteristics based on previous health interactions and interventions; and

(h) access to an alternative pathway for children and young people with underlying behavioural disorders who may not strictly have mental health related needs, but require social support.

62 A crisis outreach provider should provide community based care and/or work collaboratively with community based mental health services. If crisis outreach providers were to work out of specific emergency departments or community mental health services, there is a risk of creating a great service which is limited in its operation by the geographic bounds of the fragmented mental health system.

63 Accordingly, it is not of much relevance where a crisis outreach provider is physically located, so long as it has capability to service a large population.

POLICE

The role of police in responding to children and young people experiencing a mental health crisis in the community

64 There are situations in which it is necessary for police to lead the response to children and young people experiencing a mental health crisis in the community. This is particularly the case in response to acute presentations exhibiting behaviour which is imminently dangerous to families, carers and members of the public, or to the child or young person themselves.

65 It is unrealistic to expect to be able to equip all police officers with the skills to effectively manage children and young persons with mental health related needs. However, a team could be developed within the police with the skill set to provide a secondary or back-up response to those mental health crises, which can also work with community mental health organisations and paediatric mental health crisis outreach teams to help deliver the necessary support.

Strategies for reducing the need for police involvement in mental health crises

66 Broad strategies which could be implemented in the mental health system to reduce the need for police involvement in paediatric mental health crises include:

(a) educating and supporting families and carers in utilising appropriate and effective strategies to manage mental health crises and to access the spectrum of community mental health services;

(b) educating families and carers that emergency departments are not always well suited to presentations of paediatric mental health conditions manifest by escalating aggressive or destructive behaviours. Calling on police to facilitate transport to an emergency department in these situations is unlikely to result in an effective therapeutic intervention in hospital. These behaviours are not amenable to acute interventions in an emergency department but require long term engagement with community based specialist mental health providers;

(c) assisting schools in developing clearer pathways of escalation through school-based mental health services and the community mental health system, to minimise the need for escalation to police, paramedics and hospital emergency departments.

IT SYSTEMS

IT infrastructure to enable integrated care and care coordination

67 In order to provide system-wide coordinated care, the mental health system's IT infrastructure should support a shared mental health record, capable of sharing information between stakeholders such as hospitals, community mental health services and families and carers.

68 Currently, RCH cannot access records prepared by other mental health services, except in very limited circumstances where a joint care plan is in place. This is challenging for both shorter and longer term care. A coordinated system, recording plans in a format useful for everyone, would:

(a) reduce the need for RCH to 'be the detective' to figure out who did what for a particular patient;

(b) increase the transparency of differences in opinion which are evident in the mental health system due to overlapping and fragmented location-based systems of care; and

(c) improve the reliability and scale of datasets used as the basis of research into what is driving the dramatic increase in paediatric mental health presentations. Health care professionals must understand the problem to determine possible solutions. A 400% increase in physical health presentations would be met with enormous research into the causes, and paediatric mental health should be no different.

69 The predominant barrier that needs to be overcome before system-wide infrastructure can be implemented is the apparent lack of willingness of some stakeholders to engage and collaborate with one another. My observations of this as a stakeholder who interacts with the mental health system and its practitioners are that this manifests in:

(a) some mental health care providers refusing to share patient information;

(b) clinical disagreements between mental health care providers on diagnosis and treatment methodology for particular shared patients;

(c) fundamental disagreements between mental health care providers on approach to paediatric mental health care; and

(d) some mental health care providers being unwilling to accept referrals from other services (possibly due to resourcing constraints).

The RCH EMR

70 The RCH EMR is provided by Epic Systems Corporation and was introduced by RCH in 2016 to provide better utility and access to health care records to clinicians, parents and carers.

71 Within RCH, the RCH EMR has been hugely beneficial in improving experience of care, by providing consistency, transparency and continuity for patients with mental health conditions, their families and their carers. This has been achieved in a range of ways:

(a) Families and carers only need to fill out a single behaviour management plan for their child or young person, accessible by clinicians throughout RCH (ie, in the emergency department and in the wards). That plan identifies the characteristics of patients and any triggers for their mental health condition.

(b) Clear care plans are recorded for children and young people who frequently attend RCH, which ensures a consistent approach to their mental health treatment. This is especially important as many of the frequent attenders are in custodial care, being cared for by carers with varying levels of knowledge about the child or young person's past mental health related needs and treatment.

(c) Each patient's background and past interactions with RCH are recorded, meaning that families and carers do not have to re-explain their child or young person's past mental health situation. Health professionals simply need to check that the record is up to date. Feedback from parents, especially of children with autism, has been positive.

(d) Families and carers may access physical health care plans for patients to improve transparency (for example, about what advice was given, what medications were provided, what procedures were performed, test results and the date of the next appointment). However, mental health care plans are generally not proactively shared with families and patients due to the particular sensitivities surrounding those documents.

72 As with any system of electronic medical records, there are limitations to the RCH EMR. RCH minimises these limitations by deploying resources to carefully manage them, which can be costly. Broadly, these limitations are:

(a) Records are very information-rich which can limit their usefulness in real time, such as during a consultation, particularly in an emergency setting. While it is great to have that information, it can be an overwhelming amount of information for a clinician in a time limited environment. Without succinct records, the RCH EMR records risk losing their usefulness as a tool to inform health professionals about a patient's mental health diagnosis and treatment history.

(b) It may be time-consuming and difficult to keep EMR records up to date. This is especially the case where a patient may not frequently attend RCH, and whose mental condition may change between visits. Similarly, maintaining currency is crucial to the usefulness of the record.

sign here ▶ 

print name STUART KIRK LEWENA

date 11/5/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SL-1

This is the attachment marked 'SL-1' referred to in the witness statement of Dr Stuart Kirk Lewena dated 11 May 2020.

CV – Dr Stuart Lewena

Personal Details

Dr Stuart Lewena
BMedSci MBBS(Hon) FRACP
AHPRA: MED00011960098
stuart.lewena@rch.org.au

Career Statement

To provide leadership and advocacy for paediatric emergency medicine, within The Royal Children's Hospital, and at a state wide, national and international level. Through collaborative partnership with key stakeholders, ensure the sustainable delivery of outstanding clinical care, education and research.

Current Appointments

- Director of Emergency Medicine, Royal Children's Hospital
- Research Fellow, Murdoch Children's Research Institute
- Lecturer, Department of Paediatrics, University of Melbourne

National and International Profile

- National President and Board member for Advanced Paediatric Life Support (APLS) Australia (2009 – 2018)
- Co-opted Member of Australian Resuscitation Council (2015 – 2017)
- Australian representative on Advanced Life Support Group, international working party for APLS (2015 – 2017)

Education and Qualifications

- Fellow of The Royal Australasian College of Physicians (2003)
- Paediatric Emergency Physician under the joint training program of the Royal Australasian College of Physicians and Australasian College of Emergency Medicine (2003)

- Bachelor of Medicine and Bachelor of Surgery with Honours, University of Tasmania (1992)
- Bachelor of Medical Science, University of Tasmania (1989)

Career History

Director Emergency Medicine, Royal Children's Hospital, Melbourne (2017 – current)

- Strategic leadership of the Department of Emergency Medicine to foster excellence in clinical care, research and education, recognised nationally and internationally.
- Build staff capabilities and relationships with our campus partners, the Murdoch Children's Research Institute and University of Melbourne, to deliver world class research, education and clinical care within the field of paediatric emergency medicine.
- Translate our knowledge and capabilities beyond the RCH campus

Clinical Director Emergency Medicine, Royal Children's Hospital, Melbourne (2012 – 2016)

Acting Deputy Director Emergency Department, Royal Children's Hospital, Melbourne (2011-2012)

Consultant, Emergency Department, Royal Children's Hospital, Melbourne (2004 – current)

Post Graduate Training

- Paediatric Emergency Medicine Fellow (2003). Emergency Department, Royal Children's Hospital, Melbourne.
- Paediatric Emergency Medicine Trainee (1997-2002). Princess Margaret Hospital for Children, Fremantle Hospital, Box Hill Hospital, Royal Hobart Hospital

- General Practice Registrar (1996). Kingston Beach General Practice, Tasmania.
- Residency (1993-1995) Royal Hobart Hospital and Nambour General Hospital

Non Hospital Appointments

Advanced Paediatric Life Support, Australia

- National President and Chairman of the Board of Directors (2013-2018)
- Vice President (2011-2012)
- Director of the Board (2009 – 2018)
- Chair Instructor Development Committee (2011-2015)
- Chair Course Development Committee (2015-2016)

Australian Resuscitation Council

- Representation on the Australian Resuscitation Council (2015-2017)
- Interpretation of research evidence and translation into resuscitation guidelines and education

Advanced Life Support Group

- Australian representative on Advanced Life Support Group International Working Party (2015-2017)
- Translation of research and best practice evidence into a standardised international curriculum for paediatric resuscitation training and education

Better Care Victoria

- Member of the Emergency Care Clinical Network expert working group on Behaviours of Concern (2018 – 2019)

Publications

Andrews S, Lewena S, Cheek J. Rapid Assessment, Planning, Investigation and Discharge: Piloting the introduction of a senior doctor at triage model in an Australian paediatric emergency department. Emergency Medicine Australasia 2020; 32: 112-116

Associate Editor. Advanced Paediatric Life Support: A Practical Approach to Emergencies, 6th Edition. Wiley Blackwell 2016

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Lewena S, Chaney G and Widmer R. The mouth and throat. Textbook of paediatric emergency medicine 2nd edition. Editors Cameron P et al. Churchill-Livingstone 2011

Lewena S, Chaney G. Foreign bodies and caustic ingestion. Textbook of paediatric emergency medicine 2nd edition. Editors Cameron P et al. Churchill-Livingstone 2011

Lewena S, Babl F. Central nervous system vascular disorders. Pediatric Emergency Medicine. Editors Baren J et al. Saunders Elsevier 2008

Babl F, Lewena S. Vaccination related complaints and side effects. Pediatric Emergency Medicine. Editors Baren J et al. Saunders Elsevier 2008