Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR NEIL COVENTRY

I, Dr Neil Coventry, Chief Psychiatrist of the Office of the Chief Psychiatrist, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne, say as follows:

1. I make this statement to the Royal Commission into Victoria's Mental Health System in response to letter dated 14 May 2019 (reference D19/182436), being a request for a statement in writing.

2. I am the Victorian Chief Psychiatrist appointed under the *Mental Health Act 2014* (Vic) (**the Act**). I have held this position since September 2016. Prior to my appointment, I acted in this role from September 2015 to August 2016, and was the Deputy Chief Psychiatrist for Children and Youth from December 2011 to August 2016.

3. As Chief Psychiatrist, my role is to:

   3.1 provide clinical leadership and expert clinical advice to specialist mental health service providers in Victoria;

   3.2 promote continuous improvement in the quality and safety of mental health services provided by mental health service providers;

   3.3 promote the rights of persons receiving mental health services from mental health service providers; and

   3.4 provide advice to the Minister for Mental Health, and the Secretary of the Department of Health and Human Services (**DHHS**) about the provision of mental health services by mental health service providers.[1]

4. As part of my role as Chief Psychiatrist, I am the Victorian member of the national Safety and Quality Partnerships Standing Committee of the national Mental Health Principal Committee, with a particular focus on eliminating restrictive interventions. The role of the Mental Health Principal Committee is to develop and implement a shared National Mental Health and Suicide Plan, and to advise the Australian Health Ministers' Advisory Council on mental health and drug service issues of national significance.[2]

5. All opinions expressed in this statement are my own. My opinions are informed by my own clinical experience, my observations from site visits to services, and the regular contact I have as part of my role as Chief Psychiatrist

[1] Mental Health Act 2014, s 120.
[2] www.coaghealthcouncil.gov.au/ahmac/principal-committees.

with leaders in my field in Victoria, and also Chief Psychiatrists in other Australian states and territories.

6. This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my own knowledge, and documents and records of the Chief Psychiatrist (Victoria) (**the Office**) which I have reviewed. I have also used and relied upon data and information produced or provided to me by officers within the Office.

7. This statement has been prepared with the assistance of lawyers and the Office.

8. In this statement I refer to people who receive treatment in the specialist mental health system as 'consumers', with the exception of 'forensic and security patients', which are terms that have a defined meaning in the Act. I also use the term 'people living with mental illness' depending on the context of comment. I acknowledge that many people identify with and prefer a number of different terms that for reasons of consistency I have not used in this statement.

1. Professional background

9. I have held a variety of roles in public and private clinical settings. I have over 40 years of practice in public psychiatry, including almost 22 years as the Clinical Director of the Child and Adolescent Mental Health Services at Austin Health, as well as periods as Acting Medical Director, Mental Health Division at Austin Health. I also worked part-time in private practice from 1987 to 1994 at the Pathway Centre (the forerunner of Albert Road Centre for Health), a private psychiatric facility, including periods as Acting Medical Director.

10. I have also held positions as Honorary Senior Lecturer with La Trobe University, University of Melbourne and Monash University where I lectured in undergraduate and postgraduate courses in medicine, psychiatry, psychology and related fields and training positions from 1993 to 2014. ; I was state-wide Director of Postgraduate Training in Child and Adolescent Psychiatry; Royal Australian and New Zealand College of Psychiatrists (RANZCP) from 2006 to 2008; Director of the Mindful Centre for Training and Research in Developmental Psychiatry, which provides postgraduate training for psychiatrists and allied disciplines, in 1996, 2004 and from 2006 to 2008, and was a Victorian Committee member of the RANZCP Faculty of Child and Adolescent Psychiatry, from 1990 to 2005.

11. I hold a Bachelor of Medicine and Bachelor of Surgery from the University of Melbourne (MBBS 1977), and I am a consultant psychiatrist and Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP, 1985). I hold a Certificate of Advanced Training in Child and Adolescent Psychiatry

(RANZCP, 1985) and in 1986 was a foundational member of the Faculty of Child and Adolescent Psychiatry, RANZCP. I have also completed training as a family therapist (Williams Road Family Therapy Centre, 1990).

12. I was a board director of Berry Street Victoria, a not-for-profit organisation providing out-of-home care for vulnerable children and youth, from 2003 to 2010, and since 2014 have been a member of the board subcommittee on safety and quality for Berry Street Victoria. From 2003 to 2014 I was also a member of the Take Two consortium, a trauma service for children in out-of-home care who are child protection clients, auspiced by Berry Street Victoria and funded by the Department of Health and Human Services.

13. Attached to this statement and marked '**NC-1**' is a copy of my Curriculum Vitae.

2. What are the roles and responsibilities of the Chief Psychiatrist under the Mental Health Act 2014 (Vic), specifically as they concern the public and specialist mental health sector.

14. The role of the Chief Psychiatrist was originally established in the *Mental Health Act 1986*. Under the 1986 Act, the Chief Psychiatrist was directly accountable for the 'medical care and welfare' of persons receiving treatment or care for a mental illness, and for overseeing and monitoring standards of mental health services.[3]

15. The introduction of the 2014 Act had significant implications for the Chief Psychiatrist's role, with Victoria leading the nation in having an expert clinician with broad powers to lead best clinical practice and promote continuous improvement and human rights. The purpose, powers and functions of the Chief Psychiatrist were refocussed, with the role shifting from responding to individual client and service issues and complaints to a more strategic, system-wide role with responsibilities for clinical leadership and system-wide quality assurance and improvement. Responsibility for managing individual client and service complaint issues became the purview of the newly-established Mental Health Complaints Commissioner.

16. The role of Chief Psychiatrist exists in each Australian state and territory. While the main roles and functions of Chief Psychiatrists are largely consistent across jurisdictions, Victoria's Chief Psychiatrist has the most comprehensive scope and functions as set out under the *Mental Health Act 2014*. As Victoria's Chief Psychiatrist I am also one of only two Chief Psychiatrists in Australia with a broad power to issue directions, the other being my Tasmanian counterpart.

[3] Mental Health Act 1986, s 105.

17. The Act introduced principles that mental health service providers must have regard to in performing any duty or function or exercising any power under or in accordance with the *Mental Health Act 2014*. These principles place people living with mental illness at the centre of decision making by promoting recovery-oriented practice, seeking to minimise the use and duration of compulsory treatment, and safeguarding the rights and dignity of people living with serious mental illness. The principles also recognise and support the important role of families and carers in the recovery of people living with mental illness.[4] I discuss these principles further in response to Question 5.

18. The functions of the Chief Psychiatrist under the Act are to:

18.1 develop standards, guidelines and practice directions for providing mental health services and publish or otherwise make available those standards, guidelines and practice directions

18.2 assist mental health service providers to comply with the standards, guidelines and practice directions developed by the Chief Psychiatrist

18.3 develop and provide information, training and education to promote improved quality and safety in the provision of mental health services

18.4 monitor the provision of mental health services in order to improve the quality and safety of mental health services

18.5 assist mental health service providers to comply with the Act, regulations made under the Act and any codes of practice

18.6 conduct clinical practice audits and clinical reviews of mental health service providers

18.7 analyse data, undertake research and publish information about the provision of mental health services and treatment

18.8 publish an annual report

18.9 conduct investigations in relation to the provision of mental health services by mental health service providers

18.10 give directions to mental health service providers in respect of the provision of mental health services

[4] Mental Health Act 2014, s 11.

18.11 promote cooperation and coordination between mental health service providers and providers of other health, disability and community support services.[5]

19. The *Chief Psychiatrist's Annual Report* provides an overview of the activities carried out by my office and examples of performance of each of my statutory functions, along with data about ECT, restrictive interventions such as seclusion and bodily restraint, and reportable deaths. Importantly, these reports promote transparency, public dialogue and understanding about how my statutory functions are fulfilled.

Attached to this statement and marked '**NC-2**' is the 2017-18 Chief Psychiatrist's Annual Report.

20. My statutory functions enable me to provide leadership to the sector and intervene when quality and safety concerns arise. At times, I facilitate timely resolution of access issues between services which cannot be resolved at a local level.

21. The role of the Chief Psychiatrist is primarily to intervene at system-level through promotion of cultural and clinical practice improvement. The Office operates as a resource for the specialist mental health system to drive continuous improvement and embed the principles in the Act.

22. I may become involved in issues in order to ensure the rights of consumers receiving mental health services are promoted, or to address quality and safety issues in several ways. For example:

22.1 a mental health service may approach my office for assistance, may request a review of their practice, or may disclose an issue and seek support in resolving or responding to that issue

22.2 a consumer, carer or other individual may raise concerns with my office that have not been satisfactorily addressed through other avenues

22.3 I may become aware of systemic issues through routine engagement with mental health services, peak and advocacy bodies, such as through site visits and contact with services and staff

22.4 I may respond to issues flagged through the department's regular performance monitoring processes, such as when specific indicators give rise to concerns, or when broader indicators are considered together in relation to service performance.

[5] Mental Health Act 2014, s 121.

23. In relation to quality and safety, my statutory powers enable me to carry out formal investigations, clinical reviews or clinical audits, and to issue directions where necessary. In exercising these functions, I work with consumers, families, carers, advocacy services and service providers, Boards and Executives, and seek to ensure strong engagement and agreement on actions required to respond to identified issues.

24. A formal investigation may be conducted if I believe that any person's health, safety or wellbeing is endangered as a result of those services.[6] The Act sets out a legal framework for investigations and specific powers to support an investigation, including powers of entry and the power to direct a staff member of a health service provider to produce documents and answer questions. After completing an investigation, the Act requires me to prepare a report that sets out the findings of the investigation, which may include recommendations or directions for improving quality and safety, or for assisting with compliance with relevant standards, guidelines, codes of practice and laws.

25. I also have the option of conducting clinical reviews and clinical practice audits. Clinical reviews may be carried out in relation to any aspect of a mental health service in order to identify processes and practices that need to be changed to improve the quality and safety of the services.[7] In contrast, clinical audits consider a specified practice or matter in order to identify systemic issues or trends that need to be addressed to improve quality and safety.[8]

26. My approach is to work collaboratively with services to improve the quality of treatment and ensure that consumers' rights are promoted, whether a formal investigation is carried out or in less formal engagement. My office seeks to build strong relationships with services, with services actively seeking assistance and participating in investigations and reviews. This is demonstrated through services seeking assistance and acknowledging the ongoing support of my office in enabling them to implement and sustain positive change.

27. My office fosters this strong engagement with services through frequent contact, as well as through prompt engagement when we become aware of a significant quality and safety issue. In such cases, my office or the Office of the Chief Mental Health Nurse will make initial contact, send a representative to visit the service if necessary and commence an initial clinical review where appropriate.

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[6] Mental Health Act 2014, s 122.
[7] Mental Health Act 2014, s 130.
[8] Mental Health Act 2014, s 134.

28. The strong engagement of my office with the sector represents a deliberate shift in the way the Chief Psychiatrist engages with services. This has been enabled by changes brought into effect by the Act. Previously, the Office of the Chief Psychiatrist would have devoted a large proportion of resources to responding to consumer complaints. Under the Act consumer complaints are now the responsibility of the Mental Health Complaints Commissioner.[9]

29. Even when a formal investigation is required, there is still scope for a collaborative approach. An example of this was an investigation carried out by my office in 2016 in response to a service reporting a serious sexual assault. Following this investigation, I issued a direction to all designated mental health services in November 2016 providing clear direction on how to apply the Act in relation to seclusion, particularly regarding locked spaces where more than one consumer is physically located at any given time.[10] My office then partnered with the service in which the assault occurred for over two years in order to assist them to manage the change process associated with the direction.

30. Similarly, my office will work collaboratively with services as much as is possible and appropriate during and following a clinical review. For example, Goulburn Valley Health sought my input about its mental health services for children and young people in 2016, requested a site visit, and sought advice on addressing systemic issues. In response to these concerns, I worked closely with the service to examine the underlying issues. Following my report and recommendations (a copy of which is included as NC-3 to this statement), I continued to support the service and to monitor quality and safety through regular videoconferencing, reviewing documentation for a new service delivery model and organisational structure, and visiting the service as needed to monitor implementation progress.[11]

    Attached to this statement and marked '**NC-3**' is a copy of the Goulburn Valley Child and Youth Mental Health Service: Chief Psychiatrist's Report.

31. The power to give directions to mental health service providers under the Act[12] can be important in the context of safety and quality issues, where I become aware of a breach of clinical guidelines, or when needed to ensure that a specific consumer can access appropriate services. For example, when

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[9] Mental Health Act 2014, Part 10.

[10] Victorian Chief Psychiatrist Direction 2016/01: Staffing requirements for safe practice where patients are in locked areas within mental health inpatient units <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/staffing-requirements-safe-practice-where-patients-in-locked-areas>

[11] Goulburn Valley Child and Youth Mental Health Service: Chief Psychiatrist's Report, October 2016 <https://www2.health.vic.gov.au/about/publications/researchandreports/goulburn-valley-child-and-youth-mental-health-service-chief-psychiatrists-report>

[12] Mental Health Act 2014, s 121(j)

treatment is not sustainable in a specific setting due to very aggressive behaviour of a consumer, I have been able to direct that an alternative, more appropriate service accept the consumer in a secure extended care setting. Where appropriate, I may also negotiate with services or assist services to work together towards a solution before issuing a formal direction that reflects what has been agreed.

32. As part of my statutory role, I also sit on the Forensic Leave Panel, provide oversight of suspension of leave for forensic inpatients, and have oversight of applications to court for people subject to orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA Act).

33. At a system level, I provide clinical leadership to the sector through guidelines which provide specialist advice on various aspects of clinical services and inform mental health practitioners and services about the operation of, and clinical issues relating to, the Act. A recent example of a guideline is the *Chief Psychiatrist guideline and practice resource: family violence* (June 2018).

Attached to this statement and marked **'NC-4'** is a copy of the Chief Psychiatrist guideline and practice resource: family violence (June 2018).

34. Other recent guidelines relate to treatment plans (July 2018), working together with families and carers (August 2018), electronic communication and privacy in designated mental health services (September 2018) and surveillance and privacy in designated mental health services (September 2018).[13]

35. The Office also works collaboratively with Safer Care Victoria on quality and safety improvement initiatives. An example of this is the Mental Health Clinical Network which has been established to provide clinical leadership, expertise and advice to improve outcomes for people accessing clinical mental health services in Victoria. In partnership with mental health clinicians and people with lived experience, the network facilitates state-wide quality improvement projects. The Chief Mental Health Nurse and I are ex officio members of this network.

36. I also actively engage with the sector through professional forums, which are well attended and received. These include:

36.1 quality and safety forums with interstate and international guest speakers 2-3 times per year to address priority quality and safety issues within mental health services (e.g. 'When things go wrong' in

[13] Guidelines available at <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines>

November 2017, risk assessment in June 2018 and sexual safety in December 2018)

36.2 annual ECT forums which are attended by psychiatrists, psychiatry trainees, nurses, educators, consumer and carer representatives and peer support workers from both the public and private systems. These educational initiatives address emerging clinical, practice and legal issues associated with ECT

36.3 quarterly Authorised Psychiatrists forums to discuss and share policies, initiatives and current and emerging service delivery issues with Authorised Psychiatrists within all designated mental health services

36.4 specialist sector forums (e.g. Child and Adolescent Mental Health Services, Secure Extended Care Unit, Autism Coordinators from Child and Adolescent Mental Health Services)

36.5 quarterly committee meetings on ECT, restrictive interventions, reportable deaths and sexual safety

36.6 regular meetings to discuss and share policies, initiatives and current and emerging service delivery issues with:

(a) the Royal Australian & New Zealand College of Psychiatrists

(b) the Mental Health Complaints Commissioner

(c) the Mental Health Tribunal

(d) the Safer Care Victoria – Mental Health Clinical Network.

37. Through the Chief Mental Health Nurse, my office also engages the sector via:

37.1 monthly forums with senior mental health nurses from across the State

37.2 quarterly senior mental health nurse forums on child and youth, adult, aged, and community services

37.3 bi-monthly meetings of the Victorian Mental Health Interprofessional Leadership Network (VMHILN) with a focus on practice change, service development and implementation of recovery-oriented practice

37.4 quarterly meetings with the Independent Mental Health Advocacy Service

37.5 monthly meetings to discuss and share policies, initiatives and current and emerging service delivery issues with:

(a) the Victorian Mental Illness Awareness Council

(b) Tandem (carer peak organisation)

(c) the Australian Nurse and Midwifery Federation (Victorian Branch)

(d) the Health and Community Services Union

(e) the Health Services Union.

Attached to this statement and marked '**NC-5**' is a copy of the Office of the Chief Psychiatrist: sector engagement summary.

38. The Office works closely with consumer and carer advisers and peak bodies to develop robust approaches to supporting consumer and carer input, collaboration and co-design.

39. The Office role models the way in which we expect services to work with consumer and carer advisors and supports lived experience workers to engage consumers and carers in their service in a systemic way.

40. The Office has adopted the approach that consumers and carers will be represented within all of its activities; this is modelled to services and is articulated through guidelines and clinical frameworks, contacts with services (forums, meetings, service visits, and formalised activities such as reviews and investigations.

41. This includes the development of processes for reviewing opportunities for input, best approaches, liaison with peaks and other stakeholder groups, induction and orientation resources, debriefing and support mechanisms.

42. Lived experience workers in the Office also draw on their consumer and carer networks and leadership groups across the state as resources.

43. Consumer rights and engagement with carers are central to the activities carried out by the Office. For example, the rights of people receiving ECT have been promoted through:

43.1 writing a guideline for clinicians involved in prescribing and administering ECT that emphasises the importance of informed consent for people receiving ECT on a voluntary basis, the assessment of people's capacity to give informed consent, and the provision of support to people with compromised capacity to enable them to make an informed decision whenever possible

43.2 writing a statement of rights, in conjunction with consumer representatives, for all consumers for whom ECT is proposed as a treatment that explains their entitlement to accurate, balanced information regarding the advantages and adverse effects of ECT, support by carers, nominated persons and legal representatives in the decision-making process, and access to second psychiatric opinions for those on treatment orders

43.3 hosting an annual forum on ECT for clinicians that involves a presentation by consumer representatives

43.4 visits to services that provide ECT with directors and nurse coordinators of other services and consumer and carer representatives to check adherence to the Chief Psychiatrist's guideline on ECT. Where gaps are identified, services must submit a remediation plan with agreed timelines

43.5 providing information to services about their relative performance on selected indicators (for example, the proportion of ECT applications to the Mental Health Tribunal that are marked 'urgent' which can limit consumers' capacity to be supported at the urgent Tribunal hearing) with a requirement that outlying services analyse the factors contributing to differences in clinical culture.

3. What is the delineation of responsibilities between the Chief Psychiatrist, DHHS, service providers and other relevant statutory bodies or office holders?

44. The Secretary of DHHS appoints the Chief Psychiatrist. The role is located within the department and is supported by the Office. The Office comprises Deputy Chief Psychiatrists, the Chief Mental Health Nurse, consumer and carer Advisers with lived experience, clinical advisers and project and administrative Officers.

45. The Chief Psychiatrist is subject to the general direction of the Secretary of DHHS.[14]

46. In addition to my clinical leadership role, I hold an executive officer role in DHHS. I report to the Director, Mental Health Branch.

Regulation and oversight

47. As set out in my answer to Question 2 above, the Office, including the Chief Mental Health Nurse, oversees and promotes safety and quality in mental health services and facilitates the engagement of mental health clinicians. The Chief Psychiatrist has powers to investigate mental health services and

[14] Mental Health Act 2014, s 119(2).

has statutory obligations to monitor the use of restrictive interventions and reportable deaths.

48. The Chief Psychiatrist's statutory responsibilities relate to specialist mental health services. These include designated mental health services (18 designated mental health services, including Forensicare, that auspice or provide clinical mental health services, and which may provide compulsory assessment and treatment to people in accordance with the Act) and publicly funded mental health community support services (MHCSS).[15]

49. The Chief Psychiatrist does not have jurisdiction over private mental health services.

50. The day-to-day responsibility for providing safe and effective mental health treatment rests with individual health services.

51. Other statutory bodies that form part of the regulatory and oversight framework for specialist mental health services under the Act include:

    51.1 the Mental Health Complaints Commissioner, an independent, specialist complaints organisation which resolves complaints about specialist mental health services and recommends improvements[16]

    51.2 the Mental Health Tribunal, an independent statutory tribunal which makes and reviews compulsory orders and determines some treatment applications (electroconvulsive treatment and neurosurgery for mental illness)[17]

    51.3 the Office of the Public Advocate which provides guardianship and advocacy for people with disability, including mental illness and brain injury[18]

    51.4 community visitors who monitor services provided at prescribed premises and can assist people receiving services.[19]

Planning, policy and service development

52. In addition, and separate to, the functions carried out by the Chief Psychiatrist, DHHS undertakes planning, policy and service development for Victoria's specialist mental health system. This includes:

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[15] Mental Health Act 2014, s. 3.
[16] Mental Health Act 2014, Part 10.
[17] Mental Health Act 2014, Part 8.
[18] Guardianship and Administration Act 1986, Part 3.
[19] Mental Health Act 2014, Part 9.

52.1 Integrating and partnering with broader DHHS and government structures (e.g. Safer Care Victoria) to undertake specialist mental health system planning and performance management

52.2 system-wide planning and performance management; operational issue management; developing program and funding approaches that support efficient and high-quality service delivery; and performance and accountability frameworks for Victoria's specialist mental health services.

52.3 legal policy advice on mental health-related issues and law reform across DHHS and across government; strategic reviews and research projects; preparation of the annual parliamentary report on Victoria's mental health services and budget strategy

52.4 work to foster system integration and service design to improve outcomes for people living with a mental illness e.g. transition of mental health community support services to the National Disability Insurance Scheme; consumer and carer engagement; and implementation of initiatives under the Suicide prevention framework, fulfilment of the Royal Commission Recommendations on Family Violence and Forensic mental health implementation plan.

53. The Chief Psychiatrist and the Office provide clinical expertise and advice to support the planning, policy and service development activities for Victoria's specialist mental health system but do not have key decision-making authority in these matters.

54. Mental health policy development and implementation also occurs within, or in close collaboration with, other Victorian Government departments and agencies, including but not limited to: the Department of Education and Training; the Department of Jobs, Precincts and Regions; the Department of Justice and Community Safety; WorkSafe Victoria; Ambulance Victoria; Victoria Police; Safer Care Victoria; Family Safety Victoria; the Victorian Agency for Health Information and the Victorian Health and Human Services Building Authority.

4. What are the principal characteristics of the design of the specialist mental health system?

55. Nearly 30 years ago, Victoria led the nation in deinstitutionalising the State's specialist mental health services. This reform represented a major shift away from isolating people living with mental illness from the community to integrating them back into the community to promote recovery and end the debilitating impacts of institutionalisation.

56. Stand-alone psychiatric hospitals were replaced with inpatient mental health services co-located with general hospitals or aged care services, and community-based clinical and non-clinical mental health services. Since deinstitutionalisation, there have been a number of policies and frameworks developed by the Victorian Government to guide operations and reforms of the specialist mental health service system.

57. The specialist mental health system includes both clinical and non-clinical services:

57.1 Clinical mental health services delivered through Victoria's general health services, operating in both bed-based and community services. Compulsory bed-based treatment can only occur in services which have been publicly designated for that purpose.

57.2 Non-clinical mental health services, known as mental health community support services (MHCSS), publicly funded but managed by non-government organisations.

Specialist clinical services

58. Clinical services include inpatient services for people living with acute mental illness, sub-acute bed-based services and community-based services. If there is a need for compulsory treatment to occur under the Act, it can only be provided by public designated mental health services, although this can be in any of these settings.

59. Specialist clinical services include:

59.1 area-based clinical services:[20]

(a) 21 adult mental health services, provided in 13 metropolitan and eight rural catchments

(b) 13 child and adolescent mental health services (**CAMHS**), provided in five metropolitan and eight rural catchments

(c) 14 aged persons mental health services, in six metropolitan and eight rural catchments

59.2 state-wide services, such as specialist parent and infant units, services for people living with a personality disorder, the Victorian Dual Disability Service, and the Victorian Institute of Forensic Mental Health, known as Forensicare, which provides clinical services for

[20] Based on the Policy and Funding Guidelines volume 1 (2018).

offenders or people involved in the criminal justice system experiencing severe mental illness.

60. Approximately half of the beds in Victoria's specialist clinical mental health system are for acute inpatient treatment, 20 per cent are in community care units and ten per cent are for prevention and recovery care. The remaining 20 per cent of beds are in secure extended care units, psychiatric assessment and planning units and state-wide specialist services.[21]

61. Each area mental health service referred to in paragraph 59.1 above operates within a defined geographical catchment area. Access to an area mental health service is determined by the catchment in which a person resides.

61.1 Services in each catchment area take responsibility for providing mental health services to people living in that area, so that they have access to locally based treatment and support where possible.

61.2 Victorians who seek help from a mental health service outside their catchment area have a right to immediate assessment of their needs. Victorian mental health services are therefore sometimes required to work across catchment boundaries to provide prompt and appropriate treatment, and to determine continuity of treatment arrangements.

61.3 Catchments are a system design and funding issue, and so do not fall within the scope of the Chief Psychiatrist's role. However, the Chief Psychiatrist sometimes plays an informal role in negotiating outcomes where services have been unable to reach an agreement about where a particular consumer is to be treated. Homeless consumers can experience particular challenges when a catchment needs to be determined for them to access services.

62. Specific service components vary between age-based service types and between different areas of the State. However, the major core service components available across the State to people of all ages include:

62.1 Community-based mental health services, which are provided in clinics and as outreach services to people's homes or other locations in the community (for example, to people who are homeless). Services include crisis assessment, case management, and individual, family and group therapy. In some health services, community-based mental health services consist of discrete teams that support people with

[21] Mental health services in Australia: Specialised mental health care facilities - Table FAC.12: Public sector specialised mental health hospital beds, by hospital type and program type, states and territories, 1992–93 to 2016–17.

specific needs (for example, crisis assessment or continuing care). Other health services operate a more integrated service model.

62.2 Acute inpatient units, which are part of general hospitals. Acute inpatient units support people experiencing an acute episode of mental illness who require treatment in hospital. These services provide both voluntary and compulsory short-term inpatient management and treatment.

62.3 Community care units (**CCUs**), which provide longer term (up to two years) residential clinical treatment and non-clinical supports in home-like environments to support the recovery of people experiencing a severe mental illness.

62.4 Secure extended care units (**SECUs**), which are secure services on general hospital sites for people who need a high level of secure and intensive clinical treatment for severe and enduring mental illness. SECUs provide long-term management and treatment services at three metropolitan and three regional hospitals, and there is limited non-secure extended care bed capacity at two further hospitals.

62.5 Prevention and recovery care services (**PARCs**). These are short term (up to 28 days), recovery-focused treatment services in community-based residential settings. PARCs provide early intervention for people who are becoming unwell and for people in the early stages of recovery from an acute psychiatric admission. There are also currently two specialised youth PARCs for young people aged 16-25 years. PARCs are generally unable to accept consumers with insecure housing, suicidal ideation or substance use disorders.

Mental Health Community Support Services

63. Non-clinical MHCSSs provide psychosocial support to people aged 16-64 with severe mental illness and related psychosocial disability. In 2017-18 there were 9,765 consumers who accessed MHCSS.[22] The core objectives of MHCSS are to help people manage their own mental health better, be at the centre of decision-making related to their support, improve their health and wellbeing, and minimise long-term disability.

64. Direct client services include: individualised client support packages; bed-based residential rehabilitation services; continuity of support for clients of MHCSS programs that are transitioning to the National Disability Insurance Scheme (**NDIS**) who are not eligible for the NDIS due to age and residency; a MHCSS intake service, which provides a single easy access entry point to the MHCSS program for people experiencing a psychosocial disability; a Mutual

[22] Victoria's Mental Health Services Annual Report 2017-18, p.71.

Support and Self Help Program; Planned Respite programs; and Aboriginal mental health services provided through funding Aboriginal Community Controlled Health Organisations across the state.

65. MHCSSs are currently experiencing transformational change through the NDIS reforms. Individual client support packages, adult residential rehabilitation services and most supported accommodation services currently provided by MHCSS are transitioning to the NDIS over a three-year period from 2016-17. Funding to providers of these services is being progressively reduced as clients transition to the NDIS.

5. The Royal Commission understands that the specialist mental health system is intended to reflect design principles including that it be community-based and person-centred, that it employ a workforce which includes peers and carers, and that it employ least restrictive practices.

If this is correct, are there any key design principles? If not, what are the key design principles intended to be reflected in the system? What is the source of the design principles?

66. The deinstitutionalised specialist mental health system has evolved over time, as have the principles that inform system design and service provision. Twelve principles to guide the current provision of mental health services in Victoria were formalised with the introduction of the Act.

67. A mental health service provider must have regard to the twelve mental health principles when providing mental health services, and a person must have regard to the principles in performing any duty or function or exercising any power under or in accordance with the Act.

68. The mental health principles, set out in section 11 of the Act, are as follows:[23]

68.1 persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;

68.2 persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life;

68.3 persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be

[23] Mental Health Act 2014, s 11.

supported to make, or participate in, those decisions, and their views and preferences should be respected;

68.4 persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;

68.5 persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;

68.6 persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;

68.7 persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;

68.8 Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to;

68.9 children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;

68.10 children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;

68.11 carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;

68.12 carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

In what ways does the specialist mental health system currently embody those principles and in what way does it not do so?

69. As these principles are enshrined in the Act, they apply to all providers of specialist mental health services and are reflected in policy development and service delivery.

70. In my view, these principles are becoming embedded in the philosophy of treatment in specialist mental health services, which emphasises consumer-focused and recovery-oriented care, least restrictive practices, collaborative

decision-making, and the involvement of families and carers where possible. Examples of where these principles are well-embodied include:

70.1 Operation of oversight mechanisms, such as the Mental Health Tribunal, which ensures there is robust assessment and scrutiny of consumers' capacity to make choices about their treatment, and to ensure that consumers requiring compulsory treatment receive this in the least restrictive way possible [e.g. embodying principles in section 11, 1(a), 1(c), 1(d), 1(e) of the Act

70.2 The lived experience workforce, which works within both clinical and MHCSS service settings in a range of roles that include consumer and carer consultants, and peer support workers. In 2017 a survey of Victorian specialist mental health services identified there were 341 lived experience positions across Victoria.[24] [e.g. embodying the principle in section 1(e) in the Act]

71. In practice, however, these principles may be compromised due to resourcing and demand pressures.

72. In response to high demand, mental health service providers focus on the most acute and severely unwell consumers. Consumers may receive less treatment and treatment later in an episode of illness often resulting in increased severity of symptoms. This compromises the principles of Section 11, 1(a) and 1(b) in the Act.

73. This increases the likelihood of the need for compulsory treatment. The numbers of consumers being treated compulsorily[25] restricts the capacity of services to accommodate individuals who seek treatment voluntarily. High acuity also increases the likelihood of the use of restrictive interventions during an inpatient admission. This compromises the principles of Section 11, 1(a) and 1(b) in the Act.

74. The transition to supported-decision making has been slower to occur than is desirable. This is not only a substantial cultural shift, but one which also requires significant additional clinical engagement with consumers and carers. Resourcing and demand pressures have limited the extent to which this principle has been meaningfully adopted compromising full realisation of the principle in section 11, 1(c) of the Act.

75. Meaningful carer involvement in decisions about assessment, treatment and recovery is not always occurring. There is significant work to be done to

[24] Department of Health and Human Services, Lived experience workforce positions in Victorian public Mental Health Services (October 2017) <www2.health.vic.gov.au/mental-health/workforce-and-training/lived-experience-workforce>
[25] Mental Health Annual Report 2017-18, p. 69.

support mental health services, consumers and carers to understand how to work in partnership in a supported decision-making framework. A significant cultural shift is required for carers and services to feel comfortable with consumers making decisions about their assessment, treatment and recovery that involve a degree of risk. This is particularly difficult when demand pressures mean the treatment and support available to consumers may not be adequate to assist them to manage those risks. This impacts on the principles in section 11, 1(c), 1(d), 1(k) and 1(l) of the Act]

76. The specialist mental health system has very few ways of responding in culturally-appropriate and safe ways to the needs of Aboriginal Victorians. Although there are some initiatives to improve services, there is much more that is required to address unacceptably high rates of mental illness. This impacts on the principles in section 11, 1(h) of the Act.

77. Culturally and Linguistically Diverse Victorians (CALD communities) experience numerous barriers to accessing specialist mental health treatment including poor understanding of diverse cultural practices and barriers to accessing mental health treatment. Other barriers include an assumption of literacy, insufficient access to interpreting services and predominantly English language-based information materials. This impacts on the principles in section 11, 1(g) of the Act.

78. The separation of treatment systems, such as the alcohol and other drugs system, is a barrier to people having their medical and other health needs responded to (section 11, 1(f) of the Act. At times this separation can also result in consumers being lost between the two systems.

Insofar as the system does not embody its intended design principles, based on your experience and observations, what factors have contributed to that outcome?

79. In my opinion, resourcing and demand pressures have contributed to the current situation where service provision is not always consistent with the principles articulated in the Act.

80. The increasing demand for mental health services – and in particular for acute inpatient services – has led to an increased threshold for access to specialist mental health services. I discuss this further in paragraph 116 below.

81. In response, mental health service providers focus on the most acute and severely unwell consumers. Consumers receive less treatment and treatment later in an episode of illness often resulting in increased severity of symptoms.

82. This increases the likelihood of the need for compulsory treatment, which in turn restricts the capacity of services to accommodate individuals who seek

treatment voluntarily. High acuity also increases the likelihood of the use of restrictive interventions during an inpatient admission.

83. These factors erode the principles of least restrictive treatment and choice for both consumers and those seeking to access the system, who are then unable to receive treatment at the time of their choosing.

84. Access to other government services is also a contributing factor, particularly in relation to individuals who are homeless. The difficulties in accessing appropriate supported accommodation severely compromise the choices available to mental health consumers who are homeless. Consumers may not meet the criteria for treatment in specific settings such as PARCs or may be treated outside of their local area. In order to effectively meet the needs of these individuals, a coordinated response is required across the social services sector that addresses the mental, physical and social needs of individuals.

6. In your experience, how does the specialist mental health system we have now compare to what was envisaged in the 1990s?

85. The closing of institutions, integration of mental health services with general hospitals, focus on community assessment and treatment, and move away from long-term institutional care has fundamentally changed the way the specialist mental health system has operated in Victoria since the 1990s.

86. In my opinion, Victoria has reason to be very proud of leading the nation in the major reform of the specialist mental health system which brought people out of institutions and into the community. The vision in the 1990s was bold and ambitious.

What has been lost?

Capital infrastructure to support high quality and safe acute treatment

87. While community-based treatment is always preferred, it is important to acknowledge that mental illness is the same as many other serious illnesses. On occasion, admission to hospital for a period of treatment may be the most appropriate response. Acute inpatient treatment should be high quality and occur in a safe and therapeutic environment.

88. Infrastructure investment and bed mix settings in Victoria are no longer aligned with the needs of the community. Over time, infrastructure investment has over-emphasised low-level, sub-acute settings and under-emphasised acute inpatient, secure extended care and forensic elements of the specialist mental health system.

89. As a result, the number of acute, secure extended care and forensic inpatient beds available has not kept up with demand. This is clearly evidenced in occupancy rates for acute adult, SECU and forensic beds in comparison to PARC beds and emergency department presentations. Since 2007/08 the state-wide average occupancy rate for acute inpatient beds is 92 percent (94 percent for metropolitan services). SECUs have recorded an average of 90.5 percent, whereas the PARC state-wide average occupancy rate for the same period is 72.9 percent.[26]

90. Access to intensive treatment and support may only be available later in an episode of illness and discharge is more likely to occur before the therapeutic benefit of the admission has been realised. Community-based services are then required to provide treatment to consumers in acute stages of illness.

91. Community-based services have insufficient resources to provide the intensive treatment and support required for consumers who are very unwell. Their resources do not allow them to provide evidence-based psychological interventions which assist with longer-term recovery. These consumers are therefore more likely to experience slower recovery or a relapse of very acute symptoms.

92. Capacity constraints, leading to shorter lengths of stay in hospital, result in pressures on both community-based services and families. For example, appropriate treatment of a psychotic illness would require many weeks for major symptoms to resolve. However, consumers with this type of condition may be discharged while still acutely unwell in order to free up inpatient beds.

Unintended consequences of deinstitutionalisation

93. Deinstitutionalisation has also had significant unintended consequences for consumers with higher prevalence disorders, such as depression and anxiety.

94. Prior to mainstreaming of gazetted beds in stand-alone mental health institutions into general hospitals in the 1990s, large general hospitals across the state also had small in-patient and community psychiatry services. The inpatient beds were not gazetted and were therefore not able to admit compulsory patients under the Mental Health Act.

95. Those units developed particular expertise in high prevalence disorders and offered a variety of psychological treatments and were rich training and education grounds for the multi-disciplinary workforce.

96. With mainstreaming and the amalgamation and integration of gazetted and non-gazetted beds and services from the large mental health institutions, the

[26] Mental Health Key Performance Indicators

service focus shifted to treating consumers under compulsory orders. Consumers with higher prevalence disorders who required psychological treatments were gradually forced out of the system due to demand issues and the staffing with the expertise also left, mostly for the private system.

97. Those general hospitals also had high-functioning responsive consultation liaison psychiatry teams (CLP teams) prior to mainstreaming, providing in-reach to ED and general hospital wards and outpatient clinics.

98. CLP teams provide psychiatric services to acute and subacute (non-mental health) systems. CLP is a recognised psychiatry sub-specialisation, with extensive research and evidence.

99. CLP teams undertake assessments, provide treatment and management plans (consultation function) as well as support and education to medical services (liaison function). Some consultation liaison services will be actively involved in treatment and care for mental health conditions during a general hospital admission.

100. CLP teams can provide consultation and liaison to:

100.1 general medical and surgical wards

100.2 transplant units

100.3 paediatric units

100.4 geriatric medicine units

100.5 obstetrics and gynaecological services

101. Often very large metropolitan hospitals will have specialist CLP teams attached to specialist medical units. Generally, smaller metro and regional hospital will have single CLP teams to cover the entire hospital, including ED. Consultation liaison service may also be available in ambulatory care settings, for example in psycho-oncology, memory clinics and perinatal services.

102. CLP teams are generally multidisciplinary and are configured in different ways depending on the unit they are attached to. For example, Emergency mental health (ECATT) are specialized consultation liaison teams that are specifically funded and work only in emergency departments.

103. Aside from some additional funding in 2016/17 when funding was increased by approximately 55% to $8.5 million per annum state-wide, there has been insufficient growth in consultation and liaison funding for many years. This has limited the capacity of CLP teams to see all referrals, particularly sub-acute referrals and participate in liaison work with medical units.

104. Expertise has similarly been gradually eroded with mainstreaming resulting in less access for people who do not meet the threshold for services in the specialist mental health system.

What has been gained?

105. The focus on recovery principles, enshrined in the Act, has led to improved choices for, and involvement with, consumers, families and carers.

106. Each individual's functional capacity, and their ability for recovery, is now considered. The introduction of alternative, innovative models of care has also benefited individuals who can be appropriately treated in the community, as well as tackling stigma through increased awareness and visibility of mental illness.

What new trends have impacted on community needs since the 1990s?

107. Since the 1990s, population growth has had a marked impact on service provision. In the last 10 years Victoria's population has increased by 24.7 per cent.[27] The prison population has grown by 81 per cent.[28] At the same time, demand for mental health services has grown at a rate greater than for population growth.[29]

108. Recent analysis of service data by the Auditor-General in the report *Access to Mental Health Services* indicated that over a four-year period, the number of people seeking access to, but not accepted by, area mental health services increased by 63 per cent. Triage service demand increased by 43 per cent between 2010-11 and 2016-17.[30]

Attached to this statement and marked '**NC-6**' is a copy of the Victorian Auditor-General's Office, Access to Mental Health Services report.

109. Private psychiatry has also experienced growth since the 1990s, providing alternative treatment options for those who are able to access and afford these services.

110. Changes in employment patterns have made it harder to maintain stable employment for many people living with mental illness. There has been a reduction in secure, unskilled jobs which were suitable for people whose education and employment histories may have been interrupted. The rise of the 'gig economy' requires workers who have high levels of confidence,

[27] ABS – 3101.0 – Australian Demographic Statistics, September 2018
[28] ABS – Cat 4517.0 – Prisoners in Australia, 2018
[29] Access to mental health services, Victorian Auditor-General's Office, 2019, p 43.
[30] Access to mental health services, Victorian Auditor-General's Office, 2019, p 46.

organisation, initiative and tolerance for uncertainty. This can be challenging in the acute stages of mental illness.

111. Insecure employment and reduced access to affordable and supported accommodation - leading to housing insecurity and homelessness - has exacerbated the vulnerability and difficulties in accessing ongoing treatment and support for people living with severe mental illness. I discuss this further in paragraph 143 below.

112. Changes in substance use have led to corresponding changes in the needs of consumers with co-occurring substance use disorders and mental illness. I discuss this further below in paragraph 149.5 below.

113. While there has been some expansion in community support over the last decade, demand for mental health services for ageing Victorians is increasing however, the number of inpatient beds has remained stable.

114. In terms of trends in government investment, there has been insufficient growth in funding to cover the price of inpatient services. Higher levels of acuity and occupancy require increased staffing numbers, in turn increasing the cost of inpatient services.

How has the system got to where it is now?

115. The system as it was envisaged in the 1990s had merit, as did the principles on which it was based. As Victoria led the nation in the process of deinstitutionalisation, the state did not have the benefit of observing and learning from the operation of models in other jurisdictions. The service system therefore evolved and responded during implementation and in the decades since. The Act also introduced new requirements and its own set of principles, with the system further evolving to encompass these changes.

116. While the specialist mental health system has evolved incrementally since the 1990s, the growth in demand has increased at an unexpected rate. This is also partially due to some unintended consequences of the 1990s reform that are discussed in paragraphs 93 to 97 of this statement. Increased demand has led to a higher threshold for consumers to access specialist services, raising the level of acuity expected to be treated within the community. This is evidenced by the increasing HoNos scores discussed below in paragraphs 154 and 155 of this statement.

117. In my view this is due to a number of factors including a funding system that is unresponsive to demand, planning, and demand forecasting mechanisms that are not able to access information required to deliver targeted capital and workforce infrastructure investment.

118. Along the journey since deinstitutionalisation, we have failed to review the effectiveness of the design and its principles and any unintended consequences of the reforms.

7. In your experience, in relation to acute/crisis response, including the management of emergency department presentations:

(a) Is supply keeping up with demand? What gaps have you observed?

119. In my experience, supply is not keeping up with demand. An increasing number of people are accessing mental health services via presentations to hospital emergency departments. The number of mental health-related emergency department presentations has increased from 83,024 (5.14 per cent of total emergency department presentations) in 2015-16 to 92,610 (5.27 per cent of total emergency department presentations) in 2017-18.[31]

120. The Victorian wait time performance target for mental health consumers to be admitted to an inpatient bed from the emergency department is a maximum of eight hours (this is four hours in acute care). Performance against this target has fallen from 71 percent in 2014/15 to 57.5 percent in 2017/18.[32] Between 2007/08 and 2013/14 the results against the target of 80 percent have fluctuated between 73 and 69 percent.[33]

121. Clinical directors report to me that they are at times forced to discharge consumers from acute inpatient units before they are ready, in order to admit consumers who have, or are about to, breach the wait time performance targets. On occasion the person who is discharged has a greater clinical need than the person who is subsequently admitted. Mental health service staff describe deciding who is the 'least unwell' as a heartbreaking task. The average length of stay has decreased from 14.5 days in 2010/11 to 12.3 days in 2016/17.[34]

122. Lack of access to secure extended care facilities exacerbates this issue with many consumers unable to be discharged from acute inpatient units due to insufficient secure and long-term options being available. Although not strictly within the functions of my role, my Office devotes large amounts of time and effort to assisting Clinical Directors to negotiate places for consumers. This is a complex process of considering availability, consumer personal and clinical history, staff resources and consumer mix. The availability of acute inpatient mental health beds in the specialist mental

[31] Victoria's Mental Health Services Annual Report 2017-18, p. 64.
[32] Department of Health and Human Services Annual Reports 2014/15 to 2017/18
Department of Health and Human Services Annual Reports 2010/ to 2017/18 to 2017/18
[34] AIHW, Mental Health Services in Australia 2016-17, Table KPI4

health system is a critical gap that I discuss further in response to Question 7(c) below.

(b) if there is unmet need, what needs are the most critical?

123. There are multiple needs across the system. In relation to acute and crisis response, the most critical need is access for the most acutely unwell to appropriate and fully-funded beds, including acute adult, secure extended care and forensic mental health beds.

124. There is significant unmet need for children and young people living with 'dual disability'. This cohort, including children and young people living with pervasive development disorders, such as autism spectrum disorder. struggle with access to timely assessment and critical early intervention strategies. CYMHS services have autism assessment teams, with wait times up to 12 months or longer, across the state.

125. There are insufficient respite options resulting in some families becoming so distressed in extreme crisis situations bringing their child to hospital and refusing to take them home. This may result in the child being admitted to an acute mental health in-patient unit, where due to lack of viable accommodation options, they may remain for weeks, months, or in a few rare cases, years, residing in an acute mental health unit which is designed to be short term, with staff who are not disability trained.

126. If these consumers are relinquished by their carers, it can be very difficult to find suitable placements due to poor availability of placements for children in the Out of Home Care system.

127. This problem can continue into adulthood for some consumers due to a lack of appropriate community placements for consumers with complex and challenging behaviours and co-morbid mental illness.

128. This is especially the case when a consumer is unable to be co-located with other people. My Office has seen numerous examples of consumers being constantly moved from various public houses, as residential services struggle to manage the challenging and confusing behaviours, which the community is not able to tolerate.

129. There is only one publicly funded specialist eating disorder service at the Royal Children's Hospital. It offers family-based treatment exclusively. If families are not able to participate in this model of treatment, they are referred back to mainstream child services.

130. Unlike CYMHS where consumers with eating disorders and families are seen as core business, most adult area services do not treat consumers with eating

disorders. As such, there is discontinuity in transition to adult services at age 18.

131. High quality community services providing prevention, early intervention and continuity of treatment are also essential. However, the effectiveness of community treatment is compromised when acute inpatient treatment cannot be accessed when appropriate and discharge occurs too soon.

(c) What are the key drivers of unmet need?

132. Recent reviews indicate that there are not enough mental health beds in Victoria to meet current, or future, demand. At present, all major acute psychiatric units are continually operating at or above 95 per cent capacity. This rate is well above the desirable level of 80 to 85 per cent that enables area mental health services to admit acutely unwell consumers as needed.[35]

133. Victoria currently has one of the lowest acute bed bases nationally.[36] The ratio of specialist mental health hospital beds in Victoria decreased from 42.3 per 100,000 population in 1992-93 (compared with 44.4 per 100,000 in New South Wales and 52.6 in Queensland) to 22.0 per 100,000 in 2016-17 by comparison with 35.5 in New South Wales and 31.2 in Queensland.

134. The availability of acute mental health beds is different across geographic areas, with outer suburban areas not keeping pace, particularly with the population increases in growth corridors.[37]

135. Victoria's investment in bed stock has instead been focussed predominantly on sub-acute PARC bed stock. It has recently been estimated that the bed base would need to grow by 80 per cent over the next decade to meet projected demand, highlighting the existing low acute bed base per head of population in Victoria.[38]

136. There are complex interactions between the ratio of community treatment versus acute inpatient treatment and the models of care that are adopted. These interactions can be influenced by many factors including demographics, location and illness.

137. The paucity of inpatient services drives acuity levels up in community treatment settings resulting in less capacity for these services to provide intensive support and treatment to consumers in the community. Fewer consumers are able to be treated and with less intensity. In turn this can

[35] Access to mental health services, Victorian Auditor-General's Office, 2019, p 48.
[36] AIHW, Mental Health Services in Australia 2016-17, Table FAC 13.
[37] Access to mental health services, Victorian Auditor-General's Office, 2019, p 49.
[38] Access to mental health services, Victorian Auditor-General's Office, 2019, p 49.

increase the potential for crisis presentations to emergency departments and unplanned admissions to acute inpatient beds.

138. Overall, insufficient acute beds and community treatment capacity which can provide evidence-based psychological interventions and intensive support are the system drivers of unmet need. Substantial investment is required in these areas to resolve demand pressures.

139. In addition to these core elements, there are innovative and alternative models of care that could assist consumers to receive the treatment they need. For example, infrastructure and models of care that could provide clinical sub-'step-up' sub-acute care would be of great benefit to consumers and carers and help to reduce emergency presentations and unplanned admissions.

140. Other areas for consideration would be integrated residential models of care for mental health and addiction medicine or specific state-wide services for vulnerable cohorts

(d) What kinds of impact does unmet need have on people affected by mental illness?

141. In my role as Chief Psychiatrist, I see the impact of demand issues on access to services (and therefore safety and quality) with services approaching me at times reporting instances of consumers waiting more than 24 hours in emergency departments due to a lack of available beds. In these instances, services seek my assistance to have the consumer accepted into an alternative, appropriate service. While I have at times played an informal role in facilitating agreement between services, the coordination of beds is not within the scope of the role of Chief Psychiatrist.

142. Service strategies to manage bed availability vary but may result in increasing the length of stay in emergency departments,[39] discharging the least unwell regardless of readiness for discharge, and utilising other units such as aged care, that potentially place a consumer's treatment at risk.[40]

142.1 For consumers experiencing acute mental illness, the high-stimulus emergency department environment is often clinically inappropriate, and at times the presence of acutely unwell consumers in the emergency department presents serious risks to the consumer and others around them.[41]

[39] Between 2015 to 2017 the average wait time in emergency departments rose from 7.6 hours to 9.5 hours, well over the national target of 4 hours.
[40] Access to mental health services, Victorian Auditor-General's Office, 2019, p 48.
[41] Access to mental health services, Victorian Auditor-General's Office, 2019, p 46.

142.2 Most acute units are mixed-gender units, which can place women at greater risk of sexual safety violations, although there are also incidents of same sex safety violations.

8. Specifically, what are the principal service gaps for people living with enduring severe illness and people with multiple and complex needs?

143. Services for people living with enduring severe illness or multiple and complex needs can be compromised by the lack of available and appropriate supported accommodation specifically for people recovering from mental illness. Without access to suitable treatment in the community and "step-down" options such as recovery or psychosocial rehabilitation services, consumers with multiple and very complex needs may remain in inpatient settings for long periods or be inappropriately discharged into community treatment without effective supports. There is no dedicated housing stock for mental health consumers with complex needs. Consumers compete with other people for public housing and supported accommodation facilities.

144. For people with multiple and complex needs, the Multiple and Complex Needs Initiative (MACNI) provides individually tailored case coordination response based on a comprehensive assessment of need, service system capacity and case-by-case considerations.

145. MACNI provides targeted, time-limited and flexible interventions for people who meet specific eligibility criteria and where there is a combination of mental illness, substance dependency, intellectual impairment, acquired brain injury, and risk to self or others.

146. MACNI supports aim to:

146.1 stabilise housing, health, social connection and safety issues

146.2 pursue planned and consistent goals for each individual

146.3 provide a platform for long-term engagement in the service system.

147. MACNI does not provide funds for supported accommodation for mental health consumers. This service is not specifically for people living with mental illness and cannot be accessed by those under the age of 16 years.

148. For some groups of consumers with multiple and complex needs, services may also be constrained by the available discharge and transition options. This can result in consumers staying in an acute setting longer than may be clinically necessary and preventing use of the bed by others in need of care.

149. Consumers facing specific challenges can include:

149.1 Aboriginal Victorians: the impacts of colonisation, trans-generational trauma, removal to out of home care, racism, discrimination, marginalisation and disadvantage have resulted in poor mental health outcomes for many Aboriginal people, their families and their communities. The specialist mental health system is often not culturally responsive to the needs of Aboriginal Victorians and is unable to address the multiple needs of consumers.

149.2 As a result, Aboriginal Victorians are twice as likely to experience high or very high levels of psychological distress compared with their non-Aboriginal counterparts.[42] Between 2012-13 and 2015-16 the number of Aboriginal mental health-related presentations to Victorian emergency departments increased by 55 per cent.[43]

149.3 There is a clear need to work in partnership with Aboriginal Victorians to develop models of care and workforce models that are culturally safe and therapeutic.

149.4 Individuals who are homeless: mental illness is a major risk factor for becoming homeless, with a 2008 survey by SANE Australia on the housing status of people living with mental illness finding that 94 per cent of respondents had been homeless or were without suitable housing at some time.[44] It is difficult for health services and the individual themselves to address their mental health issues and move towards recovery when they are homeless or living in substandard accommodation. Lack of available safe, affordable housing is also a significant factor in delayed discharge from hospital and is a contributing factor to preventable admissions.

149.5 People who experience co-occurring substance use disorders and mental health issues, commonly referred to as 'dual diagnosis'. Some estimates suggest that up to of 63 per cent of people living with mental health needs have co-occurring substance use disorders.[45] Effective management of either substance use disorders or mental illness is challenging. Dual diagnosis adds complexity to assessment, diagnosis, treatment and recovery, and can be associated with increased incidences of relapse. For clinical staff, the illicit nature of

[42] Victorian Population Health Survey 2008: supplementary report.
[43] Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-27, p. 16.
[44] SANE Australia, Research Bulletin 7: Housing and mental illness <https://www.sane.org/images/PDFs/0807_info_rb7_housing.pdf>
[45] Mortlock, KS, Deane, FP and Crowe, TP, Screening for mental disorder comorbidity in Australian alcohol and other drug residential treatment settings. Journal of Substance Abuse Treatment, 2011:40, 397-404.

drug use can place an additional burden on employees by requiring them to remove substances or organise their disposal.

149.6 The separation of treatment systems and the specialist capabilities of the Alcohol and other Drug and mental health workforces is a barrier to person-centred care. Integrated service delivery and collaborative treatment to meet complex needs will need to become core business for services over time. Consideration of treatment models that incorporate mental health treatment and addiction medicine is required.

149.7 Individuals with complex needs associated with a Pervasive Developmental Disorders (PDDs) and/or dual disability: with the transition to NDIS, individuals in this group may experience service gaps. This cohort often presents with complex behaviours of concern associated with multiple disorders, which in many cases are not associated with an acute mental health presentation. Individuals may be brought by their carers or NDIS providers (due in part to staff safety concerns, inadequate packages under the NDIS for the complexity of care required and associated cost pressures) to an emergency department and subsequently admitted into inpatient treatment without an acute clinical need, as the carers or providers refuse to take them home.

149.8 Discharges may also be delayed due to the lack of suitable, affordable and supported accommodation options, with low numbers from this cohort being assessed as eligible for Specialist Disability Accommodation (SDA) under the NDIS, and a lack of supply of suitable SDA properties. Individuals therefore remain in acute settings while they wait for appropriate accommodation to become available in the community.

149.9 Once the person has been admitted to an inpatient unit, the urgency for associated care or support services to resolve the issues preventing the person from living in the community dissipates, because the person is now being cared for in a safe environment.

149.10 In reality, this is usually the 'least worst' option as unnecessary and clinically inappropriate admissions can have very deleterious effects on the consumer.

149.11 At times, inpatient units are also being used for sub-acute care and as a longer-term option for accommodation in the absence of a viable community housing placement.

9. What are the state-wide trends in relation to demand and capacity constraints?

(a) in terms of number of people accessing services

150. As noted at paragraph 116 above, the demand for mental health services in Victoria has increased over the last ten years at a rate that exceeds population growth, and this trend is likely to continue.[46] This demand for mental health services means that people living with severe mental illness may be unable to access the treatment and support they need. For example, in 2017 it was estimated that 184,000 people living with severe mental illness in Victoria required access to mental health services, whereas there were only 72,859 registered users of mental health services for 2017-18.[47]

151. The increasing pressure placed on the system over the last 10 years due to unmet demand is demonstrated by:

151.1 emergency department presentations increasing 9 per cent from 2015–16[48]

151.2 acute hospital admissions growing at an annual rate of 2.4 per cent[49]

151.3 length of stay in hospital trending down from 14.7 days to 11.2 days from 2009 to 2017[50]

151.4 unplanned readmission rates for adult mental health consumers remained above 14 per cent between 2015-16 and 2017-18[51]

151.5 community mental health contacts per 1,000 people declining at a rate of 2.5 per cent per annum over the last 10 years.[52]

151.6 The number of aged consumers accessing clinical mental health services grew to 8,279 in 2017-18, an increase of 12.3 per cent from the previous year.[53]

152. Forensic mental health services are also affected by demand pressures. This has an impact on access for both prisoners and civil patients. Demand for beds at Thomas Embling Hospital is affected by:

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[46] Access to mental health services, Victorian Auditor-General's Office, 2019, p 43.
[47] Access to mental health services, Victorian Auditor-General's Office, 2019, p 44.
[48] Access to mental health services, Victorian Auditor-General's Office, 2019, p 45.
[49] Access to mental health services, Victorian Auditor-General's Office, 2019, p 45.
[50] Access to mental health services, Victorian Auditor-General's Office, 2019, p 45.
[51] Mental Health Annual Report 2017-18, p 69.
[52] Access to mental health services, Victorian Auditor-General's Office, 2019, p 45.
[53] Victoria's Mental Health Services Annual Report 2017-18, p. 66.

152.1 the increasing Victorian prison population, which grew by 81 per cent from 4,224 in 2008 to 7,666 in 2018[54]

152.2 mental health conditions being overrepresented in the prison population,[55] with approximately 17 per cent of people arrested receiving treatment from a specialist mental health service.[56]

152.3 the increasing number of forensic patients subject to long term orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, reducing the number of beds available for prisoners and others.[57]

(b) in terms of the severity of illnesses?

153. Demand pressures have also increased the threshold for access to specialist mental health services so that area mental health services only see the most unwell. This is demonstrated in part by the high proportion (55 per cent) of admissions to adult inpatient units that are compulsory in Victoria.[58] This creates a flow-on effect with the number of mental health consumers accessing acute services through police, ambulance and self-presentations to hospital emergency departments.

154. Data demonstrates the increasing severity of adult consumers' illnesses, measured using the Health of the Nation Outcome Scale (HoNOS). The average HoNOS score on admission increased from approximately 15.9 in 2010-11 to nearly 16.4 in 2014-15, and the score on separation increased from 8.3 in 2010-11 to almost 8.6 in 2014-15.[59]

155. HoNOS improvement scores (change in score from intake to discharge) in adult community mental health services also suggest that more people are being discharged without significant improvement.[60]

156. Capacity challenges at Forensicare's Thomas Embling Hospital[61] have resulted in only the most unwell prisoners being admitted for treatment, and increased wait times for prisoners requiring compulsory treatment. The average number of days between being certified for compulsory treatment and admission increased from 5.3 in 2009-10 to more than 60 days in March

[54] ABS – Cat 4517.0 – Prisoners in Australia, 2018
[55] AIHW, The Health of Australia's Prisoners 2018, p. 27.
[56] Targeting Zero, p. 138.
[57] Targeting Zero, p. 139
[58] Mental Health Annual Report 2017-18, p. 69.
[59] Targeting Zero, p. 136-137.
[60] Targeting Zero, p. 136-137.
[61] Victoria's specialist inpatient hospital for prisoners requiring acute compulsory treatment and those who have been found guilty under the Crimes Mental Impairment Act

2016, with fewer than 40 per cent of certified prisoners transferred to a bed within 28 days against a target of 90 per cent.[62]

157. Some unwell prisoners conclude their sentence before being admitted for treatment at Thomas Embling Hospital. In these circumstances they are usually placed on an Assessment Order before they leave prison and are transported to an area mental health service.

10. What are the principal constraints on, and gaps in relation to, the design and performance of triage services?

The function of triage

158. Mental health triage is a process in which a clinician or a person with mental health training assesses available information about a person to determine the type and urgency of the response required from mental health or other services. If specialist mental health services are not the most appropriate option, the person may be referred to another service (for example, a general practitioner or medical specialist) or given other advice.

159. Triage services are managed on an area basis. Each area mental health service will configure their triage resources according to the size of their organisation and the demographics of consumers who use their service.

160. Area mental health services arrange their mental health triage systems according to local service size, location and other factors. For example:

160.1 Very large mental health services generally have large, dedicated 24-hour triage services for their entire mental health programs. Specialist programs within the health service such as child and youth mental health services, youth or older persons mental health programs will usually manage their own triage during business hours, with calls diverted to the centralised triage team at other times. Electronic medical records within an area mental health services will allow for clinical handover between various mental health programs and triage for existing and new referrals.

160.2 In smaller rural, regional or metropolitan area mental health services, the triage function is typically managed by an office-based service or Crisis Assessment and Treatment Team (CATT) service and is then transferred to a 24-hour program such as an Emergency Crisis Assessment and Treatment Team (ECATT) or an inpatient unit where senior mental health staff will field calls.

[62] Targeting Zero, p. 138-142.

161. Intake into the specialist mental health system can and should occur via mental health triage.

Design of triage services

Telephone triage

162. Mental health triage typically occurs over the telephone. Each area mental health service has a single telephone contact point to provide access to a triage clinician, 24 hours a day, seven days a week.

163. The telephone number is available for existing consumers, new referrals, family or carers seeking advice, health professionals such as general practitioners, psychiatrists and psychologists, and police and ambulance services.

164. Once referred to a mental health triage service, the triage process may occur:

164.1 as a telephone contact with an area mental health service

164.2 as a face-to-face contact with clinicians in emergency departments and other hospital settings (for example, through Consultation Liaison Psychiatry, which provides triage and assessment of consumers who are identified by medical, surgical and specialist services as needing mental health assessment and treatment)

164.3 through forensic mental health services and the court system.

165. MHCSS often work closely with area mental health services in the provision of psychosocial support and residential options and may be involved in mental health triage.

166. After-hours triage is typically handled by CATT / ECATT staff which means that clinicians manage dual roles covering both emergency departments and performing triage functions.

Emergency department triage

167. Individuals presenting to hospital emergency departments may present on their own, with family and carers, or with police and ambulance services. Common presenting problems include:

167.1 suicidal thoughts, attempted suicide or self-harm

167.2 severe depression and anxiety

167.3 symptoms of psychosis

167.4 drug-induced psychosis and intoxication from alcohol or other drugs, or symptoms of acute withdrawal.

168. When a person presents to a hospital emergency department, general triage will be undertaken in the emergency department. Where an emergency crisis assessment and treatment team (ECATT) exists in an Emergency Department, staff will usually refer a person to ECATT for further evaluation.

169. ECATT staff generally include mental health trained nurses, social workers and occupational therapists, as well as a psychologist, psychiatrist and registrars. For emergency departments that do not have ECATT, specialist mental health clinicians fulfil this function.

170. A small number of services have developed Behaviour of Concern team to enable a combined response by emergency department and mental health staff where appropriate. This team reduces the risks of violence and injury, as well as the necessity to call a Code Grey (an acute hospital urgent response code).

171. For consumers who require further acute treatment, or stabilisation prior to mental health triage and assessment (for example, a person who has taken an overdose as an attempt to end his or her life), they may be transferred to a bed-based service such as a Short Stay Unit co-located with the emergency department for ECATT staff to provide mental health triage and management. A small number of hospitals have a co-located Psychiatric Assessment and Planning Unit (PAPU).

Constraints of triage services

172. In collaboration with sector clinicians, DHHS developed and implemented a state-wide triage scale in 2008. The Mental Health Triage Scale classifies the outcome of a triage assessment according to the person's eligibility and priority for mental health services, and the response required by mental health or other services.

Attached to this statement and marked '**NC-7**' is a copy of the State-wide Mental Health Triage Scale Guidelines.

173. The state-wide triage guidelines map assessments to seven categories (Codes A to G) to reflect different levels of need, risk and urgency. For example, Code A is reserved for situations in which there is an imminent risk to life and an emergency services response is required, whereas Code G is appropriate where triage clinicians determine that no further action is

required of the mental health service and referral to another service is not required.[63]

174. This scale does not reflect standard international Emergency Department Triage Scales, resulting in mental health consumers being triaged differently to other consumers when they present to an Emergency Department.

175. The state-wide mental health triage scale and associated guidelines do not provide consistent clinical protocols for assessing and prioritising referrals.

176. Demand for triage services is resulting in extremely long wait times and high abandoned call rates. Feedback from health services, consumers, carers, emergency services and referral services is that there are often long waits.

177. My Office experiences long wait times first hand when contacting triage services and Ambulance Victoria reports that paramedics are forced to present to Emergency Departments with consumers rather than wait for a response.

178. Rural and regional hospital Emergency Departments will generally have access to specialist mental health clinicians during business hours, however, it can be difficult to access specialist advice out of hours.

179. For the triage system to work effectively, individuals, families and carers need to be referred to the right services, which may be within or outside the specialist system. However, feedback from services suggests that people who do not access clinical mental health services may not always be directed to other appropriate treatment or support pathways (for example, the NDIS and primary care pathways).

180. Some individuals may be appropriately triaged but are not accepted into a specialist mental health service because they do not meet current eligibility requirements. In these circumstances, those that are too unwell or have treatment needs too great to be treated in the primary care system, but not unwell enough to access the specialist system, may not receive the treatment they need.

181. ECATT staff will usually undertake mental health triage and an extended mental health assessment if required. However, triage in the emergency department is sometimes complicated by substance intoxication and behavioural issues, as well as physical health concerns.

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[63] Statewide Mental Health Triage Scale Guidelines (2010) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/triage-scale-mental-health-services>

182. Mental health services are not necessarily equipped to assist consumers and carers from culturally and linguistically diverse (CALD) backgrounds, who may need a qualified interpreter and information in a language they understand. This is a particular challenge in the context of telephone triage services, as language may be a barrier to individuals contacting the service and may affect the quality of the assessment.

183. While health services collect records of mental health service contacts on the Client Management Interface/Operational Data Store (CMI/ODS), the data collected by the Victorian Government does not capture information on those who are not accepted into specialist mental health services, or the reasons for non-acceptance.[64] Without this information, it is unclear whether these individuals are not accepted due to resourcing pressures, or whether or not they are being appropriately triaged.

184. Victoria does not have a central triage service. As such, consumers and carers who are new to specialist mental health services may find it difficult to get information about triage services and to access the right catchment-based area mental health service based on their place of residence. Services have also reported to me that people may be advised to bypass mental health triage and to go directly to an emergency department instead.

185. Telephone triage systems operate in other Australian states and territories, with jurisdictions other than Western Australia having a single, central telephone line as a first point of contact. The central telephone services are generally staffed by clinicians who will ask questions to determine the most appropriate response, in accordance with the processes for their jurisdiction (such as the New South Wales Mental Health Triage Policy[65] and the Queensland Mental Health Triage Scale).[66] This is worthy of consideration in the Victorian context.

11. State funded clinical capacity varies significantly across the State. What are the variations and why do they exist?

186. As outlined in paragraph 61 above, mental health services in Victoria operate within defined geographic catchment areas. The catchment areas for clinical mental health services were established in the 1990s, and catchment boundaries mean that a person's place of residence determines where they

[64] Access to mental health services, Victorian Auditor-General's Office, 2019, p 46.
[65] NSW Mental Health Triage Policy <https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2012_053>
[66] Queensland Mental Health Triage Scale <https://www.health.qld.gov.au/cq/gp/services/mental-health/mental-health-triage-and-referral-categorisation>

will access services. This has caused the following problems that hinder service access, including:[67]

186.1 catchment areas that are not aligned with other health and human service areas or local government area boundaries. It can therefore be difficult to coordinate services for consumers and carers, many of whom need support from multiple services

186.2 geographic catchments and age-based service groupings that are not aligned

186.3 lack of coordination when consumers need to access services across catchment boundaries

186.4 service levels and types within a catchment are not aligned with the population growth and demographic changes that have taken place in that area.

187. The distribution of different service types throughout the state means that not all services can be accessed locally. For example, SECUs are not located in all parts of the state, so various services host SECU beds for other catchments.

188. There is also limited access to private psychiatrists or psychologists in rural and regional areas, so that consumers living with moderate mental illness who could benefit from these services instead rely on their local specialist service.

12. In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

189. In my experience, clinical mental health services have become crisis driven. This is demonstrated by the growth in emergency department presentations and subsequent acute admissions by mental health consumers, and the increasing severity of consumers' illness on admission to acute inpatient units, as described in paragraphs 154 and 155 above. In addition, there are service gaps and new models of care are required, particularly for vulnerable cohorts that create barriers to entry to the system.

190. From my observations, I believe that community treatment is also crisis driven. This is due to the acuity of illness of consumers in their care and insufficient funding to deliver evidence-based psychological treatments.

191. Increasing demand for services, described above at paragraph 107, means that services only have a limited capacity to intervene early and avoid an

[67] Access to mental health services, Victorian Auditor-General's Office, 2019, p 51.

episode of inpatient care. This means that consumers tend to be referred or present in crisis once their condition has deteriorated, and diversion to community-based treatment is no longer appropriate.

192. Similarly, consumers are entering the system in crisis and through triage or emergency departments and not earlier through referrals from other professionals to less acute community services.

13. What treatment is available for people who do not meet the criteria for treatment at the service? What are the barriers to people receiving appropriate treatment from a systems perspective?

193. Those who do not meet the criteria for treatment at a specialist mental health service may instead seek non-specialist mental health care from other providers. Providers include general practitioners, primary health networks and non-government organisations, community clinicians, private practitioners (including psychiatrists, psychologists and paediatricians), school counsellors, and other universal services.

194. The Hospital Outreach Post-suicidal Engagement (HOPE) initiative also provides practical support and follow-up for people leaving the Emergency Department after an attempt to end their life who may not otherwise meeting thresholds for treatment in the specialist mental health system.

195. In my view, the greatest barrier to appropriate treatment from a system perspective is the increasing demand for mental health services. Demand pressures have increased the threshold for access to specialist mental health services so that only the most unwell consumers are seen, as described in paragraphs 154 and 155 above. It can therefore be more difficult for consumers to access appropriate treatment at the right time.

196. In addition, service gaps exist for vulnerable consumer cohorts and for consumers transitioning between services. Addressing the needs of these individuals will require the development of new treatment models, as well as review of existing ones.

14. Do you have experience of the 'missing middle' - people whose needs are too complex for the primary care system alone but are not sick enough to obtain access to specialist mental health services?

197. There are barriers to access to mental health treatment for many cohorts of the Victorian community that are not related to the primary, secondary and tertiary systems or their underlying funding arrangements.

198. Prior to deinstitutionalisation, consumers with high-prevalence disorders could seek treatment from general hospitals which had small inpatient and community services for voluntary patients. These services had significant

expertise in psychological treatments. Other people admitted to hospital also had the benefit of consultation and liaison psychiatry services. This has been eroded under the current system. I have addressed this in my response to Question 6 above.

199. People with lower acuity mental illness are now likely to initially seek treatment from a general practitioner.

200. General practitioners are likely to treat the consumer predominantly with pharmacotherapy. Benefits payable under the Medicare Benefits Schedule do not provide an incentive for general practitioners to provide sufficiently long appointments to effectively treat mental illness.

201. A general practitioner may also establish a Mental Health Care Plan under the Commonwealth Better Access to Psychiatrists, Psychologists and General Practitioners Initiative through the MBS (Better Access Initiative). This subsidises access to private mental health treatment.

202. Private psychiatrists and psychologists are an important part of the system; however, consumers are only able to access a limited number of sessions per year under the Better Access Initiative and most still need to privately fund gap payments.

203. A general practitioner may not have the skills or competency to treat the more unwell members of this group, who then turn to the specialist mental health system for treatment, often by presenting in crisis at Emergency Departments.

204. People with the means to hold appropriate health insurance who seek treatment voluntarily are able to access the inpatient, group programs and outreach of the kind previously provided through the general hospital community mental health teams and consultation and liaison psychiatry services through private clinics. They can also access MBS services.

15. In what ways do the transitions between services impact on people's ability to access services and navigate the system?

205. Consumers can experience difficulties when making transitions, such as between primary care and specialist mental health services and also within the specialist mental health system.

(a) Acute and community services

206. Despite electronic medical records being rolled out in most acute health services, information sharing is problematic when a person transitions between services. Even when a service has transitioned from paper-based to electronic records, electronic record systems vary across the state meaning

there can be issues of inter-operability between the systems used by health services and other agencies (including the justice system, mental health services and social services).

207. Although there are various options within community services for supportive care, there are not always appropriate options for 'step-up' and 'step-down' treatment between acute and community services, and specific factors can impede access to an appropriate level of stepped care. For example, in PARCs:

207.1 access criteria prevent consumers with no fixed address or with suicidal ideation or with substance use disorders from being accepted

207.2 the level of clinical input may prevent them from accepting a consumer who could otherwise be discharged from an acute inpatient setting, or avoid an admission

207.3 service providers report that PARCs can take 48 hours or more to respond to referrals, meaning that this is not a timely 'step up' or 'step down' option.

208. Catchment-based service provision also means that when an individual moves residence, responsibility is transferred to a new area-based service. Homeless people may also experience difficult transitions when moving between regions as the continuity of their treatment can be compromised.

(b) Age based services and specialist streams

209. Within the specialist system, transitions can be particularly problematic for children and youth, as services are delivered with different models of care and under different governance arrangements. This results in a confusing system and variable access to appropriate treatments for young people. For example:

209.1 due to scale and expertise, child and adolescent services are not located in all parts of the state so various services host services for other catchments

209.2 access to specific programs (such as early psychosis programs) can be variable across Melbourne, resulting in delayed treatment and potentially delayed recovery

209.3 age groupings vary across the system, with some services open to consumers up to the age of 25 and others limited to those up to the age of 18

209.4 for services open only to those aged 18, the young person may need to transition to an adult service at a critical time in their development when the more intense, family-oriented treatment offered by child and adolescent mental health services would be of greater benefit

209.5 young people receiving treatment for a specific condition, such as an eating disorder or a developmental disorder, may not meet the criteria for specialist adult services.

210. In comparison, mental health services for aged persons are more comprehensive, with in-reach services to support people in their homes. Difficult transitions can often be avoided if appropriate treatment is provided at this stage. However, many people are not aware of the in-reach services that are available and may therefore be more likely to present to residential aged care services or private providers.

211. Information sharing within the specialist system can also be problematic, particularly where individuals move address or are homeless.

(c) Area based services and primary care

212. In some cases, primary care providers do not have the capacity, responsibility or skill to provide appropriate care, particularly for people living with high-acuity conditions. This can be problematic for people following discharge from an area-based service, as the primary care provider may simply refer the person back for specialist care, or the person's condition may deteriorate, and a crisis response will be required. There can also be limitations in the information that is shared between primary care providers and area mental health services.

213. Shared or transitional care arrangements – where a general practitioner works with an area-based service – can assist in the transition from area-based services to primary care.

(d) Justice system in-reach and specialist services

214. Victoria's prison mental health system has a stepped model of mental health treatment to meet the needs of prisoners. Prisoners who require compulsory treatment must be transferred to Thomas Embling Hospital for treatment, where they are admitted as security patients.

215. The large increase in the prison population combined with the static bed base for forensic services, described at paragraph 152 above, has led to a shortage of forensic beds in which to adequately and safely treat forensic

patients. This has led to extensive waiting lists for prisoners requiring compulsory treatment,[68] with the effect that:

215.1 the person becomes more unwell in the prison environment,

215.2 the acuity of the patient may be extremely high when they are transferred, and restrictive practices may then be required

215.3 the prisoner may only have a limited window in which to receive treatment before their sentence ends or may be released into the community untreated.

216. Following release from prison, the person's treatment will generally be transferred to an area mental health service. At this point they may be in crisis, and the treating health service may not be equipped to manage extreme aggression, particularly where there is co-occurring substance use.

217. Significant issues can arise when individuals move to a service which is not appropriately structured to respond to the person's needs. In the past some of these consumers could have been treated at Thomas Embling Hospital until they could safely step down into a Secure Extended Care Unit. Bed pressures in both of these settings result in consumers being transferred directly from prison to area mental health services, which are not able to safely receive them. This poses risks to the consumer, other consumers, staff and visitors.

16. In your experience, how do access constraints contribute to unsatisfactory outcomes for people who need specialist mental health services?

218. Access constraints contribute to unsatisfactory outcomes for people who need specialist mental health services through:

218.1 the increased threshold for access so that only the most unwell consumers are seen, as described at paragraph 116 above

218.2 the average wait time for mental health consumers in emergency departments, which is well over the national target and can be clinically inappropriate, as described at paragraphs 120 and 121 above

218.3 the decreasing average length of stay for mental health consumers in hospital, as described at paragraph 121, 142 and 151.3 above

218.4 the increasing severity of consumers' illness on admission to acute mental health units, as described at paragraph 116 above

[68] Victorian Ombudsman's report, Investigation into deaths and harm in custody, p 121.

218.5 increased waiting time for prisoners to receive treatment at Thomas Embling Hospital, as described at paragraph 152 above.

17. Are the needs of vulnerable cohorts met? If not, what are the gaps?

219. Members of vulnerable populations often face specific challenges, particularly in relation to access and stepped treatment options. As described earlier in my statement:

219.1 Children and adolescents face access challenges in parts of rural and regional Victoria, and treatment may not be available close to their home

219.2 Aged persons may experience difficult transitions due to a lack of awareness of the in-reach options available

219.3 Individuals who are homeless may experience access issues, restricted stepped treatment options and delayed discharge where safe, affordable accommodation is not available

219.4 The specialist mental health system is not culturally responsive to the needs of Aboriginal Victorians, and may not be able to address the multiple needs of consumers outside of the specialist mental health system

219.5 Supported accommodation and "step down" options are lacking for individuals with complex needs, and services do not have the capacity to provide intensive, long-term treatment for those whose treatment cannot be managed in the community

219.6 People with co-occurring substance use disorders and mental health issues, where staff may not have the capability to provide the complex treatment needed for both conditions as service delivery is not integrated

219.7 Prisoners face extensive waiting times for treatment at Thomas Embling Hospital, often resulting in a deterioration of their condition, greater likelihood that restrictive practices will be used, and the risk of being released untreated into the community.

REFORM

Reflecting on your answers in the preceding questions:

18. What do you think are the critical elements of a well-functioning mental health system?

220. The critical elements of a well-functioning mental health system are:

220.1 A system which is responsive and resourced to meet the needs of the broad spectrum of the Victorian population through holistic, evidence-based treatment at the different stages of illness including:

(a) Acute bed-based services

(b) Sub-acute bed-based services that provide genuine step-up and step-down options

(c) Secure and extended bed-based services

(d) Long term recovery-oriented bed-based services

(e) Humane and accessible bed-based services for compulsory treatment of prisoners

(f) Community-based services that can offer psychological treatments as well as pharmacotherapy.

220.2 The specialist mental health system needs to provide treatment which is:

(a) recovery-oriented and planned in partnership with consumers

(b) age and developmentally appropriate

(c) person-centred with seamless transitions through the treatment journey

(d) integrated and using a stepped care approach

(e) family-sensitive and trauma-informed

(f) delivered by multi-disciplinary staff with the required training, supervision and commitment to human rights and compassionate treatment.

220.3 Prevention, early identification and early intervention mechanisms must be built into a well-functioning mental health system.

220.4 Clear and meaningful collaboration between primary, secondary and tertiary mental health services and other government services is required to address all of the needs of people living with mental illness.

19. What do you think are the most significant challenges facing the mental health system in meeting needs of people affected by mental illness?

221. The most significant challenges facing the mental health system in meeting needs of people affected by mental illness are:

221.1 Underfunding, particularly in acute capital infrastructure which undermines the foundations of the system, reducing the return on investment in all other areas of the system

221.2 Lack of a supported strategy to attract, retain and develop the required workforce, particularly in light of the ageing workforce

221.3 Insufficient expertise and training environments, such as used for the workforce to ensure evidence-based psychological treatments

221.4 Rebuilding services for consumers with high-prevalence mental illnesses

221.5 Breaking down the boundaries between primary, secondary and tertiary services

221.6 Lack of integration with general health in order to improve the poor physical health of mental health consumers.

221.7 Stigma and discrimination

20. What changes do you think would bring about lasting improvements to help people affected by mental illness in relation to: Access to treatment and services; Navigating the specialist mental health system; and Getting help to people when they first need it?

222. In my opinion, the critical elements of a well-functioning mental health system – and the challenges facing the current system – include the ability to provide access to appropriate services for those in need, the capacity to provide early intervention and support, and coordinated and connected service delivery.

223. My view is that actions to address existing challenges should focus on safety and quality, capital infrastructure, models of care, interfaces with other services, and workforce development.

224. Additional investment in capital infrastructure is needed to provide more acute beds in both area mental health services, secure extended care and forensic services. This would improve the ability of services to meet demand pressures and consumer needs, and give services the capacity to:

224.1 work with consumers and carers to provide recovery-focussed and trauma-informed treatment and support in all specialist mental health system settings

224.2 provide ongoing treatment, relapse prevention support, early identification and intervention and meaningful post-discharge support in the community for consumers with enduring mental illness

224.3 provide high quality, multi-disciplinary acute treatment options in safe, therapeutic environments when it is first required and for as long as it is required

224.4 undertake robust discharge and recovery planning that addresses the multiple needs of the consumer and carers.

225. There is an opportunity to review and improve models of care, including:

225.1 subacute models, such as SECUs, CCUs, PARCs and transitional service units (TSUs) for clients with dual disability, such as mental illness and intellectual disability. These services were designed over a decade ago. Increasing acuity of illness on admission and numbers of consumers presenting with complex needs mean that these models require updating. New models may require refitting of infrastructure and alternative staffing models.

225.2 treatment provided in the gap between primary and specialist mental health services, where there is potential for specialist mental health services to partner with Primary Healthcare Networks to provide early intervention and community treatment that diverts clients from acute inpatient care.

225.3 using developmental perspectives to structure models of care for child and youth services, with subspecialty areas such as pre-school - kindergarten, primary, secondary, and tertiary developmental stages and training to deliver models appropriate to each developmental stage.

226. Interfaces between specialist mental health and other services could be improved through:

226.1 partnerships with AOD services to enhance cross-referrals, develop staff expertise, and take a joint approach to enable access to treatment in step-down facilities

226.2 introduction of specific mental health services for people who are homeless, which could include services that provide joint in-reach from AOD and specialist mental health services;

226.3 Restructuring of PARC models to enable therapeutic medium-term residential models of care;

226.4 specific services to address the needs of child protection clients who are under 18 or exiting residential services at the age of 18

226.5 Supported long term accommodation, including supported access to the private rental market specifically for consumers with insecure housing.

226.6 reviewing Consultation and Liaison Psychiatry, embedding evidence-based models for higher prevalence disorders within mainstream health services and specialist mental health services to improve health outcomes for consumers, and considering options for services such as community health clinics.

227. There is potential to strengthen both the specialist and lived experience workforces through:

227.1 further training and development to strengthen the capability of the specialist mental health workforce in high-prevalence disorders, trauma-informed care, family sensitive practice and family therapy models

227.2 strengthening and expanding the peer workforce and connections with consumers and carers, particularly in child and youth services.

21. Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

228. Since the major reforms of the 1990s, the specialist mental health system evolved and changed incrementally until the next fundamental reform -the introduction of the Act. Over those decades much has improved, but many aspects of the system are not delivering.

229. While everyone should receive high quality and safe mental health care, I believe it is critical for the Royal Commission to ensure that the needs of the most unwell and vulnerable are addressed as a matter of urgency.

230. Immediate and large-scale investment is required for acute inpatient, forensic and secure extended care beds, community-based treatment and in fit-for-purpose community facilities and workforce attraction, development and retention strategies.

231. Rebuilding the specialist mental health system will take time. Creating change will require commitment, sustained effort and substantial and ongoing investment. This needs to be the highest priority of the Royal

Commission and the Government. Once the core system elements have been stabilised and strengthened, there is enormous scope for reform and improvement in outcomes, quality and safety.

232. Once the longer-term changes have been set in motion, there are many ways to reform and improve the system in the short term.

233. Investment in digital technologies, data analytics and funding reform is critical to establishing a system that is responsive to community needs.

234. This work needs to be based on evidence of demand and the premise that the system will soon be operating on different and more flexible principles. New initiatives need to be supported with an extensive evidence base.

235. The highest priority of these include:

235.1 Models of care which are funded to enable truly multi-disciplinary treatment teams to deliver a variety of evidence-based treatment, including psychological and behavioural treatments in addition to pharmacotherapy

235.2 Allied health (particularly psychology) graduate and pre-qualification programs and employment opportunities

235.3 Consultation and liaison psychiatry programs with capacity for short term ongoing treatment

235.4 Capacity building programs and in-reach into other services e.g. primary care.

235.5 An integrated and holistic government services delivery model for consumers, that includes psychosocial determinants such as appropriate housing with specialist mental health support to maintain tenancies.

Royal Commission into
Victoria's Mental Health System

SUPPLEMENTARY QUESTIONS

S1. Data analysis

(a) Does the OCP systemically analyse and present all available data and intelligence on an annual basis? Is this analysis made publicly available?

236. The Office holds various data relating to the performance of specialist mental health services, and the specialist mental health system more broadly, as it relates to safety, qualify, and practice. While not all of the data available to the Office is analysed and published, much of this data is available for public consumption.

237. Each year the Office publishes an annual report that is made available online.[69] Data that is analysed and presented in the annual report relates to:

237.1 Use of ECT

237.2 Deaths of people receiving mental health treatment

237.3 Use of restrictive interventions (i.e. seclusion and restraint).

237.4 The Office (and the Mental Health Branch of the DHHS more broadly) works with the Victorian Agency for Health Information (VAHI) in the interpretation of clinical data reported in Inspire reports. VAHI developed the *Inspire* report series to support clinicians to understand the performance of their health service against key measures that impact safety, quality and performance. Inspire is produced quarterly and sent electronically directly to clinicians. Two specialist issues of Inspire focused on mental health have been released so far.[70]

238. The Office also analyses and presents data on inpatient deaths. Two audits have been conducted and published, both of which are available online:[71]

238.1 Chief Psychiatrist's audit of inpatient deaths 2008-2010

238.2 Chief Psychiatrist's audit of inpatient deaths 2011-2014

239. Other data that the Office holds and analyses to inform safety and quality functions include data relating to:

239.1 Sexual safety

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[69] https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/annual-reports
[70] https://bettersafercare.vic.gov.au/our-work/performance-and-safety-reporting/Reporting
[71] https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/annual-reports

239.2 Mental health workforce

239.3 Safewards implementation

239.4 Sentinel events

239.5 Contacts made with the Office

239.6 Advance statements and nominated persons (ad hoc).

(b) Has mental health data collections and reporting been redeveloped since the 2016 Review? If so, in what ways?

240. Subsequent to the 2016 Review of Victoria's Office of the Chief Psychiatrist (OCP Review), data collection and reporting within the Office, and across the Mental Health Branch more broadly, has been redeveloped. The amount of data that is both collected and shared is more than was the case prior to 2016, noting the extensive synthesis of data now available via *Victoria's Mental Health Services Annual Report.*

241. A new customised case management system has been designed and rolled out for the Office. This system has capability to collect more granular information and enable detailed trend analysis. Improvements to the system (Phase II) are currently being planned to automate data entry for area mental health services and increase reporting capabilities.

242. Within the branch, the Mental Health Outcomes Framework has been developed since 2016 which draws on data from a number of sources, including the Office and is reported annually in *Victoria's Mental Health Services Annual Report.* The framework continues to be expanded as part of ongoing work within the branch.[72]

243. VAHI Inspire reports (described above) have also been a development that has occurred since the 2016 OCP Review.

244. Within the Office more specifically, data collection and reporting has been redeveloped for the following:

244.1 sexual safety – data on sexual safety was previously reported by health services on an ad hoc basis. This data is now collected in a standard template and analysed systematically by the Office. Matters are reviewed daily and follow up is undertaken with services as required.

[72] Mental Health Annual Report 2015-16; Mental Health Annual Report 2016-17; Mental Health Annual Report 2017-18.

244.2 restrictive interventions –the processes for review and feedback to services have been streamlined. A statutory governance structure has been developed which has internal (DHHS) and external (sector) processes for reporting, reviewing and providing timely feedback to services. This includes monthly reporting to the Chief Psychiatrist and Chief Mental Health Nurse and direct contact to service directors when state-wide benchmarks are breached to request review and feedback for the reasons for prolonged restrictive intervention. A state- wide committee oversights the data and themes. This committee includes lived experience representation from the Department and also Tandem and VMIAC, the peak consumer and carer bodies. The Action Plan for the committee has created a program of work which endeavours to eliminate restrictive interventions in mental health services in Victoria.

244.3 reportable deaths – while reportable deaths were previously collected and reported on, the process has been redesigned, with changes made to the data being collected, the processes for collecting and reviewing data and providing feedback to services. New protocols for information exchange with the Coroner have also been put in place.

(a) sentinel events – Critical adverse incidents, including suicides on mental health inpatient units, are judged to be sentinel events and must be reported to Safer Care Victoria. Services' reports of these incidents, and their associated recommendations, are reviewed jointly by Safer Care Victoria and members of the Chief Psychiatrist's Morbidity and Mortality Committee, including consumer and carer advocates. Services may be asked to make their recommendations more focused and practicable and Safer Care Victoria now engages with services to check that agreed actions are implemented. The Office has worked with Safer Care Victoria to develop a joint and more timely process for the collection, analysis and responding to mental health sentinel events and oversight of local root cause analysis reviews of sentinel events. .

245. The Office now issues Quality and Safety Bulletins up to twice per annum that provide information to services about trends or issues that are current and emerging from all of these sources of data.

Attached to this statement and marked '**NC-8**' is an example Quality and Safety Bulletin.

(c) Please explain the nature and type of data available to the OCP insofar as it relates to consumers' and carers' experiences and outcomes. Does the OCP report on consumers' and carers' experiences and outcomes? If so, who receives those reports?

246. The Office has lived experience consumer and carer adviser positions and engages with carers and consumers through:

246.1 inclusion of consumers and carers in the composition of audit teams conducting death audits

246.2 regular meetings with peak and advocacy bodies

246.3 representation of consumers and carers on all committees.

247. Input and engagement with consumers and carers occurs as part of policy development, site visits, investigations, and representation on all committees and reference groups that relate to the work of the Office. The Office relies on advice from consumers and carers in undertaking the functions of the Chief Psychiatrist.

248. While the Office does not collect data on consumers' and carers' experiences and outcomes, these are regularly reported as part of Victoria's *Mental Health Services Annual Report* from a variety of information sources such as the YES Survey. The Office works with the Mental Health Branch each year in the preparation of these annual reports.

249. The Mental Health Branch has a separate Lived Experience Engagement Team. which is responsible for building the department's capacity to engage people with lived experience of mental illness. The team facilitates connection with consumers and carers, oversees the participation registers, provides advice, supports the Lived Experience Advisory Group, and is involved in developing and maintaining key measures for people's experience of the mental health system.

250. The team is the key departmental contact for VMIAC, Tandem, the Mental Health Foundation Australia, Our Community and Independent Mental Health Advocacy.

251. The Office monitors the volume of contacts from consumers and carers to its Office in order to identify hot spots and practices that may need to improve. The volume is reported in the Chief Psychiatrist's Annual Report. More sophisticated reporting functionality is available since the rollout of the new case management system in December 2018. This will enable more granular reporting of this information.

(d) Have new measures for consumers' and carers' experiences and outcomes been developed since the 2016 Review? If so, what are the measures?

252. Since the 2016 OCP Review, the Your Experience of Service (YES) survey has been recurrently funded for mental health services in Victoria. Services are responsible for collecting responses from consumers and carers as part of the Statement of Priorities. The data is centrally collated and provided back to services and reviewed by a number of areas in the Mental Health Branch. While the data provided can be a valuable source of information, the response rate is currently low. In addition, a carer's experience survey is currently being developed. This work is being led by the Lived Experience Engagement Team with involvement from the Office. The Office will participate in the analysis and interpretation of the data.

Attached to this statement and marked '**NC-9**' is a copy of the Your Experience of Service (YES) survey.

(e) Has a data VPS-6 OCP data analytics position (as recommended by the 2016 Review) been created and filled? If so, what are the responsibilities of that position?

253. A VPS 6 data analytics position is in the process of being created and recruited to. This position will be responsible for implementing Phase II of the new case management system which will deliver automated data entry and sophisticated data analytics capacity. Responsibilities will also include establishing a monthly reporting and analysis framework of all Office data holdings.

(f) If not, how has the OCP otherwise improved its internal data collection systems and processes since the 2016 Review?

254. The Office has taken the following steps to make better use of data:

254.1 Appointed an Office Manager in 2016 with sophisticated analytics capability to assist the functions of the Chief Psychiatrist

254.2 Introduction of a clinical governance framework for reporting on and analysing statutory reporting of ECT, reportable deaths and restrictive interventions

254.3 Upskilled existing staff through training and mentoring to develop the data capability with the Office

254.4 Introduced a new case management system (see paragraph 241)

(g) Does the OCP's infrastructure otherwise constrain the OCP's ability to analyse the data it holds? If so, in what ways?

255. The Office collects a range of data that could usefully be analysed, interpreted and acted upon to improve the safety and quality of specialist mental health services. However, it is often beyond the current capacity of existing resources to analyse and use all of this data in a meaningful way.

256. The demand pressures in the mental health system are mirrored in the workload of the Office. The Office responds to demand-driven requirements and operates with limited resourcing. There is limited surge capacity to augment the staff required to undertake much of this work, including interpretation of clinical data, when demand from consumers, carers and services is high, as staff require specialist qualifications. When demand is high, less immediate work takes a lower priority.

257. Reducing the manual work required to analyse and interpret data will enable data to be more effectively used. It is for this reason that Phase II of the new case management system implementation (described above in response to question (e) is required as this will lead to:

257.1 automated data entry (forms) by services into case management systems, reducing time taken, errors, and duplication of reporting

257.2 a more sophisticated and customisable reporting function, making it easier for Office staff to run data queries/reports.

(h) What assistance, if any, does the OCP seek in order to enhance its ability to analyse the data it holds?

258. The Office holds rich, extensive data that could be better utilised for the public benefit. This could be facilitated by improving existing systems infrastructure such as implementing Phase II of the case management system and changes to the CMI/ODS and resourcing to improve access to and release of data reports.

259. The Office would benefit greatly from a priority-status when collaborating with and seeking information from VAHI.

260. Although the Office does have some resources to collaborate with research and academic bodies, additional resourcing and flexibility in the authorising environment to review, renew and build these partnerships would be of great benefit.

S2. In what circumstances does the OCP provide reports for mental health services? Does the OCP report annually, or does it only report in relation to serious incidents?

261. As has been described above, the Office generates a number of reports that are published online.[73] These include:

261.1 The Chief Psychiatrist's Annual Report – published annually

261.2 Quality and Safety Bulletins – published 6-monthly

261.3 Literature reviews – when appropriate

262. In addition, the Office generates reports that are shared specifically with specialist mental health services. These include:

262.1 ECT audit reports – shared with each service following individual service audits, which are planned to occur on a rolling schedule. The full program of audits takes approximately two years to complete.

262.2 Site visit reports – shared with the relevant service(s) following individual site visits. Site visits occur according to a planned schedule, however some flexibility is required to accommodate visits following serious incidents, to conduct investigations and to provide ongoing support and monitoring of recommendations made by the Office.

262.3 Investigation reports provided to the relevant health service(s) – shared with the relevant service(s). Investigations can relate to serious issues or systemic matters

262.4 Thematic review reports – as available

262.5 VAHI Inspire reports – two issues have been published to date

262.6 Evaluations of programs – shared with services as and when appropriate

262.7 Verbal reporting at 6-monthly performance meetings with specialist mental health services.

S3. How many staff does the OCP have? Of those, how many are consumers or carers?

263. The Office currently has a full-time equivalent staff (FTE) of 24.9 including the Chief Psychiatrist and the Chief Mental Health Nurse. There are currently 9.8 FTE that sit under the Chief Psychiatrist, while a further 13.1 FTE sit under the Chief Mental Health Nurse.

[73] https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/annual-reports

264. The Office staff includes 1.8 FTE consumer advisers and 1.0 FTE carer adviser. As has been described elsewhere, these consumer and carer advisers are a key component of the Office and form part of a broader engagement strategy with consumers and carers.

S4. Have recommendations 8, 9 and 10 of the 2016 Review been implemented? If they have not, what are the barriers to implementation?

265. As part of the 2016 OCP Review it was recommended that:

265.1 Recommendation 8. That the director of Mental Health either formally allocates 50 per cent of the time of the current consumer and carer representatives to the Office (with a consequent reduction in the time available to other areas) or increases the resourcing of the Office to enable the appointment of two half-time additional positions.

265.2 Recommendation 9. That the Office nominates a team member responsible for coordinating consumer and carer input to the Office's work and to act as a point of contact and support for consumer and carer representatives who work in or with the Office.

265.3 Recommendation 10. That Mental Health Branch and the Office collaborate on a consumer and carer involvement framework including (a) updated guidelines advising mental health services about how to operationalise key legislative and policy principles around consumer and carer involvement and (b) a statement of how the department will engage with consumer and carer representatives and draw expertise from peak consumer and carer agencies.

266. Both recommendations 8 and 9 of the 2016 OCP Review have been implemented within the Office.

267. Recommendation 10 has been endorsed by the Lived Experienced Advisory Group and DHHS. It will be launched in July 2019 with implementation to follow.

S5. How does the OCP ensure genuine co-production with consumer and carers?

268. The Office is careful to observe the strict definitions of the terms relating to levels of engagement with people with lived experience. The Office aspires to undertake work that includes different methods including consultation, engagement, co-design, co-production, consumer or carer led and consumer or carer owned.

269. As described elsewhere in my statement, the Office has strong engagement with consumers and carers including having lived experience consumer and

carer adviser positions within the Office. As discussed in paragraphs 38 to 42 of this statement.

270. The benefits of having consumer and carer adviser positions in the Office are innumerable. They assist us to hear the consumer and carer voice across the entire program of our work in everything that the Office does. As well as their consumer and carer-specific advisory roles, they run programs and projects in more general fields.

271. Working with consumer and carer advisers also brings other members of the Office face to face with the prejudice and discrimination faced by consumers and carers on a daily basis even in professional contexts and increases the determination to dispel the attitudes and stigma behind this.

272. The Office also engages with consumers and carers in other ways, for example through:

272.1 inclusion of consumers and carers in the composition of investigation panels and audit teams

272.2 regular meetings with peak bodies and advocacy services

272.3 representation of consumers and carers on all committees and reference groups.

273. Engagement with consumers and carers is guided by a consumer and carer involvement framework that has been developed within the Mental Health Branch, described in response to Question S4 above.

S6. Have the Mental Health Branch and the OCP collaborated on a consumer and carer involvement framework? If so, what is the outcome of that collaboration?

274. As has been described above in response to Question S4, the Mental Health Branch and the Office have collaborated in the development of a consumer and carer involvement framework. The framework outlines the way in which consumers and carers are engaged in the work done within the branch (including through the Office).

S7. The 2016 Review recommended that the Chief Psychiatrist should have an opportunity to raise matters of concern directly with the Secretary and Deputy Secretary. Has recommendation 13 of the 2016 Review been implemented and if not, has another mechanism been implemented to achieve the same objective?

275. In the role of Chief Psychiatrist, I report to the Director, Mental Health Branch within DHHS.

276. This is the mechanism for day-to-day engagement and reporting within DHHS. I meet as required with the Executive Director, Health Services Policy and Commissioning.

277. I brief the Deputy Secretary, Secretary and Minister via the formal written briefing process. For example, I brief the Secretary on all major investigations, clinical reviews and audits undertaken by me and the Office.

278. I have briefed the Minister for Mental Health directly on specific matters at his request.

279. Arrangements have been put in place for me to meet with the Deputy Secretary quarterly and the Secretary twice per annum.

sign here ► Neil Coventry.

print name Dr Neil Coventry

date 28/6/19