Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR JOHN RICHARD NEWTON

I, John Richard Newton, Clinical Director, of 2 Hastings Road, Frankston 3199, say as follows:

1 I am authorised by Peninsula Health to make this statement on its behalf.

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

PROFESSIONAL BACKGROUND

3 My full name, title and postnominals are: Professor John Richard Newton, MB ChB, MRCPsych, FRANZCP.

Qualifications and experience

4 I currently work as the Clinical Director of the Peninsula Mental Health Service. I am an Adjunct Professor in psychiatry at Monash University and an Associate Professor in psychiatry at the University of Melbourne. I am a Board member of the Butterfly Foundation and a Board member of Mental Health Victoria.

5 I qualified as a psychiatrist in 1989 before working as a psychiatrist in Melbourne between 1989 and 1997. Since then I have held the following positions:

(a) Chair of the Royal Australian and New Zealand College of Psychiatry (**RANZCP**) Victorian Branch Committee (from 2016 to 2019);

(b) Medical Director, Mental Health Clinical Service Unit, Austin Health (from 2009 to 2017);

(c) Clinical Director, Body Image Eating Disorders Treatment and Recovery Service (from 2010 to 2017); and

(d) Clinical Director of Mental Health, Peninsula Mental Health Service (from 2004 to 2009).

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

Current role and responsibilities

7 I provide overarching clinical direction to the Peninsula Mental Health Service, and manage, recruit and seek to retain medical staff. My role involves ensuring the service meets its obligations under the *Mental Health Act 2014* (Vic) (**Mental Health Act**), the National Standards for Mental Health Services and other key performance indicators. I am responsible for the clinical safety and quality of the service.

COMMUNITY-BASED MENTAL HEALTH SERVICES

Core components of a well-functioning community-based mental health system

8 I was involved in the development of, and was a signatory to, the submissions from the RANZCP and Mental Health Victoria, as well as the joint submission entitled 'The Adult Psychiatry Imperative', to the Royal Commission. All three submissions outline potential future models of community mental health care that share many similarities in terms of what could constitute the core components of a well-functioning community mental health service. I will not repeat their contents here but will elaborate upon areas that were not emphasised within these submissions.

9 A well-functioning community-based mental health system must be accessible, acceptable and effective for consumers, have good linkages with other primary care and support services, and rely on evidence-based treatment. Better community health services will help to keep consumers engaged after they leave the public health services. To achieve these goals, community health will need to become a funding priority. Relevantly, Victoria currently has the lowest per-capita spend on community mental health and has the lowest rate of provision of community mental health support of any of the States.

10 Effective treatment requires structures which deliver care that is accepted, wanted and valued by consumers. Community-based care should be easy to navigate; so there needs to be clear processes for assessing and treating consumers in outpatient, inpatient and residential contexts. Furthermore, access points and entry criteria for public mental health services should be simplified so consumers can understand how to access the care that they need and the right place for them to obtain the appropriate treatment. There is a strong signal from consumers and their families that the public mental health system is extremely difficult to access and navigate and they often feel unwelcome when they do try and enter the service. A concierge function that is specifically constructed to assist and advocate for consumers and their carers to enter the service, along with clear and consistently applied inclusion and exclusion criteria and roles and responsibilities of mental health services, is urgently needed.

11 We urgently need a shared documentation suite and clinical informatics platform that supports basic principles of health care assessment, collaborative patient-centred treatment planning, clinical review and transfer of care within services, between services and across State and federal health systems We need a system that allows the best quality information about a consumer to be owned by that consumer, collected, updated and shared as appropriate and that is of high quality and is able to collect information once and enable that information to be used many times as appropriate. We currently have a system that is almost the opposite of this. Clinical information is repetitively obtained from the consumer, entered multiple times into multiple clinical systems, and with no quality control so that accurate information is often lost and lower quality information is used as the basis for clinical decisions that are subsequently flawed and place consumers at risk. The time taken to enter this information removes clinicians from completing their clinical work and alienates consumers and their families.

12 We need linkages to services outside the public mental health system, such as Medicare-funded psychology services, private services and local not-for-profit agencies, so that people who do not necessarily require State-funded specialist mental health services can access and be linked to other appropriate services. There are limited resources for follow up treatment in the community (noting that spending on community health is low); once a person is out of the public mental health system, it is easy for the person to cease receiving treatment and 'fall off the precipice'.

13 Linking community-based care to other services would keep consumers engaged and deliver more effective treatment once they leave the public health system. Community-based care should integrate a broad scope of services including other primary health and rehabilitation services, as well as housing and vocational services. Families and carers should also be involved and supported where possible. We urgently need a physical health care approach that is consistently applied across all services and ensures adequate health and lifestyle support, including the use of exercise physiologists and dietitians as well as ensuring physical health monitoring and screening of our consumers. Such an approach can lead to effective interventions to reduce the significant early mortality of consumers, noting that the difference in life expectancy between those who have severe mental illness and their peers is more than 10 years, which should be an enormous call to arms.

14 Despite a strong evidence base for all the main diagnostic categories of severe mental illnesses, public mental health services often fail to deliver evidence-based care. Clear expectations about best-practice pharmacological therapy and psychotherapy will allow community-based services to provide effective care. It is vital that clear expectations and appropriate accountability mechanisms are put in place to ensure that consumers and their carers receive therapies that we know, and have known for decades, work to reduce

symptoms and distress and to support people to manage their own illness with more autonomy, dignity and improved quality of life. The current situation whereby each mental health service has been left to develop its own therapeutic programmes has resulted in an ineffective approach at the State-wide level. Only about one in five of our consumers will receive an effective dose of an evidence based therapy delivered in a rigorous way.[1] This should not be allowed to continue.

15 The RANZCP and Mental Health Victoria have also made submissions to the Royal Commission which included details on the core components of a well-functioning community-based system. The submissions made recommendations in relation to community-based mental health hubs that may be similar to the headspace model (which entails having community non-governmental organisations, the primary and secondary health sectors and the public health sector working in the same location with good communication between them). Such hubs would be overwhelmed if everyone went there. There is a need for a better funded structure with clearly delineated pathways and linkages to services outside the public health system. I will refer to this below.

Integrating and coordinating general health and mental health services to ensure better outcomes

16 Systematic linkages to primary health networks and private psychiatry and psychology services does not take place. If a patient has a General Practitioner (**GP**), then community-based mental health services should take more responsibility for ensuring the linkages with GPs are used to assist with self-care and self-monitoring (including in relation to physical health), and to deliver better care to patients. This sort of relationship would require regular communication with GPs (including through discharge summaries and review communications) and keeping accurate records. In relation to the latter, Peninsula Health audited the accuracy of GPs' addresses in our database and found they are often inaccurate and patients have not seen those GPs for a long time.

17 Peninsula Health has a Wellness Clinic which screens for a range of physical health changes such as early mortality and smoking. Information relating to these issues are communicated with GPs, but there is still work to be done to understand whether this translates into clinical action. Most patients, however, do not have a GP, cannot afford to see a GP they wish to see, or have lost the drive to care for their physical health. This

[1] (a) Drake RE, Goldman HH, Leff HS, Lehman AF, Dixon L, Mueser KT, Torrey WC. Psychiatr Serv. 2001 Feb; 52(2):179-82. Implementing evidence-based practices in routine mental health service settings;

(b) Thornicroft G, Tansella M. Br J Psychiatry. 2004 Oct; 185:283-90. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence; and

(c) Ganju V. Schizophrenia Bulletin. 2003; 29(1):125-131. Implementation of Evidence-Based Practices in State Mental Health Systems: Implications for Research and Effectiveness Studies.

is a primary health issue but linkage of primary healthcare with community mental health services can be helpful.

18 Peninsula Health previously had co-located GPs but there were structural issues regarding using GPs in mental health services, including funding issues. We are currently readdressing this gap and how to fill it by collocation of GPs within the service. The proposed mental health hubs with embedded primary and secondary care would be a much more effective approach to improving physical health care.

REGULATION AND INDEPENDENT OVERSIGHT

Contemporary, best practice regulatory approaches to safety and quality in mental health service delivery

19 I am an accredited assessor with the Australian Council on Healthcare Standards (**ACHS**) and a member on the Comprehensive Care Advisory Committee of the Australian Commission for Safety and Quality in Health Care Services (**ACSQHC**) which developed the National Safety and Quality Health Service Standards (**NSQHS Standards**). The ACSQHC sets general standards for health care, which have now integrated standards for mental health services in the NSQHS Standards. As an accredited assessor, I support the approach of assessing Peninsula Health's performance against the NSQHS Standards.

20 The integration of mental health into the NSQHS Standards represents outstanding progress. All health services now have a framework to their approach to recognising and responding to mental health needs in patients and to changes in risk. Such a framework did not exist under previous versions of the NSQHS Standards and has been an excellent change across Australia. The NSQHS Standards and training also promote attention to relevant mental health issues within general physical health care components of the health service. For example, the NSQHS Standards now contain a requirement that health services are to have mechanisms for detecting deteriorations in people's mental health. Completed suicides in hospitals occur quite frequently in non-mental health areas (noting that this may a consequence of the delivery of devastating diagnoses) – this is something that can now be expected to be recognised and acted upon by general health care services.

Current changes in regulatory approaches to safety and quality in mental health services

21 A number of factors have driven changes to regulatory approaches to safety and quality in mental health services. Regulatory standards for mental health services had been static for some time and needed to be updated. There was also recognition by public health services that it is not helpful to separate mental health standards from general health standards and assess the performance of these systems separately.

22 In addition, consumers and carers asked questions of services and clinicians and called out stigma and discrimination against people experiencing mental illness. They energetically and vocally contributed to the integration of mental health in the NSQHS Standards.

Future changes in regulatory frameworks

23 Regulatory frameworks require input from not only clinicians but also consumers and carers who bring the value of their actual experience of the mental health system. Ensuring we have an approach to support people with lived experience to effectively contribute to service system design requires more work. Co-design and co-production are developing approaches to this along with an improved understanding of how health care professionals can support the decision-making capacity of consumers and carers across the spectrum of clinical governance.

Innovative best practice for regulating for quality and safety in mental health service delivery

24 Best practice quality and safety standards for the mental health system should:

(a) take active steps to eliminate stigma and discrimination against people experiencing mental health problems;

(b) treat all consumers with dignity and ensure that they have access to an equal standard of care; and

(c) give a voice to consumers and carers while recognising the expertise of clinical professionals.

QUALITY AND SAFETY MONITORING BY MENTAL HEALTH SERVICES

Reporting by Peninsula Health

25 Peninsula Health has provided details on its reporting (including on Key Performance Indicators (**KPIs**)) in its submission to the Royal Commission. Our KPI report is also available on the Department of Health and Human Services (**DHHS**) website.

26 Relevantly, our report to the Chief Psychiatrist has included data on the use of physical restraints on consumers.

Use of reported data within Peninsula Health

27 Data which compares how health services are performing provides a useful benchmark for Peninsula Health to assess its services and plan improvements.

Feedback that Peninsula Health receives

28 Peninsula Health receives immediate feedback from consumers and carers through the Mental Health Complaints Commissioner. Peninsula Health also receives feedback from DHHS regarding its performance against KPIs, and from ACHS regarding its performance against clinical KPIs.

29 The Victorian Agency for Health Information (**VAHI**) provides feedback through its *Inspire Report: Mental Health* (**Inspire Report**), which focuses on particular issues such as Electroconvulsive Therapy (**ECT**) and restrictive interventions.

How Peninsula Health uses feedback

30 Peninsula Health has a systematic process for responding to all feedback, whether it is from consumers, carers or departmental bodies. This includes ensuring we understand the substantive issues and identify improvement opportunities and how these need to be responded to (either through an immediate change to how we provide care or by incorporating into strategic clinical improvement activities).

31 For example, Peninsula Health has used feedback in VAHI's Inspire Report as follows:

(a) We recognised that Peninsula Health had a high rate of community consumers receiving ECT as compared with other services. We conducted an investigation of this issue and changed our practices, including reducing the use of maintenance ECT which has a small and inconsistent evidence base.

(b) The Inspire report indicated that we had a high use of physical restraints relative to our extremely low use of other restrictive practices such as seclusion. We therefore had a very careful look into this data as, at the clinical care level, we felt that we had a very low use of restrictive interventions. We developed an understanding that our services were all reporting every single incidence where clinical staff had physical contact with a consumer in order to affect the consumer's behaviour (for example, gently redirecting a consumer away from situations where there may be risk). It became clear that this physical contact was not coercive and in the vast majority of cases lasted only for seconds. We have decided to continue to report every instance of physical restraint (whenever we meaningfully interfere with a consumer's freedom of movement) in order to maintain a culture of care that seeks to minimise any restrictive practice.

SERVICE SAFETY

Peninsula Health's arrangements to minimise the occurrence of harmful incidents and to respond to the needs of consumers and staff

32 Peninsula Health has a whole range of policies and procedures to minimise the occurrence of harmful incidents, and to respond to the needs of consumers and staff when harmful incidents do occur, including:

(a) a clinical handover process, where any incidents of occupational violence, seclusion and physical restraints are identified;

(b) daily local leadership huddles, where every incident is reviewed and acted upon to protect individuals;

(c) daily hospital-wide huddles where concerns can be raised. The hospital-wide huddle includes a focus on the use of physical restraints, and hospital-wide supports for areas which are struggling with occupational health and safety issues; and

(d) the provision of training such as the Risk Identification, Safety, Containment and Environment program.

These policies can be made available to the Royal Commission for review.

33 We have a group that is specifically tasked with reducing the risk of harm. Mental health clinicians are regularly asked to assess different types of risks (including risks relating to suicide, self-harm, absconding, aggression and deterioration) in a structured manner. By and large this assessment does not help to predict adverse outcomes (for example, completed suicide). There is perhaps too much focus on structured risk assessments, some of which may be driven by criticism from coroners' inquiries, and insufficient focus on evidence.

34 We have looked at international and Australian literature and what local leaders are doing, so as to understand what they have done, what they are doing now, what we can predict and what we can do about it. These sources (for example, the National Centre for Clinical Excellence, which has published a list of "Do Not Do" recommendations on mental health) suggest that we should not think about risk in a formulaic or box-ticking way, but instead should adopt a narrative, holistic approach to understanding risk.

Challenges in ensuring consumer and staff safety

35 Evidence-based treatment practices focus on a trauma-informed understanding about the approach to, and experience of, care. Health services need to understand that a person's behaviour in responding to distress, asking for help and responding to help is often mediated by the consumers' past, and possibly repeated, experiences of parenting

trauma, trauma in other relationships and powerlessness. These past experiences can be reawakened by the experience of clinical treatment. Health services must also understand that staff may also have had traumatic experiences within the health care setting and that staff personal experiences therefore impact on their provision of care to consumers.

Improving safety and wellbeing

36 State-wide education and training of mental health staff should be implemented to address the effects of trauma on both consumers and staff. Staff should develop reflective practices (including considering how trauma has impacted on themselves, and reflecting on their own experiences of trauma in health services) and allow consumers to talk about their trauma. Health services should also have wellbeing groups and consider initiatives such as music therapy which has a developing evidence base. Peninsula Health has adopted a health service-wide staff wellness and pet therapy program. Such initiatives can be evaluated through feedback and standardised outcome measures; also, if the purpose of the initiatives is to provide better care, then consumers' experiences are the most important indicator.

OCCUPATIONAL SAFETY

Factors contributing to occupational violence and other safety concerns

37 If consumers and carers are able to easily access adequate mental health services and receive effective treatment then they are less likely to be distressed and to manifest that distress through aggression. The currently impoverished service system sets up many consumers and carers to feel more distressed as they try and obtain the right treatment or care.

38 Occupational violence is a massive and increasingly severe problem. Every day, our staff experience occupational violence; they have a high risk of being assaulted in the workplace and consumers often display aggressive and sexually inappropriate behaviour towards each other and to staff. Almost every single staff member has personally experienced occupational violence. No other industry would accept the level of violence to which mental health and emergency department staff are exposed.

39 For example, a consumer with a history of aggression recently presented at our hospital while intoxicated on methamphetamine. The patient had also experienced psychotic symptoms and behavioural disinhibition in the past. The patient violently assaulted a number of staff members who were injured physically and psychologically and had to take time off work to recover.

Improving the safety of people working in mental health services

40 Peninsula Health has a service-wide approach to reducing occupational violence. Episodes of aggression are reported every day at a service-wide huddle and actions are taken to support staff and to mitigate the risks of further episodes. We are currently developing an architect's brief for the design of a new mental health inpatient unit. This is a great opportunity to incorporate evidence-supported design features of inpatient units that can greatly reduce occupational violence. However, many of the inpatient units in the State were built decades ago and are run-down, impoverished and do not contain any occupational violence and risk reduction design features.

41 Occupational safety should be approached with an understanding of staff experiences of trauma. Staff may carry around fear from past assaults and attempted assaults and can be triggered while at work. This can result in staff responding to patients in a hyper-vigilant or controlling way to gain power over the situation and ensure their own safety. Such an approach may, however, worsen the situation rather than making it better. Instead, staff should avoid responding in a coercive or controlling manner or using restrictive interventions (when they are most likely to be assaulted); staff need to break the cycle by stepping back and trying not to control patients.

COMPULSORY TREATMENT

Alternative methods to compulsory treatment

42 There are many alternatives to compulsory treatment that services can use to support people who may be difficult to engage in treatment and support, particularly in the community setting. A central component of these approaches is to engage the patient in a therapeutic relationship that focusses on what matters to the consumer and on working with them to deliver care. This takes time, patience and resources, and is very difficult if consumers are actively avoiding contact or treatment and pose significant risks to themselves or others.

43 If there is sufficient time for treatment, there are many alternatives to compulsory treatment, such as voluntary treatment or working with people in a manner that maximises therapeutic alliance to identify what matters to the consumer. In an acute crisis situation, however, people often experience distress in a very short timeframe and have limited capacity to make choices that are safe.

Necessary changes at a systemic level for alternative methods to work

44 If consumers are in crisis and making decisions that put themselves immediately at risk because of mental illness as opposed to intoxication, there is good evidence that suggests that short-term compulsory treatment saves lives.

45 The position is much more vexed in relation to long-term compulsory treatment, as the evidence of good outcomes from long-term compulsory treatment orders is insubstantial.[2] Compulsory treatment also undermines a person's rights and autonomy. The risk of being under a long-term compulsory treatment order outweigh the benefits except for a small cohort of consumers who are at high risk and may benefit from such treatment. The issue is how to devise a regime that is limited to this cohort.

46 Careful incorporation of the evidence base around compulsory treatment, along with a regulatory framework that is more effective at reducing rates of compulsory treatment, are necessary. The introduction of the Mental Health Act has not led to markedly reduced rates of compulsory treatment despite the massively increased bureaucratic burden and the investment in legislated checks and balances such as the Mental Health Tribunal and the Independent Mental Health Advocacy.

Factors that influence how clinicians may seek to use compulsory treatment

47 In Victoria, the Mental Health Act states that compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or to another person. In addition to these requirements, resource constraints influence how clinicians may seek to use compulsory treatment.

48 A serious undersupply of mental health services has caused an increase in compulsory treatment orders. Data from the Retrieval and Critical Health Information System shows that the number of free beds in emergency departments is consistently lower than the number of people waiting to be admitted. Due to high demand, a consumer will need to become seriously unwell before they are able to access services. In practice, this means that only people who are involuntary patients can be admitted when beds are very scarce. Anecdotally, this may lead to some consumers inappropriately being placed under the Mental Health Act in order to obtain a bed – this is clearly contrary to the principles of the Mental Health Act.

49 Peninsula Health has a relatively low rate of involuntary admissions to its inpatient unit. This means that despite demand outstripping our bed-based resources most days of the week, we are still managing to admit people when they absolutely need it without artificially inflating the use of involuntary treatment.

50 The undersupply of services encourages some GPs and private psychiatrists to send patients to hospital under the Mental Health Act because it will ensure that they are

[2] Jorun Rugkåsa. Can J Psychiatry. 2016 Jan; 61(1):15–24. Effectiveness of Community Treatment Orders: The International Evidence.

treated. Paradoxically, an increase in compulsory treatment orders means that there are fewer resources to administer compulsory treatment when it is really necessary.

Use of compulsory treatment in Victoria's future mental health system

51 The use of compulsory treatment should be reduced and resources should be directed to comprehensive treatment pathways that don't require involuntary treatment. Involuntary treatment should be limited to those who really need it. For example, there have been cases where people behaving erratically, but not dangerously, have been admitted under compulsory treatment orders even if they are not necessarily unwell. It is legal to behave erratically. People should have the right to make decisions about their own lives so long as their behaviour is not seriously impacting on the health and safety of others.

52 Where compulsory treatment is used, clinicians should focus on what is actually best for the patient, including by assessing their risk of dangerous behaviour.

Methods other than legislation to reduce rates of compulsory treatment use

53 Resourcing should be increased to help consumers to receive treatment early and avoid the need for compulsory treatment. Services should be patient-centred and develop an understanding of stigma and discrimination in order to reduce the use of unnecessary compulsory treatment. We need to take steps to reduce the risk of consumers being treated involuntarily and with a poor standard of care.

Ensuring that methods to reduce rates of compulsory treatment use are successfully implemented

54 A cultural change is needed to reduce the rate of compulsory treatment use. Peninsula Health is endeavouring to reduce the number of people on Community Treatment Orders, who comprise 12% of our patients. This is a relatively low proportion compared to other health providers in the state, but we are hoping to get it lower because there is a weak evidence base to support their effectiveness. To facilitate a broader cultural change, healthcare providers and the community should develop tolerance and overcome a fear of erratic behaviour that is not otherwise dangerous or harmful to anyone.

55 There has been a strong emphasis on mental health awareness campaigns. It is recognised that in the future, the community needs to move from awareness to a level of mental health activism. This must include strategies that enhance acceptance and inclusion of people with behaviours associated with psychosis and other severe illnesses into mainstream society, whilst emphasising that dangerous behaviour is not acceptable regardless of the presence of or absence of mental illness.

Necessary governance and accountability arrangements if catchments were removed in Victoria

56 People should have the right to choose where they access mental health care, just as consumers of other health services (for example, orthopaedic or cancer services) are allowed to choose. For example, a consumer should be allowed to choose Peninsula Health because of our low rates of seclusion if that is important to them.

57 Nevertheless, if catchments were removed in Victoria, there needs to be governance accountability arrangements to ensure that people requiring compulsory treatment would be adequately treated by a local health service. Experience suggests that even where catchment areas are abolished, consumers still tend to choose their local area mental health service. In that event, area mental health services should still be responsible for the consumers in their respective services areas if they arrive at such services. There should, however, be a provision for activity-based funding where consumers come from another catchment area.

RESTRICTIVE PRACTICES

Factors which contribute to the use of restrictive practices

58 Physical restraints and seclusion are more likely to be used where patients exhibit physical aggression, including as a result of substance abuse. I have discussed some of the service drivers that also contribute to the use of seclusion and restraint above.

Variance in the use of restrictive practices between mental health services

59 In my experience as a Clinical Director at Peninsula Health and previously as Chair of the Victorian Branch of RANZCP, I have noticed an extraordinary variation in the use of seclusion and restrictive practices between services. In the last quarter, daily seclusion rates between mental health services varied from 0.7 per 1,000 beds to 26 per 1,000 beds.[3] This level of variation should not be acceptable, and indicates that we need to set better standards and have a much more robust clinical governance system that explicitly identifies and acts to reduce variation when it is an indication of low quality.

60 Peninsula Health has had the lowest rate of seclusion in the state since 2008 and Austin Health also has had low rates since 2010. Alfred Health, Monash Health and St Vincent's Hospital Melbourne have also made great improvements in recent years.

61 As a sector, we need to reconsider whether seclusion is the only way to manage consumers that exhibit highly aggressive behaviour and to protect staff. We also need to understand why seclusion rates are high and set some standards. There is currently no

3 Victorian Agency for Health Information, *Inspire: Mental Health* (June 2018).

accepted target range for seclusion rates. Services with higher rates of seclusion and restrictive practices may continue to maintain such higher rates either on the basis of protecting their staff or because they are so accustomed to these rates that they are not concerned with them. This can create a cycle of expectation on the part of both clinicians and consumers.

Different approaches to restrictive practices across different age demographics

62 The use of restrictive practices for older people varies from service to service. Some services do not use seclusion on older patients because they don't have adequate resources. Other services do or do not use seclusion at all, regardless of the consumer's age. I am not otherwise aware of whether the use of restrictive practices is lower for the aged population.

63 VAHI's Inspire Report has statistics on the use of restrictive practices in Victoria.

Use of seclusion and restraint to address risks of self-harm

64 There is no doubt that on occasion both seclusion and mechanical restraint are used within services to reduce the risks of a person seriously harming themselves. These rates are low compared to the rates of restrictive practice that are associated with risks of aggression.

Common characteristics among consumers who experience restrictive practices

65 In my experience, a particular group of consumers with challenging behaviours is more likely to be subject to restrictive practices. These patients have typically experienced substance abuse and present as disinhibited and physically aggressive. Consumers who are scared, fearful or hyper-aroused are also likely to be placed in restrictive care. The use of restrictive practices creates a pattern of behaviour. For example, some patients find the use of seclusion traumatic, which results in a greater fear of seclusion and causes them to subsequently behave erratically.

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

66 Changes to the following factors have influenced when, and how frequently, restrictive practices are used within mental health services:

(a) **Legislative and policy settings**: Monitoring of restrictive practices are much more robust now, but system-wide action to address unacceptable variation in rates is under-utilised. The incorporation of consumers and carers into clinical

service systems at the point of care, training and governance levels has been very impactful.

(b) **Consumer demographics**: Young, substance-abusing males have always been the modal client group who exhibit aggressive behaviour. 'ICE' use has massively changed the intensity of that aggression in recent years. There has also been a general diminution in community standards of acceptable behaviour, such that aggression to health care workers is now commonplace.

(c) **Acuity of consumers**: There has been an increase in acuity in inpatients over the past 20 years. This is a result of an increase in demand and a lack of resources to keep pace with population growth, meaning that only the most severely unwell people are admitted.

(d) **Presenting behaviours due to changing patterns of alcohol and other drug use**: There has been an increase in consumers who present with substance abuse problems, particularly methamphetamine use, which has impacted services. These patients can be aggressive and a large proportion of them experience paranoid delusions, hallucinations and disinhibition.

Impact of restrictive practices on consumer rights and empowerment

67 By definition, restrictive practices impact upon a person's rights, sense of autonomy, control, respect, dignity and power.

Potential of restrictive practices to be traumatising or re-traumatising

68 Restrictive practices can gravely impact on patients. Many people with mental illness have past experiences of trauma, for example, from feeling powerless in relationships. The use of restrictive practices can traumatise patients, or reawaken trauma by creating a similar power dynamic to past relationships of abuse.

Impact of experiences of restrictive practices on consumers' choice to seek help

69 In my experience, where a patient has been traumatised by the use of restrictive practices in a mental health service, they may have trouble asking for help with mental health problems in the future.

Impact on staff due to the use of restrictive practices

70 The use of restrictive practices impacts staff in mental health services by increasing their risk of being assaulted at work. If staff react to aggressive behaviour by attempting to restrain a consumer, it may only worsen the consumer's behaviour and increase the risk of harm to the staff member. Where staff use alternative techniques, including de-

escalation, the clinically observable result is that patient behaviour improves, making a safer environment for both patients and staff.

Influence of workplace characteristics on the use of restrictive practices

71 We have a number of training programs for staff at Peninsula Health which aim to improve safety of patients and staff. For example, the Risk Identification, Safety, Containment and Environment program helps to reduce the use of restrictive practices by building communication and de-escalation skills.

72 As part of our seclusion reduction work, we have also previously learnt that high levels of staff being unfamiliar with the clients and ward contribute to risks, as do some rostering practices (particularly after hours).

Influence of clinical leadership on the use of restrictive practices

73 Peninsula Health has implemented clinical handovers and regular leadership huddles to maintain a line of communication about incidents, including the use of restrictive practices. Every instance of restraint and seclusion is recorded.

74 Clinical leadership that supports staff safety and the rights of consumers to be managed in the least restrictive way is important to the reduction of the rate of restrictive practice use.

Influence of workplace culture on the use of restrictive practices

75 Workplace culture plays a large part in the use of restrictive practices. Service providers should develop a culture of questioning whether restraint is an appropriate way to manage patient behaviour. Having safety as a central tenet for all staff and consumers is an important component of culture. If services take a patient-centred approach informed by human rights they will be able to positively influence the use of restrictive practices.

Effectiveness of streaming patients in minimising the need to use restrictive practices

76 There is only some evidence to suggest that, where there is a mix of patients with different characteristics in a service setting, streaming patients presenting with challenging behaviours necessarily decreases the need to use restrictive practices. For example, streaming by gender may reduce male-to-female sexual assault, but will not avoid same-sex assault or other traumatic and aggressive behaviours.

77 Patients are currently streamed according to their level of acuity. To be admitted into a psychiatric ward, a patient will generally have to present a high risk of aggressive behaviour and of likely not complying with treatment. This type of streaming is based on a patient's level of aggression or compliance, rather than their diagnosis per se. Some

services also stream patients according to their age. There is no evidence, however, that this makes a difference to patient behaviour. In any case, it would be difficult to stream patients according to different criteria due to limited resources. There would simply not be enough bed-stock to support further streaming.

78 I have seen several examples of streaming in my work. At Metro South Health in Brisbane patients were streamed according to their diagnostic category. Here in Victoria we have a long tradition of streaming patients according to their age. It is doubtful, however, whether these methods impacted on the use of restrictive practices.

Use of security staff at Peninsula Health

79 Security staff are available at Peninsula Health to any area that requires them (for example, emergency departments and inpatient mental health units).

Role of security staff

80 Security staff are employed by Peninsula Health to ensure the safety of all patients and staff by managing patient behaviour and intervening where necessary. Without careful management, this may be problematic because we are a health service, not a prison. Security staff at Peninsula Health are trained in de-escalation techniques and how to use physical restraints safely.

81 Security staff are a visible part of the facility and they often talk to patients. Patients in high-support wards have reported that they feel safer with security staff around.

The choice to introduce security staff at Peninsula Health

82 Security staff have been introduced at Peninsula Health over the past three years to support staff when they are managing acutely distressed consumers who exhibit aggressive behaviour, after incidents where staff were harmed at work. Peninsula Health has since begun to include security staff in clinical mental health settings.

Frequency of security staff being required to intervene in mental health presentations

83 In my experience at Peninsula Health, security guards are called on to respond to a 'code grey' several times per day. These incidents are recorded and discussed at regular team huddles.

84 More recently, we have introduced security staff into our high dependency area for those periods when we have consumers in there who have manifested extreme risks of harm to others. This occurs perhaps once every 3 to 4 months. These security staff are carefully chosen and trained. As this was a change in practice, we did evaluate the impact of having security staff present in our mental health ward at these times. Importantly, this

practice has a moderating effect on the consumers' behaviour, staff felt supported, and the other consumers and their carers who were sharing the space reported that they felt safer with security present.

Responding to consumers presenting with challenging behaviours

85 We have a service-wide model at Peninsula Health. As a result, there are no differences in how consumers presenting with challenging behaviours are responded to in mental health wards or units compared to the emergency department and other areas of the health service.

Actions taken by Peninsula Health to reduce the use of restrictive practices

86 Peninsula Health was one of the first services to begin actively monitoring physical and mechanical restraints outside of the requirements in the Mental Health Act. This was done in order to reduce the use of restrictive practices. A record is made every time staff interfere with a patient's freedom of movement.

Difficulties associated with reducing restrictive practices

87 One of the biggest barriers to reducing restrictive practices is staff's fear of aggressive behaviour and past experience of trauma. This has meant that important cultural change is necessary to reduce the use of restrictive practices. There has also been discussion about a diminution of community standards of acceptable behaviour. These factors may explain why there are still high levels of seclusion despite reduction efforts.

Factors which enable professionals to employ alternative strategies and make seclusion and restraint the practices of last resort

88 The culture of practice in acute wards is a factor in managing the use of restrictive practices. At Peninsula Health, the staff are conscious of the need to create a culture of respect. For example, a junior nurse can say to a consultant psychiatrist that seclusion is not the preferred approach and take them on the journey of how things are done differently.

89 Every seclusion reduction strategy should be centred on the voice of consumers and carers, and staff should hear directly from them about the impact of seclusion.

Training support for staff to reduce the use of restrictive practices

90 Broad-ranging and detailed training packages should be made available to staff to assist in reducing the use of restrictive practices. These must be accompanied by service processes to minimise restrictive practices and to support the enactment of this training. In my opinion, incorporating the consumer and carer voice into this training is vital.

Legislative changes on the use of restrictive practices

91 It would be desirable to bring about legislative changes which limit the use of restrictive practices. It is, however, unlikely the use of these practices can be prohibited entirely. Restrictive practices should remain available for service providers as an option of last resort.

Implementation of SafeWards at Peninsula Health

92 SafeWards is a model which aims to reduce conflict in public health settings and improve the safety of patients and staff. SafeWards has been implemented in Peninsula Health's emergency departments, mental health units and a number of physical health wards.

Impact of SafeWards on service delivery

93 SafeWards has supported practice change within the inpatient units around patient-centred and inclusive service delivery.

Impact of SafeWards on the use of restrictive practices

94 At Peninsula Health, our rates of seclusion are already extremely low and it is difficult to demonstrate a reduction in rates due to the SafeWards model because of the 'floor' effect (whereby our rates are already almost as low as they can go).

Role of independent statutory bodies and central governance bodies in driving a reduction in the use of restrictive practices

95 The available data suggests an enormous variation in the use of restrictive practices. This variance indicates low quality service and poor standards, and should be the focus of attention. Requiring health services to report to independent statutory bodies and central governance bodies on their use of restrictive practices should be an effective means to keep them accountable and minimise the use of these practices. Independent statutory bodies, including the Chief Psychiatrist, and chairs of health services, already have access to data on the prevalence of restrictive practices. It is my opinion that our statutory bodies and central governance bodies need to respond much more assertively to the large variation in the use of physical restraint and seclusion across mental health services than they currently do. It is self-evident that such a wide variation in the use of seclusion and restraint, with all its attendant trauma and harm, indicates a significant safety and quality problem in some services. It is important that the mental health sector is held to more rigorous and clear expectations.

Examples of exemplary approaches to reducing restrictive practices

96 The following health services have taken outstanding efforts to implement multi-modal and multi-layered approaches to reducing restrictive practices:

(a) Peninsula Health;

(b) Austin Health; and

(c) Monash Health (Casey Hospital).

97 This list is incomplete; all health services in Victoria have made concerted attempts to reduce their use of restrictive practices.

SECURE EXTENDED CARE

Role of Secure Extended Care Unit services in the Victorian system

98 Secure Extended Care Units (**SECUs**) were established in the 1990s during the era of deinstitutionalisation. At that time, SECU services provided treatment for patients with persistent symptoms who were difficult to place.

99 In my view, the SECU model is not applied consistently in Victoria, and varies across the state. Many SECUs do not provide comprehensive psycho-social rehabilitation and, on the whole, SECU services are neither as secure nor as extended as they should be.

100 Peninsula Health has access to SECU beds but does not have a SECU itself.

Effectiveness of the current SECU model in responding to consumers with very complex treatment and support needs

101 The SECU model is run-down, does not work very effectively and is not able to match capacity with demand. SECUs are failing to rehabilitate those who can access treatment. Further, there are currently people living out of hospital in appalling conditions, who have severe mental illness and who avoid or resist treatment. This cohort needs long-term, secure residential care so they can learn how to live in the community. They cannot access support because there are not enough SECU beds.

102 To operate more effectively, SECU services need to make more beds available, including secure and open beds. Very few consumers overall need SECU beds, but those who do need stabilisation and security.

WORKFORCE SUPPLY AND CAPABILITIES

Impact of current workforce shortages on Peninsula Health's capacity to meet the needs of consumers

103 Serious labour shortages have caused an acute crisis in Peninsula Health's workforce. We have several positions we cannot fill. The availability of mental health workers drops rapidly 10 km out of the Melbourne Central Business District. We have been advertising for months for a consultant role in our Mental Health Drug Crisis Hub which we have not yet been able to fill. In contrast, services closer to the city are able to fill positions very reliably.

104 Ultimately, workforce shortages affect the quality of care for consumers because we have inadequate resources to meet their needs.

The next step, beyond the Commission's interim report recommendations, in addressing workforce shortages

105 Mental health is not a funding or policy priority, and psychiatrists are among the least powerful voices in tertiary teaching institutions in relation to curriculum development. Approximately 5 to 10% of the curriculum for doctors, nurses and social workers is mental health-specific, whereas mental health problems are prevalent in 20 to 30% of all consumers. To address workforce shortages, we need to ask ourselves why people are not choosing a career in mental health and overcome cultural issues.

106 Years of severe financial rationing coupled with ever growing demand have made mental health an unattractive career option for many people. Some of the drivers are concerns about exposure to occupational violence, reluctance on the part of service directors to employ sessional specialists, and the very real issue of moral distress resulting from values-based clinicians being asked to provide services that fall far below the standards they would expect a service to meet. The Royal Commission and what flows from it should create some optimism for the future and the opportunity to attract and retain a new generation of professionals who consider it desirable to have a career in the mental health system. Providing resources and an assurance that mental health is not a low priority might be a good start.

Implications of adapting to a contemporary workforce for services like Peninsula Health

107 Introducing evidence-based online health services could be an effective way to adapt to a changing workforce. For example, Peninsula Health is currently trialling tele-psychiatry. This service has had a slow take-up and so it is heavily under-utilised, but we accept that there this will be a gradual learning process.

Changes to workforces to provide a multidisciplinary and consumer-focused professional practice

108 A multidisciplinary and consumer-focused professional practice will require a cultural change in workforces. Mental health clinicians need to better understand the difficulties that consumers have in changing their behaviour because of their medication and the impact of their mental health illness on their ability to feel positively reinforced for new behaviour. The neuroscience involved in this is becoming clear and clinical practice needs to incorporate these learnings. Processes in the community-based services also have to take this into account for the services to be consumer-oriented. For example, clinicians should understand that therapy requires multi-layered positive reinforcement, and needs to be repeated a number of times.

Achieving multidisciplinary and consumer-focused services

109 Psychiatrists have undergone lengthy and comprehensive training, and are vital to the clinical leadership of multi-disciplinary teams responsible for the comprehensive care of people with severe mental illness.

Overcoming features of existing workforces which can operate to prevent multidisciplinary and consumer-focused practice

110 The greatest barrier to multidisciplinary and consumer-focused practice in existing workforces is the difficulty in accessing qualified staff. A lack of funding has meant that staff from cheaper disciplines are prioritised. So long as staff are available, however, multi-disciplinary practice is easy to implement.

111 Another barrier to multi-disciplinary practice is that many consumers don't believe they have an illness or that if they are unwell they don't need treatment. Practice should be trauma-informed and match the consumer's ability to change their behaviour.

COVID-19

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

112 One of the major changes in health service delivery secondary to COVID-19 has been the rapid deployment of video-enabled tele-psychiatry as an option for appropriate consumers.

113 Many consumers and their families find this option acceptable, convenient and less personally intrusive than home visits or attendance at clinics.

114 Such an approach has also allowed psychiatrists who are on call to conduct tele-psychiatric assessments without the delay involved in consumers returning to the hospital for face-to-face assessments.

Longer term opportunities for new approaches to service delivery

115 Tele-psychiatry is not suitable for all consumers and families, but should become one of the options made available to people moving forward.

116 Although most consumers have devices that are suitable for tele-psychiatry, insufficient data allowance is proving to be one of the major barriers of this approach. As such, we need to develop a 'reverse charge' type facility so that the data used during consultations do not count towards the data usage of the consumers or their families. Mental health services also need access to a number of replaceable devices that can be loaned to consumers or families who cannot afford a suitable device for tele-psychiatry.

sign here ► 

print name JOHN RICHARD NEWTON

date 7/5/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JRN-1

This is the attachment marked 'JRN-1' referred to in the witness statement of John Richard Newton dated 7 May 2020.

CURRICULUM VITAE

Adjunct Professor John Richard Newton

Clinical Director, Peninsula Health, Mental Health Service.
Adjunct Professor, Monash University
Honorary Principal Fellow, University of Melbourne,

Current positions:
Clinical Director, Clinical Director of Mental Health, Peninsula Mental Health Service.
Board Member, Butterfly Foundation,
Mental Health Victoria, Board Member
Adjunct Professor, Dept of Psychiatry, Monash University.
Honorary Clinical Associate Professor, Department of Psychiatry, University of Melbourne,

QUALIFICATIONS :	**MB ChB**	**1985**
	MRCPsych	**1989**
	FRANZCP	**1995**

REGISTRATION: Full registration AHPRA MED0001150873

CITIZENSHIP: Australian

MEMBERSHIPS:
Fellow, Royal Australian and New Zealand College of Psychiatrists
Member Royal College of Psychiatrists
Member Australian Association of Cognitive Behaviour Therapists
Member Academy of Eating Disorders
Member Faculty of Medical Leadership and Management
Alumnus, Williamson Community Leadership Programme, Leadership Victoria

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PRESENT POSTS

Clinical Director, Clinical Director of Mental Health, Peninsula Mental Health Service. 5/8/17-
Clinical Director of Mental Health, Peninsula Mental Health Service. 5/8/17-Current
Peninsula Mental Health Service is an Area Mental Health Service with a diverse population of approximately 250000 people across a suburban and rural area. Duties as the clinical director at Peninsula includes maintaining all statutory requirements under the Mental Health Act for the service, ensuring the service meets all National Standards for Mental Health Services, ensuring accreditation under ACHS review, providing overarching clinical direction to the service, ensuring the service meets it's Key Performance Indicators both clinical and operational, recruiting, retaining and managing medical staff, participating in Health Service wide clinical governance and other quality activities.
Over the last two years we have redesigned the model of care to better meet the needs of the community ensuring access to services is easy and appropriate whilst maintaining a commitment to safe effective personal and connected care. I am proud to be part of a service that has maintained the lowest seclusion rates in the state for more than a decade. When I was Clinical director here in 2004-2009 the seclusion rate dropped from the highest in the state to the lowest and it has remained so to the present. We also have one of the lowest usages of the MHA in the state reflecting our commitment to working with people and meeting their needs.

Board Member, Butterfly Foundation, 2015-
The Butterfly Foundation is the national peak body for people with eating disorders, and their family. It provides a range of on line, telephone based and clinic based treatment and support programmes. It has a key role in advocacy, public awareness campaigns and community and health sector education. During my period on the board we have moved to becoming a provider of clinical services including the launch of a residential programme for eating disorders based on the Monte Nido model from California.
Mental Health Victoria, Board Member 2018-
Mental Health Victoria is the peak body for mental health service providers in Victoria. It specialises in public policy, workforce development and training, and services that build individual, organisational and community capacity. Mental Health Victoria translate best evidence into practice for the benefit of its members and their staff, consumers and communities. It has played a pivotal role in advocating for improved mental health services in the state via the Royal Commission.

Adjunct Professor, Dept of Psychiatry and Psychology, Monash University.
Honorary Principal Fellow, Associate Professor, Department of Psychiatry, University of Melbourne,

2017 - AHPRA Psychiatrist practice assessor.

PAST POST

Chair RANZCP Victorian Branch Committee. 2016- Nov 2019
The Vic Branch represents the approximately 1500 Fellows, SIMGEs and trainees working in Victoria. Over the last three years we have taken a strong strategic direction to advocacy for improved community mental health service provision. We have taken a number of steps to ensure that Psychiatrists participate in planning, redesign and improvement of the state's mental health service system. This has included partnering with stakeholders with lived experience and promoting and developing tools to embed coproduction, codesign and supported decision making into the college, and also have developed a package of training for

mental health clinicians that has been successfully evaluated. The branch has worked with other community stakeholders to engage the government and hold it more accountable for the parlous state of public mental health in Victoria. This culminated in the launch of the Mental Health Royal Commission MHRC. The branch has maintained it's advocacy and submitted a strong comprehensive submission to the MHRC whilst aligning our message with other advocacy groups such as Mental Health Victoria, the AMA and lived experience stakeholders.

Medical Director Mental Health Clinical Service Unit MH CSU, Austin Health, Appointed: 12.2.09.- 5/8/17
The Mental Health CSU at Austin Health includes an Area Adult Mental Health Service AMHS, Austin Child and Adolescent Mental Health Service CAMHS, General Hospital Mental Health Service, including Drug Dependency and Clinical and Health Psychology, a state-wide Psychological Trauma Recovery Service, including the Veterans Psychiatric Unit and the Civilian Post Traumatic Stress Disorder Recovery Service and a State-wide Brain Disorders Service. The North East Area Mental Health Service also includes the regional Secure Extended Care Unit, Mother and Baby Unit and a Specialist Eating Disorder Service as well as a 24/7 intensive community outreach service, adult case management and an intensive community rehabilitation service. The MH CSU comprises 131 beds currently open, with 46 new beds in the capital works stage, 520 clinical staff with a recurrent budget of $46.5 million. As Medical Director I was able to work with the teams at the Austin to reduce their seclusion and restraint practices in all areas of the service to the second lowest in the state. We also worked together to achieve performance against all mandated KPIs to be the best or within the top three best performing services in the state.

Clinical Director of **BETRS**: 2005-2009 **B**ody image, **E**ating disorders **T**reatment and **R**ecovery **S**ervice,a regional community Eating disorders programme jointly run by Austin and St Vincent's, and Consultant Psychiatrist to the Specialist Eating Disorder In Patient Service, Austin Health. After many years of advocating for a day programme able to meet the needs of people with severe eating disorders we developed this service in a partnership between two separate health services and using a collaborative leadership model across operational and clinical governance have demonstrated it's ability to provide safe effective and acceptable care to our community.
BETRS is a community based specialist eating disorders programme that provides comprehensive assessment, treatment and support to consumers and their families and carers who are affected by severe eating disorders. It places an emphasis on developing a shared understanding of the role and effect of the eating disorder in a person's life, a comprehensive treatment programme that is realistic, relevant and acceptable to patient and family or carers, and is focussed on recovery and return of function and quality of life. The day programme component is primarily focussed on assisting participants to restore health when this has been compromised by effective nutritional rehabilitation in an empathic, supportive environment that is respectful and empowering. The day programme component is able to accept participants with BMIs as low as 13 provided they are physically able to attend and has demonstrated that it is an effective and valued alternative to traditional in patient care.

Clinical Director of Mental Health, Peninsula Mental Health Service 2004 - 2009
Peninsula Mental Health Service is an Area Mental Health Service with a diverse population of approximately 250000 people across a suburban and rural area. During my 5 years as the clinical director at Peninsula I initiated and led to full implementation a six sigma redesign of the service. Responsibilities of the Director post included maintaining all statutory requirements under the Mental Health Act for the service, ensuring the service meets all National Standards for Mental Health Services, ensuring accreditation under ACHS review, providing overarching clinical direction to the service, ensuring the service meets it's Key Performance Indicators both clinical and operational, recruiting, retaining

and managing medical staff, participating in Health Service wide clinical governance and other quality activities.

MEMBERSHIP OF OTHER COMMITTEES

- 2018-2020 MBS Review Eating Disorders Working Group, DOHA.
- 2016-2020 Member Workforce reference group, 10 year mental health plan, DHHS
- 2016-2017 East Melbourne Primary Health Network, Clinical Council
- 2016-2019 Chair, Victorian Branch RANZCP
- 2015- Australian Commission Safety and Quality in Health Care. NSQHS Comprehensive Care Standard Advisory Committee.
- 2012 -2018 Member, Independent Health Pricing Authority Mental Health Working Group.
- 2011 –2019 Victorian Public Health Care Awards. Chair or member of judges panel.
- 2010– ACHS Surveyor
- 2009 – Member, Quality Assurance Committee, Morbidity and Mortality Committee, Office of the Chief Psychiatrist. Vic
- 2010 – Membership, Steering Committee, NEDC.
- 2016 25 year design, service and infrastructure plan for Victoria's mental health service system advisory group.
- 2016 2015-2016 Chair, Supported Decision Making Committee. RANZCP/DHHS.
- 2014-2015 National Health Performance Authority, CWS Advisory Committee.
- 2014-2015 Health Innovation Reform Council, Minister of Health. Mental Health group
- 2013-2016 Secretary, RANZCP, Victorian Branch
- 2013-2015 RANZCP Eating Disorders Clinical Practice Guideline Project
- 2013-2014 Member, National Scoping Study on the Implementation of National Standards for Mental Health Services Project Advisory Group, Australian Commission on Safety & Quality in Health Care.
- 2013 -2014 Chair, Reducing Restrictive Interventions Project, DoH, Vic.
- 2012 -2013 Ministerial Taskforce on Eating Disorder Service Reform, DoH, Vic.
- 2010 –2015 Co-Chair, National Eating Disorder Collaborative – National Standards Working Group.
- 2009 – 2012 Inaugural Member, Victorian Mental Health Reform Council
- 2009 – 2010 Member Ministerial Health Reform Round Table
- 2007 – 2010 Federal Minister of Health advisory committee on enhanced medical education

- 2006 – 2009 Board Member, Centre for Psychiatric Nursing, University of Melbourne
- 2007 – 2009 Chair, Clinical Director's Conference.
- 2007 – 2009 Deputy Chair, Peninsula Headspace
- 2006 Ministerial Advisory Sub-Committee for 'Front End' services

Examples of External Consultancies in last 5 years

2018 Review of models of care to enable community care of residents of major long term institution
2017 Safety, Governance and Culture Review of Major Metropolitan Mental health Service
2016 Review of MH patient flow and leadership across a large metropolitan service
2015 Review of state-wide patient flow across ED, Acute and Subacute mental health
2014 Thematic review of MH mortality through a community MH and ED.

AWARDS AND PRIZES

- 2019 Victorian Public Healthcare Awards. PH MHS Wellness Clinic Category award Highly Commended for Responding to mental health and drug and alcohol need.
- 2010 Victorian Public Healthcare Awards. Category award Silver for Responding to mental health and drug and alcohol needs. For improved inpatient management of eating disorders. BETRS
- 2009 Victorian Public Healthcare Awards. Minister's award for outstanding achievement for a team in mental health care, Austin Health, Mental Health CSU, Centre for Trauma related Mental Health Bushfire recovery team.
- 2009 RANZCP Margaret Tobin Award. Awarded to individuals who have made an outstanding contribution to clinical psychiatry at an administrative level.
- 2008 Victorian Public Healthcare Awards. Minister's award for outstanding achievement for an individual in mental health care, Highly Commended.
- 2008 Victorian Public Healthcare Awards. Minister's award for outstanding achievement for a team in mental health care, 2W in-patient team for the work in reducing seclusion.
- 2008 THEMHS. Silver Achievement Award awarded by the Mental Health Services Conference of Australia and New Zealand to recognise and encourage best practice, excellence and innovation in mental health service delivery for the Reducing seclusion project.
- 2007 Victorian Public Healthcare Awards. Highly Commended, "Excellence in consumer and carer participation" for "About Psychosis DVD".
- 2006 PH Quality and Patient Safety Award. Winner "Leadership and Management"
- 2005 Victorian Public Healthcare Awards. Winner in partnership with Frankston Community Health Service, "Excellence in Community Participation" for the 'Men Behaving Positively" community forums.
- 1992. International Conference on Eating Disorders. Most important new research paper. Osteoporosis and Normal Weight Bulimia Nervosa.

PUBLICATIONS

Refereed Journal articles

1. Rachael Green, Penelope Fay Mitchell, Kira Lee, Ella Svensson, Jia-Wern Toh, Carolyn Barentsen, Michala Copeland, **J Richard Newton**, Kari Christine Hawke, Lisa Brophy . Key features of an innovative sub-acute residential service for young people experiencing mental ill health. BMC Psychiatry. September 2019.

2. Jennifer Beveridge; Andrea Phillipou; Zoe Jenkins; **Richard Newton;** Leah Brennan; Freya Hanly; Benjamin Torrens-Witherow; Narelle Warren; Kelly Edwards; David Castle Peer mentoring for eating disorders: Results from the evaluation of a pilot program Journal of Eating Disorders 2019 doi.org/10.1186/s40337-019-0245-3

3. **R Newton**, A Beasley, P Bosanac, D Castle, D Copolov, M Hopwood, N Keks, N Paoletti, J Tiller, The challenges facing the public mental health sector: Implications of the Victorian Psychiatry workforce project. Australasian Psychiatry 2019

4. Harvey C, Brophy L, Tibble H, Killaspy H, Spittal MJ, Hamilton B, Ennals P, **Newton R**, Cruickshank P, Hall T and Fletcher J (2019) Prevention and Recovery Care Services in Australia: Developing a State-Wide Typology of a Subacute Residential Mental Health Service Model. Front. Psychiatry 10:383. doi: 10.3389/fpsyt.2019.003

5. **Newton J R** Borderline Personality Disorder and Eating Disorders – a trans-diagnostic approach to unravelling diagnostic complexity. Australasian Psychiatry 2019 DOI:10.1177/1039856219852297

6. Yardley P, McCall A, Savage A, **Newton R.** Effectiveness of a brief intervention aimed at increasing distress tolerance for individuals in crisis or at risk of self-harm. Australasian Psychiatry, 2019. DOI:10.1177/1039856219848835

7. Crespo-Facorro, Benedicto, Rouleau, Alice; Nylander, Anna-Greta; H. Loze, Jean-Yves; Resemann, Henrike Steeves, Sara, **Newton, Richard**; The burden of disease in early schizophrenia, a systematic review. Schizophrenia Bulletin. Dec 2018

8. **Richard Newton**, Anna-Greta Nylander, Alice Rouleau, Jean-Yves Loze, Henrike Resemann, Sara Steeves, and Benedicto Crespo-Facorro. Diverse Definitions of the Early Course of Schizophrenia – A Targeted Literature Review NPJ Schizophrenia. 2018. 4:21 ; doi:10.1038/s41537-018-0063-7

9. Jennifer Beveridge, Andrea Phillipou, Kelly Edwards, Alice Hobday, Krissy Hilton, Cathy Wyett, Anna Saw, Georgia Graham, David Castle, Leah Brennan, Philippa Harrison, Rebecca de Gier, Narelle Warren,Freya Hanly, Benjamin Torrens-Witherow, **J. Richard Newton.** Peer mentoring for eating disorders, evaluation of a pilot program. Pilot and feasibility studies. 2018; 4, 75

10. Jake Linardon[1], Andrea Phillipou[2,3,4,5,] **Richard Newton** [5], Matthew Fuller-Tyszkiewicz[1], Zoe Jenkins[3], Leonardo L Cistullo[6], & David Castle [4,6] Testing the relative associations of different components of dietary restraint on psychological functioning in anorexia nervosa and bulimia nervosa. Appetite 2018 May. DOI: 10.1016/j.appet.2018.05.138

11. Jake Linardon[1], Andrea Phillipou[2], David Castle[3], **Richard Newton[4]**, Philippa Harrison[5], Leonardo L Cistullo[5], Scott Griffiths[6], Annemarie Hindle[7] & Leah

Brennan[7]. Feeling fat in eating disorders: Testing the unique relationships between feeling fat and measures of disordered eating in anorexia nervosa and bulimia nervosa. 2018, Body Image, 25, 163-167.

12. Jake Linardon[1], Andrea Phillipou[2], David Castle[3], Richard Newton[4], Philippa Harrison[5], Leonardo L Cistullo[5], Scott Griffiths[6], Annemarie Hindle[7] & Leah Brennan[7]. The relative associations of shape and weight over-evaluation, preoccupation, dissatisfaction, and fear of weight gain with measures of psychopathology: An extension study in individuals with anorexia nervosa. Accepted Feb 2018. Eating Behaviours. Apr;29:54-58. doi: 10.1016/j.eatbeh.2018.03.002. Epub 2018

13. Jessica Green[1], Andrea Philipou[1,2,3,4], David Castle[3,4], Leonardo Cistullo[3], **Richard Newton** An evaluation of the predictive validity of the URICA and ANSOCQ scales for weight gain in adults with AN in an Outpatient Eating Disorders Program: A Prospective Cohort Study. JED October 2017.

14. **J R Newton**, M Hopwood, N Paoletti, D Copolov, N Keks, P Bosanac, J Tiller, D Castle. 2017, Targeting Zero; Implications for Public Psychiatric Services. P1-3. DOI 10.1177/0004867417700732. ANZJP

15. Dark F, Patton M, **Newton R**. 2017 A substantial peer workforce in
    a. a psychiatric service will improve patient outcomes: the case for. Australasian Psychiatry. 2017, Vol 25(5) 441–444

16. Lee Y Wong, Rinaldo Bellomo, Shaun L Greene, Ray Robbins; Johan Martensson,; Richard Kanaan,; **Richard Newton**; Jason Hu; David McD Taylor. 2016. Long-term outcome after severe overdose. Critical Care and Resuscitation. 18: 247-254.

17. Saraf S, **Newton R.** 2016. Care or Recovery? Redefining residential rehabilitation. Australasian Psychiatry. DOI: 10.1177/1039856216671662..

18. Bibb, J., Castle, D., & **Newton, R**. (2016). 'Circuit breaking' the anxiety: Experiences of group music therapy during supported post-meal time for adults with anorexia nervosa. *Australian Journal of Music Therapy, 27*, 1-11.

19. Peter Bosanac, Malcolm Hopwood, Nicholas Keks, **Richard Newton**, John WG Tiller, David Coplov , Paoletti N, Castle D. 2016. Recovery is a core goal of psychiatrists, Australian and New Zealand Journal of Psychiatry. 50(10): 935 – 936

20. Keating C, Castle D, **Newton R**, Huang C, Rossell S. 2016. Attachment insecurity predicts punishment sensitivity in Anorexia Nervosa. July 2016 Journal of Nervous and Mental Disease 204 (10) 793-798.

21. Sellars M, Fullam R, O Leary C, Mountjoy R, Mawren D, Weller P, **Newton R,** Brophy L, McEwan T, Silvester W, 2016 Australian psychiatrists' support for Psychiatric Advance Directives: responses to a hypothetical vignette. July 2016, Psychiatry, Psychology and Law. . http://dx.doi.org/10.1080/13218719.2016.1198224

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24. Caudle Henry, Pang Christine, Mancuso Sam, Castle David, **Newton Richard**, 2015. A retrospective study of the impact of DSM-5 on the diagnosis of eating disorders in Victoria, Australia. Journal of Eating Disorders.2015, 3:35. 10.1186

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26. The prestige model of spectrum bipolarity. 2015. Le Bas J, **Newton R**, Sore R, Castle D. Medical Hypotheses, 84 (2) Dec 2014

27. **Newton JR.** 2014**.** Improving access to psychosocial interventions for psychosis. AP J Psychol Med 2014; 15(2): 157-61.

28. Grocke, D; Bloch, S; Castle, D; Thompson, G; **Newton, R**; Stewart, S; Gold, C. 2014. Group music therapy for severe mental illness: a randomized embedded-experimental mixed methods study. Acta Psychiatrica Scandinavica. 130(2):144-53.

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31. **Newton, R**. (2013) "Prevention of Relapse in Patients with Schizophrenia: The Role of Long-Acting Antipsychotics." *International Clinical Psychopharmacology*, 28, Suppl 1, Sept, S28-S34.

32. **J R Newton** 2013 Presentations of Eating Disorders in later life. Journal of Pharmacy Practice and Research, Geriatric Therapeutics. 2013; 43; 231-236

33. Castle D, Keks N, **Newton R**, Schweitzer I, Copolov D, Paoletti N, Burrows GD, Tiller J. (2013) "Pharmacological approaches to the management of schizophrenia: Ten years on." *Australasian Psychiatry*, 21 (4) 329-334.

34. **Newton, R**, Bosanac P, Castle, D, Mancuso S. (2013) Bridging the gap - Does a specialist eating disorder service, aimed at developing a continuum of community care, make a difference? *Australasian Psychiatry*, 21 (4) 365-370.

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36. Nick O'Connor, Beth Kotze, Ruth Vine, Murray Patton and **Richard Newton** 2012 The emperor's edicts stop at the village gate; *Australasian Psychiatry* 20: 28-34

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Books and Book Chapters

Freeman C.P. **Newton J.R**. (1993). 'Eating Disorders in General Practice.' '*Women's Problems In General Practice* ', Third Edition, Editor McPherson A. January, Chap 17, pgs 424-448. Oxford University Press

Freeman C.P. **Newton J.R**. (1992). '*What Is The Best Treatment For Anorexia Nervosa?*' 'Practical Problems in Clinical Psychiatry.' First Edition, Ed. Hawton K. Cowen P. Dec, Chap 7, pgs 77-92. Oxford University Press

Daly M, Hemley H, and **Newton J.R**. (1995). "The Homeless Handbook". *A General Health Manual for those working with Homeless People*. Commonwealth Development Grant sponsored publication, launched by Fr. Peter Norden at press conference June 1995. Second Edition Published 1996.

Newton .J.R. (1996). Day Hospital Management of Eating Disorders. In Ed. Brown E, Johnson D. *Current Dilemmas and Possibilities in Treating Dieting Disorders* (pp85-95). Pub Davellen

Newton R. Trauer T., Farhall J. , Cheung P. (1999). Community Care Units Evaluation Project: One Year Report 1999, Dept of Human Services, 1999.

Newton R. "Treating anorexia nervosa: a collaborative conceptualisation-based approach" In: Castle DJ, Hood S, Starcevic V (eds.) Anxiety Disorders: Current Understandings, Novel Treatments. Australian Postgraduate Medicine, Melbourne 2012: 153-164

Toovey, A. C., Castle, D. J., & **Newton, R.** 'Caring for a Loved One with an Eating Disorder: A Carer's Guide to Understanding the Illness and Keeping Well,' 1st Edition, January 2015

Multi-media and DVD recordings

May 2017 The conversation.com Therapy for life threatening eating disorders works so

why cant people access it?

2015-2016 Caring for Carers MOOC in partnership with KCL and EUFAMI

"Psychiatry- a fascinating career." Produced on behalf of the RANZCP Strategy and Policy division. Launched RANZCP congress 2007

"About Psychosis-a guide for consumers and carers." Funded by an independent grant from Janssen-Cilag. 2007. Currently in process of widespread distribution with enthusiastic feedback. Has been submitted to VHA as a quality of care submission.

CBT training programme for advanced trainees in Psychotherapy. Institute of Psychiatry, NSW. A complete CBT course filmed on site 2008

Austin Health Pod Cast 2010. New approaches to the Treatment of Anorexia Nervosa.

Published Abstracts

Richard Newton, Lindy Bennett, Raju Lakshmana "Turning the Ship around" – Changing the approach to clinical governance can change clinical outcomes in an Australian Mental Health Service. The International Society for Quality in Health Care. 28th International Conference. 2011

Richard Newton, Saji Damodaran, Harry Hustig , Raju Lakshmana , Joseph Lee, Balaji Motamarri, Peter Norrie, Robert Parker. Australian and New Zealand Journal of Psychiatry (2011) 45 (suppl. 1) Paliperidone Palmitate: place in therapy and practical usage guidelines for a new long-acting injectable antipsychotic.

Richard Newton, Steve MacFarlane, Ann Hamden, John Wooles, Bob Allardice, Priscilla Yardley. (2008). Using six sigma methodology to redesign a community psychiatric service. *Australian and New Zealand Journal of Psychiatry*, Vol 42, Supp 1, 38-40.

Tom Callaly, Harry Minas, Paul Cohen, Alex Cockram, **Richard Newton**, Penny Mitchell. (2008). Creating the Future for Psychiatric services. *Australian and New Zealand Journal of Psychiatry*, Vol 42, Supp 1, 8.

Richard Newton. (2008). Engaging staff in service change**.** *Australian and New Zealand Journal of Psychiatry*, Vol 42, Supp 1, 10.

Newton R, Yardley P. (2007). Putting evidence into Practice: An Evaluation of CBT training for mental health clinicians as part of routine care in a a mental health service. WCBCT abstracts 2007.

Farhall J., Trauer T., **Newton R**., Cheung P. (2000). Replacing long term wards with community care units: what have we learned? Creativity and Development Services for the Future. *Proceedings of the 10th Annual The MHS conference 2000*.

Farhall, J., Trauer, T., Cheung, P., & **Newton, R**. (2000). Moving long-stay psychiatric patients into the community: The importance of living environment. In: *Whose Dreams? Whose Reality? Contemporary The MHS in Mental Health Services, Proceedings of the 9th Annual Mental Health Services Conference of Australia and New Zealand*, (Melbourne, Sept 1999).

Trauer, T., Farhall, J., **Newton, R**., & Cheung, P. (1999). Moving long stay psychiatric patients into the community: Tenure and progress in clinically staffed accommodation units. In Robertson S, Kellehear, K., Teesson, M, Miller V (Ed.), *Making History: Shaping the Future. Contemporary The MHS in Mental Health Services, Hobart Conference Proceedings 1998*. Sydney Australia: TheMHS Conference.

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Farhall, J., Trauer, T., Attwood, R., **Newton, R**., & Cheung, P. (1996). The short term impact of moving from psychiatric ward to community care unit. *Proceedings of the 6th Annual Mental Health Services Conference of Australia & New Zealand*, Brisbane, Sept. 1996.

Trauer, T., Farhall, J., **Newton, R**., Cheung, P., Keks, N., Robinson. T. & Vaddadi, K. (1995). The evaluation of the impact on patients, staff and carers of moving long stay patients into the community. In Kellehear, K., Teesson, M., Farhall, J., Peters, J., Miller, V. & Robertson, S. *Contemporary The MHS in Mental Health Services, Proceedings of the 5th Annual Mental Health Services Conference of Australia & New Zealand*, Melbourne, Auckland, Sept. 1995, Lilyfield, NSW:Liddell.

Newton J.R., Kehoe R.F. (1992). *'Who attends a psychiatric emergency clinic?'* In 'Proceedings of the 2nd International Conference on Emergency Psychiatry'. Elsevier Science Publishers, Amsterdam.

RESEARCH ACTIVITIES

Current NHMRC Grant 2016-2018

NHMRC Partnership Project ID 1115907 Building the Evidence Base for Prevention and Recovery Care Services. Brophy L, Pirkis J, et al, Newton R Awarded. $365,902.90

Recent Successful Grants

ACURF Does collaborative case conceptualisation enhance engagement and outcome in the treatment of anorexia nervosa?
Reference Number: 2013000423 Awarded $40000 across 2013-2014

AMRF The effect of group music therapy on adults with eating disorders post – meal, in comparison to standard care. Awarded $10000 across 2013 -2014

Other Current Research with HREC approval

- A Randomised Controlled Trial to Examine the Effectiveness of Oxytocin to Improve Treatment for Anorexia Nervosa

- Evaluation of an innovative day and community program for severe eating disorders 2011 – 2016

- Advanced Care Planning in Mental Health National survey of Mental Health Practitioners, consumers and carers.

- Culturally relevant psychotherapies for depression in Sri Lanka **PhD Supervisor**

- Ethical considerations in collaborative care in severe and enduring anorexia nervosa: an application of an ethical decision-making model **PhD supervisor**

Past Research
Pharmaceutical Industry sponsored trials

- A range of multi site RCTs, in Depression, Schizophrenia and Bipolar Disorder.

Health services research

- Seclusion and its environmental contributors
- Evaluation of CBT training for mental health clinicians
- Clinical and social outcomes of patients discharged from CCUs
- Implementation of evidence based clinical practice in generic mental health services
- Dietary control of weight gain secondary to anti psychotics

Co-investigator NHMRC funded project on mindfulness based CBT

International Research Group member, Eating Disorders.

Editorial Board Memberships:

- AP Journal of Psychological Medicine

- Journal of Eating Disorders

Reviewer for the following journals:

- Australasian Psychiatry
- Australian and New Zealand Journal of Psychiatry
- Stress and Health Journal
- Journal of Mental Health
- Journal of Eating Disorders
- Dove Medical Press
- PLOS one

Completed PhD Supervision

Affect on the Prestige Landscape- The prestige model of bipolarity. Dr James LeBas. Feb 2012 Completion 2015, Co supervisor with Prof David Castle.

Other supervision activities

RANZCP Accredited Supervisor
RANZCP Board of Examiners

Provision of private supervision

CBT psychotherapy supervision for consultant psychiatrists
Leadership and management supervision to a number of Clinical Directors of Victorian AMHSs.

Coroner's Court of Victoria. Provision of expert opinions on mental health service care following a sudden or unexpected death whilst a public mental health service patient - at the request of the coroner

Teaching Activities

- Development of two modules for University of Melbourne, Master of Mental Health Science, A year one introduction to structured psychotherapies and a year 2 advanced competency development in structured psychotherapy.
- Undergraduate teaching and tutorials, Medical School, Uni Melb.
- Post Graduate Teaching MPM/Mphil, Structured Psychotherapy
- Accredited RANZCP Advanced Training Formal Education Course CBT. A colleague and I run this 18 month advanced training course in CBT. This course is now running for the fifth time, and was the first advanced training course in Australia available to College Fellows or Trainees wishing to undertake approved training in CBT in order to receive the advanced training certificate in psychotherapy. It has been filmed in it's entirety by the Institute of Psychiatry NSW and will be made available as a digital download.
- Monash University Masters Unit; Cognitive Behavioural Therapy for Mental Health Professionals. This course will be run for the second time this year. It has had a strong take up and very positive feedback from a wide range of mental health clinicians.

EDUCATION

SCHOOLING	St Wilfrid's, Featherstone, W Yorkshire
UNIVERSITY	Edinburgh University Medical School 1980-1985.
QUALIFICATIONS	MB ChB 1985 MRCPsych November 1989 FRANZCP November 1995
PRIZES	Ellis Prize in Child Life and Health 1985 Class Medal: Anaesthetics 1985 Distinctions in Final MB Examination: Psychiatry 1985 Child Life and Health 1984 Surgery 1985

Research Prize for most important scientific presentation: International Conference on Eating Disorders, NY 1992. 'Osteoporosis and Bulimia Nervosa; which patients are at risk?'

Extracurricular activities at university included:
Senior President, Royal Medical Society, 1985-1986.

PSYCHIATRIC EXPERIENCE

General Adult Psychiatry Private Practice special interest in Eating Disorders and CBT, 1995- 2005

Programme Director, The Melbourne Clinic Anorexia Nervosa Day Programme. November 1995 -March 1997

Director and Consultant Psychiatrist, Homeless Outreach Psychiatric Service (HOPS), Waratah Area Mental Health Service, Melbourne.1992-1997

We evaluated and demonstrated the efficacy of this service and it has been expanded consistently across the inner city psychiatric services. This service received a silver medal for the most innovative service at The Mental Health Services Conference in 1997.

Assistant Psychiatrist, Royal Melbourne Hospital, Eating Disorders Programme. March 1993 - November 1995

Consultant Psychiatrist, Eating Disorders Program, Academic Unit, North East Metropolitan Psychiatric Services (NEMPS). April 1994 - November 1995.

Community Psychiatrist, Ellery Clinic, Royal Park Corporation. November 1992 - March 1994

UK PSYCHIATRY TRAINING

AUGUST 1986-OCTOBER 1992: Registrar, Senior Medical Research Fellow and subsequently **Honorary Senior Registrar,** Royal Edinburgh Hospital, Dept. of Psychiatry.

1. Two years and four months half time clinical placement acting as Senior Registrar at **The Cullen Centre,** Royal Edinburgh Hospital.
Supervisor: Dr C P Freeman F.R.C.Psych. Consultant Psychotherapist and Part time Senior Lecturer, Dept. of Psychiatry, University of Edinburgh.

The Cullen Centre is a unique out-patient and day-patient centre for the **Cognitive Behavioural Treatment** of non-psychotic psychiatric disorders. It had a special interest in the **day-patient management of Anorexia Nervosa** for which it is building an international reputation. It is staffed by a multi-disciplinary team of Nurse Therapists, Medical Staff, Psychologists, and a Dietician.

My senior registrar placement there included my own supervised in the use of **Cognitive Behaviour Therapy** for a wide range of psychiatric disorders.

2. Two years and four months half time Senior Medical Research Fellowship, Department of Psychiatry, Royal Edinburgh Hospital.

Supervisor: Dr. C.P.Freeman. F.R.C.Psych, Part Time Senior Lecturer, Consultant Psychiatrist and Chairman of The Royal College of Psychiatrists Research Committee. Duties included responsibility for running a major intervention study in bulimia nervosa.

3. One year Senior Registrar placement in **General Adult Psychiatry** for the South East Sector of Edinburgh.

Supervisor: Dr. A.K.Zealley, F.R.C.Psych. Physician Superintendent, Royal Edinburgh Hospital.

REGISTRAR AND SENIOR HOUSE OFFICER POSTS

Royal Edinburgh Hospital Psychiatry Training Scheme, August 1986-1989