Consultation Draft of the National Consensus Statement: Essential Elements for Recognising and Responding to Deterioration in a Person’s Mental State

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INTRODUCTION

People can experience deterioration in their mental state in all healthcare settings. An acute deterioration in a person’s mental state is an adverse outcome in itself. It can also be associated with further adverse outcomes, including suicide, aggression, and the traumatic use of restrictive practices.

People experience and express deterioration in mental state in different ways, making recognition of the signs of deterioration a complex task. A person can experience deterioration in mental state due to internal factors, including exacerbation of mental illness, psychological distress, physical conditions including delirium, atypical responses to prescribed treatments, or intoxication with licit or illicit substances. They can also experience deterioration in mental state as a result of factors arising from their social context, or their response to the environment.

Acute deterioration in a person’s mental state is an emergency, and members of the healthcare workforce must be able to initiate an effective response, using locally developed processes. The response may be differently enacted in different settings, but will be guided by the overarching concepts of recognising signs early, and planning and implementing response collaboratively with the person, their family and carers, and all relevant members of multidisciplinary teams.

There is currently marked variation in the effectiveness of responses to deterioration in a person’s mental state, both within specialist mental health services, and in the broader health system. Moreover, there is evidence that many people who experience a deterioration in mental state are further traumatised by interventions delivered by health services, even when these interventions are implemented within existing national and jurisdictional guidelines.

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed a draft National Consensus Statement: Essential Elements for Recognising and Responding to Deterioration in a Person’s Mental State (the Consensus Statement) to address the issue, with a view to bringing a consistent approach nationally. The Consensus Statement was developed in consultation with people with lived experience of mental health issues, clinicians from mental health and other specialities, health service organisation managers, researchers, policy makers and peak body representatives. The Consensus Statement was also informed by review of relevant literature, including existing policies and guidelines.

The draft Consensus Statement is adapted from the model that has been successfully implemented for recognising and responding to acute physiological deterioration, and described in the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration.¹ This model was based on the evidence that many people experienced preventable adverse outcomes after early signs of physiological deterioration were either not recognised, or not promptly responded to. The earlier consensus statement explicitly excluded deterioration in mental state. This reflected the clinical situation, whereby models of recognising and responding to acute physiological deterioration had been established, and there was a body of evidence that they were effective, but similar
evidence about the application of this model in relation to mental health was not available at the time.

The success of the original model is related to the systematic approach to recognising signs of physiological deterioration, documenting these, and escalating care through agreed and available pathways. The standardised processes do not replace or dilute clinical judgement but support it, with the capacity to escalate care solely on the basis of clinical concern built into the system.

The language associated with the use of the ‘recognising and responding’ model to addressing deterioration in a person’s mental state has not typically been used in mental health services. However, there are similarities between the recognition and response model and existing processes used in mental health, including comprehensive assessment of a person’s needs, risk assessment and risk management. The Commission undertook Recognising and Responding to Deterioration in Mental State: A Scoping Review in 2014, which reported provisional support among stakeholders for adaptation of the original model to mental health care.

The Commission is now undertaking national consultation on the draft Consensus Statement, to elicit feedback on the feasibility of implementing the proposed approach to recognising and responding to deterioration in a person’s mental state, and to allow all stakeholders to provide input into the final Consensus Statement.

**Purpose**

The purpose of the Consensus Statement is to describe best practice in providing safe and effective health care to people experiencing deterioration in mental state. The Consensus Statement sets out seven guiding principles that describe the philosophy of care underpinning the recognition and response approach to deterioration in mental state and describes ten essential elements to support delivery of care. These are divided into three interrelated components, ‘processes of care’, ‘therapeutic practice’ and ‘organisational supports’.

This Consensus Statement aligns with the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration, released by the Commission in 2010. The Consensus Statement also aligns with the Delirium Clinical Care Standard, and A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital, reflecting acknowledgement that deterioration in a person’s mental, cognitive and physical state are often closely connected.

The Consensus Statement describes best practice. It aims to guide health services in developing their own recognition and response systems in a way that is tailored to their communities and the resources and personnel available, and in line with relevant jurisdictional or other programs. The Consensus Statement is not intended to replace existing systems designed to care for people experiencing deterioration in mental state, including the expertise practised by members of the healthcare workforce.
The Consensus Statement is also designed to support health service organisations to implement new actions related to comprehensive care contained within draft version 2 of the National Safety and Quality Health Service (NSQHS) Standards, which are currently being developed.

The Consensus Statement is not a legal document and clinicians must continue to be aware of, and abide by, the laws of the jurisdiction in which they practice. Any inconsistency between the Consensus Statement and a law of a state, territory or the Australian Government, will be resolved in favour of the relevant law.

Scope

The Consensus Statement applies to all settings in health service organisations where people can experience deterioration in mental state. This includes specialist mental health settings, medical and surgical wards, maternity and paediatric units and emergency departments. The principles and elements of the Consensus Statement are also applicable in situations where people whose mental state is deteriorating are being cared for in other settings, for example, in remote clinics, specialist outpatient clinics, justice health and community managed organisations.

This is necessarily a broad scope, as acute deterioration in a person’s mental state is frequently preceded by early warning signs, and effective recognition and response improves the potential to prevent an adverse outcome.

The Consensus Statement has been developed for:

- members of the healthcare workforce who are involved in the provision of health care
- health service executives and managers responsible for the development, implementation and review of systems for delivering health care, including mental health care
- providers of clinical education and training, including universities and professional colleges
- health professional registration, regulation and accreditation agencies
- planners, program managers and policy makers responsible for the development of state, territory, or other strategic programs dealing with the delivery of mental health care
- people who may experience deterioration in mental state, and their families and carers.

By describing what best practice looks like, the Consensus Statement enables people who experience deterioration in mental state to understand how they can collaborate with health care workers to safely and effectively manage their situation. Specific resources for people who may experience deterioration in mental state will be developed to accompany the Consensus Statement. These will be designed to align with existing advance care directives and wellness and recovery plans.

The Commission will collaborate with stakeholders to develop resources to support health service organisations to implement the elements in the Consensus Statement.
in different healthcare settings. As certain terms are understood differently in different healthcare settings, Appendix A contains definitions for key terms and describes how they are used in this document.

Values

Experiencing deterioration in mental state can be distressing for a person, whether it is the first experience, or a recurrence. It is also distressing for their family members and carers. How members of the healthcare workforce respond to the person can be a critical factor, not just in the short-term resolution of the episode, but also in terms of the person’s future willingness to engage with health services.

All members of the healthcare workforce enact values in their everyday practice. Delivering health care that is holistic and person-centred is consistent with the principle of partnering with consumers, an approach that is now familiar, both at an organisational and individual level.6

In mental health services, frameworks have been developed, in collaboration with people who have experienced mental health issues, describing the overarching values that should be used in recognising and responding to deterioration in a person’s mental state. These interconnected values contribute to an approach to mental health care that is:

- recovery-oriented
- culturally competent
- trauma informed.

These concepts are embedded in the guiding principles and actions in the Consensus Statement, and inform implementation of the essential elements.

Recovery-oriented mental health care

In contemporary mental health practice, the word ‘recovery’ has meaning beyond the reduction of clinical symptoms. Australian Health Ministers endorsed A national framework for recovery-oriented mental health services7,8 in 2014. The framework separates clinical recovery from personal recovery, which is defined as, ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.’8

Delivery of recovery oriented mental health services forms part of the National Standards for Mental Health Services.9

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.8

Members of the healthcare workforce can maintain a recovery oriented approach when they are recognising and responding to deterioration in a person’s mental state in any health setting, through consistently creating opportunities for the person to resume effective control of the situation.
Culturally competent health care

Cultural competence describes both the direct delivery of care, and an underpinning systemic approach: ‘cultural competence focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.’

Culturally competent health care is defined as:

A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.

When a person experiences deterioration in mental state, the cultural values and beliefs about health and illness they hold can impact on their experience. Similarly, beliefs about the individual and their place in their family and community differ, and these can influence how people and their families and support networks experience health care. Many stakeholders have identified problems when they access ‘one-size-fits-all’ health care. These include people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islanders, and people from lesbian, gay, bisexual, transgender and intersex communities. There are existing frameworks and other guides that support health services to deliver culturally competent care.

Trauma-informed care

Trauma-informed care and practice acknowledges that many people who access mental health services have experienced trauma in their lives. Trauma can arise from physical, psychological and sexual abuse, as well as from protracted neglect.

Trauma-informed care is:

an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. It is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Recurrent thoughts about past trauma can trigger deterioration in a person’s mental state. The experience of deterioration in mental state itself can be traumatic, and recall past traumatic experiences. Further, responses by others, including members of the healthcare workforce, can contribute to re-traumatising people. It is therefore critical that members of the healthcare workforce are aware of trauma informed approaches to recognising and responding to deterioration in a person’s mental state. Integrated into practice, these values will contribute to the goals of creating safety, and supporting the person to resume control of their mental state.
GUIDING PRINCIPLES

1. Members of the healthcare workforce are alert to the risk of deterioration in mental state for all people accessing health care, in all healthcare settings, at all times.

2. Members of the healthcare workforce are able to recognise deterioration in a person's mental state, initiate response, and escalate care to clinicians with mental health expertise, either within the organisation, or through established partnerships with other organisations.

3. Responding to deterioration in a person’s mental state includes comprehensive assessment of potential causes, including: mental illness; psychological or existential stress; physiological changes; cognitive impairment, including delirium; intoxication or withdrawal from substances; and responses to social context and environment.

4. Response to deterioration in a person’s mental state is person-centred, culturally competent and recovery-oriented.

5. Decision making is shared between the multidisciplinary team and the person. Family and carers are involved in accordance with the person’s expressed wishes.

6. Response to deterioration in a person’s mental state is consistent with legislation.

7. The response to deterioration in a person’s mental state does not cause trauma to the person, their family and carers, or members of the healthcare workforce.
ESSENTIAL ELEMENTS

The Consensus Statement outlines ten essential elements that provide guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to deterioration in a person’s mental state.

Section A: Processes of care describes the actions that members of the healthcare workforce take, in partnership with the person, to safely and effectively recognise and respond to deterioration in mental state:

1. Recognising deterioration in a person’s mental state
2. Escalating care
3. Responding to deterioration in a person’s mental state.

Section B: Therapeutic practice describes the collaborative approach that members of the healthcare workforce adopt:

4. Creating safety and minimising restrictive practices
5. Teamwork and shared decision-making
6. Communicating for safety.

Section C: Organisational supports describes the structural and organisational factors that support the healthcare workforce to effectively recognise and respond to deterioration in a person’s mental state:

7. Leadership and governance
8. Workforce development
9. Standardised processes to support high quality care
10. Evaluation and feedback.

The three components are inter-related: for instance, how a member of the healthcare workforce escalates care is described in ‘processes of care’, the values enacted while escalating care are described in ‘therapeutic practice’, and the system-level components of the health service organisation’s escalation protocol are described in ‘organisational supports’.
A. PROCESSES OF CARE

Being alert

As part of best practice, all people accessing health care should be screened for physical, mental and cognitive health. Risk identification and categorisation can support effective care for people with known risk of deterioration in mental state. However, a level of alertness must be maintained for all people accessing care, as people with no identified history of risk may still experience deterioration in mental state.

Recognising deterioration

The key factor in recognising deterioration in a person’s mental state is noticing changes in a person’s behaviour, cognitive function, perception, or emotional state. While there are a number of typical signs that can indicate deterioration, these can vary significantly and individual changes that are reported or observed are critical in recognising deterioration in a person’s mental state.

If a person has previously experienced deterioration in mental state, they typically have good understanding of specific factors that can precipitate deterioration for them, as well as factors that contribute to maintaining wellbeing. They will also be likely to have knowledge about what responses are effective should they experience a deterioration in their mental state. This knowledge may be formalised in an advance care plan. Engagement with family and carers, where culturally and developmentally appropriate, will further support early recognition, as the people who know the person best are the most likely to recognise critical changes.

The use of assessment tools can support clinicians in assessing a person’s mental state, through prompts to check for specific signs. However tools do not replace the need for clinicians to use their clinical judgement to make a holistic assessment of the person’s mental state, including contextual factors that may influence their mental state, and the person’s own knowledge of their experience.

Escalating care

An escalation protocol sets out the organisational response required to deal with different levels of deterioration in a person’s mental state (see Essential Element 9: Standardised processes to support high quality care). Members of the healthcare workforce without mental health expertise should be aware of the referral criteria, processes and timelines for accessing specialist mental health services. Mental health clinicians should have a clear process to enable access to assistance from colleagues, including senior clinicians.

Responding to deterioration

All members of the clinical workforce should be able to initiate a response when they recognise the signs of deterioration in mental state in a person for whom they are providing health care. An empathic and calm response to a person’s distress can immediately de-escalate a situation.
In responding to deterioration in a person’s mental state, clinicians should consider if symptoms indicate the person is experiencing delirium, and manage the condition when it occurs.\(^4\)

The essential elements described in processes of care will support services to implement new actions in draft version 2 of the NSQHS Standards related to *Standard 5: Comprehensive care* and *Standard 8: Recognising and responding to acute deterioration*. 
1. Recognising deterioration in a person’s mental state

**Actions:**

1.1 Members of the workforce in all healthcare settings are alert to the potential for deterioration in a person’s mental state.

1.2 Members of the healthcare workforce use relevant screening processes:
   - at presentation, during clinical examination and history taking, and when required during care
   - to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
   - to identify social and other circumstances that may compound these risks.

1.3 Members of the healthcare workforce comprehensively assess the conditions and risks identified through the screening process.

1.4 Members of the healthcare workforce use process for shared decision making to develop and document a comprehensive and individualised plan that:
   - addresses the significance and complexity of the person’s health issues and risks of harm
   - includes the person’s known early warning signs of deterioration in mental state
   - identifies agreed goals and actions for the person’s treatment and care
   - identifies any support people a person wants involved in communications and decision making about their care.

1.5 Members of the healthcare workforce in all healthcare settings assess possible causes for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported.

1.6 Members of the healthcare workforce anticipate factors that may contribute to deterioration in a person’s mental state, and where possible, modify these factors in order to prevent deterioration.

1.7 Members of the healthcare workforce communicate their observations of changes in a person’s mental state to relevant senior clinical colleagues at the time they occur.

1.8 The person experiencing deterioration in mental state is consulted about what is happening for them.

1.9 The person’s family, carer, or other designated support person are consulted about specific signs of deterioration in the person’s mental state.

1.10 Members of the healthcare workforce can use standardised tools to recognise and communicate typical signs of deterioration in a person’s mental state.

Typical signs include, but are not limited to:

- **Appearance:**
  - reduced self-care
  - restlessness
  - slumped posture.
• Behaviour:
  o agitation
  o confusion
  o self-harm
  o hostility and aggression
  o changes in rapport
  o isolation and withdrawal
  o increased requests for help, including for extra medication.

• Communication:
  o reported distress
  o reported unusual thinking
  o reported suicidal ideation
  o delusions
  o hallucinations
  o concerns reported by family and carer.

1.11 Members of the clinical workforce document their observations of changes in a person’s mental state in the person’s clinical record.
2. Escalating care

**Actions:**

2.1 If early signs of deterioration in a person’s mental state are noted or reported, clinicians screen the person’s mental, physical and cognitive status, to determine the immediate actions to prevent further deterioration.

2.2 The health service organisation has an escalation protocol, which sets out graded responses to deterioration in a person’s mental state.

2.3 Members of the healthcare workforce are aware of, and use, the escalation protocol.

2.4 The person experiencing deterioration in mental state, their family and carers are aware of how to request an urgent clinical review if they recognise signs of deterioration.
3. Responding to deterioration in a person’s mental state

**Actions**

3.1 A person experiencing deterioration in mental state is comprehensively assessed for contributing factors, including mental illness, cognitive impairment, physiological deterioration, intoxication or withdrawal from licit or illicit substances.

3.2 Delirium is considered as a potential cause of a person’s deterioration in mental state, and differential investigations are conducted.

3.3 Deterioration in a person’s mental state is responded to within agreed timeframes.

3.4 Clinicians develop a collaborative plan to respond to the person’s deterioration in mental state.

3.5 The person whose mental state is deteriorating and, with permission, their family and carers, are involved in the response as much as possible.

3.6 Where available, peer workers can be involved in the response.

3.7 Responses to deterioration in mental state include, but are not restricted to:
   - listening to the person’s current stated needs
   - addressing practical needs (e.g. wellbeing of family members)
   - verbal de-escalation techniques
   - relocation to a calm environment
   - sensory modulation techniques
   - increasing the frequency and/or level of nursing observations
   - support and encouragement for the person to manage their own mental state
   - further assessment by specialist mental health clinician
   - use of additional medication to treat symptoms (*pro re nata* or PRN).

3.8 Where practical, response to deterioration in mental state is led by a team member known to the person.

3.9 Where practical, response to deterioration in a person’s mental state is undertaken in low stimulus, private environments.

3.10 The effectiveness of the response to deterioration in a person’s mental state must be continuously assessed, and adapted to current need.

3.11 The person and their family or carer are engaged in the evaluating the effectiveness of the response.

3.12 Members of the healthcare workforce document detailed and structured information about the outcomes response in the healthcare record.

3.13 Strategies evaluated as effective are integrated into the person’s individualised management plan, and can be incorporated into future advanced care plans.
B. THERAPEUTIC PRACTICE

Creating safety and minimising restrictive practices

Deterioration in mental state can be a distressing experience for a person and their family and carers. It can also result in people acting in ways that risk harm to themselves or others. Early recognition and response significantly mitigates these risks, and ideally detects deterioration at a time when the person can still participate in shared decision making.

There is strong impetus to minimise and, where possible, eliminate the use of restrictive practices, which have traditionally been strategies used in responding to deterioration in a person’s mental state. Reducing the use of restrictive practices was identified as a key national safety priority in 2005, and significant effort has gone into implementing this strategy within the National Mental Health Seclusion and Restraint Project (2007-2009), resulting in reductions in the documented rates of seclusion across Australia over the past few years. Enacting values of recovery-oriented, culturally competent and trauma-informed care can contribute to minimising the use of restrictive practices.

Teamwork and shared decision making

Shared decision making is a critical part of making sure that people with deteriorating mental state are partners in their own care. Shared decision making is more than just providing information to people and their families or asking them questions to inform a clinically driven decision. It is a process that allows people, families and multidisciplinary teams to work together to make decisions in the person’s best interests based on the best scientific evidence available, the realities of the person’s clinical condition and treatment options, and the person’s choices, values and preferences.

Some people may have fluctuating or reduced capacity to participate in decision making, due to deterioration in their mental state, or for other developmental, cultural or physical reasons. Members of the multidisciplinary team should undertake assessment of decision-making capacity and maximise opportunities for participation by people with reduced capacity for decision making. Advance care plans should be incorporated into decisions about care when they are available.

Communicating for safety

Communication is an integral part of teamwork and shared decision making, but stands as a discrete essential element because poor communication has been identified as a contributing factor to incidents where there has been an ineffective response to deterioration in a person’s mental state. The person’s goals of care, and the treatment plan, need to be clear to all members of the multidisciplinary team so that care can be effectively coordinated. This includes ensuring effective communication and liaison with care providers in the community, such as general practitioners, nurse practitioners, community nursing services, Aboriginal health services, home care workers, and managers of community and residential services.
Processes for structured clinical handover assist with effective communication about a person’s health care. These processes align with NSQHS Standard 6: Clinical Handover (Standard 6: Communicating for safety in draft version 2 of the NSQHS Standards).
4. Creating safety and minimising restrictive practices

Actions

4.1 Members of the healthcare workforce practise with empathy and use skills in developing rapport with people experiencing deterioration in mental state.

4.2 Members of the healthcare workforce recognise that many people who experience deterioration in mental state have previously experienced trauma, and deliver care in ways that acknowledge this history, and minimise the risk of re-traumatising people.

4.3 Members of the healthcare workforce practise with cultural competence, acknowledging that cultural beliefs may influence the way in which people express their experience of changes in mental state.

4.4 Members of the healthcare workforce working with people from Aboriginal and Torres Strait Islander communities recognise that broader issues related to social and emotional wellbeing impact on individuals’ mental states.

4.5 Members of the healthcare workforce anticipate potential sources of conflict, and seek to mitigate these.

4.6 Members of the healthcare workforce recognise the influence of their own behaviour on others, and ensure their behaviour does not contribute to escalating conflict.

4.7 Members of the healthcare workforce use restrictive practices as a last resort, after other methods to manage deterioration in mental state have been trialled and assessed as ineffective. Trialled strategies are documented in the person’s clinical record.

4.8 Only members of the healthcare workforce who have been trained in safely implementing restrictive practices participate in the intervention.

4.9 Members of the healthcare workforce implement restrictive practices consistent with legislation.

4.10 Restrictive practices are used for the shortest duration consistent with maintaining safety.

4.11 People who have experienced restrictive practices, their families and carers, and members of the workforce are offered debriefing subsequent to the event, with a peer worker involved where available.

4.12 When restrictive practices have been implemented, the person’s care plan is reviewed, in order to identify precursors to the incident, and prevent recurrence.

4.13 Members of the healthcare workforce report incidents of restrictive practices to the highest level of governance in the health service organisation.
5. Teamwork and shared decision making

**Actions**

5.1 Members of the healthcare workforce seek to understand and respond to the individual healthcare preferences and needs of all people, families and carers.

5.2 Members of the healthcare workforce involve the person experiencing deterioration in mental state and, with permission, their families and carers, in shared decision making regarding treatment options.

5.3 The clinician with overall responsibility for leading and coordinating a person’s clinical care is clearly identified to the person, their family and carers, and other members of the multidisciplinary team.

5.4 Members of the healthcare workforce recognise the scope of their expertise, and engage other multidisciplinary team members if a person is experiencing deterioration in mental, physical or cognitive state, which is outside their professional scope.

5.5 The roles and responsibilities of different multidisciplinary team members are clearly defined and understood by all those involved in a person’s care, including by the person themselves and by their family and carers.

5.6 Peer workers and Aboriginal mental health workers are engaged in responses to deterioration in a person’s mental state when appropriate.

5.7 Team members with expertise in mental health provide leadership to develop the skills and capacity of other staff in relation to deterioration in mental state.
6. Communicating for safety

Actions

6.1 Members of the healthcare workforce clearly communicate their assessment of deterioration in a person’s mental state, what they consider to be appropriate and feasible options for response, and any risks or potential side effects related to proposed interventions to the person, their family and carers.

6.2 Members of the healthcare workforce tailor their communications with the person experiencing deterioration in mental state, and their families and carers, to their level of understanding, and current preparedness to process information, and check with the person and their families and carers if they have effectively understood previous communications.

6.3 Members of the healthcare workforce use interpreters when providing care for people who experience deterioration in their mental state, who are not confident in speaking English.

6.4 Clinical communication is conducted consistent with privacy legislation.

6.5 Members of the healthcare workforce check with people accessing care regarding consent prior to sharing information with carers and other family members, and work with them to review their choices regarding privacy as their mental state changes.

6.6 Members of the healthcare workforce use clinical communication processes to effectively communicate critical information, alerts and risks when they emerge or change.

6.7 Members of the healthcare workforce use processes for structured clinical handover to effectively communicate about the health care of patients, particularly when care is being transferred:

- between clinicians within the team
- between multidisciplinary teams
- between organisations
- at discharge.
C. ORGANISATIONAL SUPPORTS

Leadership and governance
Successful and sustainable systems for delivering safe, high-quality care when recognising and responding to deterioration in a person’s mental state require a robust safety culture within health service organisations. Executive and clinical leaders at all levels of the organisation’s clinical and corporate governance structures can provide proactive and practical support to the multidisciplinary teams and managers responsible for delivering recognition and response systems. These actions align with NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations (Standard 1: Clinical governance for health service organisations in draft version 2 of the NSQHS Standards) and Standard 2: Partnering with Consumers (Standard 2: Partnering with consumers in draft version 2 of the NSQHS Standards).

Workforce development
A suitably skilled and qualified healthcare workforce is integral to a health service organisation providing an appropriate response to deterioration in a person’s mental state. Health service organisations use recruitment processes to ensure that the healthcare workforce has the appropriate skill mix to deliver safe, effective and culturally competent care. Where appropriate, this may include recruitment of peer workers and Aboriginal mental health workers.

Members of the healthcare workforce benefit from ongoing professional development, accessed within the health service organisation, or through external training programs, in order to augment their skills.

Dealing with deterioration in mental state can be challenging for members of the multidisciplinary team, and for other staff members such as ward clerks, porters and cleaners. It can add considerably to workplace stress. Chronic, unmanaged stress can erode empathy and potentially contribute to poorer experiences for people accessing health care. Members of the healthcare workforce should have access to peer support, mentoring and appropriate clinical supervision.

Standardised processes to support high quality care
Many health services have escalation protocols to respond to specific aspects of deterioration in a person’s mental state, including:

- a process for review by specialist mental health staff
- support for people who have thoughts of self-harm, or who have harmed themselves
- support for people who have suicidal thoughts
- management of delirium
- drug and alcohol intoxication or withdrawal
- management of aggression or violence
- discharge against medical advice, including an assessment of competency.
Technological systems such as MyHealthRecord may also provide benefits to people, for example, by contributing to improved communication with external care providers and improved continuity and coordination of care as people are transferred in and out of acute health services.

**Evaluation and feedback**

Ongoing monitoring and evaluation of processes and systems for recognising and responding to deterioration in mental state is essential to establish their efficacy, track performance over time and determine priorities for improvement.

Evaluation should address the quality and safety of responses to deterioration in mental state, not just the potential preventability of adverse outcomes.
7. Leadership and governance

Actions

7.1 The health executive lead and sustain the development of a safety culture that incorporates recognition and response to deterioration in a person’s mental state in all parts of the health service.

7.2 The organisation has a formal governance process in place to oversee the development, implementation and ongoing review of systems for recognising and responding to deterioration in a person’s mental state.

7.3 People who use health services, and their families and carers, are partners in the development and governance of organisational systems for recognising and responding to deterioration in a person’s mental state.

7.4 The organisational approach to recognising and responding to deterioration in a person’s mental state is documented in a formal policy framework which operates together with recognition and response systems for people who experience deterioration in physical health and/or cognitive function.

7.5 The health service executive consider how best to allocate resources within the context of the organisation’s strategic plan to support the delivery and effective functioning of the systems for recognising and responding to deterioration in a person’s mental state.

7.6 Appropriate policies and documentation regarding advance care planning in relation to mental health decision-making are in place, to ensure that the care delivered in response to deterioration in a person’s mental state is consistent with appropriate clinical practice and the person’s expressed wishes.

7.7 The health service organisation has processes to identify the capacity of a person to make decisions about their own care, and a substitute decision maker if the person does not have this capacity.
8. Workforce development

Actions

8.1 The health service organisation uses recruitment processes to maintain a healthcare workforce with the capacity to recognise and respond to deterioration in a person’s mental state.

8.2 Peer workers and Aboriginal mental health workers are integrated into the mental health workforce.

8.3 All members of the multidisciplinary team receive education about their roles and responsibilities in relation to the local systems and processes in place for recognising and responding to deterioration in a person’s mental state.

8.4 People who have experienced deterioration in mental state, their families and carers are invited to participate in providing education about mental health care.

8.5 Education covers medico-legal issues, including the relevant legislation in the state or territory of clinical practice.

8.6 The principles of delivering health care that is culturally competent, recovery-oriented, and trauma-informed are included in education.

8.7 Education includes specific training for providing mental health care to people with limited capacity to participate in shared decision-making.

8.8 All members of the multidisciplinary team receive education about how to recognise feelings of moral distress and burnout in themselves and their colleagues. They are supported to develop skills in self-care, reflective learning and providing peer support to colleagues and are informed about how to seek help if required.

8.9 A policy framework outlines how reflective supervision and support is provided to members of the healthcare workforce.
9. Standardised processes to support high quality care

Actions

9.1 The health service organisation has a clear process for escalating care when deterioration in a person’s mental state is recognised, which includes:
   - designation of roles and responsibilities for members of the healthcare workforce
   - timeframes for response.

9.2 The escalation protocol is tailored to the specific health setting, taking into account:
   - the size, location and role of the setting
   - the available resources, including healthcare workforce skill mix
   - the capacity to engage specialist help.

9.3 The health service organisation develops and maintains partnerships with other organisations where they are required to provide safe and effective response to deterioration in a person’s mental or physical state.

9.4 The health service organisation implements processes to improve communication between multidisciplinary teams within the organisation, and external health service partners at transitions of care.

9.5 Systems are in place to provide access to essential psychiatric medications at all times.

9.6 The health service organisation provides members of the healthcare workforce with access to legal advice relating to delivery of treatment under mental health and other relevant legislation.

9.7 Systems are in place to facilitate appropriate documentation about mental health, and to reduce the burden of documentation and data collection when possible.

9.8 The health service organisation maximises safety and quality of care through the design and maintenance of the environment.

9.9 The health service organisation provides access to a calm and quiet environment when it is clinically required.
10. Evaluation and feedback

Actions

10.1 Data about the effectiveness of processes for recognising and responding to deterioration in mental state are collected, reviewed, and reported locally and over time.

10.2 Monitoring and evaluation strategies capture feedback about the quality of responses from multiple stakeholders, including people who have experienced deterioration in mental state, their families and carers, and members of the healthcare workforce from multiple disciplines.

10.3 Evaluation and monitoring are simple, inexpensive, feasible, and use routinely collected data, and data linkage, where possible.

10.4 Methods for collecting data include:
- tracking rates of use of restrictive practices (restraint and seclusion)
- tracking rates of use of mental health legislation to treat people
- retrospective audit of case notes (for example, documentation of discussions, person preferences, anticipatory plan of care, the plan of care, appropriateness and frequency of physiological and nursing observations)
- medication chart safety review (for example were appropriate psychiatric medications prescribed and administered appropriately)
- follow up with families, carers, clinicians and other staff involved in a person’s mental health care
- the use of tools developed for specific settings (for example consumer and carer surveys)
- multidisciplinary mortality and morbidity review.

10.7 The local use of restrictive practices is continuously reviewed, with trends noted, and contributing factors to improvement or deterioration recognised and addressed.

10.8 All critical incidents are routinely reviewed to determine whether the quality and safety of the response to deterioration in a person’s mental state was appropriate, and in what ways it could have been improved. People who have experienced deterioration in mental state are represented in review processes.
REFERENCES


APPENDIX A: Terms used in this document

There is a lack of clarity and agreement about the meaning of many terms that are commonly used in relation to recognising and responding to deterioration in mental state. It is important for all those involved in the provision of mental health care to have a common understanding about what such terms mean in practice. Some common terms, and a description of what they mean in the context of this document, are listed in this appendix.

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Acute healthcare facility(^{21})</td>
<td>A hospital or other healthcare facility providing healthcare services to people for short periods of acute illness, injury or recovery.</td>
</tr>
<tr>
<td>Advance care plan</td>
<td>A plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person’s behalf and should be prepared from the person’s perspective to guide decisions about care.(^{22})</td>
</tr>
<tr>
<td>Assessment/comprehensive assessment</td>
<td>A clinician’s evaluation of the disease or condition based on the person’s subjective report of the symptoms and course of the illness or condition, and the clinician’s objective findings, including data obtained through laboratory tests, physical examination, medical history, and information reported by carers, family members and other members of the healthcare team.(^{4})</td>
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</tbody>
</table>
| Carer                               | A person who provides personal care, support and assistance to another individual who needs it because that other individual has a disability, medical condition (including a terminal or chronic illness), a mental illness, or is frail and aged.  

An individual is not a carer merely because he or she is the spouse, de facto partner, parent, child or other relative of an individual, or is the guardian of an individual, or lives with an individual who requires care.\(^{23}\) |
<p>| Clinician                           | A healthcare provider, trained as a health practitioner, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements not specified here. They may include nurses, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision. |</p>
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<tr>
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<tr>
<td>Cultural competence</td>
<td>A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross et al 1989 cited in Eisenbruch 2004a). Cultural competence focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.</td>
</tr>
<tr>
<td>De-escalation</td>
<td>De-escalation techniques consist of a variety of psychosocial techniques aimed at reducing violent and/or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, through the use of verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient’s trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.</td>
</tr>
<tr>
<td>Deterioration in mental state</td>
<td>Change in a person’s perception, cognitive function or mood which negatively influences their capacity to function as they would typically choose.</td>
</tr>
<tr>
<td>Escalation of care</td>
<td>The process whereby a member of the healthcare workforce, recognising that the person’s current health status is beyond their scope to manage, engages additional support, either within the health service organisation, or through partnership with other services.</td>
</tr>
<tr>
<td>Goals of care</td>
<td>The aims for a person’s medical treatment as agreed between the person, family, carers and healthcare team. Goals of care will change over time.</td>
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<tr>
<td>Multidisciplinary team</td>
<td>A team including professionals from a range of disciplines who work together to deliver comprehensive care that addresses as many of the patient’s health and other needs as possible. The professionals in the team may function under one organisational umbrella or may be from a range of organisations brought together as a unique team. As a patient’s condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.</td>
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<tr>
<td>Term</td>
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| Observations/nursing observations         | In physical health care, ‘observations’ typically refer to a set of non-invasive investigative procedures, such as counting respiratory rate, and measuring blood pressure, that are routinely implemented, and used to track physical health status.  
   In mental health care, ‘nursing, or formal observations’ typically refers to the practice of increased frequency or intensity of observation of a person who has been identified as at risk. This can be for the purpose of surveillance or therapy. |
<p>| Peer workforce                            | People who are employed in roles that require them to identify as being, or having been, a mental health consumer or carer. Peer support, which is one element of peer work, is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. |
| Person                                   | The primary recipient of care.                                                                                                                        |
| Person-centred care                      | Treating each person as an individual; protecting a person’s dignity; respecting a person’s rights and preferences; and developing a therapeutic relationship between the care provider and care recipient which is built on mutual trust and understanding. |
| Recovery                                 | Recovery is understood to be more than reduction in clinical symptoms, and as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’. |
| Recovery-oriented practice               | Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. |
| Screening                                | A process of identifying consumers who are at risk, or already have a disease or injury. Screening requires sufficient knowledge to make a clinical judgment.                                                |
| Signs of deterioration                   | These are the signs that indicate deterioration in a person’s mental state. They may be generally recognisable, or they may be specific to an individual. A person, and their family and carers, may have clear knowledge about their individual signs of deterioration, or ‘relapse signature’, and this knowledge can be incorporated into a plan to maintain wellness, and inform an advance statement. |</p>
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<tr>
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<tr>
<td>Supervision (clinical)</td>
<td>Clinical Supervision is the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the clinician in their professional environment.</td>
</tr>
<tr>
<td>Team</td>
<td>See multidisciplinary team.</td>
</tr>
<tr>
<td>Trauma-informed care</td>
<td>An approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. It is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.</td>
</tr>
<tr>
<td>Triggers</td>
<td>In recognition and response system literature, the term ‘trigger’ is used to describe a sign of deterioration that ‘triggers’ the clinician to respond. However, in mental health literature, the term ‘trigger’ frequently refers to an event that potentially leads to deterioration in mental state. To avoid confusion, the term ‘sign of deterioration’ is used throughout this statement, rather than trigger.</td>
</tr>
<tr>
<td>Workforce</td>
<td>All people working in a health service organisation, including clinicians (see above) and any other employed or contracted, locum, agency, student, volunteer or peer workers.</td>
</tr>
</tbody>
</table>

Consultation Draft National Consensus Statement: Essential Elements for Recognising and Responding to Deterioration in a Person’s Mental State
APPENDIX B: Consultation participants

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