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Our Ref: RD-2016116591

William Doolan
Coroners Registrar
Coroners Court of Victoria

Sent via email: cpuresponses@coronerscourt.vic.gov.au

Dear Mr Doolan

RE: Inquest into the death of Harley Robert Larking (COR 2016 2137)

Thank you for your letter of 18 September 2020 concerning Coroner English's recommendation to the Chief Psychiatrist in relation to the death of Harley Larking. Apologies for the delay in responding to this recommendation.

The Coroner has recommended that:

The Office of the Chief Psychiatrist review other public mental health service inpatient units that may not have an Aboriginal mental health liaison officer, with a view to encouraging the embedding of the principles and practice of cultural competence in the provision of mental health services to Aboriginal and Torres Strait Islander patients.

The Department of Health has recently developed an Aboriginal and Torres Strait Islander cultural safety framework. This framework was published in June 2019. The framework requires every person and every mainstream organisation to work to create culturally safe services and workplaces. It outlines three phases;
Phase 1; reflection and planning
Phase 2; key standard development to help individuals and organisations track their growth (focus on improvement and development)
Phase 3; individuals and organisations required to meet and be measured against cultural safety standards – aimed at accountability and compliance.
Mental Health Services, including inpatient units, will be required to meet these standards.

We note that the issues raised in this recommendation, namely Aboriginal mental health, have also been considered by the Royal Commission into Victoria's Mental Health System (the Commission) and acknowledged as an important area to address. The Commission's recommendations are comprehensive and far reaching.

In the Commission's interim report, it was identified that there was an urgent need to address mental illness in Aboriginal communities and the central role of self-determined Aboriginal social and emotional wellbeing services in promoting Aboriginal social and emotional wellbeing.

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The report recommended expanding the delivery of multi-disciplinary social and emotional wellbeing teams across Aboriginal community-controlled health organisations. It also recommended the establishment of a new Aboriginal Social and Emotional Wellbeing Centre to support the transformation of Aboriginal mental health care across the state.

In February 2021, the Commission handed down its final report and recommendations which built on the interim report recommendations in addressing Aboriginal mental health.

The Commission recommended a suite of reforms to provide children and families with early, culturally safe and flexible support through Aboriginal-led organisations in partnership with mental health services. Aboriginal children and young people would be able to have access to specialist mental health services, family-oriented therapeutic care and intensive multidisciplinary care delivered within community settings. These reforms would focus on care being delivered through Aboriginal organisations.

With many Aboriginal people accessing mental health services for their care, it is incumbent on mental health services to provide culturally safe, responsive and inclusive treatment, care and support. It was the Commission's vision for a mental health and wellbeing system where Aboriginal self-determination is respected in the design and delivery of care.

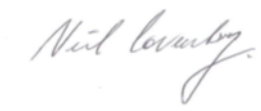
In the proposed new system, Aboriginal people should be able to choose to receive care within Aboriginal community-controlled organisations, within mainstream services, or a mix of both, in order to ensure safe, inclusive, respectful and responsive treatment.

In line with the Commission's recommendations, the office of the Chief Psychiatrist will continue to provide quality and safety advice to designated mental health services regarding service provision for all mental health consumers. It will be a key support for services liaising with other areas of the Department which will take lead roles in the implementation of recommendations and new ways of working. This will include working with the Mental Health Improvement Unit situated in Safer Care Victoria to support improvements in processes and implementation of recommendations as well as with the workforce development projects which have identified aboriginal cultural safety as an early workforce priority.

The Coroner's recommendations arising out of this tragic case were discussed at an Authorised Psychiatrist's meeting. We will also be including the clinical scenario and recommendations in a future Quality and Safety Bulletin.

If you have any further queries, please contact my office on email ocp@health.vic.gov.au.

Yours sincerely



Dr Neil Coventry
Chief Psychiatrist
12 / 08 / 2021

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