non-violent offenders from prisons, given the increasing risk of transmission in custodial facilities. There has been, however, a relative silence when it comes to the plight of those held in mental health units for the purpose of involuntary treatment, most of whom are obviously not subject to any criminal charge.

During the herald wave of COVID-19 in March 2020, emergency amendments to the NSW Mental Health Act (2007) were made, known as Section 202. These changes allowed the Mental Health Review Tribunal to adjourn inquiries for people detained in locked units for 28 days, leaving some patients to wait close to a month before they can put a case to be discharged.

The initial life of Section 202 came to an end in March 2021. Thereafter, a Practice Direction Amendment issued in July of that year enabled the timeframe to be extended.

Whatever the rationale behind such provisions, the effect has been to extend the period of involuntary treatment without independent review at a time where the health and safety of those in psychiatric settings has never been more imperilled. When the Delta variant spread throughout Sydney in mid-2021, mental health consumers in wards at Nepean, Cumberland and elsewhere were at the mercy of outbreaks in locked units from which there was little chance of escape.

In the months since, most pandemic control measures have been lifted for the general community, despite recent spread of the Omicron variant at a rate that was amongst the fastest in the world. Yet those who find themselves in psychiatric detention remain confined to a high-risk environment in which infection control of an airborne pathogen is especially challenging, and where any secondary attack rate is likely to be high.

Outbreaks of COVID-19 in some mental health units overseas have resulted in serious morbidity and mortality. The retirement of these provisions would lower the risk of a similar scenario occurring in Australia, while restoring timely access to the right of review for those detained.

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References
1. Mental Health Act 2007 (NSW) – Sect 202 (n.d.). Available from: http://classic.austlii.edu.au/au/legis/nsw/consol_act/mha2007128/s202.html
2. Mental Health Amendment (COVID-19 Special Provisions) Regulation2020. (NSW) Schedule 1 Amendment of Mental Health Regulation 2019. Available from: https://legislation.nsw.gov.au/view/pdf/asmade/sl-2020-573
3. Mental Health Review Tribunal. Practice Direction Amendment 2021 July. Available from: https://www.mhrt.nsw.gov.au/files/mhrt/pdf/COVID-19%20Practice DirectionAmendmentJuly2021.pdf

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COVID-19 vaccination clinics within community mental health services: Strategies to boost uptake

Dear Sir,

It has been recognised that individuals with serious and enduring mental illness are at increased risk of contracting COVID-19 and have higher rates of adverse outcomes, including both morbidity and mortality. As Looi et al. noted, patient education can play an important role in health promotion. Innovative interventions to assist patients to protect themselves against COVID-19 are discussed.

In response to low vaccination rates within our patient cohort, we established a series of vaccination clinics co-located within our community mental health sites. These were established in conjunction with local non-government organisations already providing COVID-19 vaccinations at other sites. At that time our community mental health service had 636 registered clients, from a catchment area encompassing south-western metropolitan Melbourne. Through a series of clinics, we were able to provide COVID-19 vaccination for a total of 84 patients at two sites. Data about whether vaccination status of the other patients, or whether these were first, second or booster vaccinations were not available for this paper.

Our process attempted to be as streamlined as possible. Each patient’s assigned clinician clarified their vaccination status with them. Unvaccinated patients interested were offered an appointment at one of our sites. Information from a trusted clinician can increase vaccination uptake. The vaccination staff attended the clinic on prescheduled days and administered COVID-19 vaccinations to patients who had not been vaccinated elsewhere and could consent to the vaccination process. This process was able to capitalise on a familiar environment and also minimised any additional effort on the patient’s part, as it was often timed to coincide with other reasons for attending the clinic.

While ostensibly small numbers were vaccinated, our vaccination program commenced after the community vaccination program had already been running for 3 months. Those patients more able to be proactive about vaccination were more likely to have already received it. Nonetheless, our program amply demonstrated the ability of proactive strategies to significantly improve the health of patients with serious mental illness. While also being an effective public health measure by helping to break chains of potential transmission.

It is recognised that patients with serious mental illness may struggle to comply with public health directions, such as isolation or mask-wearing, and that they are at risk of
increased illness severity if they are infected with COVID-19. As such, strategies to increase vaccination in this clinical population represent a significant public good. We urge other mental health services to examine the feasibility of creating similar clinics.

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References
1. Wang Q, Xu R and Volkow ND. Increased risk of COVID-19 infection and mortality in people with mental disorders: analysis from electronic health records in the United States. World Psychiatry 2021; 20: 124–130. Published online October 7, 2020.
2. Looi J, Allison S and Bastiampillai T. What should psychiatrists advise their patients regarding COVID-19 protective measures and vaccination? Australas Psychiatry 2022; 1039856221106016.
3. Lorenz RA, Norris MM, Norton LC and Westrick SC. Factors associated with influenza vaccination decisions among patients with mental illness. Int J Psychiatry Med 2013; 46(1):1–13.

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Hitting balls in the dark or taking air swings in the light? Response to Suetani and Parker

Dear Sir,

In their recent editorial, Suetani and Parker wrote, ‘to advance the art of psychiatry and achieve clinical excellence, we must embrace and learn from our failures as well as our success’. They began by highlighting two contemporary facts about mental illness: recovery rates are not improving and life expectancy is worsening. They reiterated the Productivity Commission conclusion that more psychiatrists were needed, but added that improved quality of psychiatric practice was also needed. The rest of the piece essentially argued that one crucial method of improving quality was acknowledging and learning from ‘failures’ (ill-defined). The piece was, in a technical sense, reasonable.

However, the irony of the editorial was that it failed to acknowledge its own conceptual failure. It spoke of mental health problems as though they are individual technical problems requiring individual technical solutions. It promulgated the narrow biomedical conceptualisation of ‘mental illness’ as a predominant problem of brain structure and function rather than a predominant problem of social structure and community in vulnerable people. The authors opined that without scrutiny of practice, psychiatrists risked ‘playing golf in the dark’, ‘hitting the balls’ but not ‘knowing where they are going’ – the implication being: psychiatrists are on the right track but just need to tweak their performance, ‘much like a golfer may improve by making small adjustments to his techniques’, to achieve ‘clinical excellence’.

But this confidently assumes psychiatrists are actually ‘hitting balls’ in the first place – what if they are actually taking air swings? Many argue that it is precisely this – the biomedical ‘psychiatrisation’ of human suffering – that is material to psychiatry’s ‘failures’. Suetani and Parker’s call for ‘direct observation of performance’ and ‘immediacy of feedback’ may hove individual technical skills but will do nothing to ameliorate the key structural catalysts of mental health problems: poverty, violence, substance use, crime, social inequality and social marginalisation. As Jureidini recently wrote, ‘changes need to be made to the conditions of living, rather than to the brains, of people who suffer’. Though potentially clinically useful, the suggestion of conducting psychological ‘pre-mortems’ on challenging cases ignores the reasons why the case became a ‘case’ in the first place.

Regarding outcomes, the authors’ push for more ‘local’ measurements may be clinically relevant but it overlooks the core issue – unless the social and structural determinants of the problem are addressed, refined measurements, no matter how local, will not improve population outcomes.

There will always be a place for individual psychiatric practice and, naturally, this should always be subject to a process of continuous quality improvement. However, as the World Health Organisation put it, ‘mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual, solutions.

References
1. Suetani S and Parker S. Shine a light: acknowledging and learning from psychiatric practice failures. A Technical sense, reasonable.

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References
1. Suetani S and Parker S. Shine a light: acknowledging and learning from psychiatric practice failures. Australas Psychiatry 2022; 30: 5–7.
2. Jureidini J. Jon Jureidini’s published letter to the editor in response to Rick Morton’s article: ‘The truth about spiralling mental-health waitlists’ in The Saturday Paper February 19-25, 2022, No. 367, 2022. https://www.adelaide.edu.au/robinson-research-institute/medical-and-ethical-mental-health/news/letter-2022/03/09/a-letter-to-the-editor-at-the-saturday-paper. (accessed March 10, 2022).
3. Friedli L. Mental health, resilience and inequalities. Denmark: WHO, 2009. http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

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