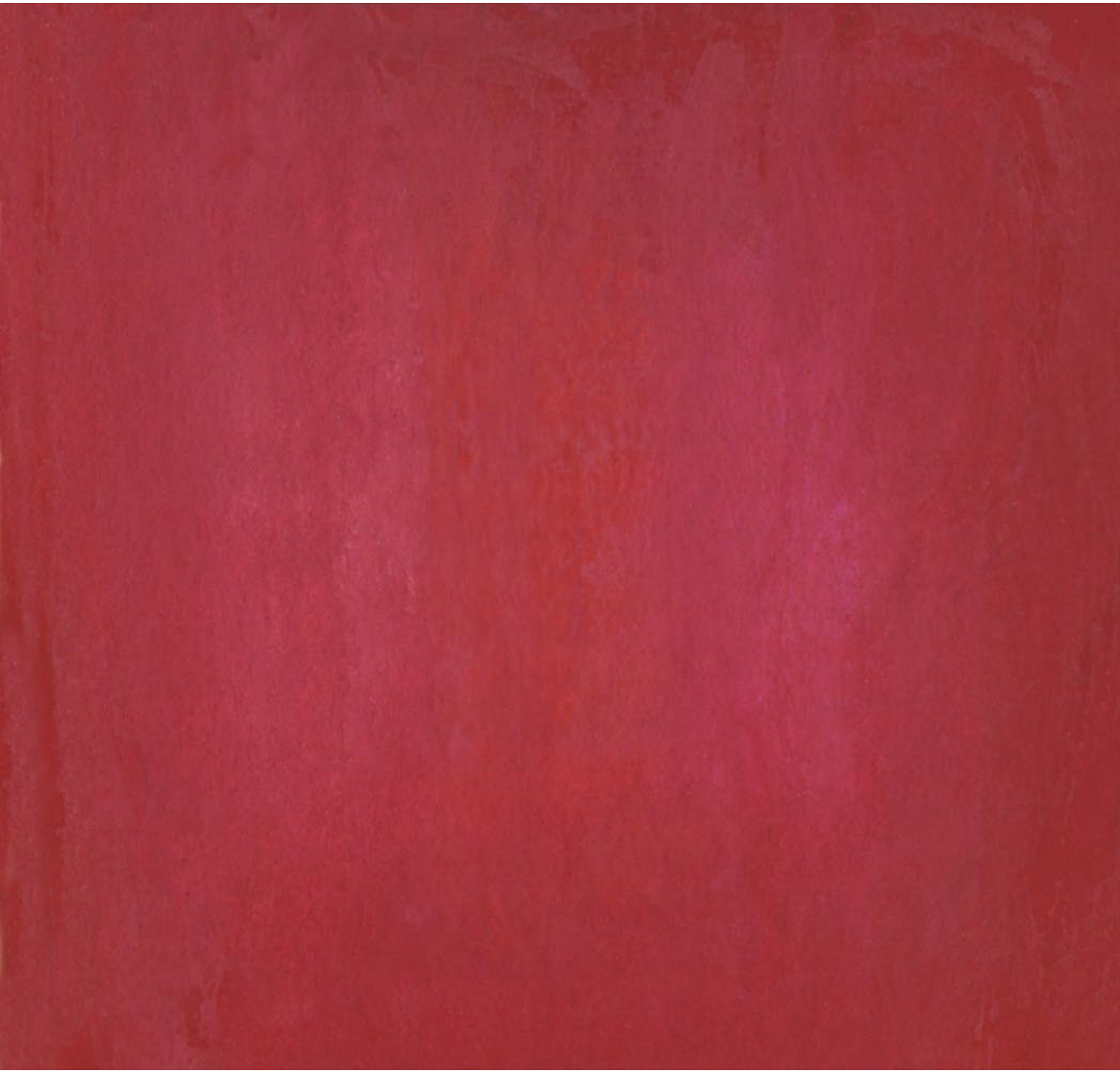
Chief Psychiatrist's annual report 2006



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Chief Psychiatrist's annual report 2006

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April 2008 (080401)

Foreword

March 2008

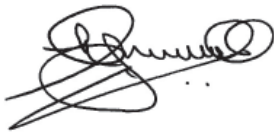
The Honourable Lisa Neville MP
Minister for Mental Health
50 Lonsdale Street
Melbourne VIC 3001

Dear Minister,

I am pleased to enclose the Chief Psychiatrist's annual report for the period 1 January 2006 to 31 December 2006. This fourth published annual report reflects a continuing commitment to inform the Victorian community about the key activities and functions of the Chief Psychiatrist in relation to the treatment and care of people with a mental illness in public mental health services.

In doing so, I would also like to acknowledge the establishment of a dedicated Ministry for Mental Health and your appointment as the inaugural Minister. I look forward to working together in the best interests of people with a mental illness in the State of Victoria to improve the quality and responsiveness of public mental health services.

Yours sincerely,



Professor Kuruvilla George
Chief Psychiatrist
MBBS, MPhil, DPM, FRCPsych, FRANZCP

Contents

1 Chief Psychiatrist's summary

I am pleased to present the Chief Psychiatrist's annual report for 2006. The report also serves as the annual report of the Chief Psychiatrist's Quality Assurance Committee.

During 2006, the office was led by Associate Professor Amgad Tanaghow who completed his five-year term in September 2007. The report reflects work undertaken by Associate Professor Tanaghow and the Chief Psychiatrist's office during that period. I would like to acknowledge Associate Professor Tanaghow's dedication to improving services and outcomes for people with a mental illness, and their carers, during his period in office.

Purpose of the annual report

The purpose of the report is to inform mental health consumers, carers, clinicians, service providers and members of the public about the role, functions and activities of the Chief Psychiatrist. It provides information on specific statutory practices that must be reported to the Chief Psychiatrist under the *Mental Health Act 1986 (Victoria)*, and reports on a range of activities that monitor and promote standards of treatment and care for people with a mental illness in Victoria.

Throughout 2006 mental health services across the state continued to face high levels of service demand and increasing complexity in consumer presentations, particularly of people with comorbid mental illness and substance use. Community and carer expectations of mental health services also continued to grow as people become better informed about mental illness and the importance of early detection and intervention. As an avenue of complaint and enquiry, the Chief Psychiatrist's office had a large number of contacts with consumers, carers, service providers and the public on a wide variety of issues that help identify pressure points on the service system and areas of practice for further attention. Common themes continued to be about timely access to services and information, particularly on the part of carers, and various aspects of involuntary treatment and choice on the part of consumers in respect to their treatment and care. During the latter part of 2006, the office introduced a new data management system to streamline its complaints handling processes and better support the analysis of complaints in the future.

The Chief Psychiatrist has a key responsibility under the Mental Health Act for the standards of treatment and care delivered to people with a mental illness. During 2006, the office continued its routine statutory monitoring activities, as well as undertaking some specific initiatives and contributing to a range of policy and service development projects within the Mental Health Branch.

The introduction of treatment plans for all involuntary patients in the 2004 amendments to the Mental Health Act was a major step forward in promoting better collaboration and communication between clinicians, consumers and carers. A Chief Psychiatrist forum was held in July 2006 to discuss progress in implementing the plans and examine their operation. Perspectives presented by mental health services, clinicians, consumer and carer representatives, and the Mental Health Review Board stimulated lively discussion. This information will be used to further inform the Chief Psychiatrist treatment plan guidelines and assist services in creating more effective and user-friendly treatment plans.

An area of ongoing concern has been the challenges facing adult mental health acute inpatient units. Consumers speak of negative experiences during their admission, especially the experience of being secluded, while clinical staff speak of a perceived increase in levels of violence. The combination of demand for admission, shorter lengths of stay, levels of disturbed behaviours and workforce issues pose special difficulties for the delivery of high-quality care that strikes the right balance between safety and a therapeutic environment. In a significant new initiative in October 2006, the Chief Psychiatrist's Quality Assurance Committee (QAC) entered a joint

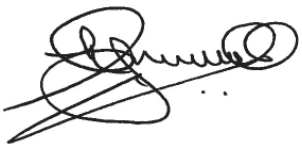
partnership with the Victorian Quality Council (VQC) for a two-year collaborative project: *Creating Safety: Addressing Seclusion Practices*. This is the first mental health focussed project to be endorsed by the VQC and I welcome the opportunity to work closely with them and the mental health service sector on this important area. The key aim of the project is to strengthen and support safety in adult acute inpatient units and minimise, wherever possible, the frequency, duration and use of seclusion. The project will use a variety of methods to assist and support acute inpatient clinicians to examine current practices and identify opportunities for practice change.

Changes to the *Sentencing Act 1991* came into effect on 1 October 2006, replacing 'hospital orders' with 'restricted involuntary treatment orders'. The Chief Psychiatrist's office had a lead role in informing and educating mental health service clinicians about the changes, and communicating with individual consumers on current orders affected by the changes. The operation of the new orders offer more flexibility in their clinical management and specify a maximum duration of two years in place of the previous indefinite orders.

The Chief Psychiatrist continues to be supported by experienced clinical advisers and administrative staff. I would like to thank all the staff of the office who worked with a high level of commitment and skill throughout 2006 and assisted the Chief Psychiatrist in the performance of his statutory duties.

As current Chief Psychiatrist, I will seek to continue the important work of the office. Improving clinical outcomes for people with a mental illness in Victoria requires the collective endeavour of government, policy makers, service providers and consumers and carers and I look forward to working with the many stakeholder groups to address the key challenges that impact on the public mental health service system and those who use it.

I trust that this report informs the Victorian community about the programs and activities of the office in 2006.

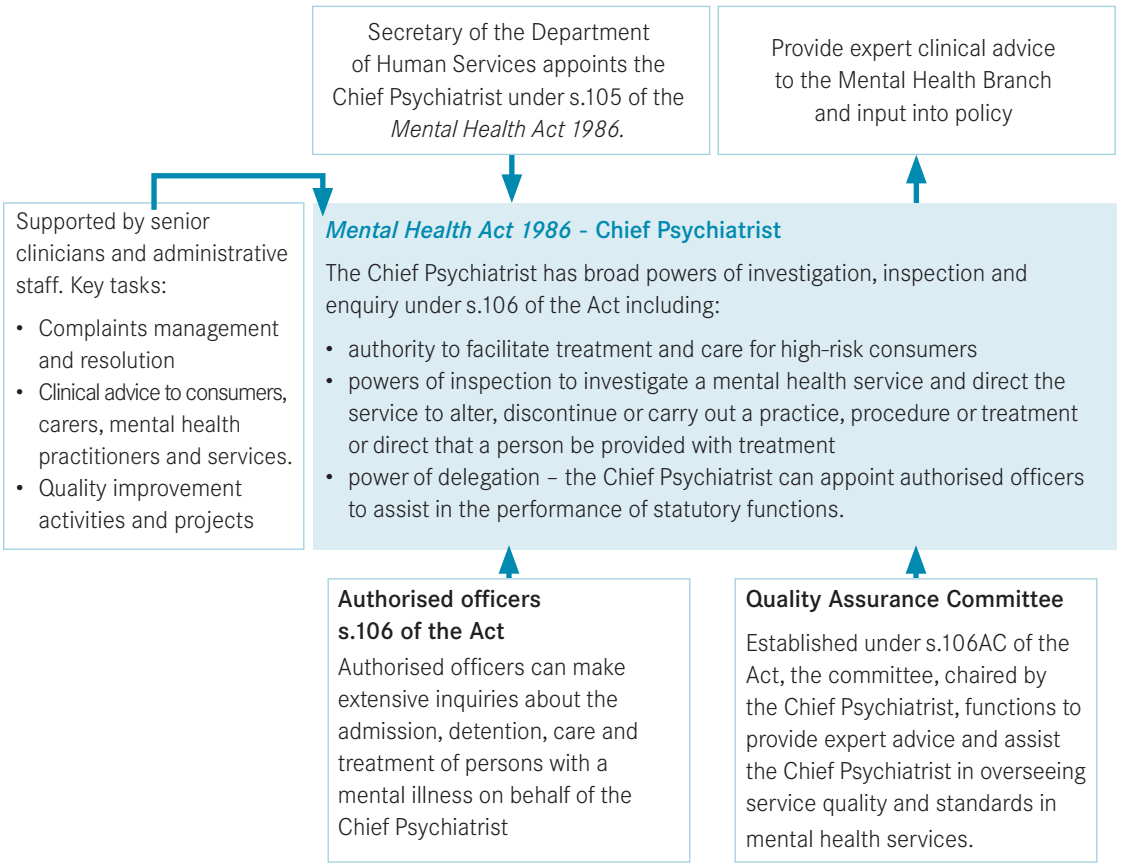


Professor Kuruvilla George
Chief Psychiatrist

2 Overview of Chief Psychiatrist's statutory responsibilities

The *Mental Health Act 1986* ('the Act') establishes the appointment of a Chief Psychiatrist who is responsible for the medical care and welfare of people receiving treatment or care for a mental illness. In fulfilling these responsibilities, the Chief Psychiatrist undertakes a range of statutory and monitoring activities with the intention of improving outcomes for individual consumers, and the safety and quality of the mental health services they receive. To perform these functions under the legislative framework provided by the Act, the Chief Psychiatrist has broad powers of investigation, inspection and enquiry as described in Figure 1.

Figure 1 Statutory framework



Core statutory and other functions

Investigate treatment -related issues as deemed warranted by the Chief Psychiatrist in accordance with the legislation.	Monitor statutory practices and undertake other statutory responsibilities.	Monitor and improve standards of treatment and care and consistency of clinical practice.
• Investigate and address consumer and carer complaints. • Protect the rights of people with a mental illness. • Ensure consumers receive the most appropriate treatment and care in the least restrictive environment. • Facilitate access to services and improve service outcomes for consumers and carers. • Contribute to the education and training of consumers, carers and others .regarding their rights and appropriate standards of care.	• Monitor and review statutory reports in relation to seclusion, mechanical restraint, electroconvulsive therapy and reportable deaths. • Monitor ECT licences in public and private sectors. • Perform statutory functions relating to patients detained under the *Sentencing Act 1991* and *Crimes Mental Impairment (Unfitness to be Tried) Act 1997*.	• Work with clinicians to improve service quality and safety, and ensure the application of the Act to clinical practice. • Investigate and resolve issues raised by practitioners. • Provide support and clinical advice to services through quality improvement initiatives, such as clinical guidelines. • Undertake clinical reviews of approved mental health services. • Provide expert advice to government, the Mental Health Branch and other mental health stakeholders.

3 Core statutory activities in 2006

3.1 Monitoring and improving service standards

The Act requires mental health services to report monthly to the Chief Psychiatrist on the use of the clinical interventions of seclusion, mechanical restraint and electroconvulsive therapy (refer to Table 1 for a description of these interventions). These reports are known collectively as the 'statutory reports'. Examination of the statutory reports enables the Chief Psychiatrist to monitor the use of these regulated practices and analyse trends over time.

The Act also requires mental health services to report on the annual medical examination of involuntary patients who have been in continuous care for 12 months, and the death of any patient that is a 'reportable death', within the meaning of the Coroners Act 1985.

Table 1 Overview of statutory practices

Guideline on clinical intervention[1]	Description of clinical intervention	Circumstances of use	Policy and practice standards
Seclusion For more information on minimum practice standards on seclusion see the *Clinical guideline on seclusion* (Department of Human Services 2006).	Under section 82 of the Mental Health Act, seclusion of a mentally ill person can only occur in an approved mental health service, and is defined as the 'sole confinement of a person at any hour of the day or night in a room in which the doors and windows are locked from the outside'.	Seclusion should only be used as an intervention of last resort to protect the person, or others, when the person is highly disturbed and unable to be treated in a less restrictive manner.	A registered nurse must review the secluded person at not more than 15 minute intervals and a medical practitioner must examine the person at intervals of not more than four hours (unless varied by an authorised psychiatrist). Each seclusion episode must be appropriately recorded and reported monthly to the Chief Psychiatrist.
Mechanical restraint For more information on minimum practice standards on the use of mechanical restraint see the *Practice guidelines on mechanical restraint* (Department of Human Services 2006).	Under section 81 of the Mental Health Act, mechanical restraint of a mentally ill person can only occur in an approved mental health service and is defined as 'the application of approved devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted to their arms) that restrict the person's capacity to get off the furniture'.	Mechanical restraint should only be applied as an intervention of last resort to protect the person, or others, or to allow the person necessary medical treatment.	A registered nurse or medical practitioner must continuously observe a person who has been mechanically restrained and must review that person at no more than 15 minute intervals. A medical practitioner must examine the restrained person every four hours at a minimum (unless varied by an authorised psychiatrist). Each restraint episode must be appropriately recorded and reported monthly to the Chief Psychiatrist.
Electroconvulsive therapy (ECT) For more information on minimum practice standards on ECT see the *ECT manual: licensing, legal requirements and clinical practice guidelines* (Department of Human Services, 2000).	ECT is a psychiatric procedure performed under general anaesthesia and muscle relaxation. Under section 74 of the Act, ECT can only be administered in licensed premises. ECT can be administered as a course (a number of consecutive treatments) or as a continuation or maintenance treatment after the acute phase of illness.	ECT is most commonly administered for the treatment of severe depression but may be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric disorders. It is most often prescribed as part of a treatment plan in combination with other therapies.	ECT can only be provided in premises licensed by the Secretary of the Department of Human Services (in practice delegated to the Chief Psychiatrist) and is strictly regulated under sections.72-80 of the Act. Licences are granted for up to five years.

1 For further information, the Chief Psychiatrist's guidelines can be downloaded at www.health.vic.gov.au/mentalhealth/cpg/index.htm

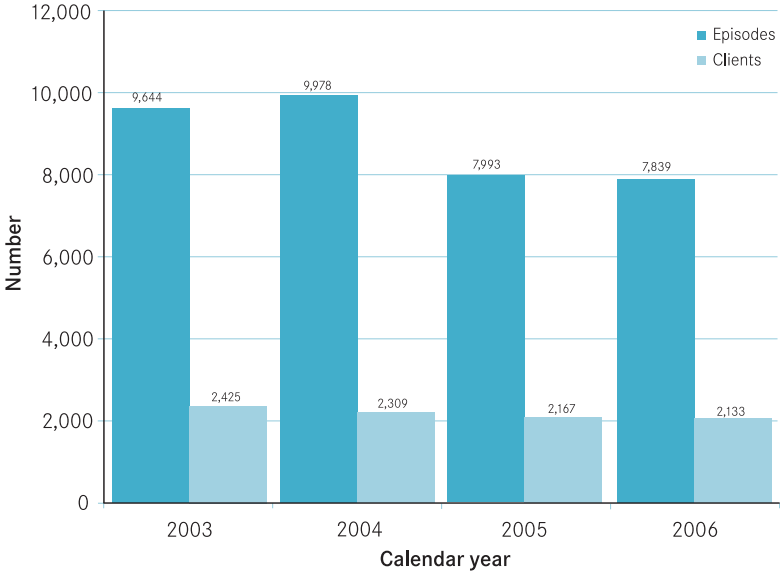
Seclusion

Between 1 January 2006 and 31 December 2006, a total of 59,564 consumers received treatment from public mental health services. Consistent with contemporary mental health care, the majority received their treatment in the community. Only 20.3 per cent (12,060 consumers) were admitted to hospital for an acute episode of care during the reporting period, a similar proportion to 2005 (20.1 per cent). Of this group, 17.7 per cent (2133 consumers) were secluded at some time during their admission.

There were a total of 7,839 seclusion episodes for the reporting period, with the duration of most episodes being less than four hours (66 per cent). Consumers who were secluded averaged 3.6 episodes each, compared to 4.3 episodes in 2004 and 3.7 episodes in 2005. The decreased use of seclusion over the past two years may reflect the growing awareness in mental health services of the need to reduce the use of seclusion and seek alternate clinical interventions wherever possible. The majority of seclusion episodes occurred in adult mental health services (89.7 per cent) and involved a male consumer (60.9 per cent), a similar pattern to previous years.

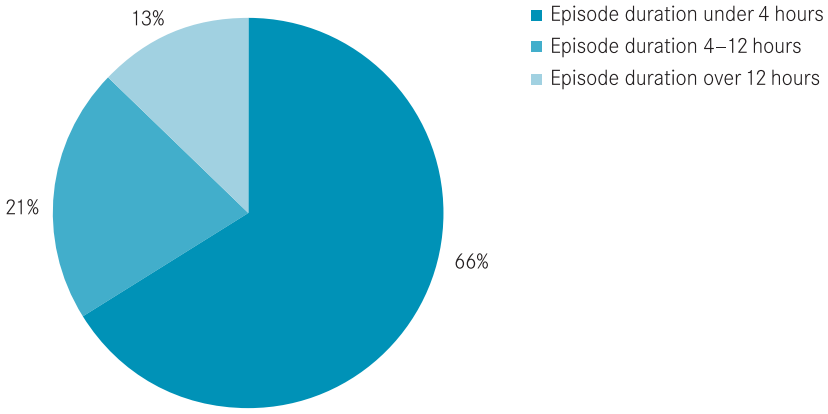
Figure 1 shows the number of consumers secluded and seclusion episodes from 2003-06. While the number of episodes declined markedly from 2004-05 and continue a downward trend, the number of episodes and persons secluded in 2005 and 2006 have remained relatively constant. These figures will provide a useful baseline for evaluating the impact of the joint VQC-QAC seclusion project on future seclusion practices.

Figure 1 Use of seclusion 2003-06



The pie chart below shows the proportion of seclusion episodes by episode duration. Two thirds of episodes (66 per cent) were less than four hours, compared to 70 per cent in 2005. Twenty one per cent of episodes lasted between four-12 hours, while 13 per cent of episodes lasted longer than 12 hours, both slightly up on the respective 2005 figures of 20 per cent and 10 per cent.

Figure 2 Proportion of seclusion episodes by episode duration 2006



Mechanical restraint

During 2006, there were 661 episodes of mechanical restraint of 129 individual consumers of mental health services (See Figure 3). This represents a notable and continuing decrease in the use of mechanical restraint since 2004 and 2005. The overwhelming majority of episodes of mechanical restraint (79 per cent) occurred in aged persons mental health services (See Figure 3). This marked reduction may be attributed to the considerable work done by the aged persons mental health sector to minimise the use of mechanical restraint and move to restraint-free environments wherever possible. The average number of episodes of mechanical restraint per person (5.1 per person) also decreased relative to 2004 and 2005 (an average of 6.6 and 7.2 episodes per person respectively).

Figure 3 Use of mechanical restraint 2003-06

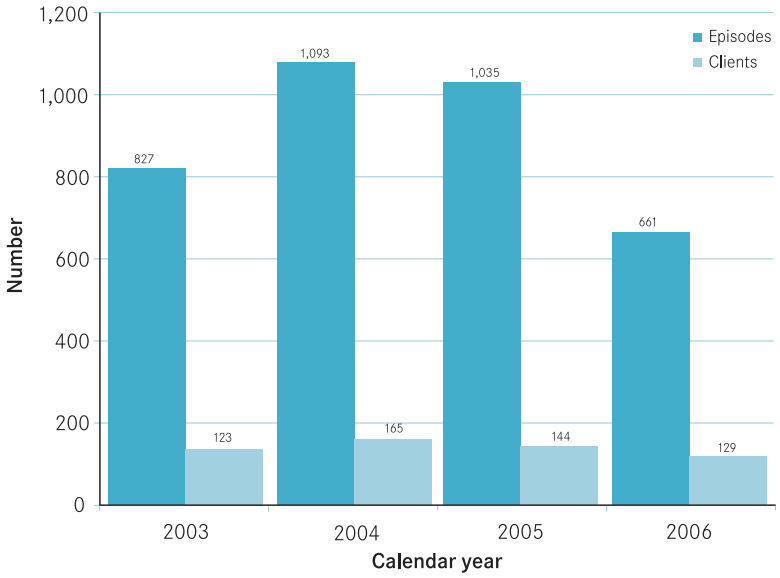
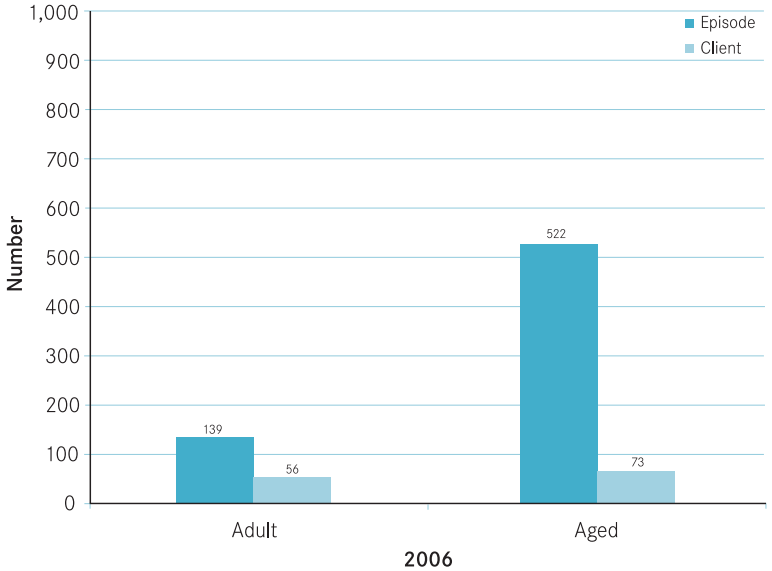


Figure 4 Use of mechanical restraint by age group – 2006

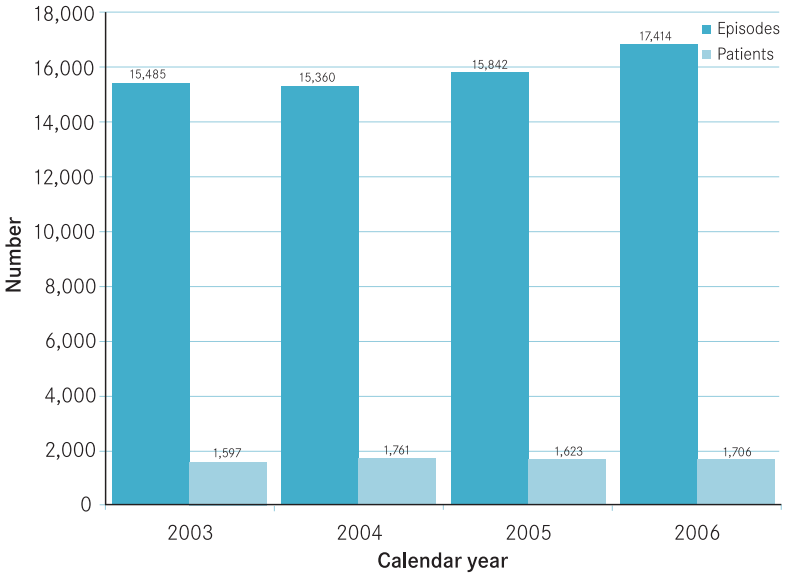


Electroconvulsive therapy

During the 2006 reporting period, 17,414 electroconvulsive therapy treatments (ECT) were given in public and private mental health services in Victoria (See Figure 5). The number of individual consumers to have electroconvulsive therapy was 1,706 and the average number of treatments per person was 10.2. Females received 65.0 per cent of electroconvulsive therapy treatments (See Figure 6). This finding remains consistent with previous years and international findings on usage patterns by gender.[2] Slightly more than two thirds of all treatments (69.6 per cent) were administered in the public mental health sector (See Figure 7). Consumers with a diagnosis of major affective disorder (depression and mania) were the largest single diagnostic group for whom ECT treatment was given (41.4 per cent), which accords with the expected indications for use.

The total number of ECT treatments delivered has increased by approximately 10 per cent over 2005, although the number of individuals treated with ECT has not increased significantly. Traditionally ECT has tended to be used as a treatment for the acute phase of an individual's illness. Over recent years, further developments in ECT treatment have led to an increased use of 'maintenance' ECT as a clinical intervention to sustain an individual's recovery and prevent relapse.

Figure 5 Use of ECT 2003-06



2 Mark Olfson et al, 'Use of ECT for the inpatient treatment of recurrent major depression,' *American Journal of Psychiatry*, 155, 22 at 24.

Figure 6 ECT treatments by gender 2003-06

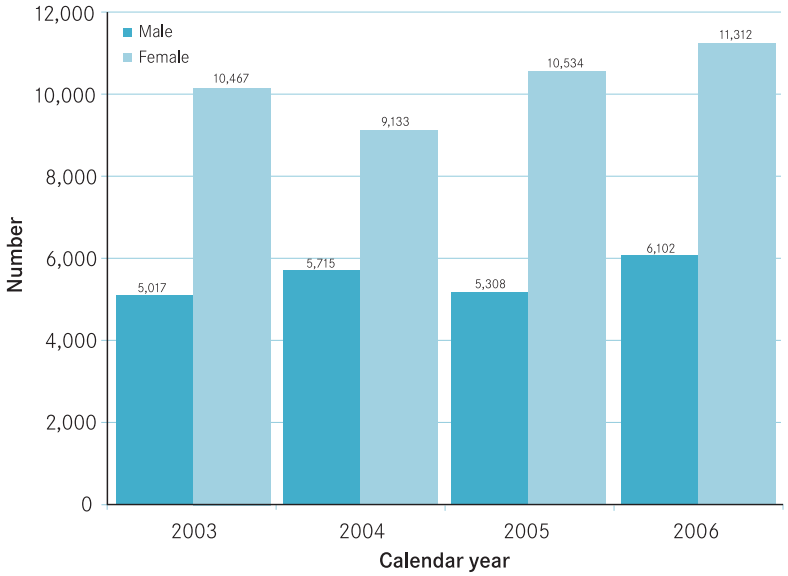
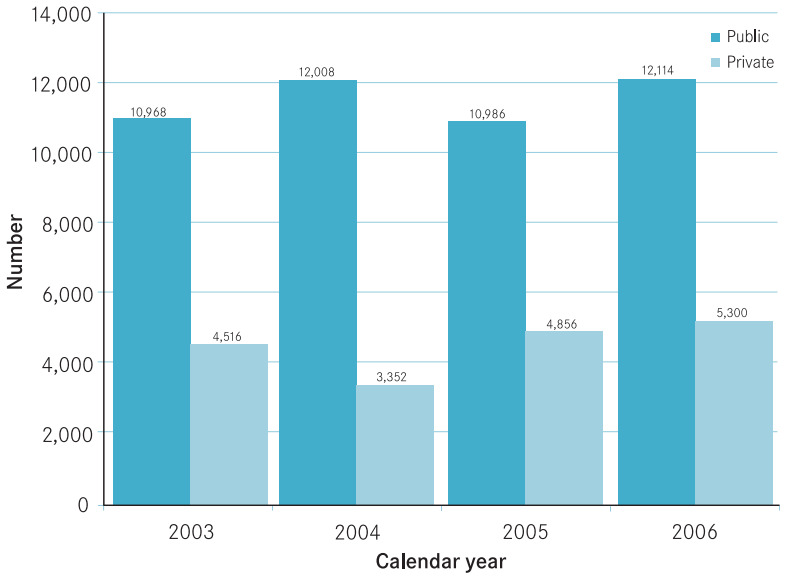


Figure 7 Administration of ECT by sector 2003-06



Annual examinations

See clinical guideline *Physical examination, the annual examination and attention to clients' general medical health needs* (Department of Human Services 2002) for further information relating to the responsibilities of mental health services under s.87 of the Act.

Section 87 of the Mental Health Act requires that consumers who are involuntary patients for a period of 12 months must have their mental and general health examined at least once a year, and a report of this examination be sent to the Chief Psychiatrist. Increasingly the practice is for mental health consumers to be linked with a local general practitioner for their physical health needs, in much the same way as any other member of the community. However, given the known increased morbidity of consumers with a mental illness, and tendency to poorer health status, the authorised psychiatrist of each approved mental health service retains a responsibility for ensuring the consumer's health status has been appropriately reviewed. The Chief Psychiatrist reviews all *Annual Examination of Patient forms* submitted and may request further information from a service if necessary.

Reportable deaths

See clinical guideline *Reportable deaths* (Department Human Services 1999; revised 2004) for further information relating to the responsibilities of mental health services under s106A of the Act.

The Act requires an authorised psychiatrist of an approved mental health service, or a person in charge of any other psychiatric service, to report to the Chief Psychiatrist, the death (within the meaning of the Coroner's Act) of any involuntary, security or forensic patient from any cause, and the unnatural, unexpected or violent death of any consumer (voluntary, involuntary, inpatient or outpatient) of any mental health service. On receipt of a notice of death, the Chief Psychiatrist reviews the report and may seek additional information from the service. If the circumstances surrounding the death cause particular concern, the Chief Psychiatrist may conduct a formal investigation. No investigations of this nature were undertaken in 2006. In almost all cases of a reportable death, the Chief Psychiatrist registers an interest with the coroner to ensure the office receives the coroner's findings and any recommendations.

Consistent with the Chief Psychiatrist's Reportable Deaths guideline, a death must be reported to the Chief Psychiatrist when the deceased person is a current registered mental health consumer or has been a registered client within the past six months. As mental health services are not always informed of a consumer's death once contact with the service has ceased, the reporting of these deaths to the Chief Psychiatrist is not always reliable. Clearly, the reporting service can only provide as much information as is available at the time of reporting. The service is required to identify whether a death appears to be 'unexpected, unnatural or violent' and describe the manner of death on the basis of the information available at the time of reporting.

Only a coroner of the Victorian State Coroner's Office can legally determine the cause of a death, including a finding of suicide. Such determination may be made some time after the year in which the death occurred. The data provided in this report is based on information reported to the Chief Psychiatrist at the time of a death and, as such, is provisional until the coroner's findings are completed.

Between 1 January 2006 and 31 December 2006, the deaths of 333 individuals were reported to the Chief Psychiatrist. Of these, 227 (68.2 per cent) were males and 106 (31.8 per cent) were females. The reporting service attributed the majority of deaths (44.4 per cent or 148) to natural causes and 96 to suspected suicide (28.8 per cent). At the time of reporting, the cause of death for seventy-two persons was reported as 'unknown' (21.6 per cent). In these situations the reporting service generally has very limited detail about the particular circumstances of the death at the time of reporting. It is likely the coroner will determine the cause of death to be suicide for a number of these deaths, though a number may be found to have a different cause or remain unknown.

Similarly, the coroner does not always make a finding of suicide for all deaths reported to the Chief Psychiatrist as suspected suicides. The remainder (5.2 per cent) of the reported deaths grouped in the 'Other' category, were attributed to a range of other, less frequent causes such as motor vehicle accidents.

Figure 8 shows the number of reportable deaths according to gender and cause of death. Males significantly outnumbered females in all categories.

Figure 8 Reportable deaths by gender and cause of death – 2006

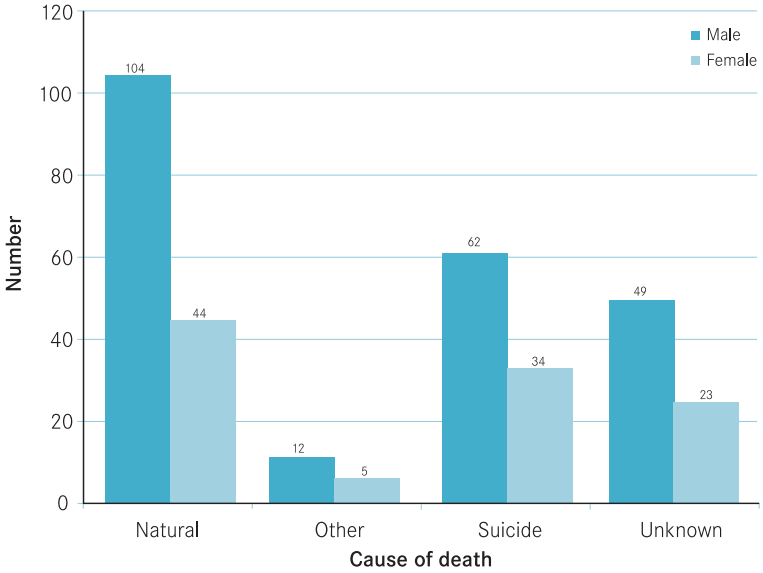


Figure 9 shows the cause of death by age group. The majority of deaths reported for persons over 65 years (74.4 per cent) were ascribed to natural causes, while suspected suicide was the largest category (47.3 per cent) for deaths in adults aged 18-64 years. Adults accounted for slightly more than half (56.4 per cent) of all deaths reported to the Chief Psychiatrist. There were no deaths reported to the Chief Psychiatrist in 2006 for young people under 17 years of age.

Figure 9 Reportable deaths, by age group and cause of death – 2006

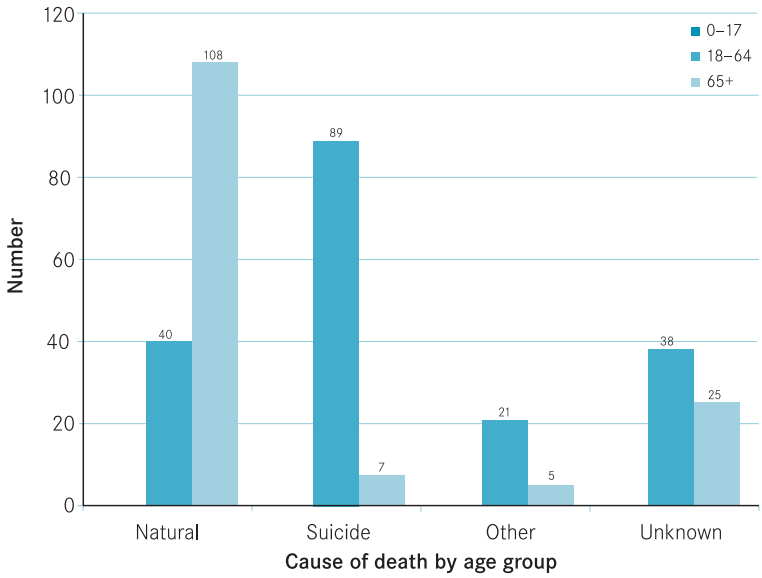


Table 2 sets out the number and percentage of reportable deaths by diagnostic group. The majority (33.8 per cent) of reportable deaths in 2006 were of persons with a psychotic disorder, followed by persons with dementia or other organic brain disorder (28.7 per cent) and persons with a mood disorder (27.6 per cent).

Table 2 Reportable deaths in 2006 by diagnostic group

Diagnostic group	Number of deaths	Percentage
Psychosis	113	33.8
Dementia and organic brain disorder	96	28.7
Mood disorder	92	27.6
Substance-related disorders	10	3.0
Anxiety disorder	10	3.0
Personality disorder	9	2.7
Other diagnosis	3	1.2
Not stated	0	0
Total	**333**	**100**

Throughout the year, the Chief Psychiatrist collates all coronial findings, recommendations and practice themes for dissemination to all area mental health services as part of quality improvement. In 2006, details of coronial recommendations relating to the following areas of practice were sent to Clinical Directors and Managers of all mental health services: monitoring of medication side effects, management of patients on Community Treatment Orders, risk assessment practices, development of policies and procedures, environmental issues in inpatient facilities, record keeping and documentation of care. Mental health services were requested to consider the information and recommendations in the context of their local policies and practices.

The Chief Psychiatrist is also a member of the Coroner's Medical Advisory Committee and the Department of Human Services Coroner's Inquest Working Group, and continued to participate in the deliberations of these groups throughout the reporting period.

Authorised psychiatrists

Under s.96 of the Mental Health Act, each approved mental health service must have an authorised psychiatrist, who is a qualified psychiatrist, appointed by the employing health service. The authorised psychiatrist's legislative obligations include the implementation of the Act and responsibility for the treatment and care of persons in the mental health service. The authorised psychiatrist can delegate any powers, duties and functions to a registered medical practitioner, or to a qualified psychiatrist ('delegated psychiatrist') employed in the approved mental health service, except the power of delegation or the duty to provide the Forensic Leave Panel with information.

The Mental Health Review Board and the Secretary of the Department of Human Services must be notified of each authorised psychiatrist's appointment within five days. In practice, the secretary delegates this function to the Chief Psychiatrist's who maintains a register of all authorised psychiatrists.

The Chief Psychiatrist convenes a quarterly Authorised Psychiatrist's Forum to assist authorised psychiatrists in fulfilling their functions, and provide an opportunity for peer support in dealing with their common role. The quarterly meetings provide education and information on relevant legislative matters, clinical standards and policy, aspects of clinical service delivery and discussion of issues of common interest or concern.

The Chief Psychiatrist also provides advice on the suitability of a person's psychiatric qualifications, especially overseas trained psychiatrists, to be employed in a public mental health service before the person can obtain registration with the Medical Practitioners Board of Victoria.

Clinical review program and other quality improvement initiatives

The Chief Psychiatrist's 1997-2004 clinical review program, conducted under s.106 of the *Mental Health Act* was a significant quality improvement activity of the office. Clinical reviews evaluated standards of clinical practice and procedures in public mental health services for their consistency with the requirements of the Mental Health Act, published policy and clinical guidelines and service agreements. Using a peer review methodology, clinical reviews examined the treatment and care delivered to consumers of public mental health services and provided feedback to services. All area mental health services were reviewed at least once during the lifetime of the program. During 2006, final feedback meetings were held with three previously reviewed services to discuss their action plans in response to the review recommendations.

Public mental health services are involved in a wide range of quality and safety activities. Consideration of a further clinical review program will need to examine the place and focus of such an activity in the broader commonwealth and state context.

A major focus of quality activity during the latter part of 2006 was the initiation of a joint project between the Chief Psychiatrist's Quality Assurance Committee and the Victorian Quality Council. The primary aim of the project, entitled *Creating safety: Addressing seclusion practices*, is to strengthen and support safe practice in adult acute inpatient units and reduce the use of seclusion. Implementation of the project will be a major priority in 2007-08.

Work also commenced during the year on a review of section 106 of the Mental Health Act to clarify policies and procedures associated with the Chief Psychiatrist's investigative powers and quality assurance activities. This work will continue in 2007.

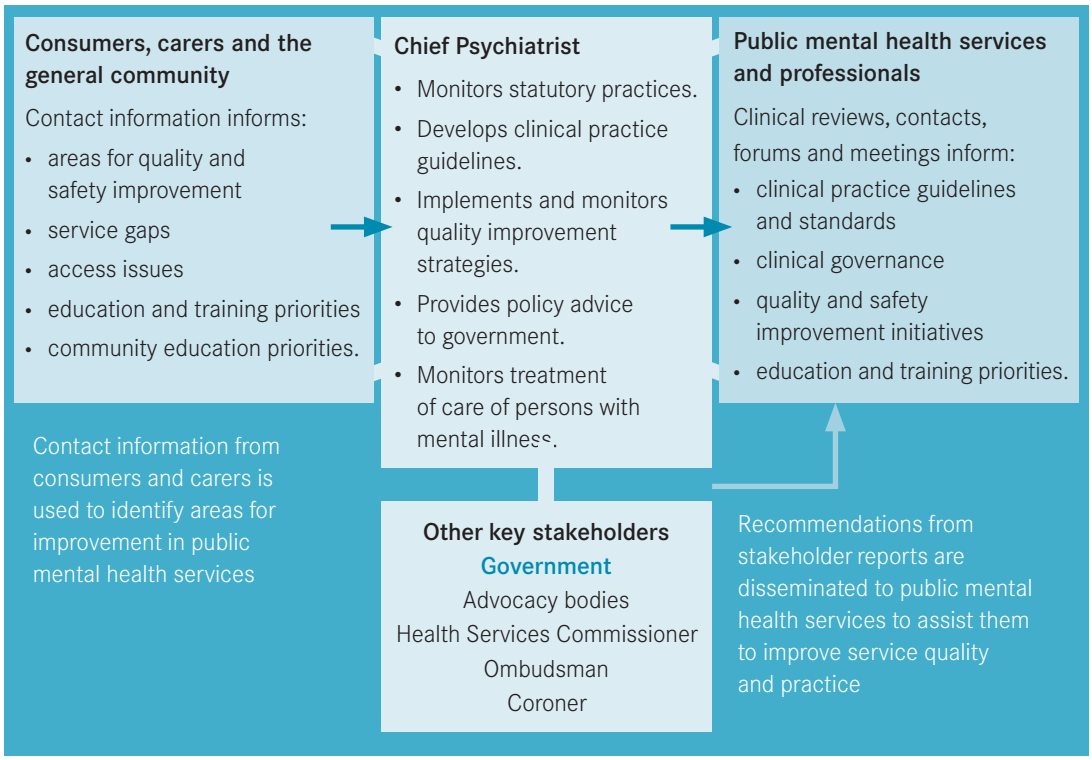
3.2 Consumer and carer complaints and enquiries

During 2006, the Chief Psychiatrist continued to receive a large number of contacts, telephone and written, from consumers, carers, service providers, members of the public and others. In his statutory capacity, the Chief Psychiatrist is one avenue of complaint and enquiry in relation to mental health treatment and care. Consumers and carers are encouraged to utilise local health service provider complaints mechanisms and are also advised of other avenues for redress. Service providers and clinicians also contact the office seeking advice on aspects of clinical practice or service delivery. Agencies such as the Health Services Commissioner, the Office of the Public Advocate, the Ombudsman, the Minister for Mental Health and other government and statutory bodies also refer enquiries and issues to the Chief Psychiatrist where appropriate. These contacts provide a rich source of information regarding consumer and carer concerns, pressure points on the service system and a wide array of practice and service delivery issues.

The office's administrative staff are generally the first point of contact, and many enquiries are dealt with at that level. Often the enquirer is seeking general information on how to access a mental health service and is either given the contact details or referred, if they have access, to the website www.health.vic.gov.au/mentalhealth/services. These simple enquiries are not formally recorded, and are not included in the reported data.

Where the issue is more complex or is a complaint, or involves a clinical matter, the enquirer or complainant is referred to a clinical adviser. Clinical advisers, who are all appointed authorised officers of the Chief Psychiatrist under s106 of the Mental Health Act, assist the Chief Psychiatrist in responding to consumer and carer complaints, enquiries and correspondence on a daily basis.

Figure 10 How contact information informs the activities of the Chief Psychiatrist



Volume and focus of complaints and enquiries in 2006

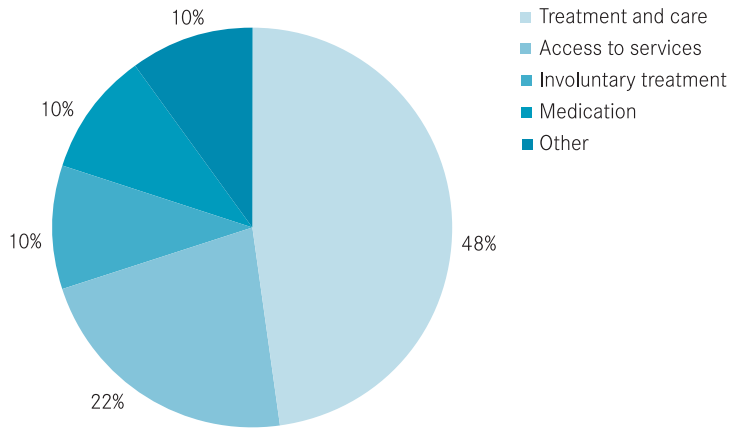
During 2006, the Chief Psychiatrist received 490 complaints and 373 enquiries about mental health service delivery matters. Of the 490 complaints, 177 were written and 313 were made by telephone. Many complaints are dealt with purely by telephone, sparing the need for the consumer or complainant to put their complaint in writing. Where the issue is of a more serious or complex nature, the complainant is requested to provide written details to enable further investigation.

Complaints are grouped according to the dominant issue or practice area of concern, where this can be reasonably identified. In practice, many complaints on further exploration have several aspects, and are often not easily categorised.

Consumers of public mental health services (54 per cent) were the most frequent callers to the office, followed by carers or relatives (36 per cent), other (eight per cent), and mental health service clinicians (two per cent). The other category is a diverse group including members of the public, members of parliament, police, other agencies, government departments and individuals.

As shown in Figure 11, most complaints were broadly about treatment and care (48 per cent), followed by difficulty accessing services (22 per cent), involuntary treatment (10 per cent), medication (10 per cent) and other (10 per cent).

Figure 11 Type of complaints as a proportion of all complaints – 2006



The treatment and care category covers a wide range of concerns such as requests to change a treating clinician, problems in consumer-clinician communication, lack of expected follow up care, inadequate discharge planning, dissatisfaction or disagreements about proposed treatments, differences of opinion about diagnosis and related aspects of treatment. Many of the complaints about involuntary treatment were from consumers who disagreed with the diagnosis given to them, or who believed they had been wrongfully detained in a mental health service. In such circumstances, consumers were advised of their appeal rights under the Act and provided with relevant contact details, including the Mental Health Review Board and Mental Health Legal Service. Complaints about medication generally relate to side effects, dose levels, preference for tablets rather than injections and a desire for more consumer choice about their medications.

Case study: Responding to concerns about involuntary treatment

An involuntary patient in an acute inpatient unit contacted the Chief Psychiatrist's office saying that he had been illegally detained and forced to take medication, which he believed was unnecessary and in violation of his human rights. A clinical advisor listened to his account of events, and established the circumstances of his admission. The patient was given information about his involuntary status and avenues of appeal. He was advised of his rights to a second opinion and about the normal clinical procedures for discharge from an inpatient admission. He was encouraged to discuss his concerns with the treating team, and to request time with the consultant psychiatrist to ask how long he might expect to be in hospital, the purpose of his treatment, and what needed to change for him to be discharged.

On admission to a mental health service as an involuntary patient, the person is provided with information on their rights as required under the Act. The patient rights booklet identifies the Chief Psychiatrist (among others) as an avenue of complaint. Calls about involuntary detention or treatment are common and while such contact does not necessarily alter a consumer's involuntary status, most consumers find it helpful to discuss their situation with an external body. Where a caller may not feel confident or comfortable raising issues with their doctor, with their consent a senior clinical adviser may contact the service on their behalf and ask a clinician to initiate discussion with the person about their concerns.

The main concern of families and carers who contacted the Chief Psychiatrist continued to be about timely access to appropriate services for their relative when needed. These include access to early intervention when the person is in the first stage of illness or showing signs of relapse, access to higher levels of treatment and support or more assertive intervention for a chronically unwell relative, and access to a greater range of supported accommodation and rehabilitation services. Families also continued to express their frustration at their perceived lack of involvement in the treatment and care process, and recognition on the part of services and clinicians of their important support role and the intimate knowledge and information they carry about their relative.

Case study: Responding to carer complaints about service responsiveness

A carer telephoned the Chief Psychiatrist's office concerned about her adult daughter's erratic behaviour and deteriorating state. She said her daughter had a longstanding diagnosis of bipolar affective disorder, which was complicated by her drug and alcohol use. She was concerned that her daughter had become itinerant, appeared to have fallen in with people who were exploiting her, and was neglecting her personal hygiene. The mother described her daughter as expressing a range of psychotic ideas, and as behaving aggressively towards her. The mother contacted the mental health service seeking help for her daughter but was told that the daughter's problem was largely due to her substance use, and that she was no longer living in the catchment area. A clinical advisor discussed the mother's concerns, and provided information on how mental health services clinically assess individuals who have been diagnosed as having both a mental illness and a substance addiction (dual diagnosis). The clinical advisor also suggested the mental health service assess the daughter's mental health needs, including consideration of a period of case management to try and stabilise her condition; and emphasised the need for a comprehensive response in the context of mental illness and co-morbid substance use.

The Chief Psychiatrist's office receives a number of complaints from carers about their son or daughter where there is co-morbid substance use. Engaging and providing treatment and care to people with dual diagnosis remains one of the most challenging areas of mental health service delivery locally and internationally. Providing information to carers about the available treatment options for people with dual diagnosis, and the role of public mental health services is often helpful in supporting carer concerns and empowering them in their interactions with the mental health service system.

Most complaints are dealt with through liaison with the relevant mental health service. In many cases this occurs through telephone discussion between a clinical adviser and the service manager or clinical director. Many complaints reflect a breakdown in communication between the consumer or carer and the service, and are resolved by facilitating the parties to get together and discuss the concerns. Complaints that involve more serious allegations are dealt with more formally, with the Chief Psychiatrist requesting a written report from the respective service. Following consideration of the report, the Chief Psychiatrist may request the service to take some remedial action.

Case study: Responding to complaints about service responsiveness

A member of the public contacted the Chief Psychiatrist's office complaining about the behaviour of her neighbour who lived alone. She described her neighbour as acting strangely, appearing very neglected, physically unwell, and making a lot of noise at all hours of the night. The complainant pursued several avenues to try and have the situation addressed, such as contacting the local council, the police, and the local mental health service. She felt very frustrated by the lack of response, including from the local mental health service, who said they were unable to act as the neighbour's name was unknown. After discussion with the Chief Psychiatrist, the clinical advisor contacted the director of the mental health service to see how an assessment of the neighbour might be facilitated. The service made a number of enquiries, eventually leading to an assessment and admission of the neighbour (who was found to be quite mentally unwell) to hospital for treatment.

The Chief Psychiatrist often has a role in facilitating access to mental health services where contact may have already been made, and where further information brought to the attention of the Chief Psychiatrist indicates a need for review of the service's response by the relevant service director to ensure all possible action has been fully considered.

Mental health service clinicians contacted the Chief Psychiatrist's office to seek information on mental health policy, Chief Psychiatrist clinical guidelines and the clinical interpretation of the Mental Health Act in complex or uncommon situations, including interstate transfer provisions. Senior clinicians often seek the Chief Psychiatrist's advice on complex clinical situations, or service system issues such as accessing acute and extended care beds, inter-service transfers, and high-need clients with forensic status or significant risk issues. The Chief Psychiatrist also has a role in resolving conflicts between area mental health services where there may be disagreements or problems in achieving effective collaboration, especially around service access and transfer of consumer care.

Investigating incidents

Under section 106 of the Mental Health Act, the Chief Psychiatrist and authorised officers have powers to visit a psychiatric service and carry out investigations, where the Chief Psychiatrist forms the view that such action is necessary. This may include inspecting premises and records held by the service, making enquiries about a person's treatment, seeing a person who is receiving treatment, and interviewing staff. No such investigations of this nature occurred in 2006.

Working with families and carers

Families and carers continue to have a vital role in supporting and advocating for their relative who has a mental illness. Carers often initiate contact with the Chief Psychiatrist's office, seeking advice on available mental health services or to complain about a lack of response from a mental health service. The Chief Psychiatrist's office continues to promote, wherever possible, greater inclusion of families and carers in the treatment and care process, whilst recognising the need to balance this with the individual's right to privacy of their health information. One of the aims of introducing legislated treatment plans for all involuntary patients was to promote better communication

with consumers and carers about treatment objectives and decisions. Families and carers were represented at the Treatment Plan Forum held during the year, and their views will be considered in the further development of the Chief Psychiatrist guidelines.

Informing the public

The Chief Psychiatrist's office recognises the need to continue to inform the public about its statutory functions and mental health issues more generally. Members of the public often call with questions about mental illness, assistance in obtaining information on mental illness, or seeking advice about how best to help a family member, friend or work colleague who they are concerned about. Such contacts provide opportunities to educate the public about mental illness, clarify misconceptions and suggest appropriate avenues of assistance, including the role and contact information of public mental health services. The Chief Psychiatrist's website is regularly updated to include any new publications issued by the office and any particular activities or projects of note. During the year, the Chief Psychiatrist gave a number of talks at public forums and to other interest groups.

Freedom of information

The Freedom of Information Unit (FOI) of the Department of Human Services receives a variety of requests for information under the *Freedom of Information Act 1982 (Victoria)*. Where these requests are about mental health clinical information or mental health consumer records[3] held by the department, the Chief Psychiatrist is required to examine the records as part of the FOI process. The Chief Psychiatrist examines the relevant material and provides advice to the FOI unit on the appropriateness or recommended circumstances of release of the documents, taking into consideration the potential impact on the consumer or others. In 2006, the Chief Psychiatrist, in conjunction with the Legal and Forensic Policy Unit of the Mental Health Branch, assisted the FOI Unit to examine documents in relation to a number of such FOI requests.

Facilitating access to mental health beds and services

The Chief Psychiatrist has an ongoing role in assisting mental health services to obtain an acute mental health inpatient bed for a person when the local mental health service has no vacancy and all efforts to secure a bed in a neighbouring service have been unsuccessful. Demand for acute and extended care mental health beds remains a system-wide pressure, but new service developments and initiatives by the Mental Health Branch aimed at providing alternatives to acute admission and enhanced emergency department capacity appear to have helped ease this situation. Planned developments over the next two to five years should further improve local service self sufficiency.

3 When mental health services were mainstreamed with general hospitals in 1995-96, inactive consumer records, which were the property of the Department of Human Services, were archived and held by the department. The FOI officers of relevant general hospitals manage FOI requests relating to current consumer records.

Consumers with complex needs

The Chief Psychiatrist's office remained closely involved with a small number of consumers with complex or multiple service needs. Clients with complex needs are those whose service needs or diagnostic profiles do not fit neatly into a single service sector. These consumers are often brought to the Chief Psychiatrist's attention by mental health services seeking assistance in responding to their needs. At other times the Chief Psychiatrist may become aware of the individual via a complaint, adverse event or public concern. The Chief Psychiatrist can provide a useful co-ordinating role in bringing together the various services and service elements to achieve an appropriate service system response.

In 2006, the department's Multiple and Complex Needs Initiative (MACNI) continued to take an increasing role in the care co-ordination of people with complex and multiple needs. However, the Chief Psychiatrist's advice was often sought to clarify the mental health needs of such individuals and identify the most appropriate role and response from mental health services.

Spectrum, the Statewide Service for Personality Disorder in Victoria, continued its important role in providing expert clinical advice in individual cases, in close collaboration with the Chief Psychiatrist, and through its consultation, supervision and education activities with the service sector.

During the reporting period, the Chief Psychiatrist or a senior clinical advisor attended more than 20 case conferences concerning clients with complex needs. Such requests are becoming more frequent and appear to reflect a growing trend for services to look centrally for assistance and direction in meeting the needs of this client group where there are exceptional needs and high-risk issues.

3.3 Improving service quality

Quality Assurance Committee

The Chief Psychiatrist's Quality Assurance Committee (QAC) is established under section 106AC of the *Mental Health Act 1986* and is also a consultative council appointed under the *Health Act 1958*. The function of the QAC is to assist the Chief Psychiatrist in overseeing and monitoring standards of treatment and care in Victorian public mental health services. The Chief Psychiatrist chairs the QAC and membership consists of senior psychiatrists and mental health clinicians drawn from across the mental health service system. Members are appointed as authorised officers under the Mental Health Act for the purposes of their work with the QAC, and are bound by the confidentiality provisions relating to authorised officers and consultative councils under the respective Mental Health and Health Acts. The QAC meets quarterly and membership is reviewed every three years. The membership of the QAC in 2006 is provided in Appendix 1.

Key activities undertaken by QAC in 2006 included:

Developing a project proposal and forming a partnership with the VQC to support the development and implementation of the Creating Safety: Addressing Seclusion Practices Project.

- Reviewing sentinel events involving mental health consumers as part of the department's Sentinel Event Program pertaining to all health services.[4]
- Monitoring and reviewing data on reportable deaths and statutory practices, including seclusion, mechanical restraint and electroconvulsive therapy.
- Reviewing coronial recommendations and considering the practice implications.
- Reviewing clinical practice guidelines.

Further information on the QAC is available on www.health.vic.gov.au/mentalhealth

Education and training

The Chief Psychiatrist's office has a broad education and training role in informing mental health service clinicians about the interpretation and application of the Mental Health Act to practice, and acceptable practice standards. This occurs through formal training sessions, often in response to a specific request from a mental health service for input in a particular area, or more informally through the frequent interactions with mental health service clinicians when they contact the office with a query or when discussing a complaint.

In 2006, the Chief Psychiatrist and senior clinical advisers provided a range of presentations and lectures on a variety of topics including mental health legislation, the mental health service system in Victoria, electroconvulsive therapy and the role and function of the Chief Psychiatrist and the office.

Clinical guidelines

The Chief Psychiatrist issues clinical guidelines and program management circulars as needed in particular areas of practice or service delivery. A guideline is often initiated by a change in legislation when there is a need to assist services and clinicians understand the clinical application of the change. At other times a guideline may be developed in response to an identified area of practice where there is an apparent need to establish standards and guidance to promote more consistent practice as part of quality improvement.

During 2006, the following new guidelines were issued:

- *Sentencing and Mental Health Acts (Amendment) Act 2005: Summary of key amendments*. Summary of the key amendments to the *Sentencing Act 1991* and the *Mental Health Act 1986* that came into effect on 1 October 2006.
- *Changes to hospital orders under the Sentencing Act 1991*. Information on changes to the law and policy requirements governing hospital orders, which came into effect on 1 October 2006.
- *Restricted involuntary treatment orders and restricted community treatment order.* Information about the legal and policy requirements governing people on restricted involuntary treatment orders and restricted community treatment orders.

4 Sentinel events are defined as "...relatively infrequent, clear-cut events that occur independently of a patient's condition, commonly reflect hospital system and process deficiencies; and result in unnecessary outcomes for patients". It is believed that the frequency of sentinel events is likely to be reduced by examining the settings in which they occur, and identifying system changes required, which may reduce the likelihood of similar occurrences in the future. Suicide of an inpatient is one of nine sentinel events that health services must report under the Sentinel Event Program. Further information is available on the program's website: www.dhs.vic.gov.au/health/clinrisk/sentinel

- *Quality improvement themes from coronial recommendations received by the Chief Psychiatrist in 2005*. Key coronial recommendations made in 2005, practice themes and the Chief Psychiatrist's comments in respect to the recommendations.

The following publications were revised to reflect relevant legislative changes and clarify aspects of practice:

- *Patients rights booklets: About your rights.*
- *Memorandum of Understanding (MOU) between the Chief Psychiatrist and the Public Advocate, Responsibilities and roles when working with people with mental illness.*
- *Seclusion: Chief Psychiatrist's Guideline.*
- *Mechanical Restraint: Chief Psychiatrist's Guideline.*

Copies of all current Chief Psychiatrist guidelines are available on the Department of Human Services website at www.health.vic.gov.au/mentalhealth

Clinical leadership

As part of their statutory responsibility for standards of treatment and care, the Chief Psychiatrist conducts a range of activities to provide clinical leadership and facilitate practice and service development. During the year, the Chief Psychiatrist held four authorised psychiatrist forums, bringing together authorised psychiatrists and clinical directors from across the state to discuss and address a range of issues. Matters considered included: mental health workforce, access to mental health services, safety and quality in practice and service delivery, coronial recommendations, implementation of the amendments to the Sentencing and Mental Health Acts, introduction to the *Charter of Rights and Responsibilities 2006*, as well as presentations on other national and state initiatives such as the Victorian Creating Safety: Addressing seclusion practices project and the National Youth Mental Health Initiative: Headspace.

The Chief Psychiatrist's Adult Nurse Inpatient Unit Managers Clinical Practice Standards Forums also met three times during 2006, bringing together senior nurses from around the state to discuss common issues. Nurse unit managers have a key role in establishing and supporting quality practice in inpatient mental health services. Forum topics included clinical documentation, seclusion practices, management of acutely aroused consumers, the new Charter of Rights and Responsibilities and its implications for practice, and the unit manager's role in clinical leadership and building a therapeutic environment.

The Chief Psychiatrist hosted an interactive forum *Treatment plans: Can we do better?* attended by 140 clinicians, carers and consumers and representatives from the Mental Health Review Board, to discuss their experiences developing, implementing and reviewing treatment plans over the 18 months since they were introduced into the Mental Health Act. Representative speakers gave their respective views on some of the issues identified and ideas about how practice might be improved. The forum provided an opportunity for clinicians, consumers and carers to work together to try and develop a shared understanding about the treatment plans' purpose, and how they might best be structured to be of most use to their intended audience, consumers and carers: for example, the focus and scope of the content, user-friendly language, incorporation of the consumer's view, carer involvement and timeliness. Feedback from the forum will assist in further developing the Chief Psychiatrist's treatment plan guideline.

The Deputy Chief Psychiatrist also convened four Aged Persons Mental Health Program Forums with clinical directors and senior clinicians from the aged persons mental health sector. These have become established as regular quarterly meetings to address issues specific to the aged sector. Among the topics discussed were rural and regional service delivery issues, specialist mental health residential care facilities, cross program and interface issues with Aged Care Assessment Services and Royal District Nursing Services, workforce and education and training.

Also during 2006, the Deputy Chief Psychiatrist participated with the Department of Human Services Mental Health Branch and the Aged Care Quality Improvement Unit in visits to Aged Persons Mental Health Residential Services (APMHRS) to provide advice and feedback on quality of care related issues. Many of the issues identified were common across generic aged residential services and included leadership, clinical governance, access to multidisciplinary teams, care planning processes and behaviour management.

The Department of Human Services will undertake a range of activities in 2007 to further support quality of care within APMHRS. The Deputy Chief Psychiatrist will also convene a forum of APMHRS unit managers to foster information sharing, best practice and innovation with the aim of further supporting leadership within APMHRS. It is anticipated that the forum will meet four times during 2007.

3.4 Department and stakeholder liaison

During 2006, the Chief Psychiatrist and senior clinical advisors participated in and contributed to a number of Mental Health Branch working parties and consultation processes. Some of the key involvements were in the area of workforce development, case management, aged care, eating disorder services, quality and safety, education and training, and triage practices.

Regular liaison occurs with a range of government, non-government and advocacy bodies including the Public Advocate, Health Services Commissioner, Coroner, Mental Health Review Board and the Ombudsman on matters of common interest and also in response to specific issues as they arise.

A Memorandum of Understanding between the Chief Psychiatrist and Public Advocate defining their respective roles and responsibilities when working with people with a mental illness was finalised and made available on the Chief Psychiatrist's website in September 2006. Where there is overlap between their roles and responsibilities under their respective legislations, the memorandum provides guidance to mental health professionals and guardians working together to make decisions on behalf of persons who are unable to consent because of mental illness or disability.

The Chief Psychiatrist and senior clinical advisers are also involved in a number of departmental and interdepartmental committees.

3.5 Forensic mental health

Forensic mental health services are provided for mentally ill offenders or consumers who present a serious risk of offending behaviour. Courts can make various orders under the *Sentencing and Crimes (Mental Impairment and Unfitness to be Tried) Acts* when determining the most appropriate disposition for a person where mental illness has been seen to play a role in the offending behaviour. Instead of a sentence, a court may direct a person to receive treatment as an involuntary patient in an approved mental health service. In Victoria, forensic mental health services are provided within the prison system, in a specialist forensic mental health hospital (Thomas Embling Hospital) and in the community. The Chief Psychiatrist has a range of responsibilities under the *Mental Health Act 1986* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* in relation to mentally ill offenders.

Implementation of Mental Health Act and Sentencing Act amendments

The *Sentencing and Mental Health Acts (Amendment) Act 2005* made significant changes to the Sentencing Act and the Mental Health Act provisions governing hospital orders, hospital security orders and restricted community treatment orders, effective from 1 October 2006. Throughout 2006, the Chief Psychiatrist's office was involved in helping prepare mental health services and clinicians to implement the amendments within their services.

Three Program Management Circulars were developed by the Mental Health Branch Legal and Forensic Policy Unit, in consultation with the Chief Psychiatrist, to provide information on the changes and expected practice: *Sentencing and Mental Health Acts (Amendment) Act 2005: Summary of key amendments, Changes to hospital orders under the Sentencing Act 1991,* and *Restricted involuntary treatment orders and restricted community treatment orders.*

The changes were publicised through the Authorised Psychiatrist's Forum and other venues, and the Chief Psychiatrist and clinical advisers provided advice to services on the application of the new provisions and the transitional arrangements for people on existing hospital orders.

One of the key amendments was the introduction of a new Restricted Involuntary Treatment Order (RITO) and Restricted Community Treatment Order (RCTO), in place of the previous hospital order regime. A RITO can only be made for people found guilty of a non-serious offence for a maximum of two years, whereas the previous hospital orders were of indefinite duration and could be ordered in relation to any offence, including a serious offence. Special transition arrangements apply for patients on existing hospital orders at 1 October 2006, including that all such orders will expire on 1 October 2008.

The amendments also give authorised psychiatrists the power to make a RCTO under section 15A of the Mental Health Act for a person on a RITO, and to vary, extend and revoke a RCTO. Previously only the Chief Psychiatrist could perform these functions. A RCTO enables a person on a RITO to live in the community while receiving treatment for their mental illness, subject to conditions determined by the authorised psychiatrist. The RCTO continues for as along as a person remains on a RITO (until it expires or is discharged) or until the RCTO is revoked or discharged. Only the Chief Psychiatrist or the Mental Health Review Board can discharge a RITO.

During 2006, 12 RCTOs were made for people on existing hospital orders under the old legislation. No RITOs or RCTOs were made under the new provisions between 1 October 2006 and 31 December 2006.

Further information about the RITOs and transitional arrangements regarding the old hospital orders can be found in the aforementioned Chief Psychiatrist's guidelines.

Security patients

Security patients are persons detained in an approved mental health service on a court order under the *Sentencing Act* (s.93 (1)(e)) as part of their sentence, or by order of the Secretary of the Department of Justice under the Mental Health Act (s.16), where a sentenced prisoner requires involuntary treatment for their mental illness. In Victoria, such patients generally receive treatment and care for their mental illness in the secure specialist forensic mental health service, Thomas Embling Hospital, until well enough to be returned to prison or when their sentence ends.

The Chief Psychiatrist is responsible for approving the person's discharge back to prison if satisfied that the criteria for being a security patient no longer apply. In doing so, the Chief Psychiatrist must have regard primarily to the person's current mental condition and consider their medical and psychiatric history and social circumstances. People requiring involuntary treatment at the expiry of their sentence may receive treatment under the standard provisions of the Act.

The Chief Psychiatrist has the power to authorise special leave for security patients for specifically-defined purposes, most commonly medical treatment or to attend court. Special leave for security patients cannot exceed seven days in the case of medical treatment or 24 hours in any other case. The Chief Psychiatrist is required to immediately notify the Secretary of the Department of Justice when approving special leave or discharging a person from security patient status.

Forensic Leave Panel

The Forensic Leave Panel is an independent statutory body established under the *Crimes (CMIA) Act 1997* to make decisions regarding leave for persons subject to custodial supervision orders. The Chief Psychiatrist (or delegate) is a member of the panel.

The Chief Psychiatrist has the power under the CMIA to suspend leave for forensic patients at any time if satisfied that the safety of the person or members of the public is at risk of serious danger. During the 2006 reporting period, the Chief Psychiatrist did not have to suspend the leave of any forensic patient.

The Forensic Leave Panel must submit a yearly report to the Attorney General that includes the number and type of leave applications made, leave refused and leave suspended. More information can be found in the Forensic Leave Panel's 2006 annual report.

4 Future priorities

The Chief Psychiatrist's office has identified a number of priorities for 2007-08:

Implementation of the joint VQC-QAC project–*Creating safety: addressing seclusion practices.* Reducing the use of seclusion and restraint in mental health services has been identified as one of four safety priorities under the National Strategy - '*National Safety Priorities in mental health: a national plan for reducing harm*', which was endorsed by the Australian Health Ministers' Advisory Council in October 2005. The Chief Psychiatrist has a statutory responsibility in relation to seclusion practice and has had an ongoing interest in promoting better practice in the management of acutely disturbed consumers and safer inpatient environments for consumers and staff.

Monitoring of electroconvulsive therapy (ECT) practice. Review of the ECT licensing and practice guidelines and ECT training to reflect current developments in the area.

Improving triage policy and practice. Development and implementation of statewide triage guidelines and a mental health triage scale for mental health services, in conjunction with the Mental Health Branch Triage Scale Advisory Committee, to promote more consistent practice.

Review of the section 106 powers of investigation. Clarification of the operation of section 106 and related policies and procedures to provide a more transparent framework for the use of the provisions.

Improving complaints-handling processes. Implementation of an enhanced complaints management system to assist with more timely management of complaints and improved data analysis.

Appendix 1
2006 membership of the Quality Assurance Committee

Associate Professor Amgad Tanaghow Chief Psychiatrist Mental Health Branch Department of Human Services	Dr Kuruvilla George Deputy Chief Psychiatrist Mental Health Branch
Professor Mark Oakley-Brown Clinical Director Latrobe Regional Mental Health Service	Ms Karlyn Chettleburgh General Manager Inpatient Services Thomas Embling Hospital
Dr Tom Callaly Chief of Services, Barwon Health Community and Mental Health Program	Associate Professor Saji Damodaran Clinical Director Department of Psychiatry Southern Health
Ms Deanna Clancy Senior Clinical Adviser Mental Health Branch Department of Human Services	Dr Paul Denborough Director Child & Adolescent Mental Health Services The Alfred
Ms Sandra Davidson Manager Aged Psychiatry Service Northeast Health Wangaratta	Ms Kate Thwaites Clinical Adviser Mental Health Branch Department of Human Services
Associate Professor Peter Doherty Director of Psychiatry The Alfred	Ms Sandra Keppich-Arnold Associate Director of Nursing Caulfield Aged Persons Mental Health Service
Mr Peter Kelly Manager Mental Health Services Melbourne Health	Dr Bob Salo Director of Child & Adolescent Mental Health Services Royal Children's Hospital
Ms Bee Mitchell-Dawson Senior Clinical Adviser Mental Health Branch Department of Human Services	Professor Daniel O'Connor Director of Clinical Services Aged Persons Mental Health Southern Health