Chief Psychiatrist's annual report

2014–15

VICTORIA State Government | Health and Human Services

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Foreword

I am very pleased to introduce the first Chief Psychiatrist's annual report prepared under the *Mental Health Act 2014*. Since 2003 the Chief Psychiatrist has published an annual report; however, this is now a requirement under the Act.

This report covers the period from 1 July 2014 to 30 June 2015 and outlines the broad and diverse range of activities my office leads or to which it contributes. The Act came into effect on 1 July 2014 following six years of preparation and consultation with the Victorian community. In-depth planning began in earnest within the Office of the Chief Psychiatrist in early 2014 to prepare for the broadened role of the Chief Psychiatrist, with the focus on system-wide clinical leadership and promoting the delivery of safe and effective mental health services. Key clinical guidelines were developed to help mental health services to implement the requirements of the Act.

Victoria's first Mental Health Complaints Commissioner commenced operation with the new Act, and a process for transitioning complaints, previously handled by my office, was put into place. The Act also saw the establishment of the Mental Health Tribunal as a safeguard to protect the rights of people with mental illness. While both the Mental Health Complaints Commissioner and the Mental Health Tribunal operate independently, we share a common commitment to improving treatment and care of people using publicly funded mental health services and promoting people's rights.

During the 12 months of this reporting period efforts in my office concentrated on overseeing and monitoring the implementation of the Act, ensuring people's rights were upheld and responding to the statutory requirements of the Act. To that end three new committees have been established that have a key role in promoting best practice through providing advice on the use of electroconvulsive treatment, the use of restrictive interventions and the morbidity and mortality of people accessing public mental health services. Membership of these committees include clinical and sector representatives to help drive continuous improvement through monitoring practice, to learn from critical incidents and to inform the work of my office.

At the heart of the Act is the aim of protecting the rights of people through enhanced safeguards. An important mechanism is the requirement for designated mental health services to report on the use of physical restraint – in addition to the existing requirement to report the use of mechanical restraint and seclusion. This is the first year that physical restraint in designated mental health services has been reported and is an opportunity to understand this practice and to continue to work with services to reduce or eliminate restrictive interventions.

The last year has seen a lot of change, including the establishment of the Department of Health and Human Services, which brought my office into the Mental Health and Drugs Branch.

I would like to acknowledge that for the 2014–15 reporting period Dr Mark Oakley Browne was the Chief Psychiatrist. Dr Oakley Browne had a key role in the 12 months leading up to and during the first year of operation of the new Mental Health Act and was instrumental in embedding the clinical leadership role of the Chief Psychiatrist. I would also like to acknowledge the contribution of Dr Daniel O'Connor, Deputy Chief Psychiatrist (Aged Persons), and his predecessor, Dr Brett Coulson. I would also like to acknowledge the significant contribution of Tracy Beaton, the Chief Mental Health Nurse, during this period; Tracey has subsequently left this position. Thank you also to the staff in my office, who are dedicated to promoting the rights of people accessing mental health services, and their commitment to supporting continuous improvement in the service system.

It is also essential that we recognise the important role consumers, carers, families and other support people have in guiding the work of my office. The feedback and advice provided is valuable in informing our quality endeavours.

Neil Coventry
Acting Chief Psychiatrist

The role of the Chief Psychiatrist

Mental Health Act 2014

On 1 July 2014 the *Mental Health Act 2014* commenced, following significant effort undertaken across the then Department of Health[1] (now the Department of Health and Human Services) in drafting the Bill and conducting community consultations. The Act aims to improve the treatment experiences of people with a severe mental illness by actively involving and supporting those people, and their families and carers, in making decisions about their treatment and exercising their rights. It does this by: encouraging partnerships among carers, service users and clinicians; minimising the use and duration of compulsory treatment in inpatient and community settings; enhancing oversight of the use of restrictive interventions; and establishing safeguards for using electroconvulsive treatment (ECT).

The Act redefines the role of the Chief Psychiatrist to include providing system-wide clinical advice and leadership, and promoting the delivery of safe and effective mental health services. This is achieved through the development of clinical guidelines, training and education. The Chief Psychiatrist continues to monitor the provision of mental health services, and may conduct investigations, clinical audits or clinical service reviews to improve patient safety and wellbeing. The Chief Psychiatrist also has a role in monitoring service provision and assisting services to comply with the Act and clinical guidelines.

The Act introduces principles that must be considered by clinicians and service providers when providing mental health treatment and care. The principles outline that:

- Treatment and assessment should be provided in the least restrictive way.
- Services should bring about the best outcomes and promote recovery and community participation.
- People should be involved in all decisions and be supported to be involved decisions that involve a degree of risk.
- People should have their rights, dignity and autonomy respected and promoted.
- Medical and other health needs, including alcohol and other drug problems, should be recognised and responded to.
- Individual needs relating to culture, communication, age, disability, religion, gender or sexuality should be recognised and responded to.
- Children and young people should have their best interests recognised and promoted.
- Carers, including children, should be involved whenever possible.

The Chief Psychiatrist is employed by the Secretary to the Department of Health and Human Services under s. 119 of the Act and is subject to the Secretary's general direction.

Role and functions

Under s. 120 of the Mental Health Act, the role of the Chief Psychiatrist is to:

- provide clinical leadership and expert clinical advice to mental health service providers in Victoria
- promote continuous improvement in the quality and safety of mental health services provided by mental health service providers
- promote the rights of people receiving mental health services from mental health service providers
- provide advice to the Minister and the Secretary about the provision of mental health services by mental health service providers.

The Act outlines a number of functions in s. 121 that support the Chief Psychiatrist in providing clinical leadership and promoting the delivery of safe and effective mental health services including to:

- develop and assist services to comply with standards, guidelines or practice directions

[1] The Department of Health and Human Services formed on 1 January 2015.

- provide information or training, and to monitor the provision of services to promote improved quality and safety
- assist mental health services to comply with the Act, regulations under the Act or any codes of practice
- conduct investigations, clinical practice audits and clinical reviews of mental health service providers
- analyse data and receive reports on the performance of ECT in public mental health services, seclusion and bodily restraint (mechanical and physical)
- undertake research and publish information about the provision of mental health services
- publish an annual report
- give directions to mental health service providers
- promote cooperation and coordination between mental health services and providers of health, disability and community support services.

Departmental role

The Chief Psychiatrist, although a statutory role under the Mental Health Act, also holds an executive officer role in the Department of Health and Human Services. The Chief Psychiatrist leads a team that consists of the Office of the Chief Psychiatrist (OCP) and the Office of the Chief Mental Health Nurse (OCMHN).[2]

The OCP provides support to the Chief Psychiatrist and consists of two deputy chief psychiatrists (Child and Youth Mental Health, and Aged Persons Mental Health), clinical advisors, project officers and administrative staff.

The Chief Psychiatrist and the Chief Mental Health Nurse work across a number of shared projects and priorities. The Chief Mental Health Nurse provides clinical leadership and strategic advice to government in relation to all aspects of mental health nursing. The OCMHN contributes to the statutory responsibilities of the Chief Psychiatrist and leads initiatives that promote a recovery-oriented and trauma-informed mental health system.

Priorities

The activities of the Chief Psychiatrist cover a range of statutory, advisory, education and departmental responsibilities.

This report has been structured around the priority areas of the Chief Psychiatrist:

- Part 1: providing clinical leadership and supporting continuous improvement in the quality and safety of mental healthcare and treatment
- Part 2: ECT activities and ECT use in Victorian public mental health services
- Part 3: morbidity and mortality portfolio, including the monitoring of reportable deaths and other serious adverse events related to clients of Victorian public mental health services
- Part 4: initiatives to reduce the use of restrictive interventions and monitoring the use of restrictive interventions in Victorian public mental health services
- Part 5: promoting the rights of people accessing mental health services.

Although the structure of this report reflects the portfolios of work led within the OCP, the portfolios are interrelated and the role of the Chief Psychiatrist to provide clinical leadership and promote the rights of people accessing services is distributed across all areas of work.

[2] In August 2015 the OCP and the OCMHN joined the department's Mental Health and Drugs Branch.

Part 1: Clinical leadership

The *Mental Health Act 2014* refocuses the Chief Psychiatrist's role to providing system-wide clinical leadership. Improving mental health service quality leads to improved outcomes for consumers and their carers and families. The OCP undertakes a broad range of activities to monitor mental health service delivery and drive continuous improvement across the Victorian specialist mental health system. To promote safe and effective mental health services, the OCP: provides expert clinical leadership and advice; monitors the outcomes of clinical reviews, audits and investigations; and conducts and contributes to education and training.

Key areas of focus during the first year of operation of the Act include supporting services to operate within the new legislation, reducing the use of restrictive interventions and establishing the three committees: ECT Monitoring Committee, Morbidity and Mortality Committee and the Restrictive Interventions Committee.

The way in which the OCP provides expert clinical leadership is diverse and is demonstrated in the day-to-day activities of the office, as well as the long-term initiatives undertaken in partnership with program areas across the department.

Training and education

The Chief Psychiatrist has a role to provide education and training about the clinical application of legislation and best practice mental health treatment and care. The Chief Psychiatrist works with several key stakeholders across the department in this regard.

The following initiatives are examples of activities undertaken throughout 2014–15 by the OCP and the OCMHN.

Gender sensitivity training

Mental health services have a responsibility to provide a safe and supportive environment for people accessing their services. The Chief Psychiatrist and the Chief Mental Health Nurse share an ongoing commitment to supporting gender-sensitive and safe services, demonstrated by previous activities such as the development of the *Service guideline on gender sensitivity and safety* (released in 2011).

Throughout 2014–15, the Centre for Psychiatric Nursing delivered a train-the-trainer package to key staff across adult acute inpatient units to sustainably embed gender safety and sensitivity practices.

Foundation skills in child and youth nursing

Commissioned by the OCMHN, the University of Melbourne's Centre for Psychiatric Nursing delivered 'Foundation skills in child and youth mental health service nursing'. The course was designed to provide nurses with engagement and reflective practice skills for working with children and youth in inpatient units.

This training was rolled out throughout 2014 within all acute child and adolescent inpatient settings in Victoria. The training aimed to improve consumers' and their families' experiences of care, and incorporate reflective practice into nursing care. Further benefits included improved capability and capacity of nursing staff to manage complex presentations and reduce restrictive interventions.

Therapeutic foundations in nursing

Embedding recovery-oriented practice in mental health service delivery is a shared commitment of the Chief Psychiatrist, the Chief Mental Health Nurse and mental health services. The Act also highlights a recovery orientation within its principles. Building on the Victorian *Framework for recovery-oriented*

practice (2011), Spectrum (Eastern Health) was funded to design and deliver the 'Therapeutic foundations in mental health nursing' training pilot. The training course links to the Victorian framework by offering a set of capabilities that enable nurses to engage with consumers at the level of their unique personal experiences, processes and journey towards wellbeing. The course introduces basic psychotherapeutic ideas within the context of mental health problems that consumers experience.

Engagement across the system

The OCP undertakes a number of initiatives to foster dialogue and engage with clinicians to promote a safe and effective mental health service system. The nature of this engagement is varied and broad, involving participation in committees and working groups or providing input during the consultation stages of policy or strategy development. The Chief Psychiatrist, deputies and other branch staff also undertake a regular program of visits to services to discuss service delivery and treatment issues, and to promote coordination of care across the health system.

Through building relationships with clinical leaders and maintaining an understanding of local priorities and challenges, the OCP can provide expert clinical advice and highlight clinical issues that require further attention or need to be considered in policy development.

Clinical leaders forum

The Chief Psychiatrist's Clinical Leaders forum includes authorised psychiatrists, senior mental health nurses, senior allied health professionals and departmental consumer and carer portfolio holders. The aim of the forum is to provide advice, discuss and resolve system-wide clinical practice issues and share information on good clinical practice. Some of the issues discussed during the reporting period included implementation of the Act, minimising the use of restrictive interventions and the new requirement to record the use of physical restraint.

Victorian senior mental health nurse forum

The Chief Mental Health Nurse hosts a statewide senior nurse forum. This multi-focus forum contributes to the promotion of strategic mental health nursing leadership, as well as issues affecting local service operations. Achievements during the reporting period included providing strategic advice on:

- *Specialist mental health workforce framework 2015–25* initiatives
- implementing the Mental Health Act
- reducing restrictive interventions.

Policy development and service planning

The OCP participates in a range of committees and working groups across the department, other government agencies and the health system, providing advice on a range of clinical issues for consideration in policy development and service planning. This work spans multiple government portfolios and priority areas.

Some of the committees the OCP is involved in include:

- Department of Health and Human Services and Victoria Police Inter Departmental Liaison Committee
- Suicide and Self-Harm Prevention Framework Project Steering Committee
- Clinical Advisory Committee, Department of Justice
- Physical Health in People with Severe Mental Illness Working Group, Royal Australian and New Zealand College of Psychiatrists
- Commonwealth Safety and Quality Partnership Standing Committee of the National Mental Health Standing Committee
- Patient Safety Advisory Committee reporting to the Minister for Health.

Within the department, the OCP works with the mental health program areas, Ageing and Aged Care Branch, Service Design and Operations (Disability Services) and the Office of Professional Practice. The Mental Health Branch[3] leads the policy, operations and performance management aspects of mental health service delivery, and the OCP contributes to this work through performance meetings with clinical services and senior leader forums. The senior leaders meeting focuses on strategic issues and the interface of the mental health system with related sectors including community health, primary health, drug treatment, disability, housing services and the justice system. The Mental Health Branch also leads age-range-specific operational meetings on child and youth and adult and aged persons, as well as meetings with each metropolitan area mental health service.

Additionally, the OCP works with a number of stakeholders across the government including the Public Advocate, the Mental Health Complaints Commissioner, the Mental Health Tribunal and the Coroners Court of Victoria.

Promoting continuous improvement

In addition to the key portfolios described later in this report, the OCP undertakes a number of projects and initiatives to improve the quality and safety of mental health services. Utilising expertise from within the branch and engaging sector representatives, the OCP is responsive to systemic issues identified by services.

Recovery-oriented practice

Throughout 2014–15 the OCMHN worked with the Centre for Psychiatric Nursing to establish an online recovery library. The library provides recovery-oriented references and resources to support mental health services and individual practitioners to continue their progress in integrating a recovery approach to service delivery.

Recovery-oriented care is a key principle of the Act, and this activity further supports the clinical and non-clinical workforce to embed the principles of the Victorian *Framework for recovery-oriented practice* (2011) in service policies, procedures and professional practice.

The library may accessed at <http://recoverylibrary.unimelb.edu.au>.

Multidisciplinary leadership

The Victorian Mental Health Inter-professional Leadership Program creates a community of practice that aims to build a culture of innovation and knowledge exchange. The program supports new and innovative ways of thinking to drive practice change and service improvement in critical areas such as recovery-oriented practice and supported decision making.

Established by the OCMHN and launched in May 2015, the program was created in partnership with the departmental health workforce branch, the Western Education and Training cluster and a multidisciplinary cohort of experts from within the mental health system, including lived experience experts.

The program will continue throughout 2015–16 and will support candidates to become future leaders of multidisciplinary teams.

Mental health nursing leadership

The Chief Mental Health Nurse has a key role in supporting and driving effective and innovative mental health nursing leadership. The OCMHN undertakes a range of projects to engage mental health nurses, promote partnership across disciplines and respond to service issues.

Throughout 2014–15, the following initiatives were undertaken.

[3] On 3 August 2015 the Mental Health Branch became the Mental Health and Drugs Branch, incorporating the OCP.

- To strengthen the assessment and intervention skills of emergency department, mental health and triage nurses in working with clients with mental health and amphetamine-type substance-use issues, a project is being undertaken to explore the current issues and needs of emergency departments. This project is aligned with the Victorian Government's *Ice action plan* and will support staff to better respond to people with substance issues.
- In June 2015 a planning day was held to bring together mental health nurses, training and education organisations, unions and the department. The theme was *Addressing the current and future needs of Victoria's mental health nursing workforce* and aimed to establish a platform to respond to issues faced by Victorian mental health services and create collaboration on addressing workforce issues. There was a strong willingness from all stakeholders to work together to find solutions.
- The Chief Mental Health Nurse, with senior mental health nurses from Victorian public mental health services, hosts a mental health nursing booth at the Australian College of Nursing's 'Nursing and Health Expo'. The event attracts more than 3,600 visitors including secondary and tertiary students and is an important activity in promoting mental health nursing as a career.
- To support mental health nurses and alcohol and other drug staff working in Aboriginal community-controlled health organisations, the OCMHN commissioned a study of professional development needs. The findings of the study informed the development of 'Naanggabun Yarning', a culturally appropriate supervision program that will be rolled out to Aboriginal workers and non-Aboriginal supervisors throughout 2015–16.

Medication safety

The Chief Psychiatrist has an interest in promoting safe medication practices and reducing adverse medication events in mental health services. Consistent with this focus, two initiatives have been established to explore medication errors that occur in acute mental health inpatient units across Australia, and to improve the safe prescribing of psychotropic medication to people with dementia living in aged mental health units.

The Reducing Adverse Medication Events in Mental Health project is being undertaken as part of the program of the Safety and Quality Partnership Standing Committee. Funded by the Australian Health Minister's Advisory Council, this project will explore the implementation of evidence-based medication safety interventions. Project findings will inform future activities in medication safety in mental health services.

To improve the quality of psychotropic medication prescribing to people with dementia in aged mental health acute units, the OCP is conducting an audit of prescribing practices. The findings of the audit will be compared with evidence-based standards and will inform the development of a clinical guideline and a quality improvement tool for services.

Aged mental health services

The OCP, in partnership with the Mental Health and Ageing and Aged Care Branch, is establishing a national survey of aged mental health services' care of older people with severe and persistent behavioural and psychological symptoms.

The survey will provide information about: current service provision in community, hospital and residential facilities; access to acute, non-acute and transitional care wards; and relationships with other services. The survey's findings will be shared to support better interventions and coordination of care.

Part 2: Electroconvulsive treatment

ECT is a procedure performed under general anaesthesia and muscle relaxation medication in which modified seizures are induced by the selective passage of an electrical current through the brain. ECT may be prescribed for treating severe depression but may also be used for other serious types of mental illness.

The OCP has published guidelines about the practice of ECT in Victoria since 1991. These guidelines incorporate new knowledge about ECT, advances in technology and major changes to the treatment environment.

The Chief Psychiatrist has the following functions under the Mental Health Act in relation to ECT:

- to receive reports from mental health services about the provision of ECT[4]
- to report on the number of young people (under 18 years of age) who received ECT[5]
- to submit a report to the Minister for Mental Health before 1 November 2019 in relation to the number of young people who received ECT between 1 July 2014 and 30 June 2019.[6]

These functions support the OCP in promoting the rights of people receiving mental health services, and driving continuous improvement in the quality and safety of mental health services through the monitoring of the performance of ECT at designated mental health services.

ECT committees

In 2014 the Chief Psychiatrist established the ECT Monitoring Committee with clinical experts and service representatives to assist and provide advice about clinical issues relating to the performance of ECT. The role of the committee is to:

- review and analyse information and provide advice about the performance of ECT
- provide advice about clinical practice audits or clinical reviews relating to ECT
- promote best practice in the delivery of ECT informed by evidence
- provide assistance in the development or review of standards, guidelines or practice directions in relation to ECT.

During 2014–15 the committee provided advice about the development of two ECT guidelines and an audit tool (developed by ECT coordinators) that will support services to self-audit ECT processes and systems. This supports continuous improvement in mental health service quality and safety in relation to the performance of ECT.

Youth ECT subcommittee

The Act strengthened the safeguards regarding the use of ECT and requires the approval of the Mental Health Tribunal to perform ECT on a person under 18 years of age. It is uncommon for ECT to be given to a young person under the age of 18 years but may be clinically indicated in limited circumstances. Mental health services are required to report to the OCP when ECT is prescribed to a young person and to outline that appropriate baseline testing has occurred.

To support the Chief Psychiatrist's strengthened role in overseeing ECT for young people, an ECT subcommittee was established. Similar to the ECT committee, this subcommittee provides advice on matters relating to providing ECT to young people under 18 years old but may also review specific cases and provide advice about the quality and safety of the care provided.

[4] Reporting requirement is for designated mental health services (s. 99 in the *Mental Health Act 2014*)

[5] Reporting requirement is for designated mental health services (s. 145 in the *Mental Health Act 2014*)

[6] Section 145 in the *Mental Health Act 2014*

Ultra-brief pulse ECT

Ultra-brief pulse ECT is a new method of delivering ECT. It may require a greater number of treatments to achieve wellness but causes less cognitive impairment. There is evidence that ultra-brief pulse ECT is an effective treatment for severe depressive episodes.

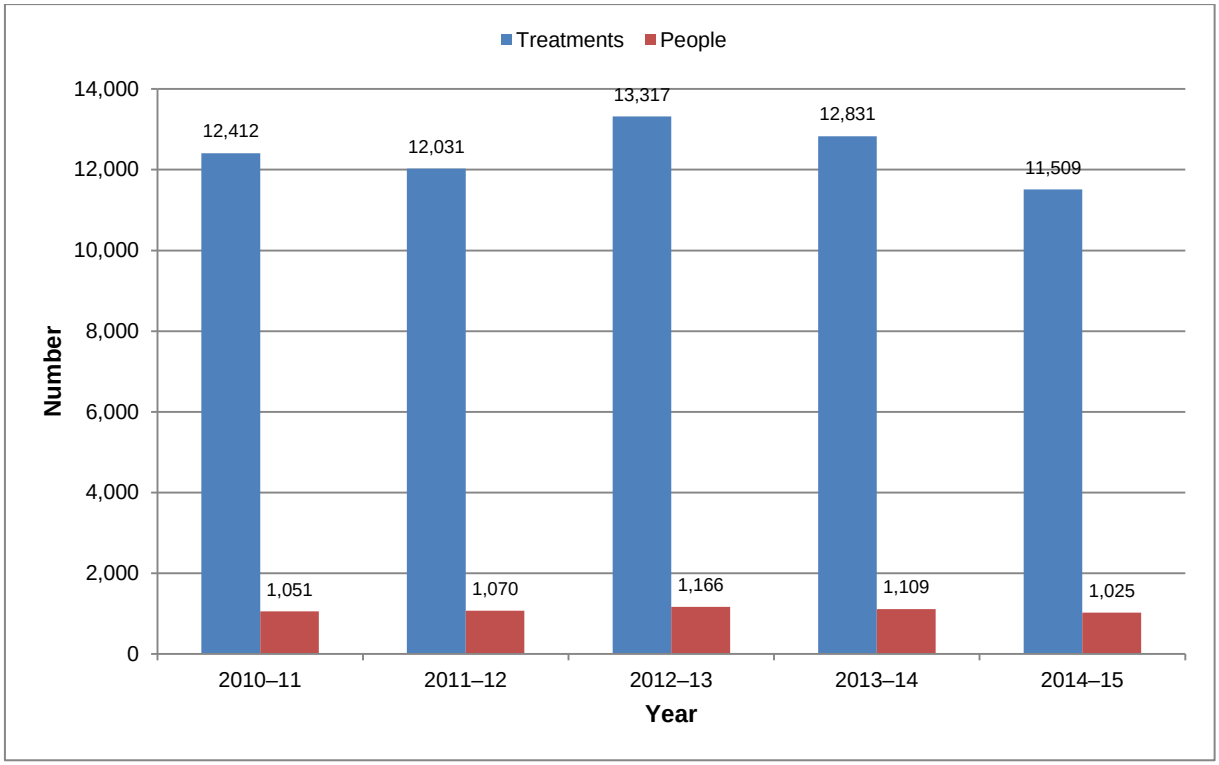
During 2014–15 the OCP undertook a survey of ECT practices in public mental health services. The findings indicated that very few public mental health services use this form of treatment. In 2015–16 the OCP will host an educational forum on the use of ultra-brief pulse ECT to support services to offer this form of treatment in order to provide people with greater choice.

ECT use

The OCP receives reports from public mental health services about the provision of ECT. The 2014 Act removed this reporting requirement for private mental health services. The Act established the Mental Health Tribunal as a safeguard to protect the rights and dignity of people accessing mental health services. The tribunal reviews applications to perform ECT on people who do not have the capacity to give informed consent and on all people under 18 years of age, regardless of whether the young person is a compulsory patient or is receiving voluntary treatment.

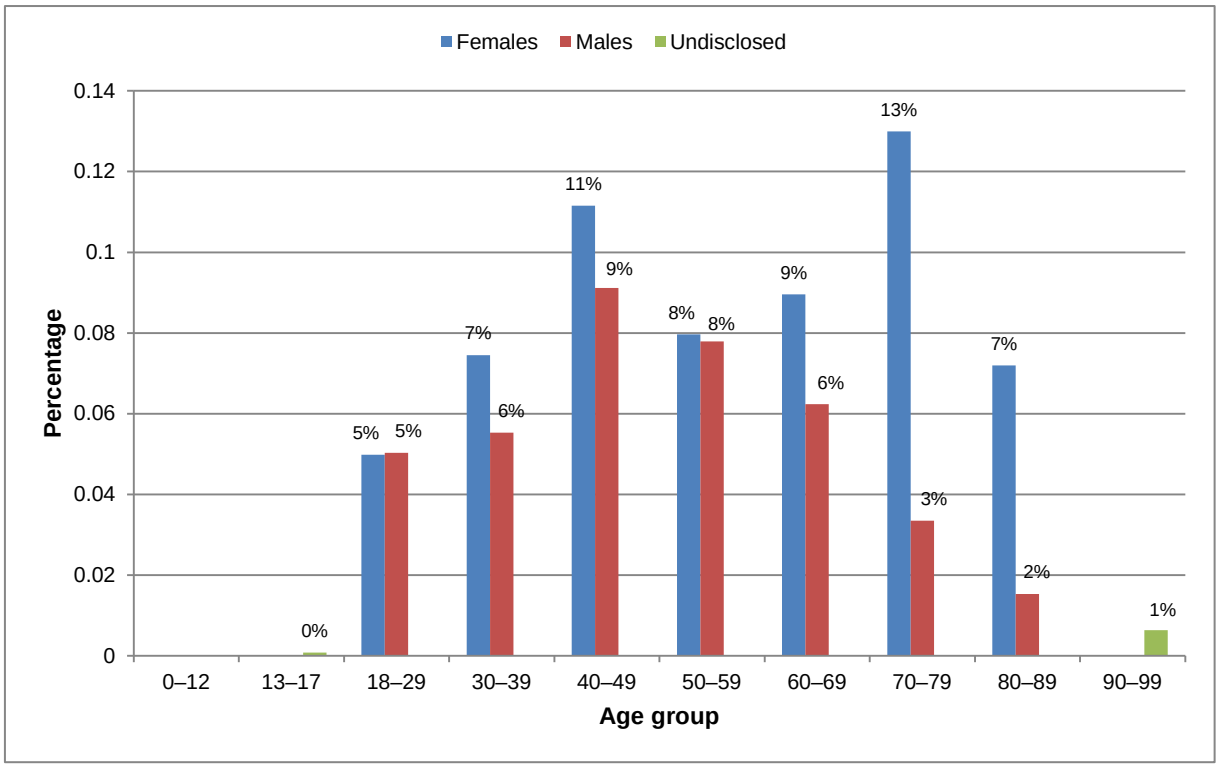
In 2014–15 public mental health services provided 11,509 ECT treatments to 1,025 people, as shown in Figure 1. This is a slight downwards shift compared with 2013–14, with 10 per cent fewer treatments prescribed and 7 per cent fewer people receiving ECT. A treatment is a single episode of ECT, and most people require a course of ECT, typically consisting of six to 12 treatments.

Figure 1: ECT use in public mental health services, 2010–11 to 2014–15



Females have a higher prevalence of mood disorders and as a result typically receive more ECT than males across all age groups. Over a number of years, the data indicates that females receive around 60 per cent of treatments (*n* = 6,987 in 2014–15). During the reporting period the peak age group for females receiving ECT was 70–79 years (*n* = 1,483). Males between the ages of 40 and 49 years accounted for the largest portion of males receiving ECT (*n* = 1,040). As shown in Figure 2, there are some age groups that show near identical treatment numbers across females and males.

Figure 2: ECT by age and gender, 2014–15



Note: Where there are low treatment numbers, the total treatments for males and females in an age group have been combined into the undisclosed category to protect people's privacy.

ECT treatment was prescribed most often for mood (affective) disorders, followed by schizophrenia, schizotypal and delusional disorders. This is consistent with 2013–14 data that indicated that 67 per cent of treatments were prescribed for mood (affective) disorders (see Table 1).

Table 1: ECT treatments by diagnosis, 2014–15

Diagnosis	Treatments	Percentage
Mood (affective) disorders	6,100	53%
Schizophrenia, schizotypal and delusional disorders	3,966	34%
Other	914	8%
Currently unavailable	529	5%
Total	**11,509**	**100%**

Part 3: Morbidity and mortality

In addition to the Chief Psychiatrist's responsibilities under the Act for providing clinical leadership and promoting continuous improvement in quality and safety, with regard to reportable deaths the Chief Psychiatrist has the following role:

- to receive reports from mental health services (including mental health community support services or 'MHCSS') on reportable deaths[7]
- to maintain a database of reportable deaths of clients of public mental health services in Victoria
- to request the findings of coronial investigations and contribute to coronial processes if requested by the coroner
- to review clinical reports provided by services, to identify systemic or management issues
- to identify statewide issues and provide guidance to mental health services to help reduce and prevent deaths and provide safe and effective services.

The OCP publishes a guideline on reportable deaths that provides advice to services about requirements under the Act and reporting procedures.

Morbidity and mortality committee

In July 2014 the Chief Psychiatrist established the Morbidity and Mortality Committee with clinical experts and service representatives to provide advice through monitoring and reviewing issues related to reportable deaths and other serious adverse events.

The role of the committee is to:

- review and analyse information and provide advice about reportable deaths and critical events
- provide advice about clinical practice audits or clinical service reviews
- promote best practice in responding to reportable deaths or critical events
- provide assistance in the development or review of standards, guidelines or practice directions in relation to reportable deaths or critical events.

The monitoring and reviewing of circumstances related to reportable deaths is one way that the Chief Psychiatrist promotes the delivery of safe and effective mental health services. The information provided from inpatient deaths will also inform the Chief Psychiatrist's inpatient death reviews, which are conducted on a three-yearly basis.

Review of inpatient deaths

In 2012 the Chief Psychiatrist undertook a review of inpatient deaths that occurred between 2008 and 2010. Planning is currently underway for the next three-year review (2011–2013) of inpatient deaths. This system-level review will focus on the adequacy and responsiveness of services following the death of an inpatient and will deliver a report outlining the key themes and findings.

Sentinel events

For mental health services, inpatient suicides are considered a sentinel event and must be reported to the Chief Psychiatrist and to the department. Through the department's sentinel event program these tragic events are investigated to determine how they may be prevented from happening again. This process is an integral part of improving the safety of services.

The Chief Psychiatrist convenes the Sentinel Event Review Committee as a subcommittee of the department's Clinical Incident Review Panel and reviews all sentinel events and critical incidents that

[7] Within the meaning of s. 4 of the *Coroners Act 2008*

occur in Victorian public mental health services. The Sentinel Event Review Committee identifies trends and themes emerging from the review of sentinel events and provides feedback and recommendations to the Chief Psychiatrist about system and process improvements.

Reportable deaths

The death of any person receiving treatment and care for a mental illness is a tragic event. All publicly funded mental health service providers are obliged to inform the Chief Psychiatrist of a client's death in certain circumstances. This requirement is articulated in the Mental Health Act as well as the *Coroner's Act 2008*, which defines a 'reportable death'.

The Chief Psychiatrist is required to be notified in the event of a death in the following circumstances:

- any inpatient death at a designated mental health service, regardless of legal status under the Act, cause or location of death
- the death of any compulsory, security or forensic patients
- the death from any cause of a person in the community on a non-custodial supervision order under the *Crimes (Mental impairment and unfitness to be tried) Act 1997*.

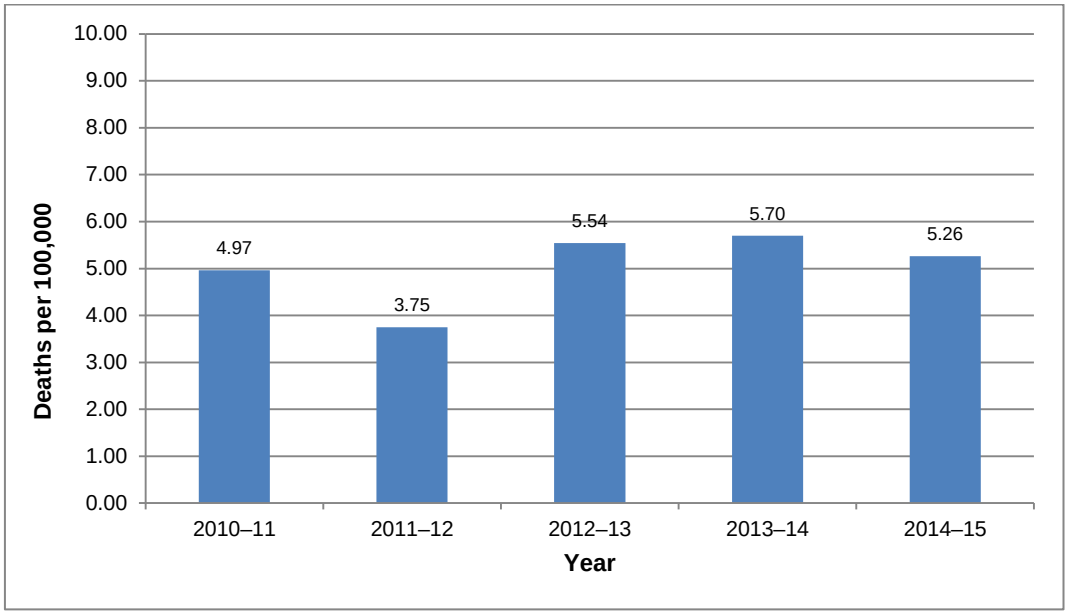
This is the first year of reporting under the Act and therefore the first time that MHCSS[8] are required to report the deaths of clients and former clients using their services.

For the period 2014–15 mental health services identified the deaths of 313 people that are considered reportable deaths. This is a decrease in the number of reportable deaths compared with 2013–14 (333 deaths).

This lower reporting number might be accounted for by the change in reporting requirements. In previous years mental health services were asked to report on client deaths if that person had been in contact with their service within the preceding six months. The requirement is now up to three months of last contact with the service.

As shown in Figure 3, this decrease is also reflected in the number of deaths as a proportion of Victoria's population.

Figure 3: Reportable deaths per 100,000 population, 2010–11 to 2014–15



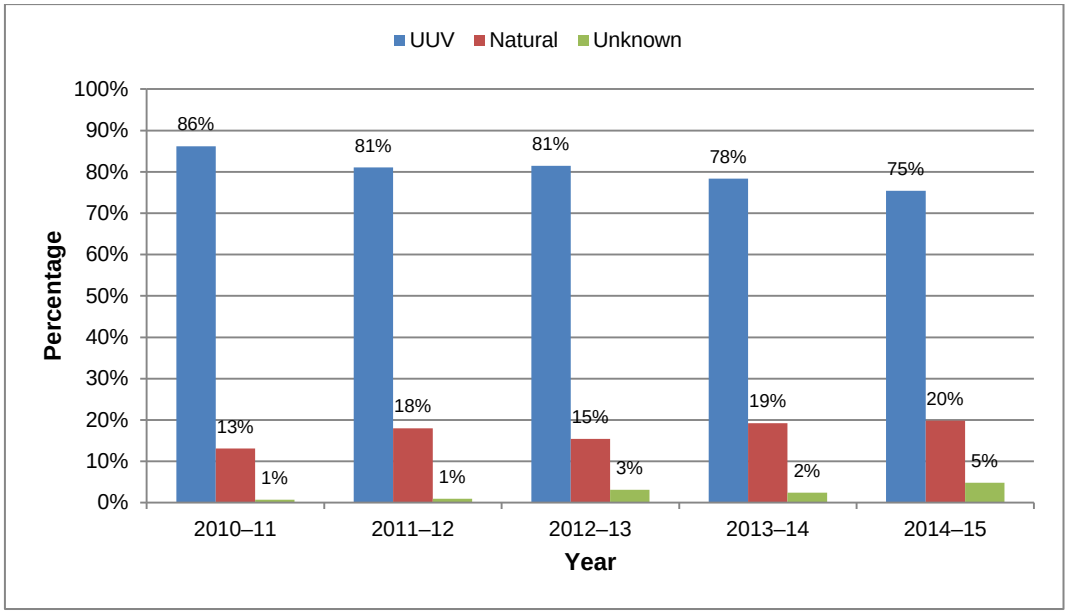
[8] Mental health community support services (formerly called 'psychiatric disability and rehabilitation support services') are non-clinical mental health services provided in the community.

Data source: Department of Transport, Planning and Local Infrastructure 2015, Victoria in Future 2015: Estimated resident population (ERP), viewed 26 August 2015, <http://www.delwp.vic.gov.au/planning/forward-policy-and-research/victoria-in-future-population-and-household-projections/data-tables>

According to the Coroner's Act reportable deaths are categorised in one of three possible categories: natural; unexpected, unnatural or violent (UUV); or unknown.

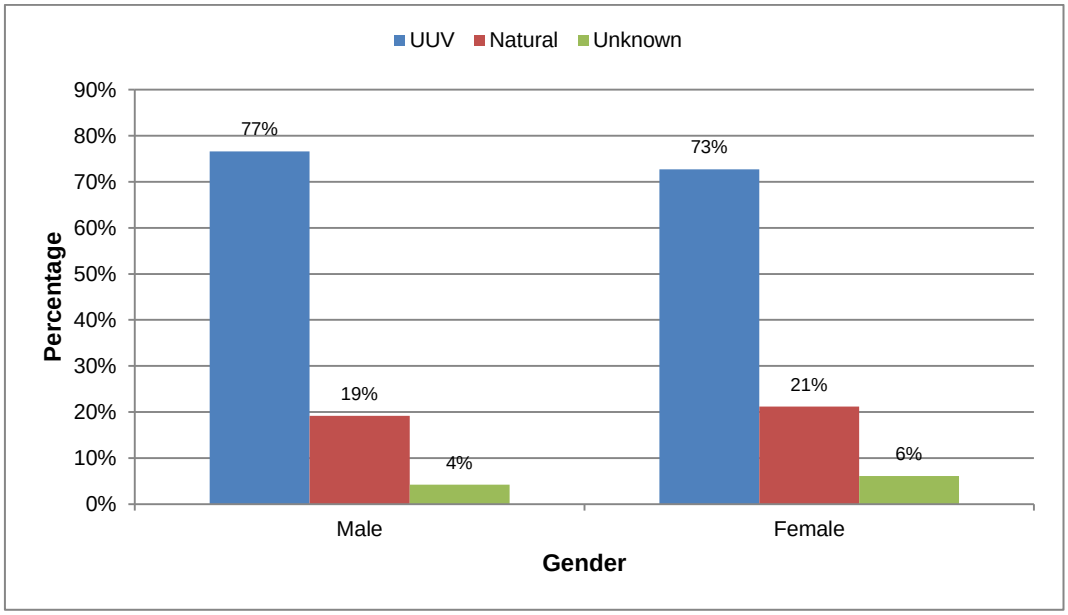
In 2014–15, of the 313 reportable deaths, 236 were UUV, which is a decrease from 261 recorded in the previous year. Natural deaths have had a small decline with 62 recorded in 2014–15, down from 64 in 2013–14. Unknown is 15, an increase from 2013–14 where the recorded number was eight. In a number of cases the OCP is still waiting for the Coroners' reports to determine cause of death. Figure 4 shows that since 2010–11 cause of death has remained relatively consistent.

Figure 4: Reportable deaths by cause, 2010–11 to 2014–15



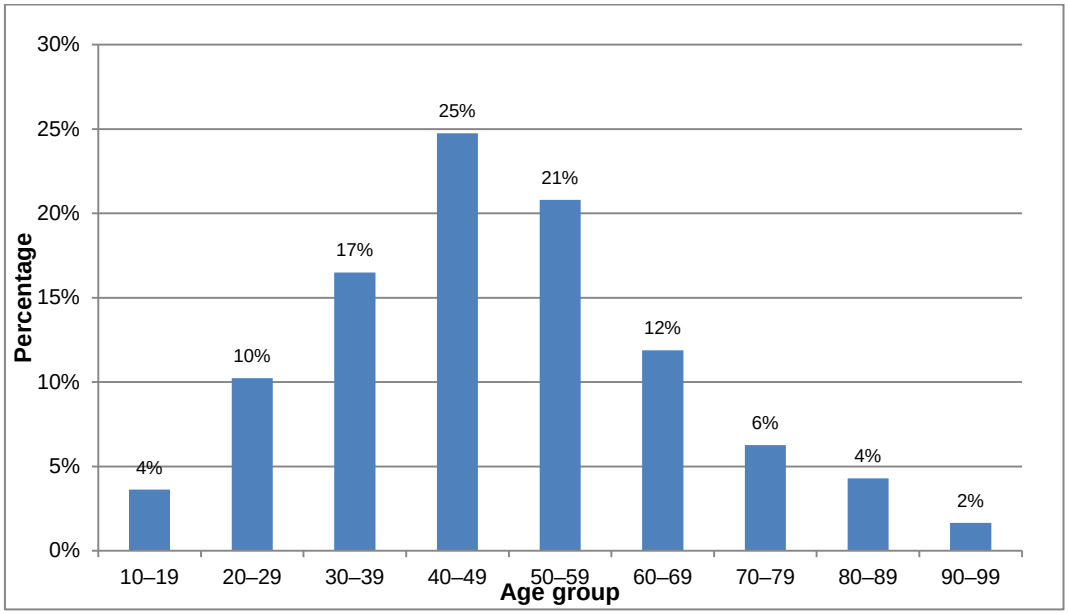
During the reporting period males significantly outnumbered females in the number of deaths, accounting for 68 per cent of all deaths reported (*n* = 214). During the reporting period the cause of death of both males and females is comparable, as shown in Figure 5.

Figure 5: Reportable deaths by gender and cause, 2014–15



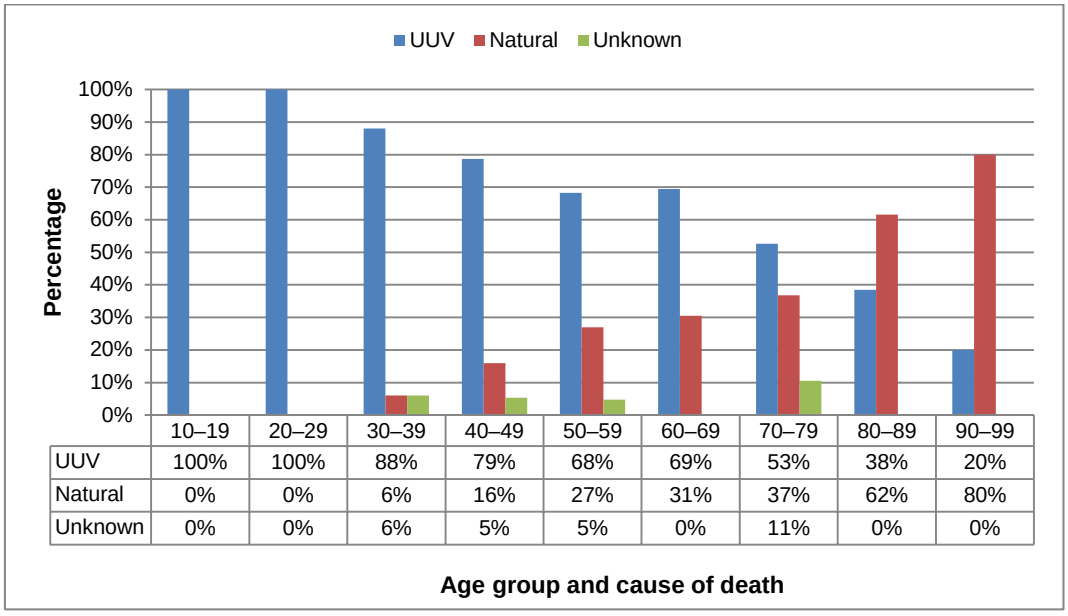
In 2014–15 the largest proportion of deaths occurred in the 40–49 age group at 25 per cent (see Figure 6).

Figure 6: Reportable deaths by age group, 2014–15



The deaths of people in the age groups up to 40–49 were by majority classified as UUV. From the ages of 50–59, deaths from natural causes begins to show a marked increase (see Figure 7).

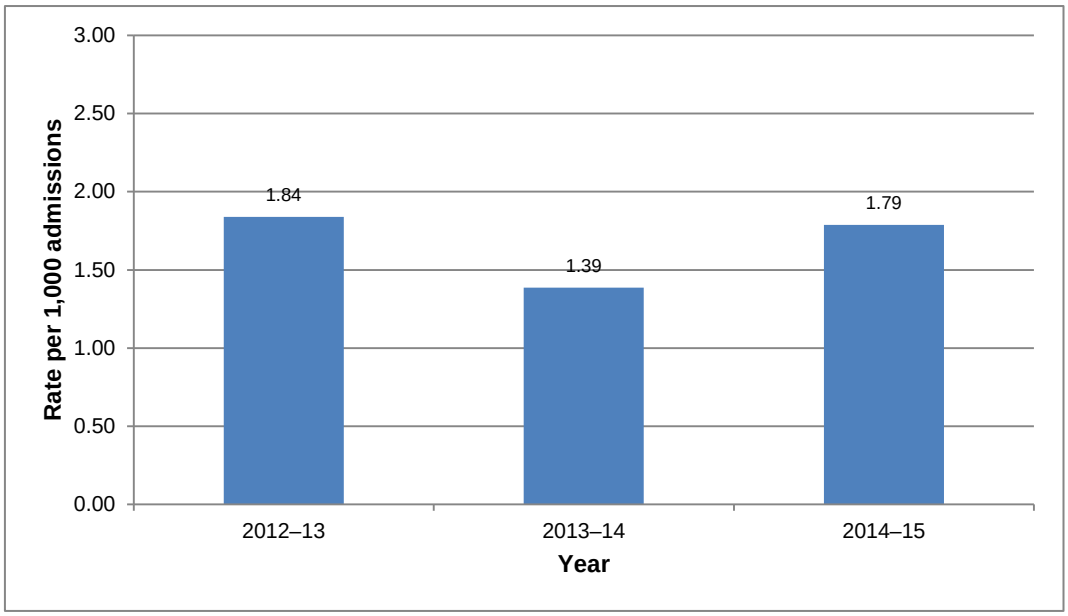
Figure 7: Reportable deaths by cause and age group, 2014–15



	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99
UUV	100%	100%	88%	79%	68%	69%	53%	38%	20%
Natural	0%	0%	6%	16%	27%	31%	37%	62%	80%
Unknown	0%	0%	6%	5%	5%	0%	11%	0%	0%

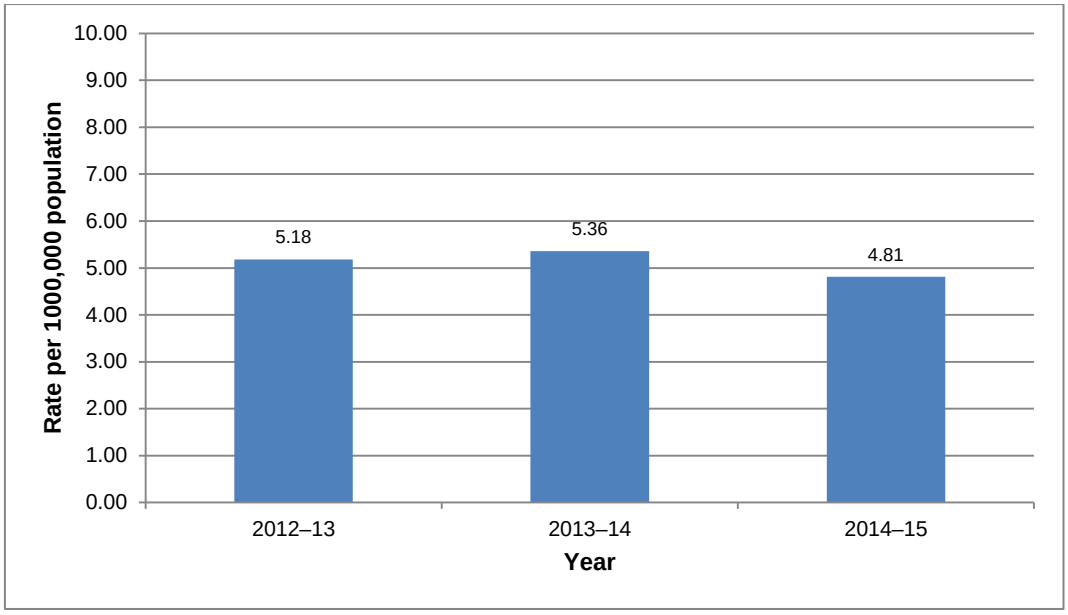
There were 27 inpatient deaths in 2014–15. Of these, 13 were categorised as UUV, with 14 deaths considered natural deaths. Of the 13 UUV deaths, seven were inpatient suicides and six were considered deaths as a result of a medical condition. The 27 deaths make up a small proportion of deaths compared with the number of clients admitted to a service in the same year (*n* = 15,107 admissions). Figure 8 outlines that the rate of inpatient deaths per 1,000 admissions between 2012–13 and 2014–14 has remained stable.

Figure 8: Inpatient deaths per 1,000 admissions, 2012–13 to 2014–15



The deaths of people receiving care in a community setting remained consistent with previous years in relation to Victoria's population (see Figure 9) at a rate of 4.81 per 100,000 population. People receiving care in the community include people receiving community-based mental healthcare and previously registered clients who have been in contact within three months of their death. This includes a broad cross-section of people who are regularly engaged with a community-based mental health service and those who may have had only one contact up to three months prior to their death.

Figure 9: Deaths of people receiving care in the community per 100,000, 2012–13 to 2014–15



Part 4: Reducing restrictive interventions

Restrictive interventions are highly intrusive practices that must only be used as a last resort after all other reasonable and less restrictive options have been tried or considered and found unsuitable. Restrictive interventions are defined in the Act as seclusion or bodily restraint. Seclusion is defined in s. 3 of the Act as 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave'. The Act defines bodily restraint as 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitting on their arms) that restricts the person's ability to get off the furniture' (s. 3). The Act provides that a person may only be placed in seclusion if it is necessary to prevent imminent and serious harm to the person or another person, and that bodily restraint may be used to prevent imminent and serious harm to the person or to another person, or to administer treatment (psychiatric or medical) to the person.

The principles outlined in the Act specify that people should receive treatment in the least restrictive way possible. The principles must be considered by all clinicians and health services when providing mental healthcare or treatment.

The department, the Chief Psychiatrist, the Chief Mental Health Nurse and mental health services share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services. There are a number of initiatives that contribute to the efforts to reduce restrictive interventions and create safe environments.

Restrictive interventions committee

In 2014 the Chief Psychiatrist established the Restrictive Interventions Committee with clinical experts and service representatives to provide advice on reducing and, where possible, eliminating the use of restrictive interventions in mental health services.

The role of the committee is to:

- review and analyse information concerning all bodily restraint and seclusion in Victoria, and provide advice on restrictive interventions
- monitor any adverse events that may occur as a result of restrictive interventions
- provide advice about clinical practice audits or clinical reviews
- promote best practice in relation to restrictive interventions
- provide assistance in the development or review of standards, guidelines or practice directions in relation to restrictive interventions.

Initiatives

The Reducing Restrictive Interventions program was initiated as a component of the implementation of the 2014 Mental Health Act. Coordinated by the OCMHN, the project aimed to reduce and, where possible, eliminate restrictive interventions in mental health services.

The project has delivered a framework to provide advice to services about the organisational factors that affect the use of restrictive interventions (*Providing a safe environment for all: Framework for reducing restrictive interventions,* released in 2013). In 2014–15 the initiative funded services to implement strategies that supported workforce development, enhanced consumer and carer participation, strengthened clinical governance and implemented sensory modulation. Several services also implemented strategies in partnership with emergency departments.

The following projects have grown out of the Reducing Restrictive Interventions project, further promoting and supporting services to reduce the use of restrictive interventions.

Safewards

Safewards is a UK model that identifies and addresses the causes of behaviour in staff and consumers that may result in violence, absconding or self-harm. Lead by the OCMHN, a Safewards trial was undertaken in seven Victorian mental health services during 2014–15.

Evaluation of the trial will determine the model's effectiveness in reducing restrictive interventions, enhancing consumer and carer experiences of care and staff safety, and determine the applicability of the model to the Victorian mental health service context. Preliminary findings from the evaluation are positive and indicate improvements in ward culture and a reduction in aggressive incidents.

National Seclusion and Restraint Reduction Forum

In May 2015 Victoria hosted the 10th National Seclusion and Restraint Reduction Forum, organised by the OCMHN. The forum brought together clinicians, consumers, carers, policymakers and academics from across Australia to consider issues and strategies, progress and future directions for reducing the use of seclusion and restraint.

The theme for the forum was 'From here to there: Shaping the path to harm-free care'. The theme was designed to inspire reflection on real-world lessons and the innovation and ideas that have arisen from research and practice for reducing seclusion and restraint.

The program featured highly esteemed keynote speakers including internationally acknowledged expert in reducing restrictive practices Professor Joy Duxbury from the University of Central Lancashire in the UK. Presentations covered a broad range of topics and included a session on Safewards. The breadth of innovation in mental health services and across broader care domains was showcased, including emergency departments and allied practice settings. During the forum the National Mental Health Commission released its position paper on seclusion and restraint, and the Minister for Mental Health, Martin Foley MP, also addressed the forum.

Variance reporting pilot project

The Chief Psychiatrist has a unique position to view statewide data and trends on restrictive interventions and highlight opportunities for ongoing improvement in safety and quality. In January 2014 a pilot project was established to review individual instances of extended periods of seclusion or restraint. The project required all mental health services to submit detailed information about the events to understand contributing factors and issues, and to explore solutions. There is an ongoing requirement for this increased reporting of mental health services, in addition to monthly reporting of restrictive interventions.

An evaluation research project has been commissioned, and outcomes are expected in early 2015–16.

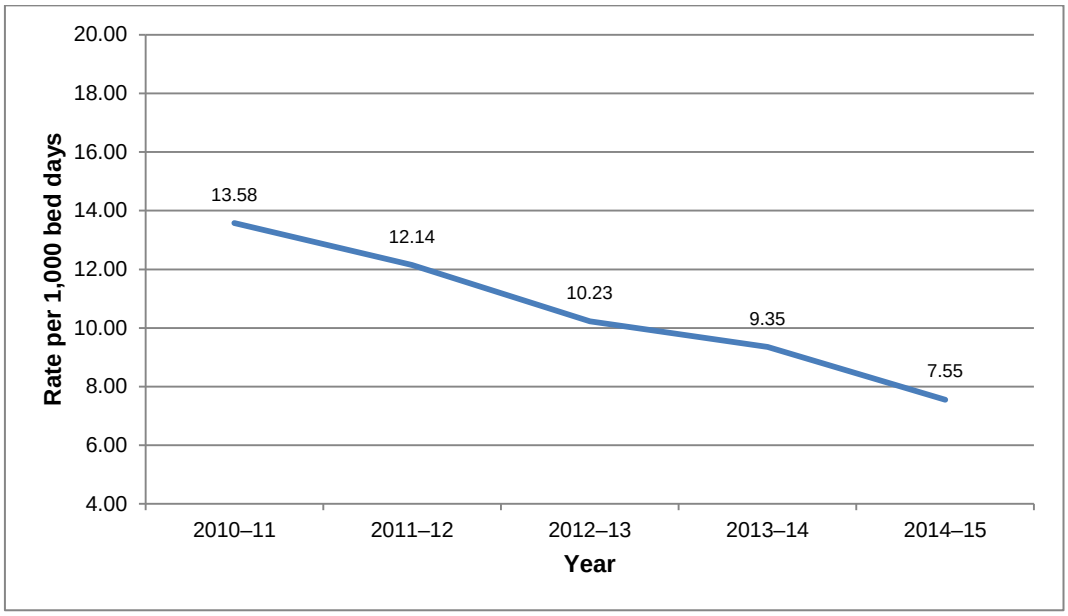
Restrictive interventions reporting

The Act requires all instances of restrictive interventions to be reported to the Chief Psychiatrist. The *Chief Psychiatrist's guideline on restrictive interventions* (released in 2014) sets out the legal and practice requirements of restrictive interventions in designated mental health services. All Victorian designated mental health services are required to have in place policies, procedures and clinical practices that reduce and, where possible, eliminate the use of restrictive practices.

Seclusion

The statewide average rate of seclusion per 1,000 occupied bed days in mental health inpatient units was 7.55 for 2014–15. The statewide key performance indicator target for the rate of seclusion per 1,000 occupied bed days is set at 15, and the rate has consistently declined below this target since 2010–11, as shown in Figure 10.

Figure 10: Seclusion per 1,000 occupied bed days, 2010–11 to 2014–15



Out of the 15,286 people admitted to a mental health inpatient unit in 2014–15, 7.8 per cent (*n* = 1,195) were secluded at some point during their admission, a decline from 8.4 per cent (*n* = 1,241) in 2013–14 (see Figure 11). The number of seclusion episodes (where people have been secluded more than once during their admission) has also consistently decreased, from 4,694 episodes in 2010–11 to 2,796 episodes in 2014–15. Figure 11 also highlights that the reduction in the use of seclusion is occurring within the context of increasing numbers of inpatient admissions.

Figure 11: Use of seclusion, 2010–11 to 2014–15

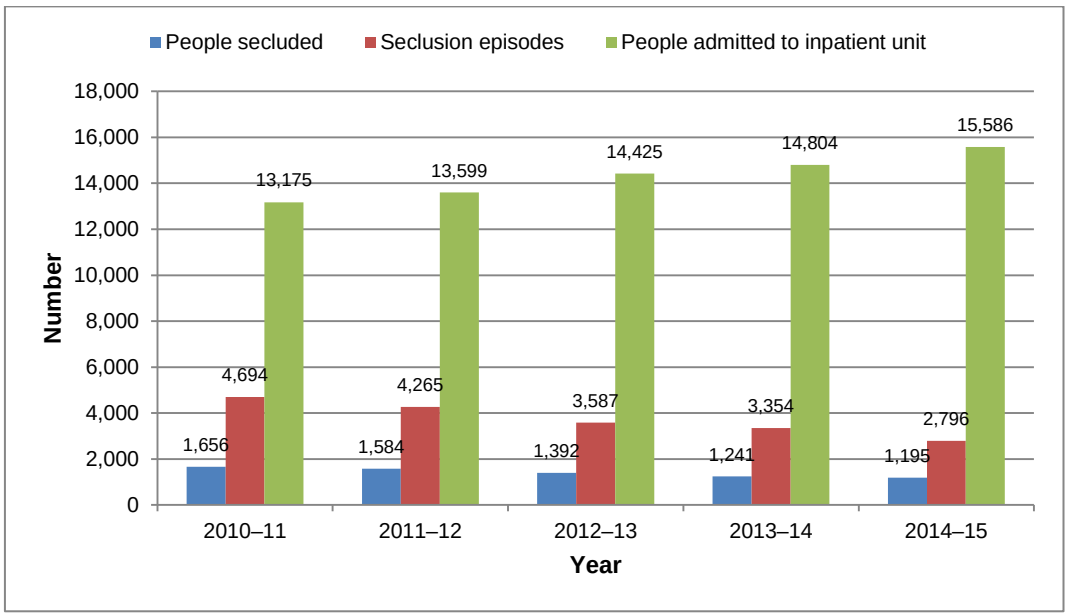
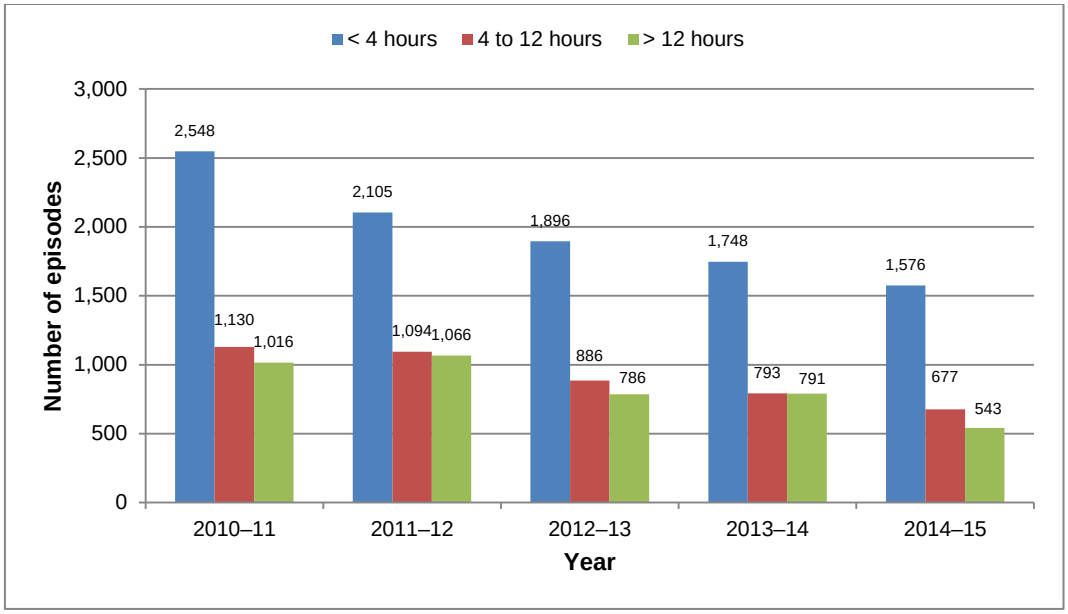


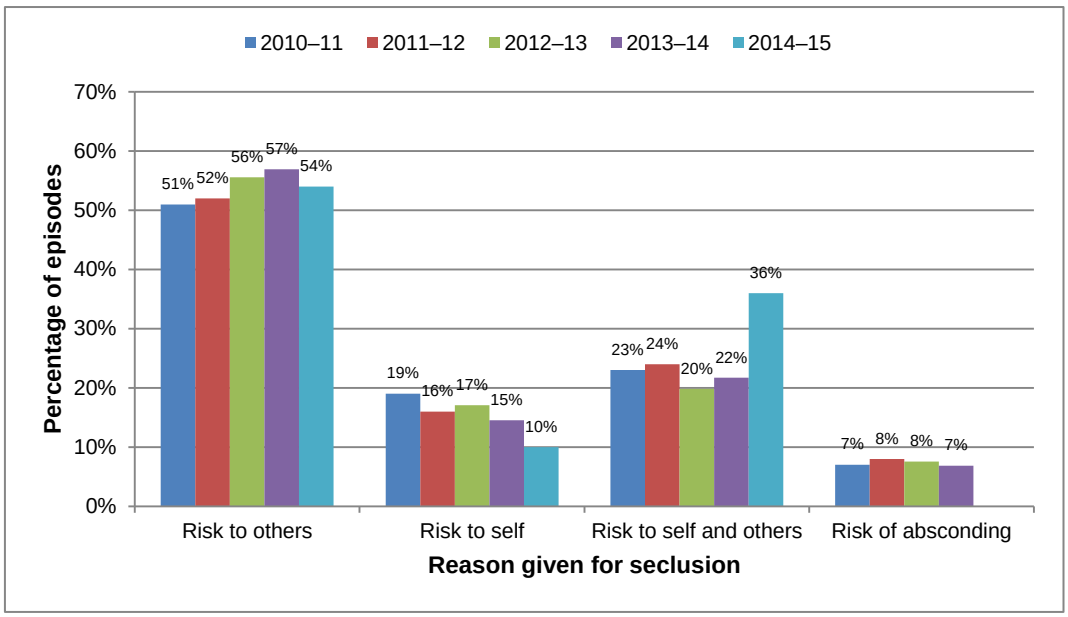
Figure 12 shows that the duration of seclusion episodes has fallen, with the majority consistently under four hours since 2010–11. This historical trend was evident since this data was first reported in the 2004 Chief Psychiatrist's annual report. Fifty-six per cent of seclusion episodes for 2014–15 are within this timeframe. Seclusion episodes above 12 hours in duration decreased from 24 per cent in 2013–14 to 19 per cent in 2014–15.

Figure 12: The duration of seclusion episodes, 2010–11 to 2014–15



The reason given for just over half of seclusion episodes (53 per cent) in 2014–15 was attributed to preventing a health or safety risk to other people, which is consistent with previous years. Of note are reductions in the 'risk to others' and 'risk to self' categories and the marked increase in the 'risk to self and others' category (see Figure 13), the reason for which is unclear. Seclusion as a means to prevent a person from absconding is no longer a permissible reason under the Act.

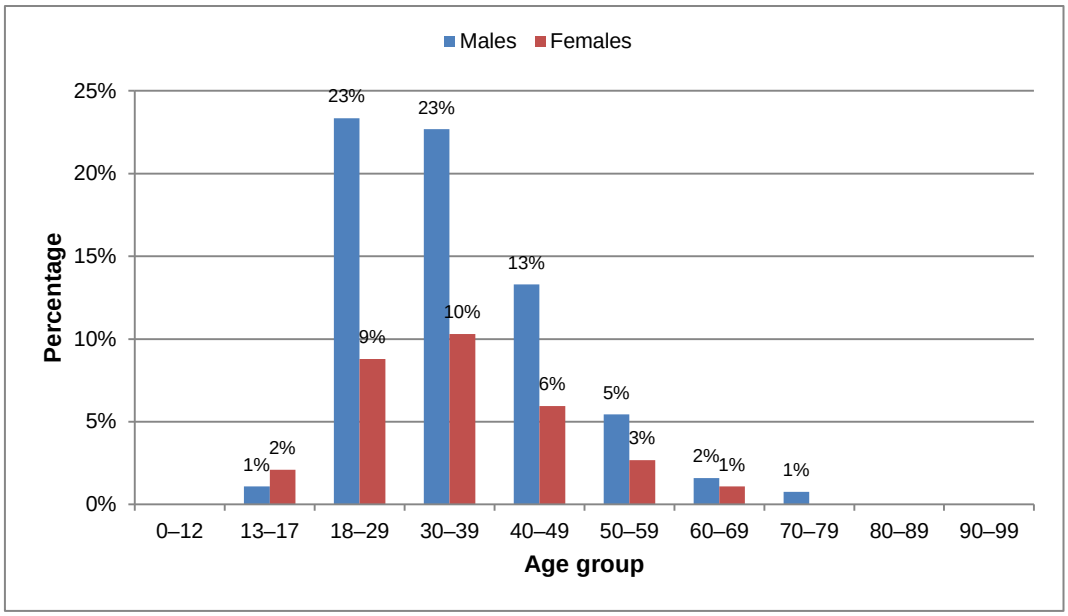
Figure 13: Reason for seclusion, 2010–11 to 2013–14



Note: Risk of absconding is not recorded as a reason for seclusion in 2014–15 as it is no longer a permissible reason under the Act. Historical data has been presented for comparison only.

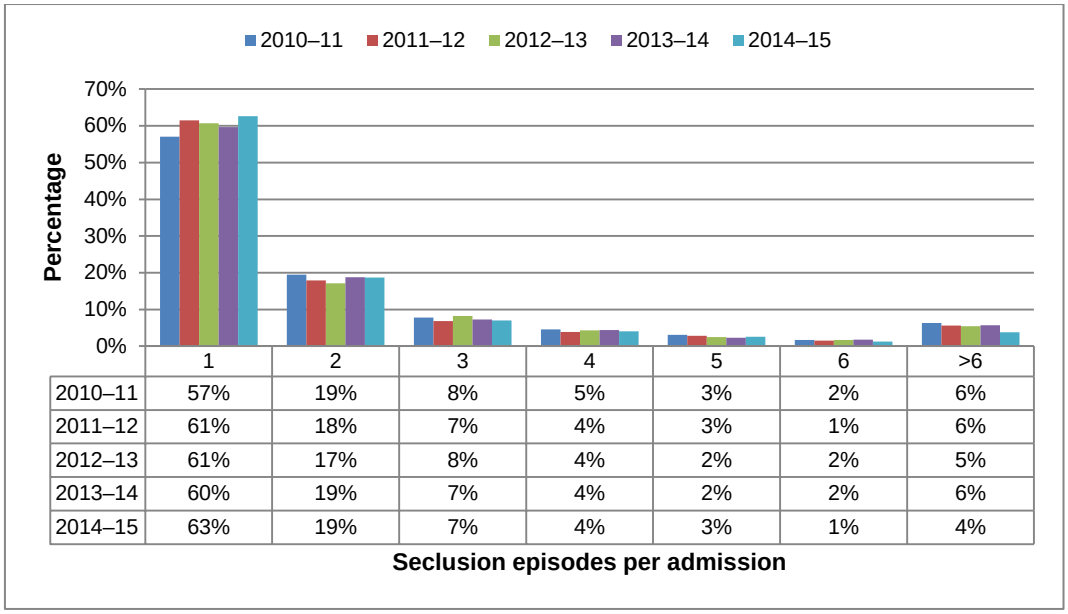
In 2014–15 males 18–39 years of age were most likely to be secluded, accounting for almost half of seclusion episodes, as shown in Figure 14. Males were consistently more likely to be secluded across the lifespan, with the exception of the 13–17-year-old age group where more females were secluded. In total, 819 males were secluded (69 per cent of the total) and 376 females were secluded.

Figure 14: Persons secluded by age and gender, 2014–15



Of the 7.8 per cent of people secluded during their admission in 2014–15, the majority were secluded once. As Figure 15 shows, the number of seclusion events within the same hospital admission has remained consistent since 2010–11. However, a slight increase can be seen in the proportion of single episodes of seclusion within an admission and a slight decrease in the proportion of episodes where there were more than six episodes within an admission. The number of people secluded more than six times during an admission has dropped from 125 in 2010–11 to 53 in 2014–15, while the number of people secluded once during an admission has dropped from 1,131 in 2010–11 to 871 in 2014–15.

Figure 15: Number of seclusion events within the same hospital admission, 2010–11 to 2014–15



	1	2	3	4	5	6	>6
2010–11	57%	19%	8%	5%	3%	2%	6%
2011–12	61%	18%	7%	4%	3%	1%	6%
2012–13	61%	17%	8%	4%	2%	2%	5%
2013–14	60%	19%	7%	4%	2%	2%	6%
2014–15	63%	19%	7%	4%	3%	1%	4%

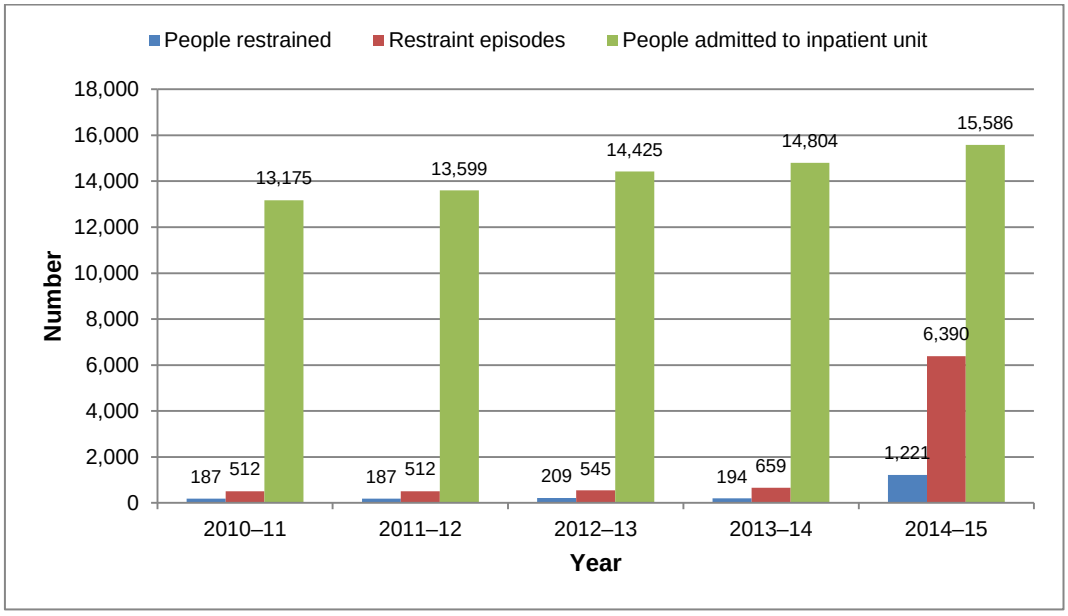
Bodily restraint

The Act introduced the requirement for mental health services to report the use of physical restraint, in addition to the use of mechanical restraint and seclusion. The reporting of physical restraint is intended to facilitate greater oversight of this practice and assist with working to reduce its use. The government has committed to developing a standardised approach to physical restraint that will be considered in the context of a trauma-informed, recovery framework. The standardised approach will support, as an option of last resort, the safest use of restraint for consumers and staff.

Prior to the commencement of the Mental Health Act and between the years 2010–11 and 2013–14 (as shown in Figure 16) only mechanical restraint was required to be reported. The Act introduced the requirement to report on the use of physical restraint and broadened the category of bodily restraint to include both physical and mechanical restraint. This has resulted in a substantial increase in the reported rates of bodily restraint and the reported number of people being restrained.

Between 2010–11 and 2013–14 the number of restraint episodes and the number of people restrained was relatively stable. With the new reporting requirement in 2014–15, 7.8 per cent of people admitted to a mental health service were restrained, and the number of restraint events reported of both mechanical and physical restraint was 6,390, as shown in Figure 16.

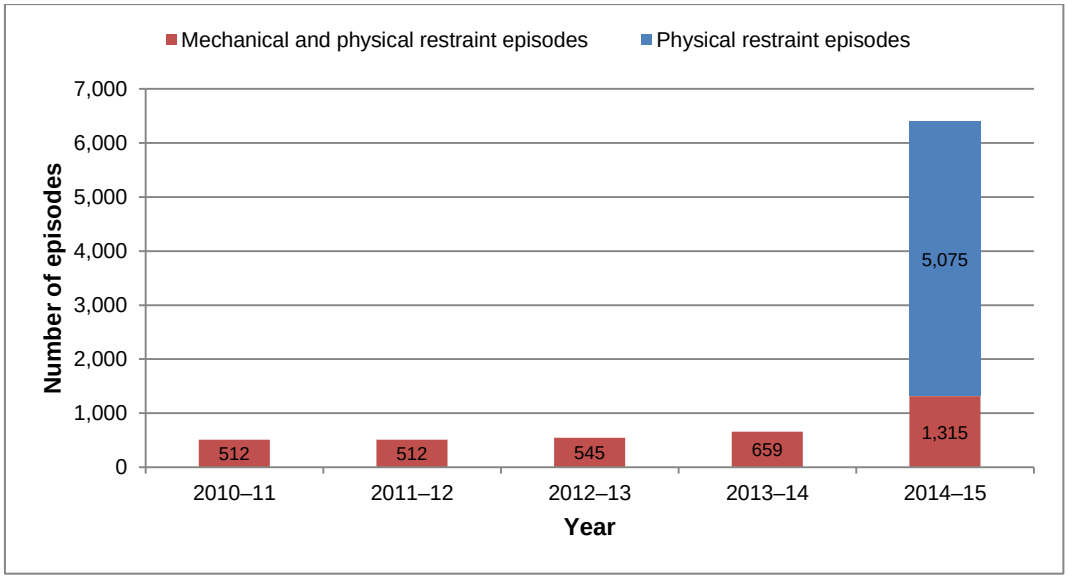
Figure 16: Use of restraint, 2010–11 to 2014–15



Note: Between 2010–11 and 2013–14 mental health services were not required to report the use of physical restraint, only the use of mechanical restraint. The data for 2014–15 includes both physical and mechanical restraint.

For the first time physical restraint has been reported, in addition to mechanical restraint, and Figure 17 shows the breakdown of physical restraint and mechanical and physical restraint (where these are used in combination) in the 2014–15 reporting period. Physical restraint episodes constituted 79 per cent of the total number of restraint episodes. The increase in total restraint episodes is not wholly attributable to the new reporting of physical restraint, with episodes of mechanical and physical almost doubling in 2014–15 compared with 2013–14. This may be explained, in part, by increases in substance-affected presentations and the greater focus on restrictive interventions within services resulting in better reporting. An additional reason relates to possible administrative issues, where anecdotal reports have been received of incidents of restraint that occurred within an emergency department being incorrectly recorded against the inpatient unit for that service. Irrespective of these possible explanations, the increased transparency and accountability provides opportunities to undertake further work in understanding these practices, setting benchmarks in the future and working to reduce their use.

Figure 17: Use of physical and mechanical restraint, 2010–11 to 2014–15



Note: In 2014–15 reports on episodes of mechanical restraint included episodes where mechanical and physical restraint occurred during the single restraint episode.

The majority of restraint episodes in 2014–15 were less than 15 minutes (84 per cent), as shown in Figure 18. Approximately 2 per cent of mechanical and physical restraint episodes lasted longer than 12 hours.

Figure 18: Duration of physical and mechanical restraint episodes, 2014–15

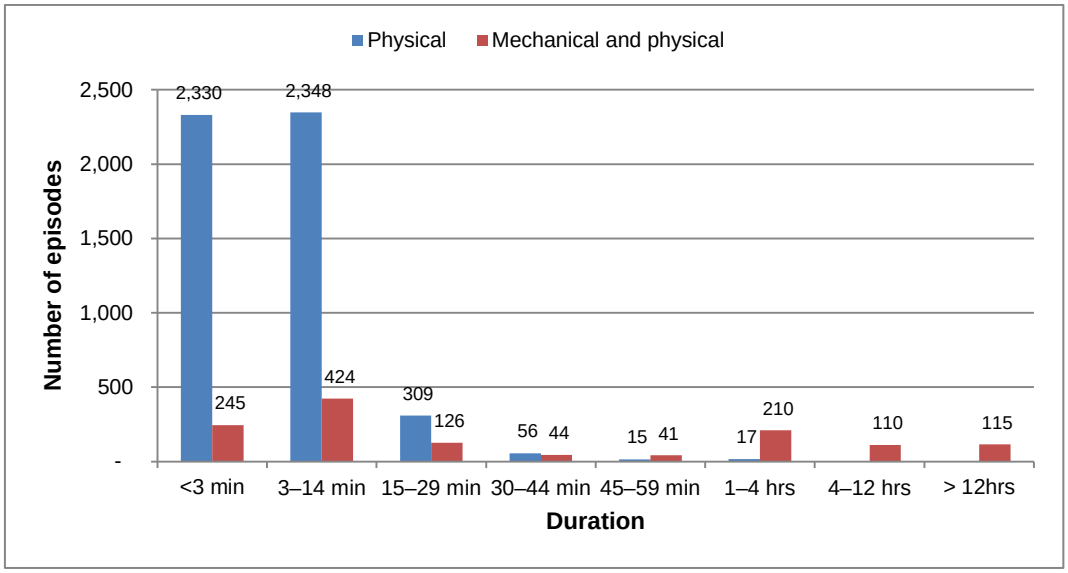
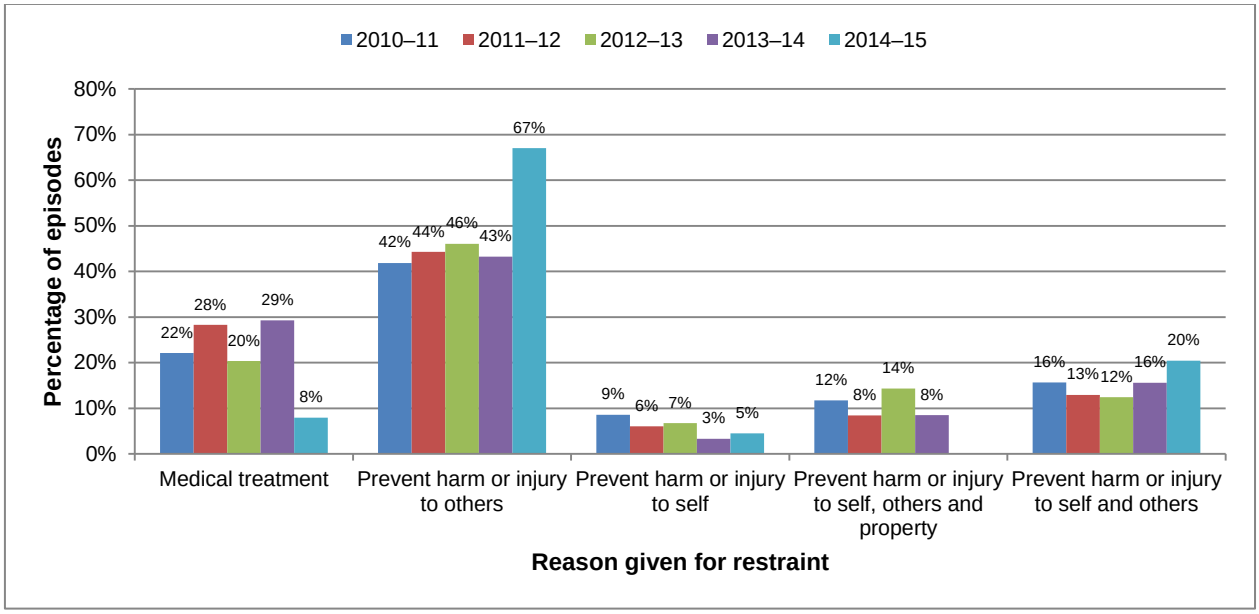


Figure 19 provides the reasons for the use of restraint, showing that, from 2010–11 to 2014–15, 'preventing harm or injury to others' has been the most frequently recorded reason for restraint. Of note is the substantial increase in the recording of 'preventing harm or injury to others' as the reason for restraint in 2014–15 compared with previous years (a 24 per cent increase from 2013–14), and a corresponding decrease (21 per cent), compared with 2013–14, in the recording of 'medical treatment' as the reason for restraint. It should be noted that 'preventing harm or injury to self, others and property' is no longer a permissible reason for restraint under the Act.

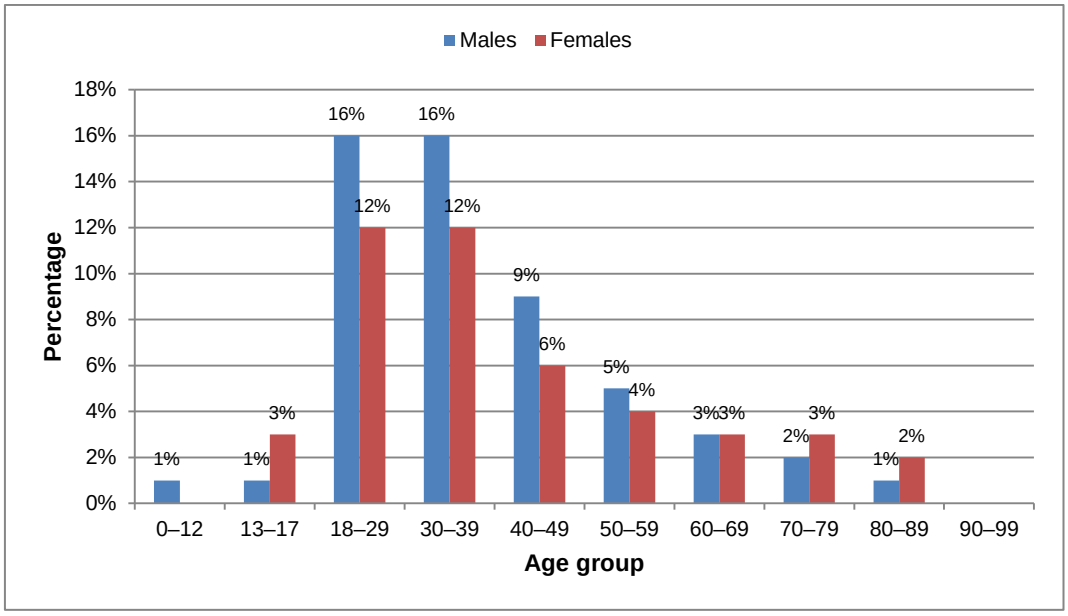
Figure 19: Reasons for restraint, 2010–11 to 2014–15



Note: Preventing harm or injury to self, others and property is not recorded as a reason for restraint in 2014–15 because it is no longer a permissible reason under the Act. Historical data has been presented for comparison only.

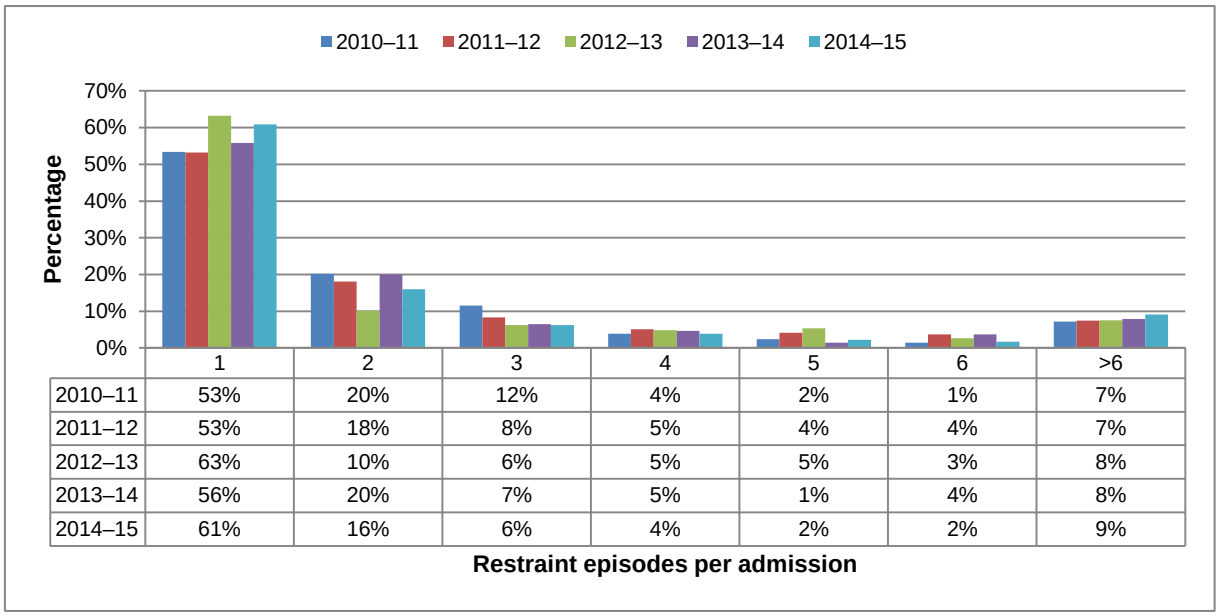
Of people restrained in 2014–15, the majority (32 per cent) were males 18–39 years old. Figure 20 shows that, while restraint follows a similar pattern to the use of seclusion in terms of age group, females constitute a greater proportion of restraint use across the lifespan (compared with seclusion events). More females than males are restrained in the 13–17 and 70–89 age groups.

Figure 20: Restraint by age and gender, 2014–15



As outlined in Figure 21, the proportion of the number of restraint events in the same admission has remained quite stable between 2010–11 and 2014–15. Of the 7.8 per cent of people restrained during their inpatient admission in 2014–15, 61 per cent (*n* = 843) were subject to one episode of restraint. A slight upward trend is evident in the 'more than six' restraint events. This small group of patients with complex presentations and highly disturbed behaviours accounts for a high proportion of all restraint episodes. Further investigation of the pattern will warrant consideration if it continues.

Figure 21: Number of restraint events in the same hospital admission, 2010–11 to 2014–15



	1	2	3	4	5	6	>6
2010–11	53%	20%	12%	4%	2%	1%	7%
2011–12	53%	18%	8%	5%	4%	4%	7%
2012–13	63%	10%	6%	5%	5%	3%	8%
2013–14	56%	20%	7%	5%	1%	4%	8%
2014–15	61%	16%	6%	4%	2%	2%	9%

Part 5: Promoting the rights of people

A major focus of the work of the Chief Psychiatrist is to promote the rights of people accessing mental health services. We know that the wellbeing and quality outcomes for both consumers and carers are improved by involving families and carers as early as possible in treatment and care. This is consistent with the objectives and mental health principles of the Act, to support people's recovery and recognise the role of carers and families.

The OCP, through a range of activities and functions, promotes the rights of consumers and carers.

Working with services

People with complex needs are frequent users of mental health services and are often at serious risk of harm. The OCP provides advice to program areas across the department, government agencies and mental health services to resolve issues and improve clinical and service coordination and responses.

Mental health services consider a broad range of issues when providing treatment and care to this client group, and the OCP may assist with these issues by:

- contributing to a coordinated response to the person's needs across a number of agencies such as justice, housing and drug and alcohol services
- facilitating an appropriate response to specialised treatment and care needs
- facilitating the provision of skills and resources required to respond appropriately.

One of the ways in which the OCP facilitates resolution of these matters is through case conferences. Case conferences bring together services to promote effective communication and help develop a coordinated multi-sector service response to address the needs of complex and high-risk consumers. The OCP plays a role in assisting services to plan and coordinate care, and to inform program areas across the department of issues raised that are impacting on the provision of effective treatment and care. Although health services have clinical responsibility for treatment and care, the OCP has a system-wide role to encourage coordination across local networks, clinicians and services, and to provide input to service improvement and workforce planning initiatives.

Families and carers

The Chief Psychiatrist recognises the important contribution that families and carers make to a person's care and recovery. The OCP receives many calls and letters from families and carers and endeavours to support and guide them as they interact with service providers.

The OCP also highlights to service providers and clinicians the need for continuing effort to improve carer engagement in the treatment and care process and in service planning and delivery.

A significant aspect of the 2014 Mental Health Act is the legislative recognition and support of the important role of carers in the assessment, treatment and recovery of people with a mental health illness.

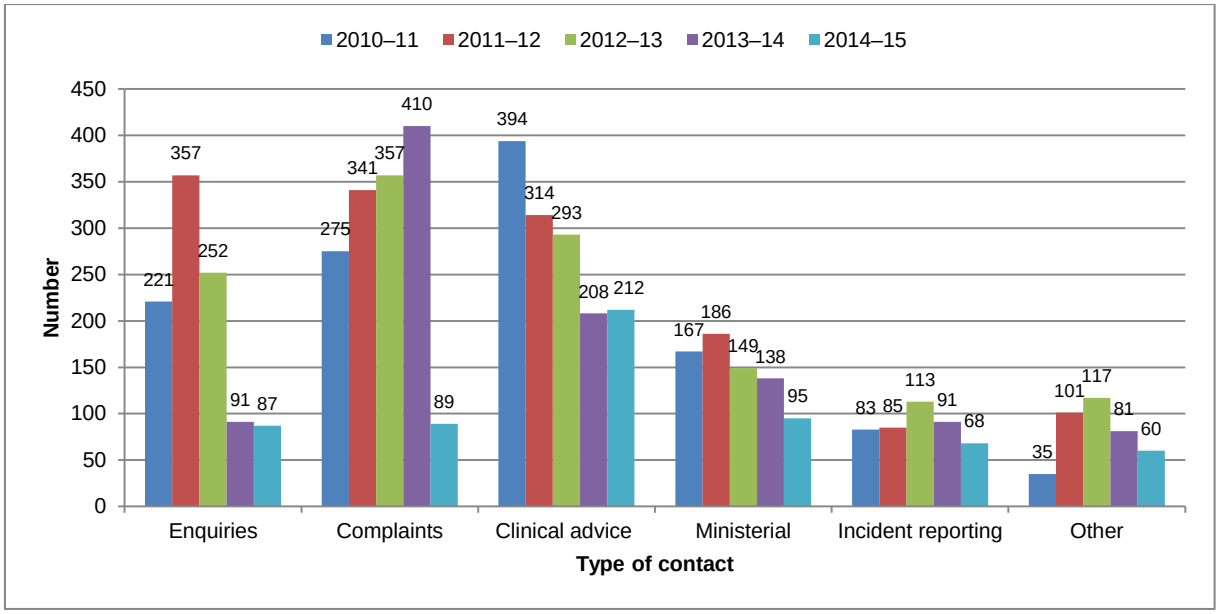
Contacts with the OCP

The OCP operates an enquiry line during business hours and provides information and clinical advice to consumers, carers, service providers, health professionals and members of the public.

The OCP responded to 611 contacts in 2014–15. This is a marked decrease from 2013–14 of 40 per cent. This decline is attributable to the commencement of the new Mental Health Act, which established the Mental Health Complaints Commissioner (MHCC). Historically, complaints were the most common type of contact made to the OCP and in 2013–14 accounted for 40 per cent of all contacts. From 1 July 2014, the MHCC was established as the independent specialist statutory body that deals with complaints about Victorian public mental health services.

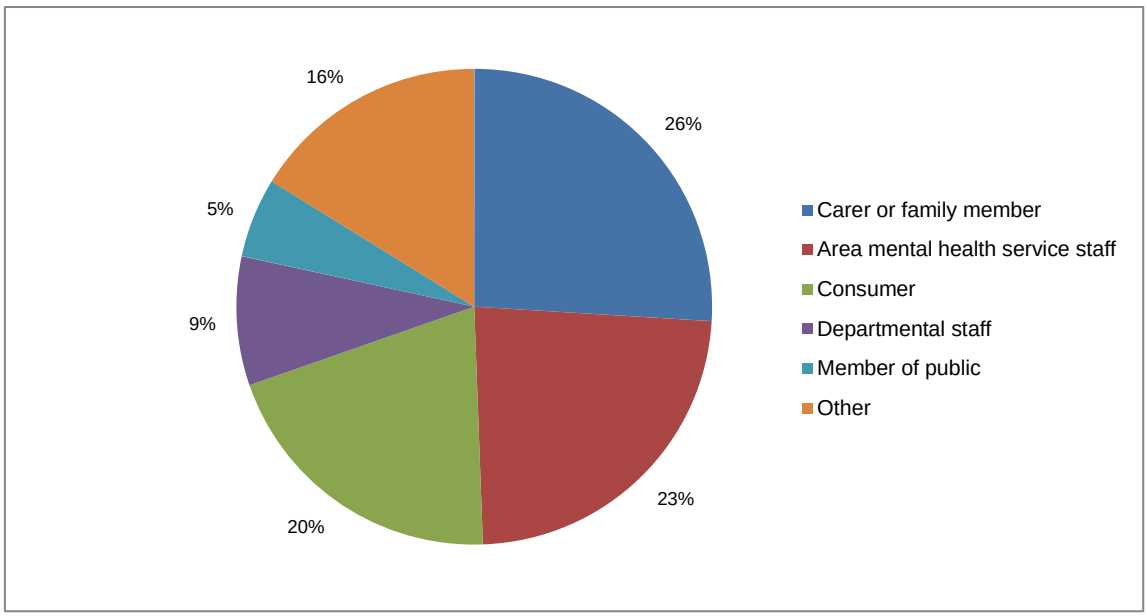
Figure 22 shows a breakdown of contacts made to the OCP over the past five years. Although it indicates that 89 contacts were classified as complaints in 2014–15, the majority of these were referred to either the mental health service or the MHCC. Depending on the nature of the concern and immediate concerns about risk or safety, the OCP may still have had involvement with the matter to support access to services or appropriate treatment. When the immediate clinical issue is resolved the person is encouraged to contact their mental health service or the MHCC, and the OCP facilitates this referral to the MHCC on occasion.

Figure 22: Number and type of contacts, 2010–11 to 2014–15



The majority of contacts made to the OCP in 2014–15 were by carers or family members (26 per cent of all contacts), followed by service providers (23 per cent) and consumers (20 per cent), as shown in Figure 23. This is generally consistent with previous years.

Figure 23: Contacts with the OCP, 2014–15



Conclusion

This is the first Chief Psychiatrist's report prepared under the 2014 Mental Health Act. The activities of the OCP cover statutory, advisory and education responsibilities, with the aim of improving the safety and effectiveness of services and the outcomes for consumers and carers. Key highlights of 2014–15 are summarised as follows.

- The OCP provided expert clinical leadership to services through the first year of operation of the new legislation, particularly in relation to the requirement for reporting of physical restraint.
- The OCMHN coordinated the delivery of training related to gender-sensitive practice, recovery-oriented practice and foundation skills in child and youth nursing.
- To promote a safe and effective mental health service system, the OCP worked with stakeholders across the department, government and sector and undertook a range of initiatives. During the reporting period the Chief Psychiatrist engaged with clinical leaders to discuss and resolve system-wide clinical practice issues. Initiatives undertaken included establishing an online recovery library, further supporting clinicians to embed the principles of recovery in professional practice.
- The Act introduced several changes to providing ECT and removed the reporting requirement for private hospitals. The OCP responded by convening the ECT Monitoring Committee, which has an advisory and oversight role of ECT-related initiatives in publicly funded mental health services and guidelines delivered by the OCP.
- The OCP monitored the deaths of people who had received, or were receiving, mental health services in Victoria and established the Morbidity and Mortality Committee to review and provide advice on reportable deaths and critical incidents. These are important activities that support the OCP's role in understanding statewide issues and promoting safe and effective service delivery.
- A number of activities throughout the year contributed to efforts to reduce the use of restrictive intervention and create safe environments. These included establishing the Restrictive Interventions Committee, the rollout of Safewards and the variance reporting pilot project. The OCMHN also organised the 10th National Seclusion and Restraint Forum.

Abbreviations

Item	Description
the Act	*Mental Health Act 2014*
the department	Department of Health and Human Services
ECT	electroconvulsive treatment
MHCC	Mental Health Complaints Commissioner
MHCSS	mental health community support services
OCMHN	Office of the Chief Mental Health Nurse
OCP	Office of the Chief Psychiatrist
UUV	unexpected, unnatural or violent