Chief Psychiatrist's annual report 2012-13 and 2013-14

Department of Health & Human Services

State Government Victoria

Chief Psychiatrist's annual report

2012–13 and 2013–14

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Available at http://health.vic.gov.au/chiefpsychiatrist/

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Foreword

The Chief Psychiatrist's report is usually published each year and covers the most recent financial year. This report covers two financial years: 2012–13 and 2013–14. During this period the Chief Psychiatrist continued to focus on legislative review and consultation leading to the transition to new mental health legislation. At the time of writing this report, the *Mental Health Act 1986* had been repealed and replaced by the *Mental Health Act 2014* which commenced operation on 1 July 2014. However, for the time period which this report covers, the *Mental Health Act 1986* is the relevant legislation.

The two year period from 1 July 2012 to 30 June 2014 saw significant change occurring in Victoria's public mental health service system and in the Office of the Chief Psychiatrist. Following six years of consultations and investment in reforming Victoria's mental health legislation the last day of June 2014 saw the transition from the *Mental Health Act 1986* to the *Mental Health Act 2014* on 1 July 2014.

The *Mental Health Act 2014* places people at the centre of mental health treatment and care, and a supported decision-making model as the foundation for promoting strong communication amongst consumers, carers, families and clinicians. The legislation promotes recovery-oriented practice, minimises the duration of compulsory treatment and safeguards the rights and dignity of people with mental illness.

Throughout the consultation of the Mental Health Bill there was strong support for the role of the Chief Psychiatrist but with a refocus on system-level clinical leadership and improving the quality and safety of mental health service delivery. Additionally, this will be the last report on the activities of the Quality Assurance Committee and the electroconvulsive therapy sub-committee both established under the *Mental Health Act 1986*.

The *Mental Health Act 2014* also established the Mental Health Complaints Commissioner (MHCC). Importantly, the previous work of my office in responding to complaints about mental health treatment and care was transitioned to the MHCC from 1 July 2014.

The first six months of 2014 saw intensive preparations for the commencement of the new Act. The Mental Health Act Implementation team lead this work, with concerted effort by the former Department of Health, the Mental Health Branch, mental health service staff and my office. The coordinated effort ensured that services were well prepared to take up the new requirements of the Act.

I would like to acknowledge my predecessor Dr Ruth Vine who was Chief Psychiatrist for the majority of the reporting period. I'd also like to acknowledge the contribution of Dr Rick Yeatman, Dr Kuruvilla George, Dr Neil Coventry and Dr Brett Coulson who held Deputy Chief Psychiatrist roles during the period. I would also like to take this opportunity to recognise and thank the staff in my Office who are dedicated to positive engagement with consumers, carers, service providers and other stakeholders to support an accessible, safe and recovery-focused mental health system.

Dr Mark Oakley Browne
Chief Psychiatrist

Reform and the Mental Health Act 2014

During the reporting period 2012–13 and 2013–14, there was considerable work undertaken across the Department of Health and with other stakeholders on the reform of Victoria's mental health legislation and transition to the new *Mental Health Act 2014*.

Reform of Victoria's mental health legislation focused on developing a contemporary legislative framework for mental health service delivery that would minimise the use and duration of compulsory treatment and support people to have meaningful involvement in decision making.

Following a two-year process of extensive review and consultation with consumers, carers, clinicians, health services and other key stakeholders, the Mental Health Bill 2014 was introduced into Parliament for debate and in March 2014 the *Mental Health Act 2014* passed through the Victorian Parliament. The Act came into effect on 1 July 2014 with bipartisan support.

This new Act aims to improve the treatment experiences of people with a severe mental illness by actively involving and supporting consumers and their families and carers in making decisions about their treatment and exercising their rights; encouraging partnerships among carers, service users and clinicians; minimising the use and duration of compulsory treatment in inpatient and community settings; and improving safeguards for the use of electroconvulsive therapy (ECT).

Impact on the role of the Chief Psychiatrist

The *Mental Health Act 2014* redefines the role of the Chief Psychiatrist to broaden the focus to system-wide issues and supporting public sector clinicians and public mental health service providers to deliver safe and effective mental health services. This will be achieved through the provision of expert clinical advice and leadership, development of clinical guidelines, specialist information, training and education. The Chief Psychiatrist will also analyse data, undertake research and publish reports about the provision of public mental health services. The Chief Psychiatrist will monitor the provision of mental health services and may conduct investigations, clinical audits or clinical service reviews or issue directions to public mental health service providers to improve patient safety and wellbeing.

The *Mental Health Act 2014* establishes an independent Mental Health Complaints Commissioner to receive, investigate and attempt to resolve complaints about public sector mental health service providers. This will provide a timely complaints mechanism that is responsive to the needs of people with mental illness, in particular compulsory mental health patients. It will also enhance oversight of public mental health services.

The role of the Chief Psychiatrist

Appointment of the Chief Psychiatrist

The Chief Psychiatrist was appointed by the Secretary of the Department of Health under s. 105 of the *Mental Health Act 1986* and is subject to the Secretary's general direction and control. The Chief Psychiatrist continues in this role under the new *Mental Health Act 2014* by virtue of the transitional provisions of that Act.[1] The Chief Psychiatrist is supported by the Office of the Chief Psychiatrist (OCP). The OCP consists of two deputy chief psychiatrists (Child and Youth Mental Health, and Aged Persons Mental Health), clinical advisors, project officers and administrative staff.

During the reporting period 2012–13 and 2013–14, the Office of the Chief Mental Health Nurse joined the OCP branch.

Responsibilities

Under s. 105 of the *Mental Health Act 1986,* Victoria's Chief Psychiatrist was responsible for 'the medical care and welfare of persons receiving treatment or care for a mental illness' and has a range of powers, duties and functions under the Act, including:

- delegation - the Chief Psychiatrist could delegate any power, duty or function (other than the power of delegation) to a qualified psychiatrist appointed under s. 95[2]
- the use of authorised officers to assist the Chief Psychiatrist in the performance of his or her statutory functions[3]
- inspection and enquiry - if concerned about the medical care or welfare of a person, the Chief Psychiatrist could visit a mental health service, inspect the premises, see any person receiving treatment and care, inspect and take copies of any documents, and make enquiries relating to the admission, detention, care, treatment and control of people with a mental disorder in or from a mental health service[4]
- direction - following investigation, the Chief Psychiatrist could direct a mental health service to provide or discontinue treatment, admit a person as an involuntary patient or transfer patients from one mental health service to another [5]
- discharge and grant special leave – the Chief Psychiatrist could discharge involuntary patients from certain orders[6], order that security patients be discharged and returned to prison[7], and consider applications for special leave to allow security patients access to the community[8]
- license premises to perform electroconvulsive therapy (ECT) – these could be public or private sector premises[9]
- receive statutory reports – on the performance of ECT in licensed premises[10], seclusion and mechanical restraint in approved mental health services[11], the death of persons receiving treatment

[1] Section 418 of the *Mental Health Act 2014*

[2] Section 105(3) of the *Mental Health Act* 1986

[3] Section 105(5) of the *Mental Health Act* 1986

[4] Sections 106(4), 106(5) and 106(6) of the *Mental Health Act* 1986

[5] Sections 106AA and 106AB of the *Mental Health Act* 1986

[6] Sections 37A, 37B and 37C of the *Mental Health Act* 1986

[7] Section 45 of the *Mental Health Act* 1986

[8] Section 52 of the *Mental Health Act* 1986

[9] Acting as delegate of the Secretary under s. 75 of the *Mental Health Act* 1986

[10] Section 80 of the *Mental Health Act* 1986

[11] Sections 81 and 82 of the *Mental Health Act* 1986

for a mental illness in public mental health services[12], and the annual medical examination of those treated as involuntary patients for a period of 12 months or more[13].

Activities

During the reporting period 2012–13 and 2013–14, the activities of the Chief Psychiatrist covered statutory, advisory and education responsibilities and focused on improving the quality of services and the outcomes for consumers and carers.

Statutory activities included working with mental health services to improve standards of treatment and care and apply legislation to clinical practice; receiving and reviewing statutory reports relating to the use of seclusion, mechanical restraint, ECT, annual examinations and reportable deaths; and performing functions relating to people detained under the *Sentencing Act 1991* and *Crimes Mental Impairment (Unfitness to be Tried) Act 1997*.

The Chief Psychiatrist provided advice to consumers, carers, mental health practitioners and services. Policy and clinical advice was provided to the Department of Health[14] and other mental health stakeholders, and departmental and ministerial briefings were provided in relation to critical incidents.

To promote the rights of consumers, carers and families, the Chief Psychiatrist responded to enquiries and investigated complaints from consumers, carers, members of the public and service providers. The Chief Psychiatrist worked with mental health service providers to improve individual and service system outcomes, particularly for consumers with complex or high-risk presentations. The Chief Psychiatrist also participated on working parties and interdepartmental committees relating to the welfare of persons receiving treatment or care for a mental illness.

To promote quality clinical practice and consumer care, the Chief Psychiatrist supported quality improvement initiatives and mental health treatment and care projects, developed clinical guidelines and delivered education and training.

[12]Section 106A of the *Mental Health Act* 1986

[13]Section 87 of the *Mental Health Act* 1986

[14] Please note in relation to all references in this document to ‘the Department of Health’, the department from 1 January 2015 has become part of ‘the Department of Health and Human Services’.

Clinical leadership

Under the *Mental Health Act 1986*, the role of the Chief Psychiatrist was to provide clinical leadership and expert advice to public mental health services and promote continuous improvement in the quality and safety of mental health services[15]. During 2012–13 and 2013–14, the Chief Psychiatrist worked with the mental health service sector to address treatment and system issues by: developing guidelines; monitoring the outcomes of clinical reviews, audits and investigations; and, conducting and contributing to education and training.

Guidelines

The Chief Psychiatrist develops guidelines to promote sector-wide understanding and application of expected requirements, to respond to identified practice issues and to promote quality improvement. In early 2014, guidelines were reviewed or developed to promote understanding and realignment with the requirements of the *Mental Health Act 2014*.

During 2012–13 and 2013–14, the Chief Psychiatrist developed the following guidelines:

- *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units*
- *Electroconvulsive treatment update*
- *Appointment of an authorised psychiatrist and delegation of powers*
- *Reportable deaths*
- *Restrictive interventions in designated mental health services*
- *Criteria for searches to maintain safety in an inpatient unit - for patients, visitors and staff.*

Services are required to incorporate the guidelines into their policy and procedures as a condition of funding.

Chief Psychiatrist's guidelines are available at <www.health.vic.gov.au/mentalhealth/cpg>.

Education and training

The Chief Psychiatrist has a role in informing mental health service clinicians about the clinical application of legislation and acceptable practice standards. This is achieved through education and training activities, including formal training sessions in response to a specific request from a mental health service or informally through interaction with clinicians who contact the office for advice or to discuss a complaint.

In 2012–13 and 2013–14, the Chief Psychiatrist, the deputy chief psychiatrists and clinical advisers hosted forums, delivered presentations and conducted training sessions on a broad range of issues.

Clinical practice forums

In June 2013, the Chief Psychiatrist hosted a forum on clinical decision making and the Mental Health Tribunal. This forum was attended by psychiatrists, clinicians and other stakeholders, and provided an opportunity to discuss the proposed establishment of the Mental Health Tribunal to replace the Mental Health Review Board and the Psychosurgery Review Board.

A clinical practice forum on physical restraint was hosted by the Chief Psychiatrist and the Chief Mental Health Nurse in September 2013. The forum informed mental health clinicians, managers, consumer and carer workers, quality managers, trainers and educators about the factors that support an organisational response to aggression in clinical settings and reduce the use of physical restraint.

[15] This role of the Chief Psychiatrist continues under the *Mental Health Act 2014*

In December 2013, the Chief Psychiatrist hosted a clinical practice forum *Electroconvulsive Therapy – thinking forward*. The forum was attended by ECT directors and nurse coordinators, clinicians, managers, consumer and carer workers, and provided an update on ECT practice and research to inform program planning in Victoria. The forum also discussed the anticipated changes related to ECT in the new legislation.

Presentations

The Chief Psychiatrist, deputy chief psychiatrists and clinical advisers delivered a range of presentations during 2012–2014. The forums and events included:

- Peninsula Health Grand Round (October 2013)
- Working with High Risk Adolescents and their Families, organised by Office of the Principal Practitioner, Department of Human Services (August 2012, July 2013, October 2013)
- National Summit on Physical and Mental Health (2013)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP) Annual Congresses (2013 and 2014)
- Annual General Meeting of the Victorian Mental Health Carers Network (November 2013)
- Mental Health Clinical Leadership Forum with Lynne Coulson Barr, 'Oversight and service improvement: What can we expect?' (June 2014)

Fostering dialogue

The OCP is involved in a range of activities to foster dialogue and promote continuous improvement in clinical practice and to provide advice to organisations and programs across the health service system. As an avenue of complaint and enquiry under the *Mental Health Act 1986*[16], the OCP was well placed to highlight clinical issues that help identify pressure points on the service system and areas of practice for further attention.

Through participation in committees and working groups across the department, other government agencies and the health system, the OCP provided advice on a range of clinical issues for consideration in policy development and service planning. The issues included forensic service planning, emergency management, Victoria Police liaison and consumer advocacy. The OCP also worked with other government, non-government and advocacy bodies, including the Public Advocate, Health Services Commissioner, the State Coroner, Mental Health Review Board, the Office of the Child Safety Commissioner, the Ombudsman and the Department of Justice[17], on matters of common interest and in response to specific issues. This illustrates the strategic role of the OCP in collaborating across government and the health system.

Some of the committees the OCP was involved in during the reporting period included:

- Advisor to the Department of Health Emergency Response Team, Psychosocial Subcommittee Team related to the Morwell fires, Department of Health
- Child Protection Practice Standards and Compliance Committee, Department of Human Services
- Committee for Therapeutic Interventions and Evidence Based Practice Committee, Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Consumer Partnership Forum, Department of Health
- Hoarding and Squalor Resource Group, Department of Health
- Medication Reference Group Committee, Australian Commission on Safety and Quality in Health Care
- Multiple and Complex Needs Initiative Central Eligibility and Review Group, Department of Human Services
- Patient Safety Advisory Committee, Department of Health
- Physical Health in People with Severe Mental Illness Working Group, RANZCP
- Reducing Adverse Medication Events in Mental Health Working Party, Safety and Quality Partnership Standing Committee
- Refugee Minor Program, Department of Human Services
- Safety and Quality Partnership Standing Committee, National Mental Health Standing Committee
- Supportive Discharge Planning Project Working Group, Office of the Public Advocate

Chief Psychiatrist's Clinical Leaders Meeting

In 2014 the Chief Psychiatrist's Clinical Leaders Meeting was established. This forum replaced the Authorised Psychiatrist's Forum and expanded the disciplines represented to include senior mental health nurses, senior allied health professionals and departmental consumer and carer portfolio holders.

[16] Under the *Mental Health Act 2014* the previous complaints role of the Chief Psychiatrist will be taken over by the Mental Health Complaints Commissioner.

[17] Please note in relation to all references in this document to 'the Department of Justice', the department since 1 January 2015 is now known as 'the Department of Justice and Regulation'.

The purpose of the Clinical Leaders meeting is to:

- provide leadership and advice to support good clinical practice
- analyse data and share information on clinical practice, including monitoring variance reports on seclusion and restraint
- advise on the integration of the *Mental Health Act 2014* within mental health service settings
- advise on clinical practices that enable supported decision making and recovery-oriented practice
- promote and share evidence-based research that supports ongoing quality improvement in clinical practice
- contribute to the development of clinical standards and guidelines for Victorian public mental health services related to the *Mental Health Act 2014*
- identify practice leaders to build capacity, foster excellence and align clinical practice with the directions of the *Mental Health Act 2014*.

National Roundtable

In May 2013, the Deputy Chief Psychiatrist attended the National Roundtable on the Mental Health of People with Intellectual Disability hosted by the NSW Council for Intellectual Disability. This landmark meeting brought together leaders in mental health and intellectual disability from consumer and advocacy representatives, health, mental health, disability, education and non-government organisations. The focus was on consultation to develop a guide for providers on accessible mental health services for people with intellectual disability. The group also raised important challenges and discussed pathways to mental health reform and service development.

Improving service quality

Improved service quality leads to improved outcomes for consumers and their carers and families. The OCP responds to identified concerns and issues and undertakes activities to monitor and promote continuous improvement across the mental health service system.

Quality Assurance Committee

During the reporting period, the Chief Psychiatrist chaired the Quality Assurance Committee (QAC), established under s. 106AC of the *Mental Health Act 1986*, which was declared to be a consultative council under the *Public Health and Wellbeing Act 2008.*

The QAC assisted the Chief Psychiatrist in overseeing and monitoring standards of treatment and care in Victoria's public mental health services. The QAC was comprised of senior psychiatrists and mental health clinicians from across the clinical mental health service system. Members were appointed as authorised officers under the Act for their work with the QAC and were subject to the confidentiality provisions relating to authorised officers and consultative councils.

During the period 2012–13 and 2013–2014, the QAC:

- reviewed data reports about statutory functions, including the use of seclusion and restraint in public mental health services and thematic summaries from coronial reports
- reviewed, updated and developed new Chief Psychiatrist guidelines
- monitored progress of the clinical review program, including service actions in response to reviews
- considered action plans submitted by area mental health services in response to clinical reviews
- considered the recommendations and findings of the *Chief Psychiatrist review of inpatient deaths 2008–2010*
- advised the Chief Psychiatrist on the development and implementation of the *Mental Health Act 2014*.

QAC ECT subcommittee

The QAC ECT subcommittee continued to monitor and oversee ECT practice and training. More than 20 reviews of ECT-related licences and site visits were undertaken during the reporting period 2012–14.

The ECT subcommittee met in 2012–13 and held an annual training forum for accredited ECT training providers. The subcommittee reviewed evidence about the use of ultra-brief ECT and proposed practices and procedures for the Mental Health Tribunal, established under the new Mental Health Act 2014.

In 2013–14, the ECT subcommittee convened the annual training forum for accredited ECT training providers. The subcommittee considered a range of issues, including new requirements under the Mental Health Act 2014, proposed practices and procedures for the Mental Health Tribunal, changes for services in relation to ECT, the role of the Chief Psychiatrist and reporting requirements. The subcommittee also considered evidence and research in relation to ultra-brief ECT and determined that its use is a service-level decision requiring clinician-patient discussion and informed consent.

Implementing the recommendations of the review of inpatient deaths

The Chief Psychiatrist reviews reports of deaths submitted by mental health services. In February 2012, the Chief Psychiatrist's investigation of inpatient deaths 2008–10 was published. This review provided an opportunity for the Chief Psychiatrist to identify any clinical, service or system issues of concern. The review made several recommendations to government and mental health services across a number of areas, including policy and procedures, staffing, training and unit design. The OCP developed a project plan to drive and monitor implementation of the recommendations.

During the reporting period 2012–14, all services developed action plans and have made significant progress in implementing the recommendations. OCP has oversight of the development and implementation of these plans.

A review of inpatient deaths will be undertaken every three years. Planning is underway for the 2011–13 review.

Service visits

The Chief Psychiatrist, deputies and clinical advisers undertake a regular program of visits to services. These typically involve meetings with clinical leaders as well as a site visit to the various service components. Service visits provide an opportunity to discuss service delivery and treatment issues and promote coordination of care across the health system.

Throughout the reporting period 2012–13 and 2013–14, the following services were visited:

- Austin Health
- Ballarat Mental Health Services
- Bendigo Health
- Box Hill Hospital
- Eastern Health
- Epworth Hospital
- Geelong Clinic
- Melbourne Health
- Royal Melbourne Hospital
- Thomas Embling Hospital
- Latrobe Regional Hospital

Reducing restrictive interventions

The Department, the Chief Psychiatrist and mental health services share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services. Significant effort has been invested in achieving safe environments through approaches that involve consumers, carers, the mental health workforce and mental health management.

In Victoria, the Department of Health and public mental health services have undertaken a number of activities to promote the reduction of restrictive interventions.

Reducing restrictive interventions project

The Reducing Restrictive Interventions (RRI) project was a Victorian Government initiative undertaken as a component of the reform of Victoria's *Mental Health Act 1986*. The RRI project was designed to reduce and, where possible, eliminate the use of restrictive interventions in mental health services and promote recovery-oriented practice.

A literature and document analysis established the evidence base for approaches to reducing restrictive practices. *Providing a safe environment for all: Framework for reducing restrictive interventions* (the framework) (2013) was developed to advise services about the organisational factors that impact on the use of seclusion and restraint. To support implementation of the framework, funding was provided to services to develop RRI local action plans and purchase sensory modulation equipment.

A statewide RRI team was established (auspiced by Melbourne Health) to support services to develop action plans outlining local strategies to reduce restrictive practices and support the development of train-the-trainer packages on trauma-informed care and sensory modulation.

The Office of the Chief Mental Health Nurse worked throughout 2013–14 with all area mental health services across Victoria to implement local action plans. Services will continue to implement and report on activities throughout the next financial year.

Variance reporting

To support the Department of Health's commitment to reduce seclusion and restraint practices, the Chief Psychiatrist implemented a variance reporting pilot project, which is a new process of reviewing the use of mechanical restraint and seclusion. This trial commenced on 1 January 2014 and is ongoing. It requires public mental health services to include variance reporting with monthly registers of seclusion and mechanical restraint. Already a number of themes related to acuity of presentations and drug use appear to be evident in the reporting and will inform future planning in the program of reducing restrictive interventions.

Collaborations with key stakeholders

The Chief Psychiatrist works with several key stakeholders across the department. One significant partnership is with the Chief Mental Health Nurse and work occurs 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 Chief Mental Health Nurse supports the statutory responsibilities of the Chief Psychiatrist through initiatives that promote continuous improvement in the quality and safety of mental health services and reduce restrictive practices. During the reporting period, the Office of the Chief Mental Health Nurse undertook several initiatives, described below.

Nursing observations through engagement in psychiatric inpatient care

Nursing observation is the purposeful gathering of information from people receiving care to inform clinical decisions. It is central to nursing practice and critical to good care. The *Nursing observation through engagement in psychiatric inpatient care Department of Health guideline* (2013) provides clinicians, services and service users with clear direction about the role of, and best practice approaches to, nursing observation of people receiving care in Victorian mental health inpatient units. The guideline was developed in response to the Chief Psychiatrist's investigation of inpatient deaths 2008–2010 and to the Coroners Court of Victoria 2011–2012 annual report.

The nursing observation guideline assists mental health services to develop local policies and procedures that promote shared understanding amongst services and practitioners. It highlights the importance of nurses engaging with people receiving care and their carers, recognising that this approach supports recovery, is positive and therapeutic and contributes to better outcomes for people and their families. Mental health services should develop local policies and procedures for nursing observation that are consistent with these guidelines.

Nursing practice – working with people prescribed and undergoing electroconvulsive therapy

In 2013, the Department of Health published *Nursing practice – working with people prescribed and undergoing electroconvulsive therapy.* This is the first dedicated guideline identifying the role of nurses and related practice for caring for people who are prescribed ECT in Victoria.

Nurses have an important role in caring for people undergoing ECT. They provide support and reassurance to individuals and their carers and use their knowledge and technical skills to provide a high standard of care to people before, during and after the ECT procedure.

This guideline was developed in response to Victoria's ECT nurse coordinators, who requested policy guidance in relation to standards for nursing care provided to people who require ECT. It articulates best practice and clarifies the role of nurses in providing treatment, care and support to people undergoing ECT. The guideline is intended to be read in conjunction with the Chief Psychiatrist's *Electroconvulsive therapy manual* (Department of Health 2009) and should influence the development or revision of local policies and procedures.

Gender sensitivity and safety

Mental health services have a responsibility to provide a safe and supportive environment for people accessing services. They must take all reasonable steps to protect people's physical, sexual and emotional safety while responding to their needs, experiences and preferences. Creating and ensuring

safety within inpatient services presents a range of challenges, including mixed-sex environments, limited physical space, and the acuity of patients' illnesses.

Since 2008, the Department of Health has worked to identify issues and concerns around gender, make recommendations for change, and guide practice development across mental health services. The department has produced the following guidelines: *Gender sensitivity and safety report* (2008), *Chief Psychiatrist guideline on promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* (2010) and *Service guideline on gender sensitivity and safety* (2011).

To support the release of the *Service guideline on gender sensitivity and safety*, the Chief Mental Health Nurse worked with the Women's Mental Health Network Victoria to develop a training resource, which was implemented in clinical mental health services in 2013. The Centre for Psychiatric Nursing managed the project to embed the gender sensitive training program within all public inpatient mental health settings in Victoria.

Promoting the rights of consumers and carers

A major focus of the work of the Chief Psychiatrist is to promote continuous improvement in the quality and safety of services delivered to people receiving treatment and care in public mental health services. Research increasingly shows that wellbeing and quality outcomes for both consumers and carers are improved by involving families and carers as early as possible in treatment and care.

Consumers with complex needs

Consumers with complex needs are often people who are frequent users of mental health services and are at serious risk of harm. The OCP provides advice to resolve issues or improve clinical and planning difficulties in relation to these consumers.

People with complex needs are brought to the attention of the Chief Psychiatrist from many sources, including the deputy secretaries within the department, mental health services, disability services, child and youth services, Forensicare, the Multiple and Complex Needs Initiative in the Department of Human Services[18], Spectrum (the statewide personality disorder service) and the Minister for Mental Health's office.

When providing treatment and care to this client group, mental health services are often asked to address a range of issues, including:

- coordinating effort across a number of agencies, such as justice, housing and drug and alcohol services
- responding to specialised and particular treatment and care needs
- ensuring skills and resources are available to respond appropriately to the person's needs
- determining the person's diagnosis and providing an effective treatment regime to meet their needs
- risk of serious harm to themselves or others in the context of limited long-stay, secure bed-based services or supported accommodation.

Case conferences

A case conference can be very helpful in resolving some of the difficulties that may arise when providing treatment and care to consumers with complex needs and in identifying and implementing strategies to best support their treatment and care.

By conducting and participating in case conferences, the Chief Psychiatrist provides an important leadership and coordinating role, bringing together the various services and service elements to ensure effective communication and help develop an appropriate and coordinated multi-sector service response to address the needs of high-need and high-risk consumers. At the same time, the OCP listens to the issues raised and informs the department of any policy or systemic issues that may be impeding the provision of effective treatment and care.

The OCP plays a critical role in assisting services to plan and coordinate care. Although health services have clinical responsibility for consumer care, the OCP has a system-wide role and an in-depth understanding of problems and constraints experienced in the sector. This places the OCP in a position to assist local networks, clinicians and services to coordinate care through discussion and cooperation, and to provide input to service improvement and workforce planning initiatives.

[18] Please note in relation to all references in this document to 'the Department of Human Services', the department from 1 January 2015 has become part of 'the Department of Health and Human Services'.

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

Providing advice and responding to complaints

During the reporting period, consumers, carers, service providers, health professionals, members of the public and others contacted the OCP seeking information and advice or making complaints. The OCP responded to a range of queries, from finding a service through to clinical matters and complaints. The OCP responded promptly to enquiries and provides informed and helpful advice.

Complainants were encouraged to first contact the local mental health or health service complaints system to resolve the issue locally where possible. Complex issues, clinical matters and complaints are generally referred to a clinical adviser who has extensive knowledge of mental illness, its treatment and care, and the mental health service system.

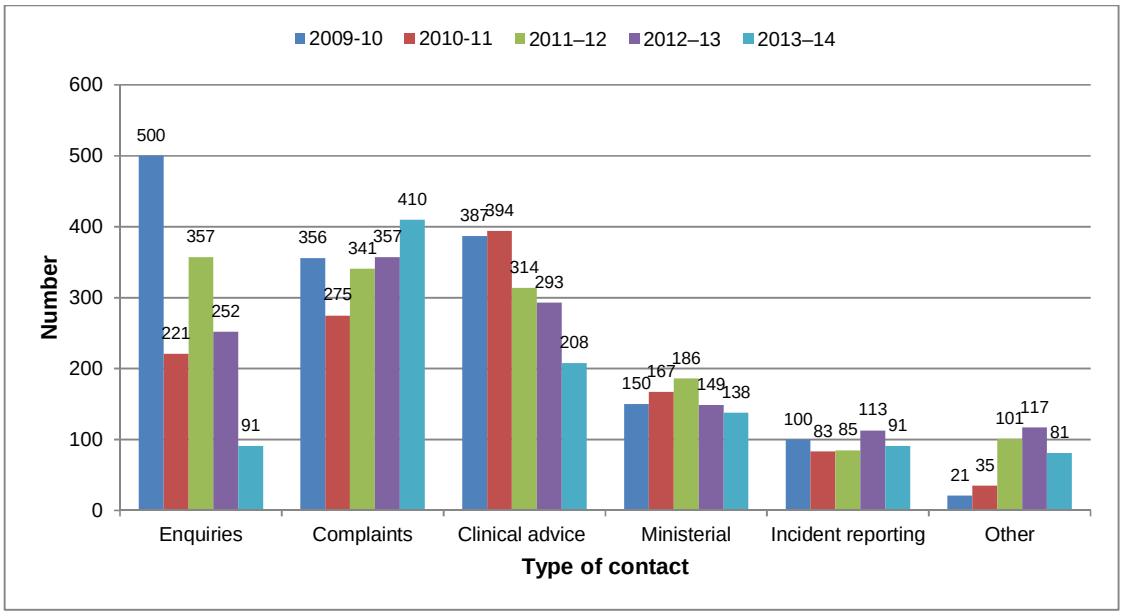
Under the *Mental Health Act 2014*, from 1 July 2014, complaints about mental health services will be directed to the Mental Health Complaints Commissioner.

Profile of contacts

The OCP responded to 1,281 contacts in 2012–13 and 1,019 in 2013–14, down by eight per cent and 26 per cent respectively from 2011–12.

Since 2007, contacts received by the OCP have been categorised according to the type of contact, the person making the contact, the method of contact (telephone or written) and the primary issue raised. Figure 1 shows the breakdown of contacts received by the OCP by type since 2009–10.

Figure 1: Number and type of contacts from 2009–10 to 2013–14



In 2012–13, complaints were the most common type of contact (28 per cent), followed by requests for clinical advice (23 per cent) and enquiries (20 per cent). Similarly in 2013–14, complaints were the most common type of contact, in that year accounting for 40 per cent of all contacts. Twenty per cent of contacts were requests for clinical advice, 13 per cent were ministerial contacts and nine per cent enquiries.

In 2012–13, most contacts were made by service providers (34 per cent) followed by consumers (29 per cent) and carers/families (24 per cent). In 2013–14, most contacts were made by consumers (32 per cent), followed by carers and families (29 per cent), then service providers (28 per cent). The breakup of contacts for the past two years is similar to the previous reporting period.

During the reporting period most contacts to the OCP were made by phone (62 per cent in 2012–13 and 55 per cent in 2013–14), with fewer made in writing (38 per cent in 2012–13 and 45 per cent in 2013–14).

Complaints

Under s. 105(2)(a) of the *Mental Health Act 1986*, the Chief Psychiatrist was 'responsible for the medical care and welfare of persons receiving treatment or care for a mental illness', and s. 106(5)(b) gave the Chief Psychiatrist the power to enquire into matters relating to the treatment and care of any individual to determine whether appropriate processes and guidelines have been followed.

Responding to complaints

The OCP endeavoured to resolve complaints by telephone without the complaint being put in writing. However, where issues were complex, the complainant was asked to provide details in writing to enable further investigation.

Most complaints were addressed through liaison and negotiation with the relevant mental health service or clinician, often to reconnect the consumer or carer and the service or clinician so that concerns could be discussed and addressed. Many complaints were about a difference of opinion or the manner in which treatment has occurred.

Profile of complaints

In 2012–13, the OCP received 357 complaints, mostly made by consumers (50 per cent) and carers (35 per cent). In 2013–14, the OCP received 410 complaints, a 15 per cent increase on the previous year. These complaints were also mostly from consumers (48 per cent) and carers (38 per cent) followed by members of the public, predominantly about treatment and care and access to services.

In 2012–13, 42 per cent of complaints related to a consumer in a community-based service and 47 per cent related to a consumer in an inpatient unit. The figures were similar in 2013–14 with 40 per cent of complaints relating to a consumer in a community-based service and 48 per cent relating to a consumer in an inpatient unit.

As in previous years, most complaints (80 per cent in 2012–13 and 81 per cent in 2013–14) related to adult mental health services, with far fewer complaints relating to aged persons mental health services (six per cent in both 2012–13 and 2013–14) and child and adolescent mental health services (seven per cent in 2012–13 and five per cent in 2013–14).

Most complaints were broadly about treatment and care (59 per cent of complaints in 2012–13 and 57 per cent in 2013–14), followed by complaints about involuntary treatment (17 per cent in 2012–13 and 16 per cent in 2013–14) and access to services (13 per cent in 2012–13 and 17 per cent in 2013–14). Figure 2 shows complaints grouped according to the primary concern.

Figure 2: Complaints received by the OCP by primary concern, 2009–10 to 2013–14

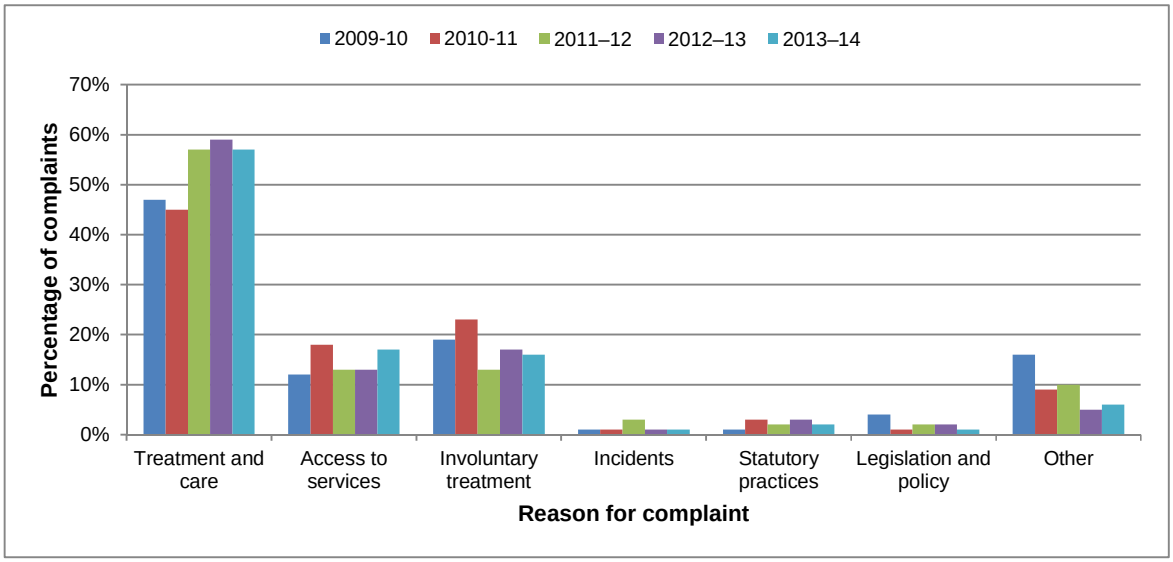


Figure 3a shows that the primary concerns for consumers lodging a complaint with the OCP in 2012–13 were related to treatment and care and involuntary treatment. For carers or family members lodging a complaint, the primary concerns were aspects of treatment and care and access to services.

Figure 3b shows that in 2013–14, the primary concerns for consumers lodging a complaint were treatment and care, access to services and involuntary treatment. For complaints by carers and family members, the primary issues of concern were appropriate services and communication.

In both 2012–13 and 2013–14, complaints about treatment and care related to issues including treatment, medication, discharge, clinicians, communications and follow-up. Complaints about involuntary treatment related to being placed on an involuntary treatment order or a community treatment order. There were a small number of complaints relating to medication and second opinions.

Figure 3a: Primary concern for complaints initiated by consumers and carers in 2012–13

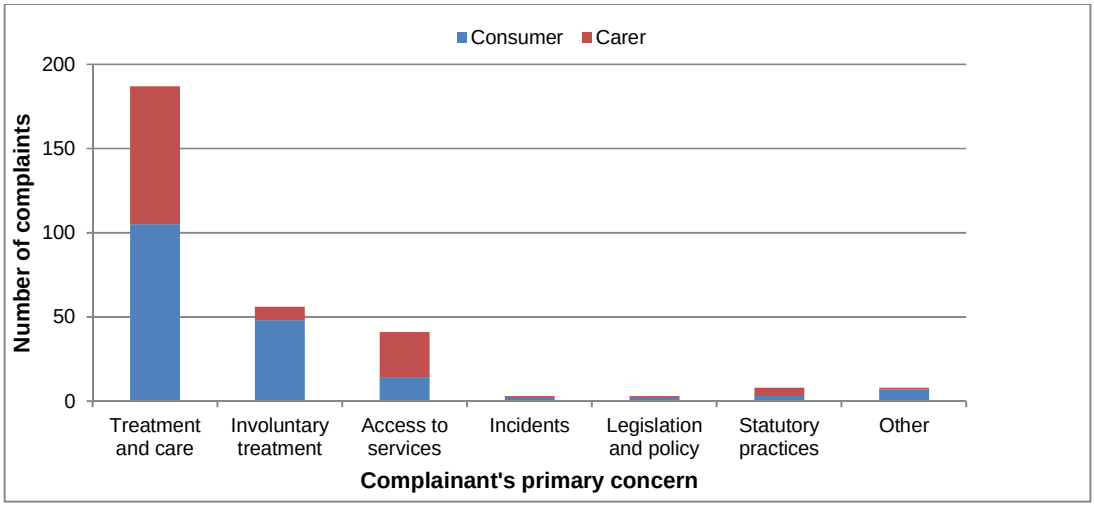
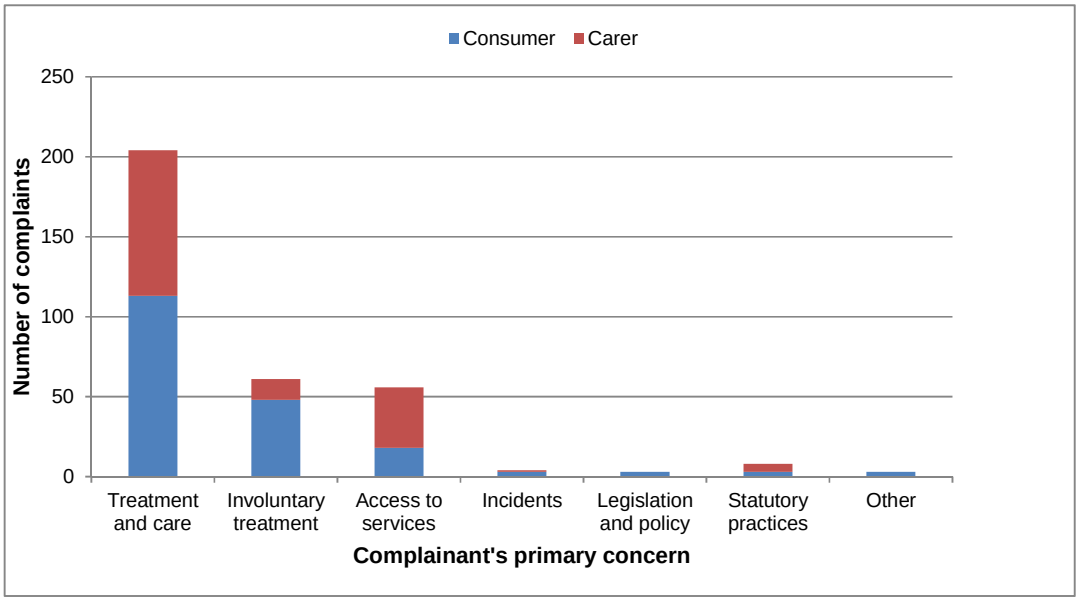


Figure 3b: Primary concern for complaints initiated by consumers and carers in 2013–14



Freedom of information

The Department of Health received a variety of requests for information under the *Freedom of Information Act 1982* (Vic) (FOI Act). Where these records related to individual mental health consumer records held by the department, the OCP was asked to provide additional advice on their release. The OCP provided advice in relation to 102 requests in 2012–13 and 54 in 2013–14.

Statutory reports for 2012–13 and 2013–14

The *Mental Health Act 1986* required mental health services to report the following to the Chief Psychiatrist:

- the death of any patient that is a reportable death within the meaning of the *Coroners Act 2008*
- the use of electroconvulsive therapy (ECT)
- the use of seclusion[19]
- the use of mechanical restraint.

Receiving and reviewing these reports enables the Chief Psychiatrist to identify trends over time, highlight and address systemic clinical issues, and understand the level of morbidity related to inpatient treatment and care in Victoria.[20]

Reportable deaths

The death of any person receiving treatment or care for a mental disorder is a tragic event. The purpose of analysing the circumstances is to improve service delivery and prevent these events where possible. Under s. 106A of the *Mental Health Act 1986*, the death of any person receiving treatment or care for a mental disorder from a 'psychiatric service' that is a 'reportable death' within the meaning of the *Coroners Act 2008* had to be reported to the Chief Psychiatrist.

Under the *Mental Health Act 1986* the deaths of the following people were to be reported to the Chief Psychiatrist:

- any inpatient death at a designated mental health service, regardless of legal status, cause or location of death
- a person who died while on leave, who had absconded, who had been admitted to a medical ward during the admission to the mental health unit, or who died soon after discharge from the mental health unit is considered an inpatient
- patients under the *Mental Health Act 1986*, including all involuntary, security and forensic patients
- people on non-custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*
- other people in care, including unregistered clients in the process of assessment, registered clients and previously registered clients who have been in contact with mental health services within six months of their death, where the service was aware of the death.

In public mental health services the authorised psychiatrist or delegate is responsible for reporting these deaths to the Chief Psychiatrist. In private hospitals, this responsibility lay with the chief executive or delegate[21]. The health service will also report the death to the Department of Health's sentinel event program[22] if the death is an inpatient suicide or falls under the 'other catastrophic event' category.

[19] Victoria's seclusion data provided within this report includes seclusion events in forensic settings. This should be noted when comparing with National seclusion reporting published by the Australian Institute of Health and Welfare that excludes data from forensic settings.

[20] There are similar requirements to report to the Chief Psychiatrist under the *Mental Health Act 2014*

[21] Under the *Mental Health Act 2014* private hospitals no longer have a requirement to report to the Chief Psychiatrist the 'reportable' death of a person receiving treatment for a mental disorder. These deaths are, however, required to be reported to the Coroner.

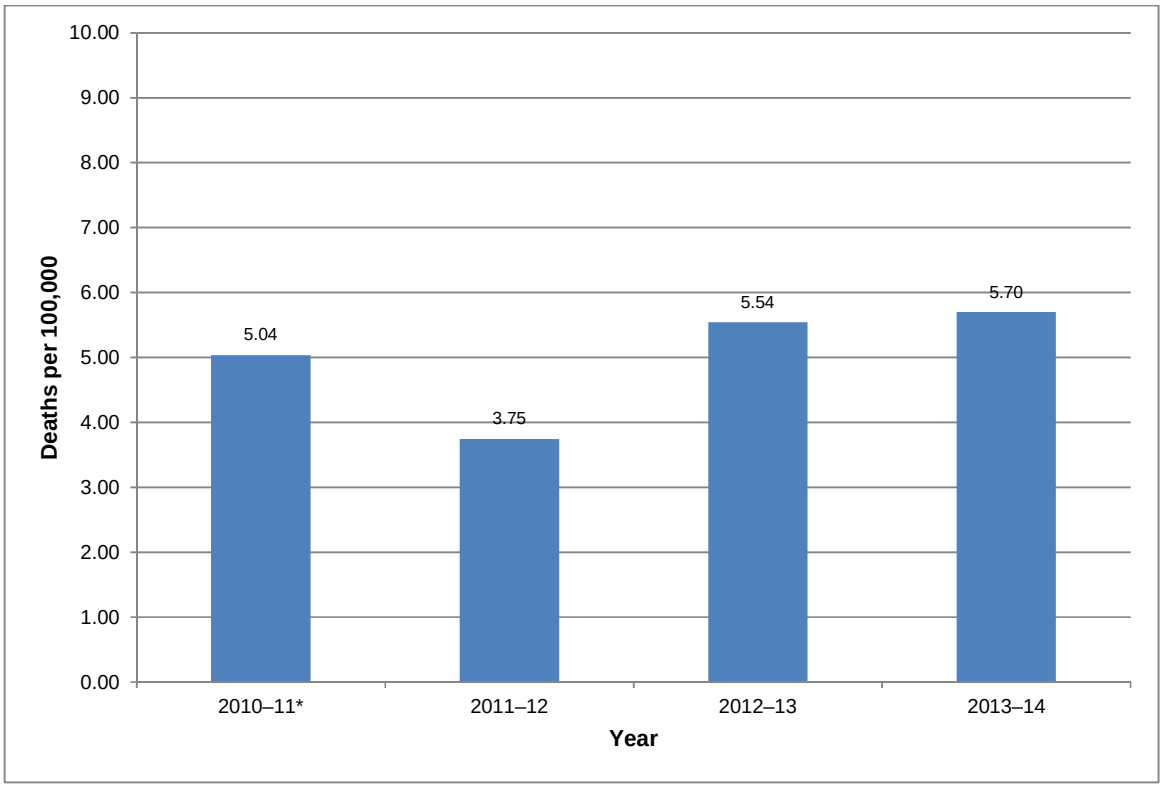
[22] Sentinel events are relatively infrequent, clear-cut events that occur independently of a patient's condition, commonly reflect hospital (or agency) system and process deficiencies; and result in unnecessary outcomes for patients.

Reportable deaths in 2012–13 and 2013–14

Mental health services reported the deaths of 318 clients in 2012–13 and 333 clients in 2013–14. Although this represents an increase in the number of deaths compared to 2011–12 (211), this is consistent with the years prior to and including 2010–11 (275). This increase may be at least partially explained by increased rigour in reporting and documentation, as well as definitional changes around deaths caused by natural causes that are required to be reported to the OCP.

As shown in Figure 4 reportable deaths have remained stable in proportion to Victoria's population. The numbers of deaths reported in 2013–14 increased by 13 per cent from 2010–11. This is generally consistent with the increase in client admissions in 2013–14 from 2010–11 (nine per cent). People who experience significant mental illness have a higher rate of physical co-morbidities, and have a reduced life expectancy compared to people in the general population (Robson and Gray 2007, cited in McKenna et al 2014).

Figure 4: Reportable deaths per 100,000 population



Data source: Department of Transport, Planning and Local Infrastructure 2014, Victoria in Future 2014: Estimated resident population (ERP) and components of change, viewed 19 February 2015, <http://www.dtpli.vic.gov.au/data-and-research/population/census-2011/victoria-in-future-2014/vif-2014-data-tables>

Data source: Australian Bureau of Statistics, Estimated Resident Population (ERP) by Region, Age & Sex, 2001 to 2013, Dataset, viewed 11 February 2015, <http://stat.abs.gov.au//Index.aspx?QueryId=1132#>*

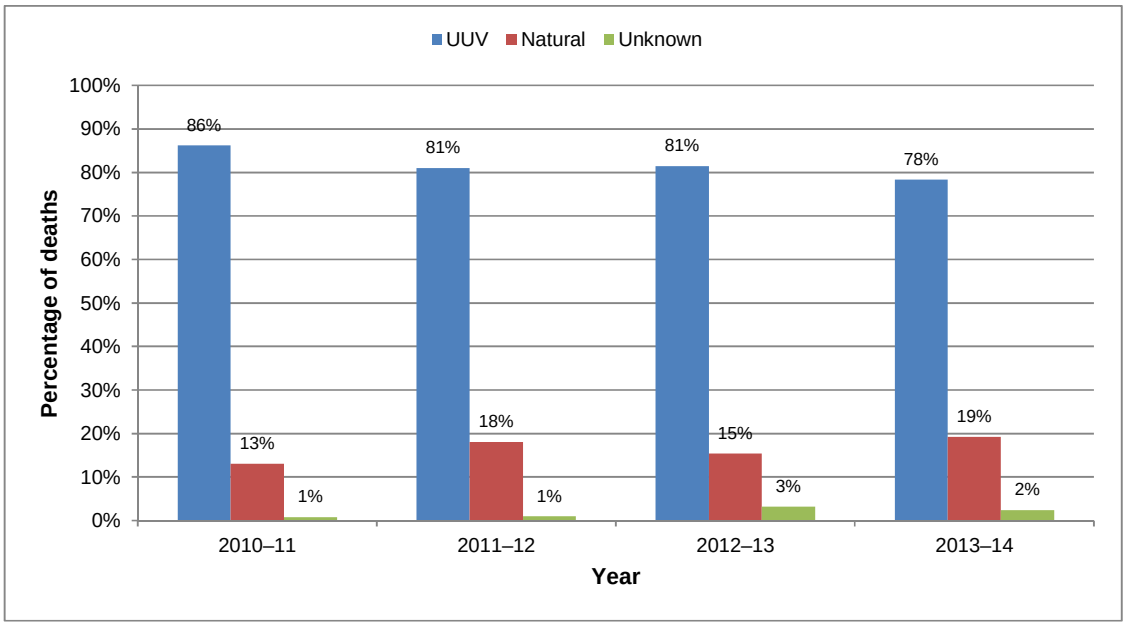
Profile of deaths reported 2012–13 and 2013–14

Deaths are categorised in one of three categories: natural; unexpected, unnatural or violent (UUV); or unknown. UUV deaths are defined by the *Coroners Act 2008* as deaths that appear to have 'resulted, directly or indirectly, from an accident or injury' (s. 4 (2)(a)).

Since 2010–11, and as shown in Figure 5, the proportion of UUV deaths has decreased from 86 per cent in 2010–11 to 81 per cent in 2012–13 and 78 per cent in 2013–14. The proportion of natural deaths remained stable over the same period. Deaths categorised as unknown increased from less than one per

cent of all reported deaths in 2010–11 to 2.4 per cent in 2013–14. This may be attributed to the time it takes for the Coroners Court of Victoria to make a verdict.

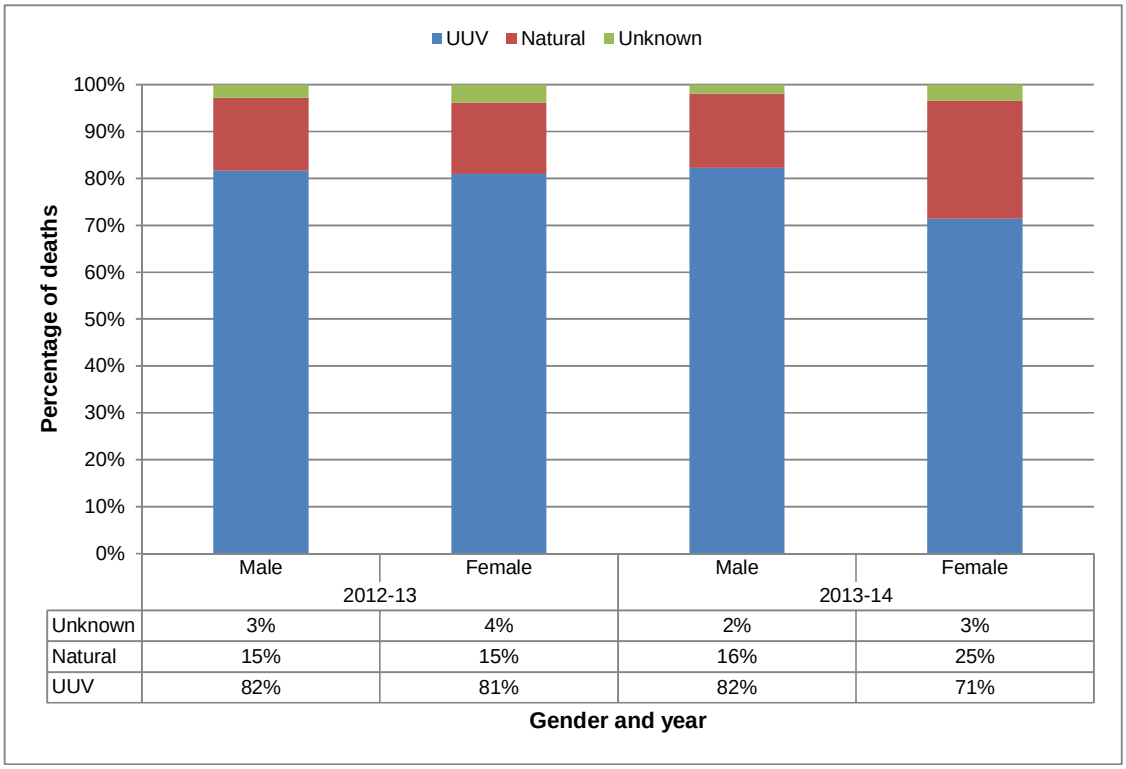
Figure 5: Reportable deaths by cause 2010–11 to 2013–14



During the reporting period males significantly outnumbered females in the number of deaths reported, accounting for 67 per cent of all deaths reported in 2012–13 (n=213) and 64 per cent of deaths reported in 2013–14 (n=214).

Although males account for a greater proportion of deaths, the cause of death amongst both males and females are comparable as shown in Figure 6. In 2012–13 the proportion of deaths that were classified as UUV for males and females was 82 and 81 per cent respectively. This is consistent with 2013–14.

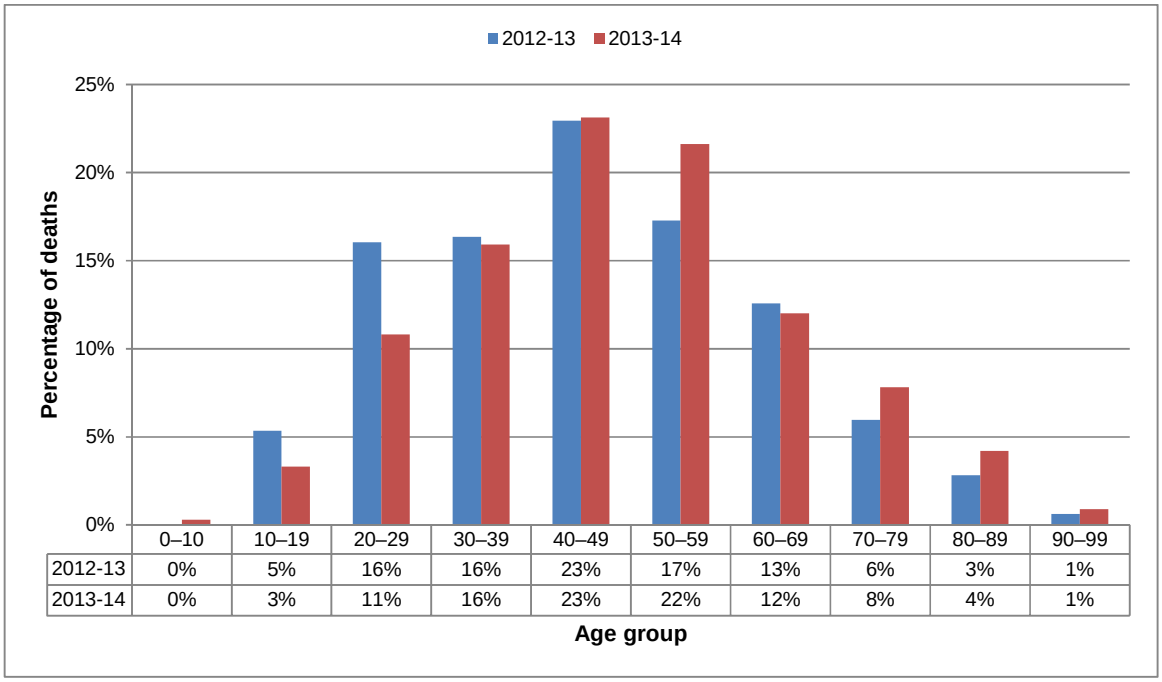
Figure 6: Reportable deaths by gender and cause 2012–13 and 2013–14



	2012-13 Male	2012-13 Female	2013-14 Male	2013-14 Female
Unknown	3%	4%	2%	3%
Natural	15%	15%	16%	25%
UUV	82%	81%	82%	71%

In 2012–13 and 2013–14 the largest proportion of deaths occurred in the age group 40 to 49 years (see Figure 7). This is a slight change from the previous year (2011-12) where the largest proportion of deaths occurred in the 30 to 39 age group.

Figure 7: Reportable deaths by age group 2012–13 and 2013–14

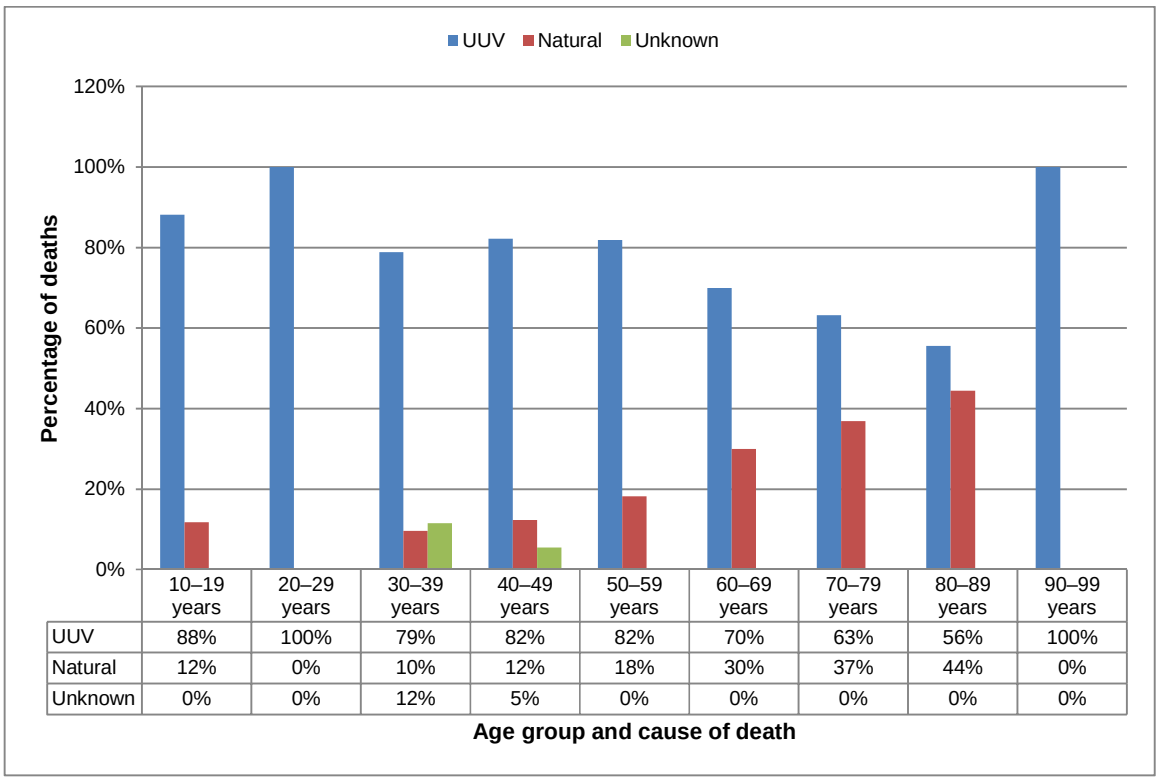


	0–10	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99
2012-13	0%	5%	16%	16%	23%	17%	13%	6%	3%	1%
2013-14	0%	3%	11%	16%	23%	22%	12%	8%	4%	1%

In 2012–13 the deaths of people in age groups up to and including 50 to 59 years (78 per cent of all deaths) were mostly classified as UUV (Figure 8a). As expected the proportion of deaths by natural causes increases in older age groups; this pattern is consistent in 2013–14 (Figure 8b). Although Figure 8a shows that 100 per cent of deaths in the 90 to 99 years age group were classified as UUV, this represents a small proportion of total deaths (n=2).

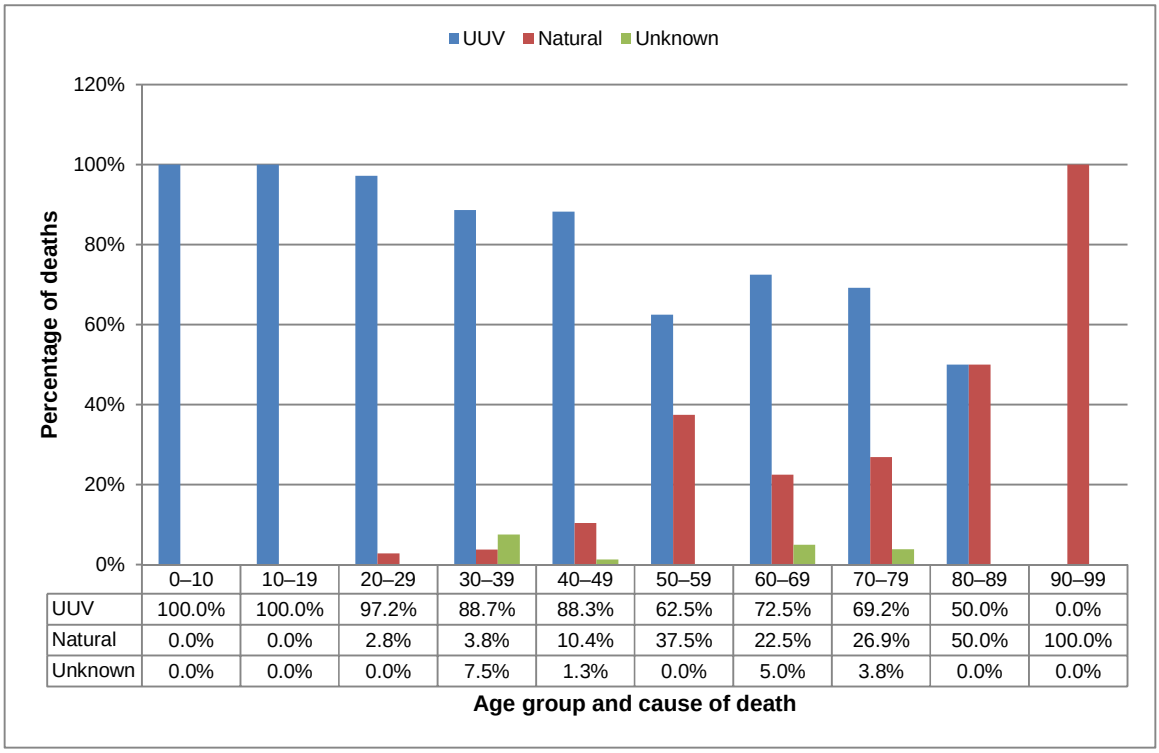
In 2012–13 all the deaths of people up to 29 years of age (21 per cent of all deaths, n=68), except two, were classified as UUV. In 2013–14 this age group represented 14 per cent of all deaths (n=48), and similarly all were classified as UUV except one.

Figure 8a: Reportable deaths by age and cause of death 2012–13



	10–19 years	20–29 years	30–39 years	40–49 years	50–59 years	60–69 years	70–79 years	80–89 years	90–99 years
UUV	88%	100%	79%	82%	82%	70%	63%	56%	100%
Natural	12%	0%	10%	12%	18%	30%	37%	44%	0%
Unknown	0%	0%	12%	5%	0%	0%	0%	0%	0%

Figure 8b: Reportable deaths by age and cause of death 2013–14



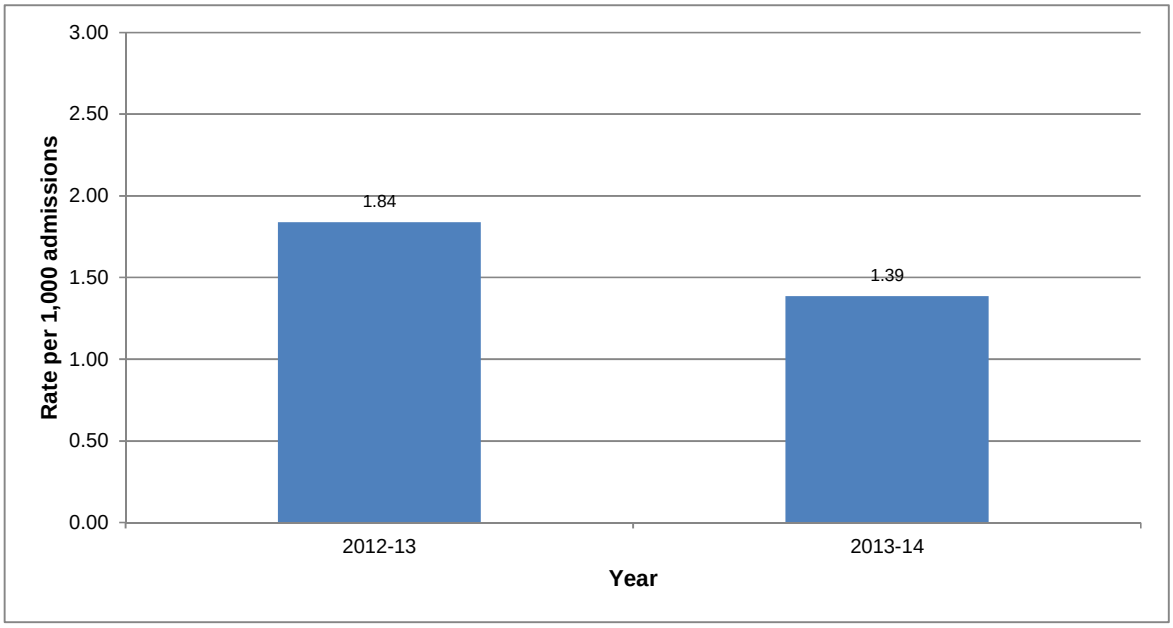
	0–10	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89	90–99
UUV	100.0%	100.0%	97.2%	88.7%	88.3%	62.5%	72.5%	69.2%	50.0%	0.0%
Natural	0.0%	0.0%	2.8%	3.8%	10.4%	37.5%	22.5%	26.9%	50.0%	100.0%
Unknown	0.0%	0.0%	0.0%	7.5%	1.3%	0.0%	5.0%	3.8%	0.0%	0.0%

Place of death

Inpatient deaths include deaths that are classified as UUV, natural or unknown. Sentinel events[23] (inpatient suicides) are also included in UUV. Additionally, inpatient deaths also include those people that were on leave or had absconded from an inpatient mental health service. As shown in Figure 9 the inpatient death rate per 1,000 distinct client admissions was 1.84 (n=26) in 2012–13 and 1.39 (n=20) in 2013–14.

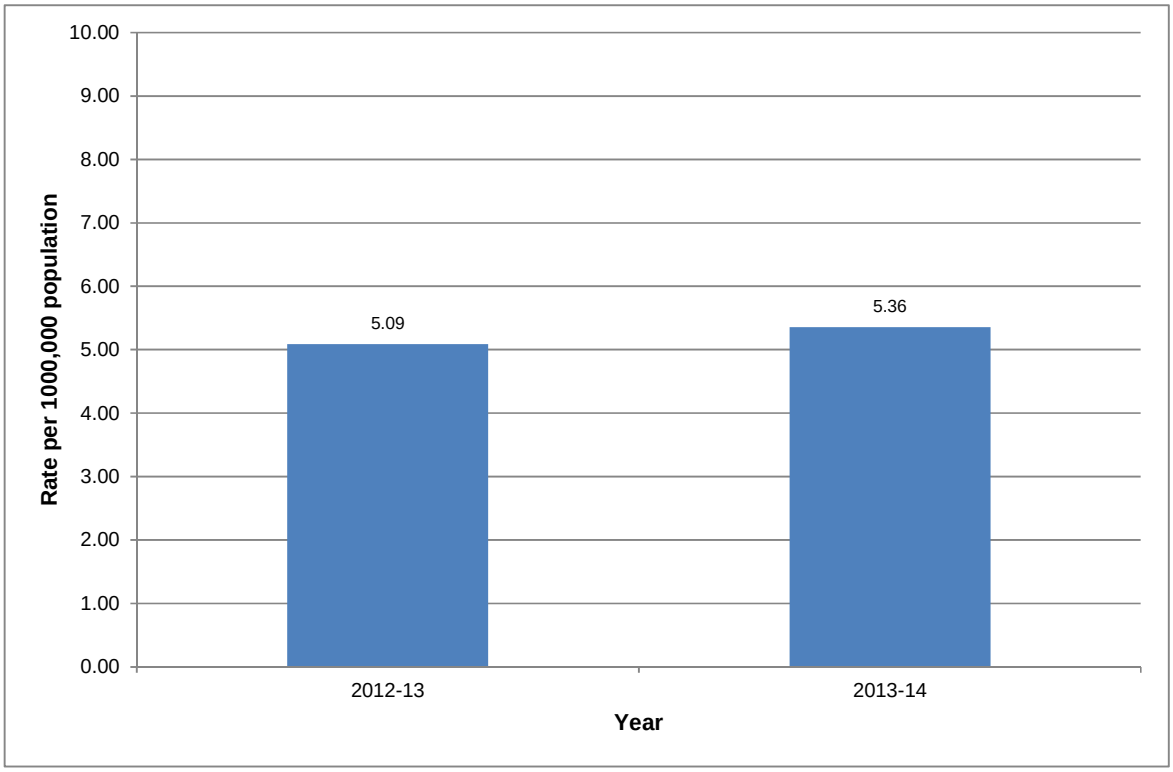
[23] Sentinel events are relatively infrequent, clear-cut events that occur independently of a patient's condition, commonly reflect hospital (or agency) system and process deficiencies; and result in unnecessary outcomes for patients.

Figure 9: Inpatient deaths per 1,000 client admissions



The deaths of people receiving care in a community setting remained consistent across the reporting period (Figure 10) in relation to Victoria's population, at 5.09 in 2012–13 (n=292) and 5.36 (n=313) in 2013–14. People receiving care in the community include people receiving community-based mental health care and previously registered clients who have been in contact within six 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 six-months prior to their death.

Figure 10: Deaths of people receiving care in the community per 100,000 population



Data source: Department of Transport, Planning and Local Infrastructure 2014, Victoria in Future 2014: Estimated resident population (ERP)and components of change, viewed 19 February 2015, <http://www.dtpli.vic.gov.au/data-and-research/population/census-2011/victoria-in-future-2014/vif-2014-data-tables>

Electroconvulsive therapy (ECT)

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 is most commonly prescribed for treating severe depression but may also be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. Where ECT is prescribed, it should form part of a treatment plan in combination with other therapies.[24]

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

A new method of delivering ECT called ultra-brief pulse ECT was discussed by the ECT subcommittee of the Quality Assurance Committee following a presentation of new research by experts. In 2013–14, the consensus of the subcommittee was that the provision of ultra-brief ECT was a service level decision to be discussed between the clinician and the patient. It was agreed that there needs to be informed consent and that services should plan for good supervision, credentialing of experience and quality control.

From 1 July 2014, the *Mental Health Act 2014* removes the regulation of ECT by the OCP. The new legislation also establishes reporting requirements in relation to the performance of ECT on young people.[25] The Chief Psychiatrist will be required to:

[24] Department of Human Services 2009, *Electroconvulsive therapy manual, Licensing, legal requirements and clinical guidelines*, http://www.health.vic.gov.au/mentalhealth/ect/ect.pdf

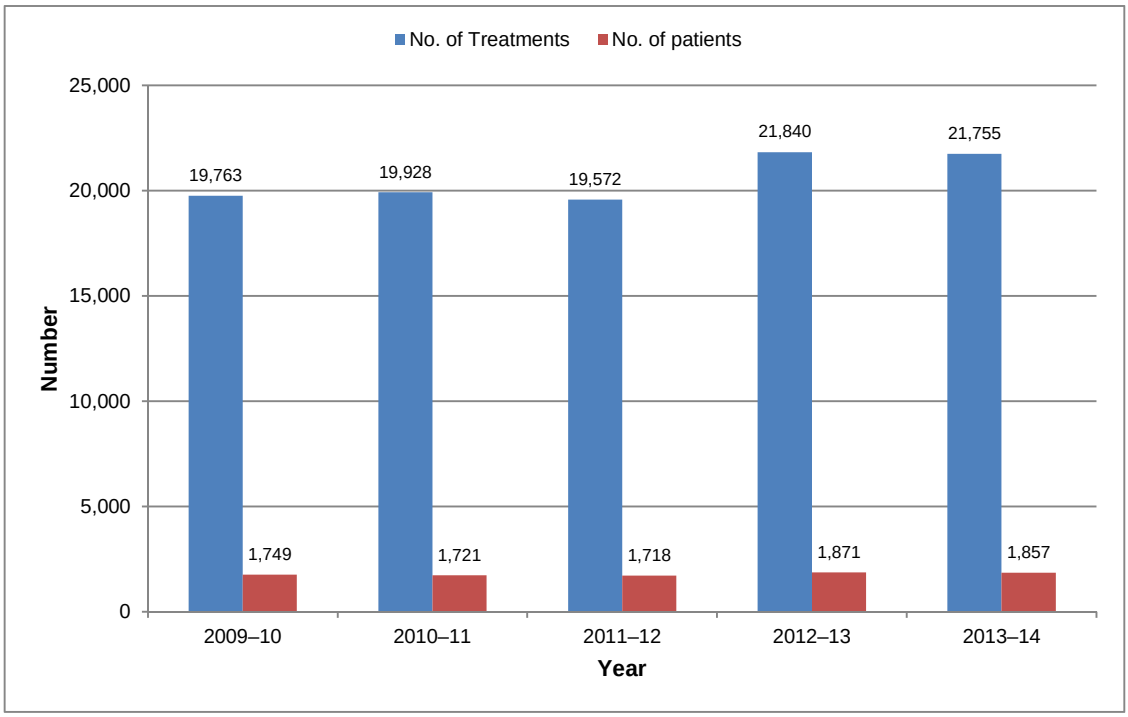
[25] Section 145 of the *Mental Health Act 2014*

- prepare a written report annually on the number of young people under 18 years of age who received one or more courses of ECT at a designated mental health service during the financial year
- report on any amendments made during the financial year to any guidelines or practice directions issued that may impact on the performance of ECT on young people
- report on the clinical outcomes for those young people resulting from the ECT from 1 July 2014.

Number of ECT treatments

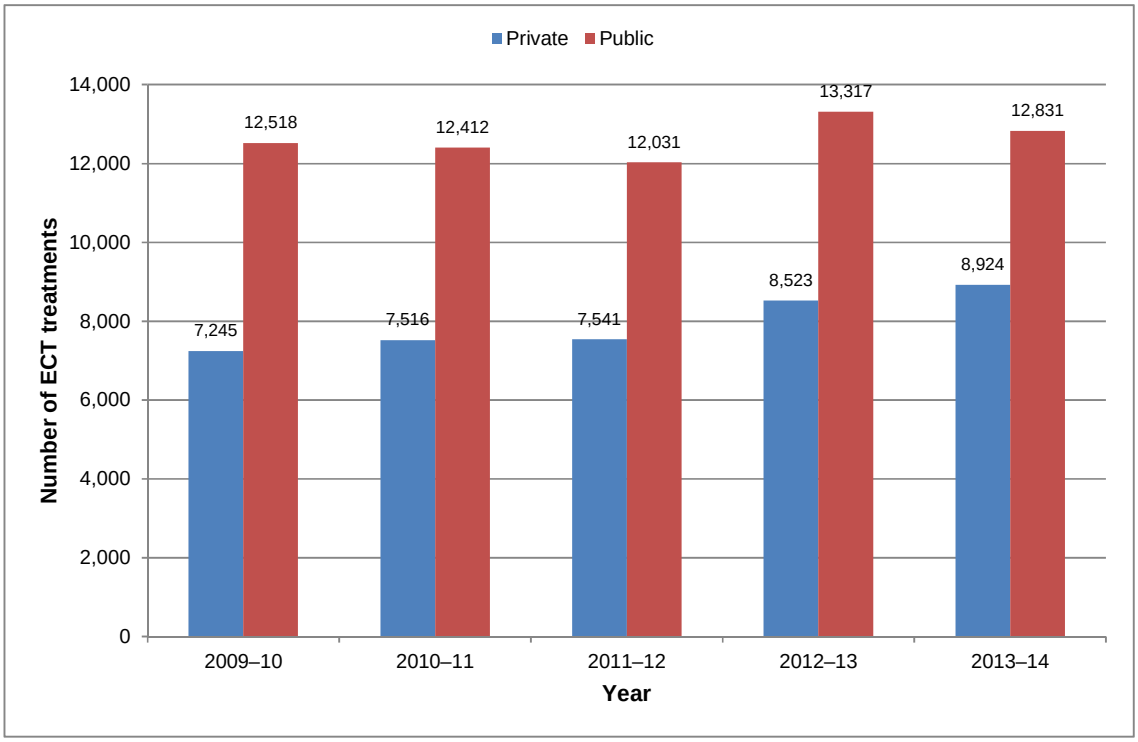
In 2012–13 and 2013–14, public and private mental health services in Victoria provided a total of 21,840 and 21,755 ECT treatments respectively, as shown in Figure 11. Between 2009–10 and 2013–14 this reflects a nine per cent increase in the number of ECT treatments. This is consistent with the 12 per cent increase in admissions over the same period.

Figure 11: Use of ECT from 2009–10 to 2013–14



As in previous years, public mental health services accounted for the majority of all ECT treatments: 61 per cent in 2012–13 and 59 per cent in 2013–14 (Figure 12). While the number of patients who received ECT in each sector has remained largely stable, the number of ECT treatments administered in private mental health services has increased by 23 per cent from 7,245 in 2009–10 to 8,924 in 2013–14. This increase may be related to the use of ultra-brief technology, which generally requires a greater number of treatments to achieve wellness. Over the same period, ECT treatments in public mental health services have increased by two per cent.

Figure 12: Administration of ECT by sector, 2009–10 to 2013–14



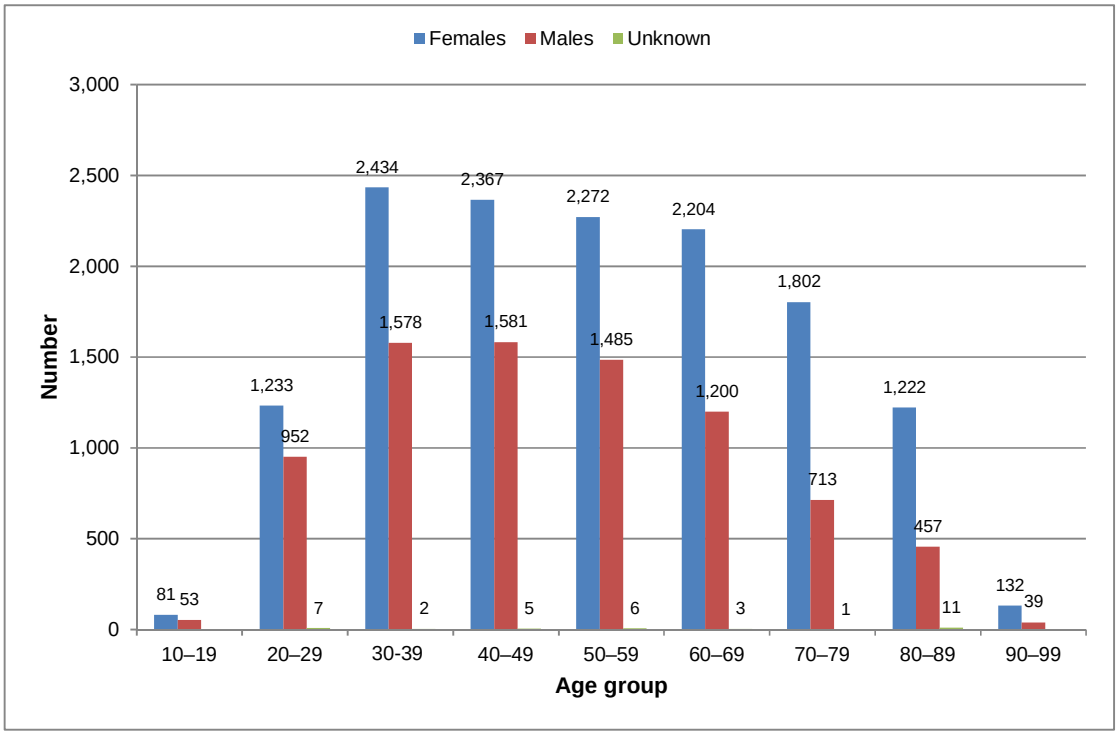
Persons receiving ECT treatment

In 2012–13, 1,871 people received ECT treatment and in 2013–14 1,857 people received ECT treatment. These figures represent an eight per cent increase on the number receiving ECT treatment in 2011–12, and an 18 per cent increase when compared to 10 years ago (2005–06). The average number of treatments per person has remained stable over recent years at around 11. For both 2012–13 and 2013–14 reporting periods, the average number of treatments per person is 11.7. Women received the greatest proportion of ECT treatments, accounting for 63 per cent of all ECT treatments in 2012–13 and 65 per cent in 2013–14.

As shown in Figure 13a, 30 to 39 years and 40 to 49 years were the peak age groups for both males and females receiving ECT treatment in 2012–13. In 2013–14, the peak age group for females receiving ECT treatments was 50 to 59 years and for males it was 40 to 49 years (Figure 13b).

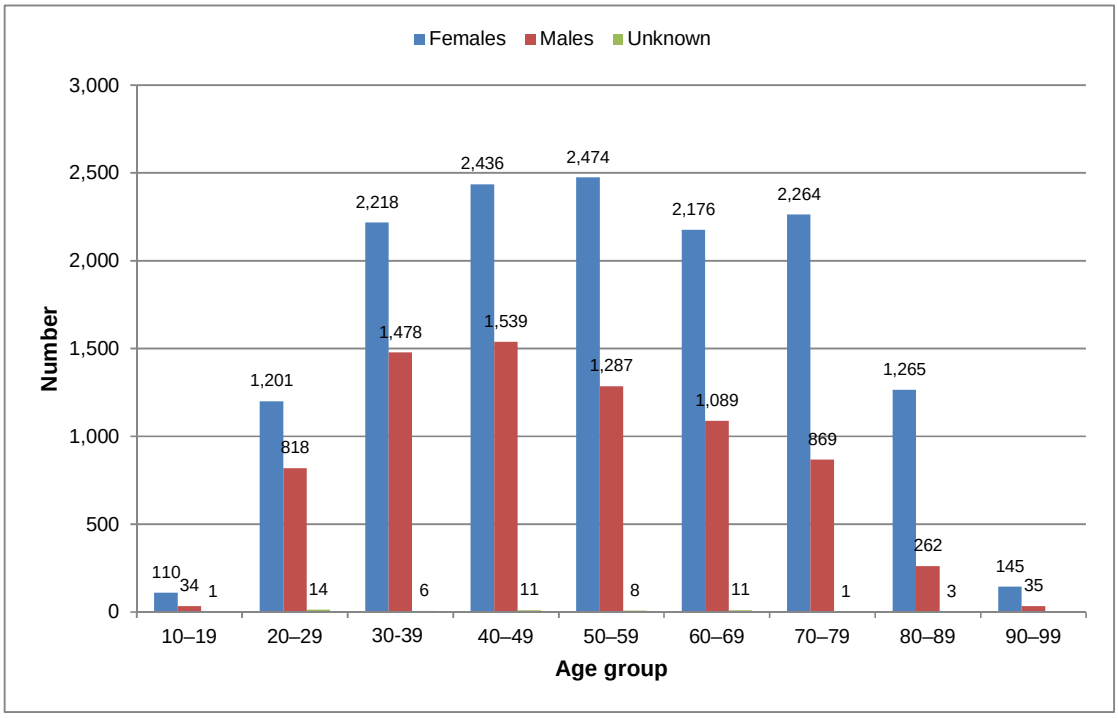
In both 2012–13 and 2013–14, more than 170 ECT treatments were provided to persons aged over 90 years. This reflects the safety and effectiveness of this treatment in elderly people who may be on multiple medications to treat other medical conditions, such that oral antidepressants may be relatively contraindicated.

Figure 13a: ECT treatments by age and gender 2012–13



Note: treatment in the age range 10–19 is generally for persons aged 15–19.

Figure 13b: ECT treatments by age and gender 2013–14



Note: treatment in the age range 10–19 is generally for persons aged 15–19.

Diagnosis

In both reporting periods, ECT treatment was given most often for a diagnosis of mood (affective) disorder, followed by schizophrenia, schizotypal and delusional disorders.

Table 1: Number of ECT treatment by diagnosis, 2012–13 and 2013–14

Diagnosis	2012–13		2013–14	
	Treatments	Percentage	Treatments	Percentage
Mood [affective] disorders	14,782	68%	14,645	67%
Schizophrenia, schizotypal and delusional disorders	4,928	23%	4,924	23%
Not Known or currently available	1,226	6%	1,323	6%
Other (including neurotic illness)	904	4%	863	4%
TOTAL	21,840	100%	21,755	100%

Licensing

The *Mental Health Act 1986* established a framework for the licensing of all premises where services performed ECT[26]. ECT could only be provided in premises licensed by the Secretary to the Department of Health.[27] In practice, this power was delegated to the Chief Psychiatrist.

2012–13

At 30 June 2013, 33 premises were licensed to provide ECT in Victoria. Of the licensed premises, 27 were within public and six were within private hospital settings.

Reviews in 2012–13 included:

- four full licence reviews three of which included recommendations
- three requests for licence amendments
- three services completed conditions attached to their licence renewal
- one service was decommissioned due to inability to fulfil conditions
- one service was scheduled for yearly monitoring
- one service had consent forms reviewed.

2013–14

At 30 June 2014, 34 premises were licensed to provide ECT in Victoria. Of these, 27 were within public settings and seven were within private hospital settings.

Reviews in 2013–14 year included:

- two full licence reviews
- one yearly monitoring
- one review of conditions of licence completed
- one report on recommendations completed
- one licence amended to add theatre suites

[26] This is no longer a requirement under the *Mental Health Act 2014.*

[27] Section 74 of the *Mental Health Act 1986*

- one request for review of amendment to licence
- one new licence provided for 12 months with visits scheduled.

Training and quality improvement

Attendance at an approved training course is a prerequisite for administering ECT to patients. Victoria has seven training providers that offer accredited training for providers of ECT:

- Albert Road Clinic
- Austin Health
- Bendigo Health
- Eastern Health
- Peninsula Health
- Southern Health
- St Vincent's Health

The Chief Psychiatrist hosted the annual ECT Training Providers Forum in October 2012 and October 2013.

Seclusion

Under the *Mental Health Act 1986* seclusion was defined as 'the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside'[28]. The Act provided that a person receiving treatment in an approved mental health service could be placed in seclusion if it was necessary to protect them or others from an immediate or imminent risk to their health or safety or to prevent the person from absconding.[29]

Seclusion is a highly restrictive intervention, and it is only used when other less restrictive treatment options have been tried or considered and excluded as inappropriate. The use of seclusion is not permitted in a private psychiatric hospital or a non-gazetted public mental health service.[30]

When seclusion is used, a registered nurse must review the secluded person at least every 15 minutes and a medical practitioner must examine the person at least every four hours (unless this is varied by an authorised psychiatrist).[31] Each seclusion episode must be recorded and reported to the Chief Psychiatrist.[32] All extended periods of seclusion[33] were required to be reported to the Chief Psychiatrist from 1 January 2014, known as variance reporting.

Seclusion episodes

While the number of people admitted to inpatient units has been steadily increasing over recent years, the number of consumers being secluded and the number of seclusion episodes have declined. Of the 14,143 people admitted to inpatient units in 2012–13, 9.7 per cent (1,384) were secluded at some time during their admission, while in 2013–14, 8.5 per cent (1,238) of the 14,420 people admitted to inpatient units were secluded at some time during their admission, this is outlined in Figure 10. This is a marked decrease on the 15 per cent of consumers who were secluded in 2007–08.

The total number of reported episodes of seclusion has continued to decline from 6,059 in 2009–10 to 3,568 in 2012–13 and 3,332 in 2013–14. This reflects the efforts to reduce restrictive interventions and, most recently, the priority placed on seclusion reduction in the 2013–14 Statement of Priorities.

The statewide seclusion rate averaged 10 events per 1,000 bed days in 2012–13 and 9 events in 2013–14 (Figure 14). This represents a steady decline since 2008–09 and the investment made by mental health services in efforts to reduce rates of restrictive interventions.

[28] Section 82(1) of the *Mental Health Act* 1986

[29] Section 82(a) of the *Mental Health Act* 1986

[30] The *Mental Health Act 2014* continues this restriction by providing that restrictive interventions including seclusion may only occur in a designated mental health service

[31] Under the *Mental Health Act 2014* the examination every four hours must be carried out by an authorised psychiatrist unless it is not practicable to do so in which case it is done by a medical practitioner (s. 112).

[32] This is also the case under the *Mental Health Act 2014* (s. 108)

[33] More than eight hours in an adult setting, or more than four hours in an aged or child and adolescent setting.

Figure 14: Seclusion per 1,000 occupied bed days 2008–09 to 2013–14

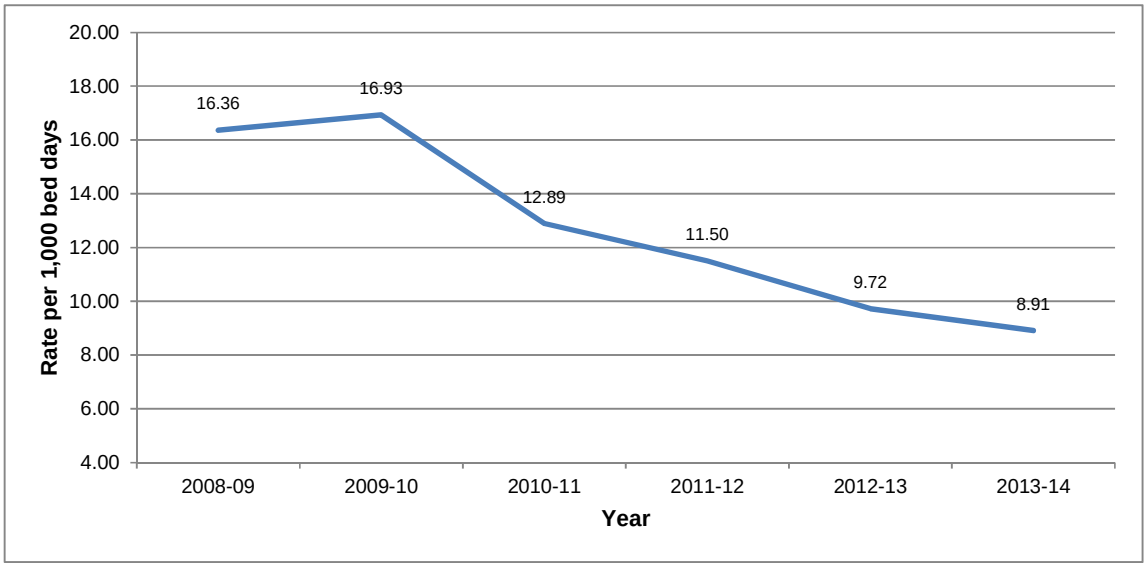
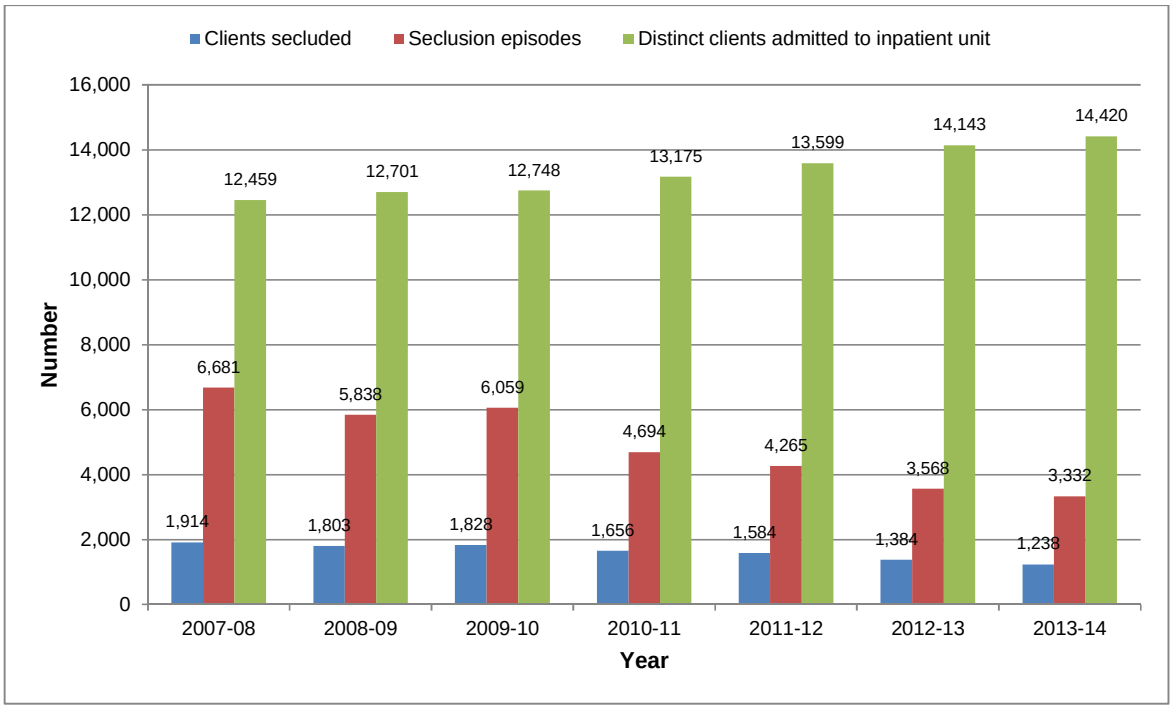


Figure 15: The use of seclusion 2007–08 to 2013–14



The duration of seclusion episodes has remained stable since 2011–12 when the proportion of short episodes (up to four hours) dropped to 49 per cent. Figure 16 shows that in 2012–13 and 2013–14, short episodes of seclusion accounted for approximately half of all seclusion episodes; one-quarter of all seclusion episodes lasted between four and 12 hours; and approximately one-quarter lasted longer than 12 hours.

Figure 16: The duration of seclusion episodes 2007–08 to 2013–14

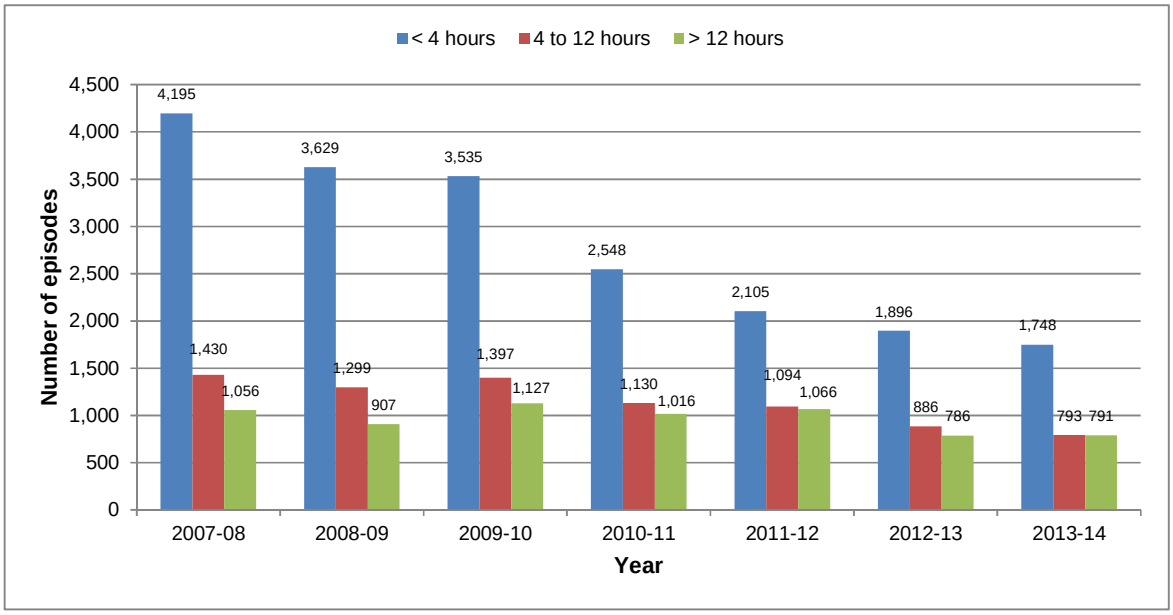
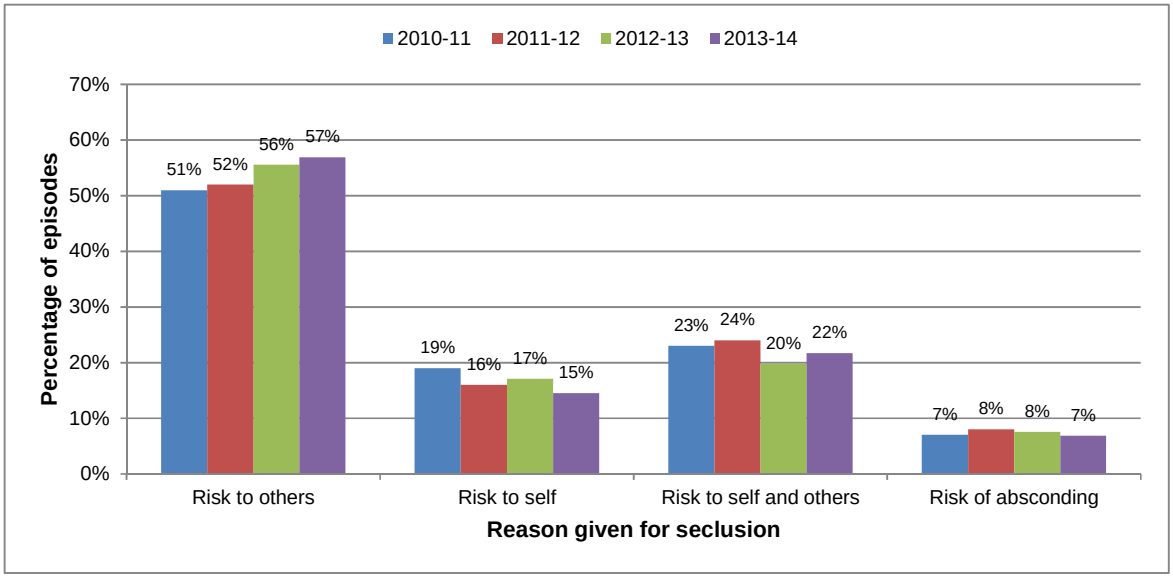


Figure 17 shows that for both 2012–13 and 2013–14 the primary reason for seclusion was to prevent a health or safety risk to other people. This is consistent with reports from previous years, though showing a slightly increasing percentage of all seclusion episodes.

Figure 17: Reason for seclusion 2010–11 to 2013–14



Persons secluded

As shown in Figures 13a and 13b, in 2012–13 and 2013–14 males accounted for most episodes of seclusion across all groups and men aged in their 20s and 30s were the most likely to be secluded. In the 10 to 19 year range, most seclusions were for 18 and 19 year olds.

In 2012–13, males accounted for 68 per cent of all episodes of seclusion, with males aged 20 to 40 years accounting for 40 per cent of all episodes. Similarly, in 2013–14, males accounted for 69 per cent of all episodes of seclusion, with males aged 20 to 40 years accounting for 42 per cent of all episodes.

Figure 18a: Persons secluded by age and gender 2012–13

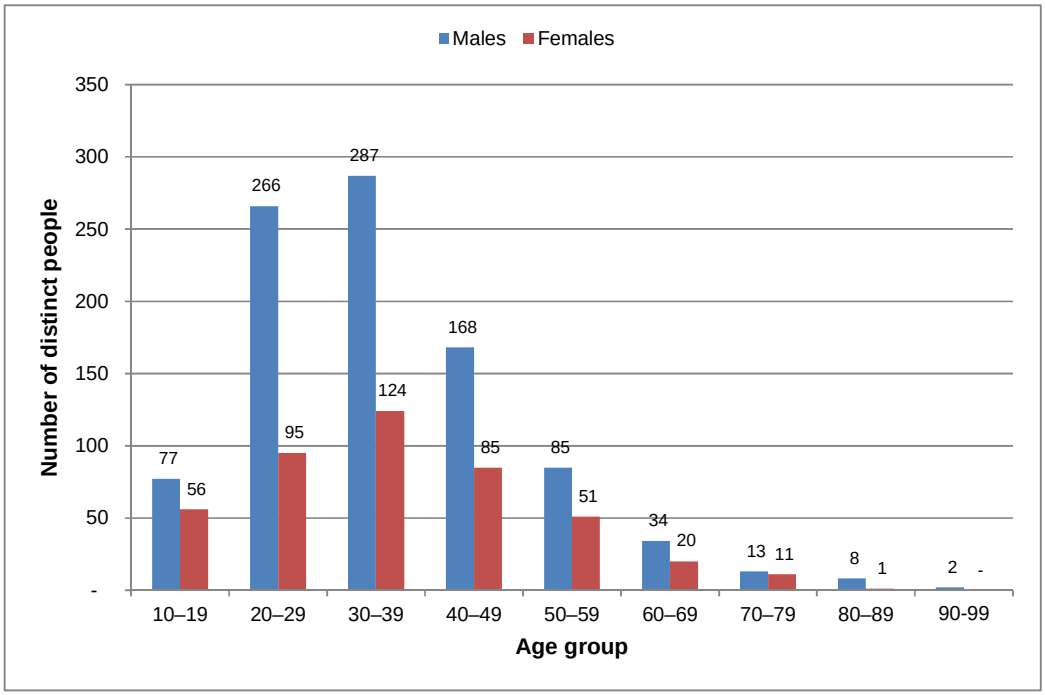
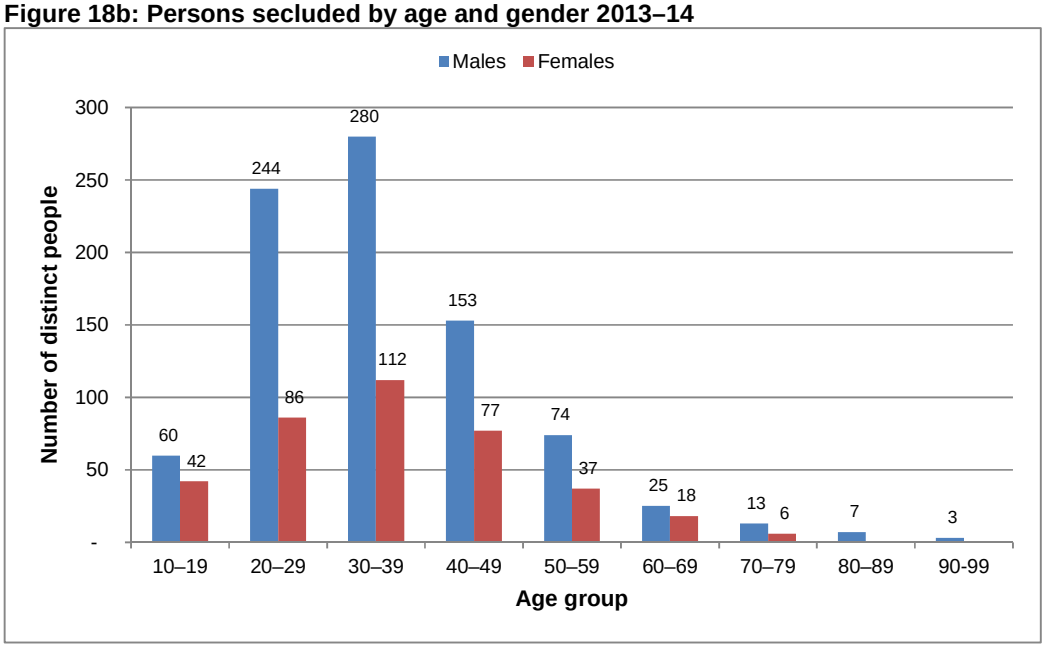
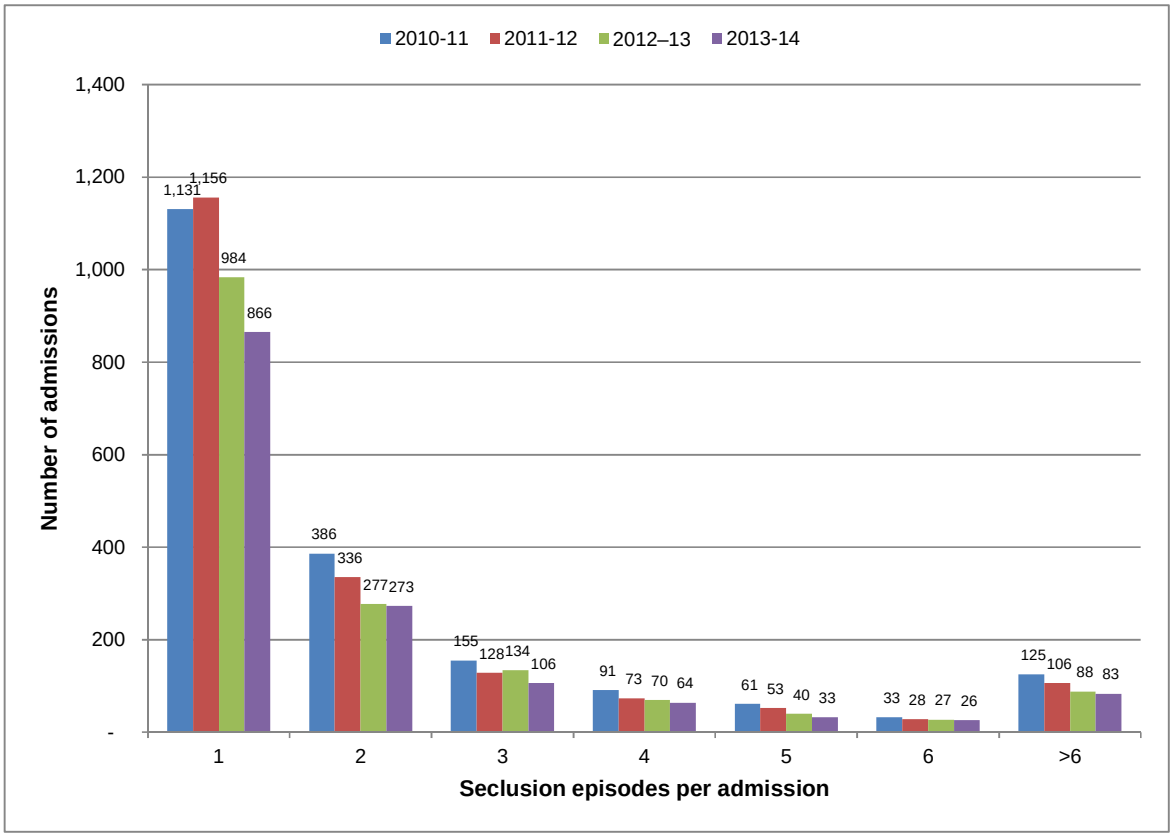


Figure 18b: Persons secluded by age and gender 2013–14



As previously stated and shown in Figure 15, in 2012–13, 9.7 per cent of consumers hospitalised were secluded and in 2013–14, 8.5 per cent were secluded. Figure 19 shows that, as for previous years, for most hospital admissions that involved seclusion in 2012–13 and 2013–14, the consumer was secluded on only one occasion during their hospitalisation. Of those secluded, a quarter was secluded two or three times during their stay. In both 2012–13 and 2013–14, six per cent of people secluded were secluded six or more times during their stay. This small group of patients with complex presentations and highly disturbed behaviours accounts for a high proportion of all seclusion episodes.

Figure 19: Number of seclusion events within the same hospital admission 2010–11 to 2013–14



Mechanical restraint

Under the *Mental Health Act 1986* mechanical restraint was defined as 'the application of 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 restricts the person's capacity to get off the furniture'.[34] The Act provided that mechanical restraint could be used on a person receiving treatment in an approved mental health service if it was necessary for the medical treatment of the person or to prevent the person causing injury to himself or herself or another person or to prevent the person persistently damaging property.[35]

The decision to apply mechanical restraint should only be taken after other less restrictive options have been considered, tried and excluded. Once the decision has been made to apply mechanical restraint, careful clinical monitoring and review is provided. A registered nurse or medical practitioner must continuously observes a restrained person, and a registered nurse must review the person at least every 15 minutes[36]. A medical practitioner examines the restrained person at least every four hours (unless varied by an authorised psychiatrist)[37].

Each restraint episode is recorded and reported to the Chief Psychiatrist.[38]

[34] Section 81(1A) *Mental Health Act* 1986

[35] Section 81(1)(a) *Mental Health Act* 1986

[36] This requirement continues under the *Mental Health Act* 2014 (section 116(3)).

[37] Under the *Mental Health Act* 2014 the examination every four hours must be carried out by an authorised psychiatrist unless it is not practicable to do so in which case it is done by a medical practitioner (s. 116).

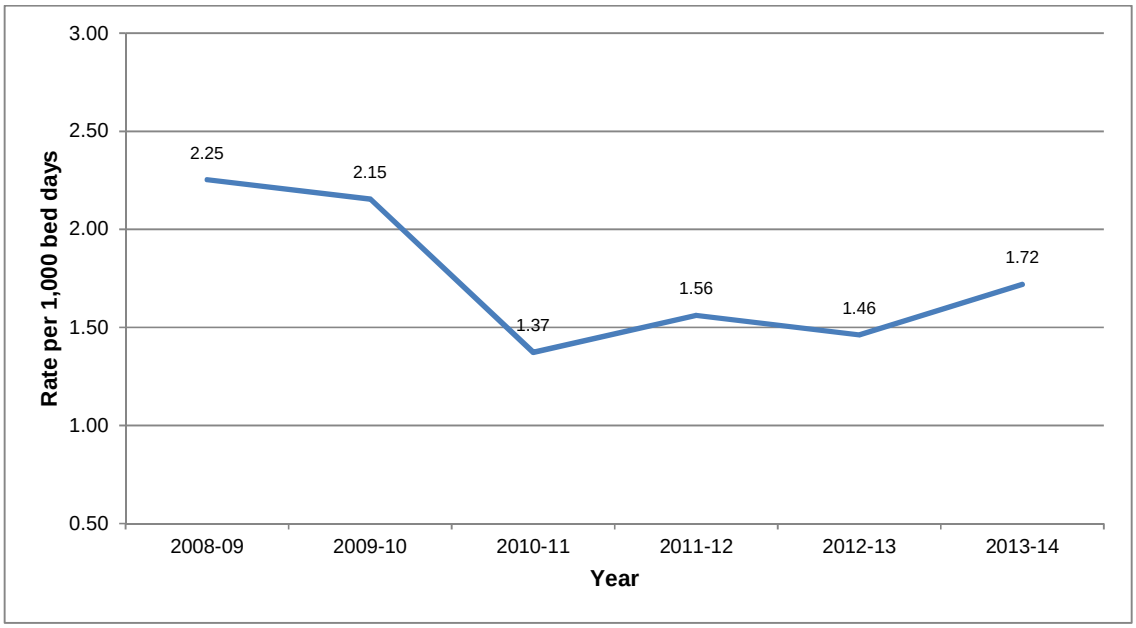
[38] This is also the case under the *Mental Health Act 2014* (s. 108)

Restraint episodes

While the number of people admitted to an inpatient service has increased every year since 2007–08, the number of episodes of restraint has generally been decreasing.

The Statewide restraint rate per 1,000 occupied bed days was 1.46 in 2012–13, but rose slightly to 1.72 in 2013–14 (Figure 20).

Figure 20: Restraint per 1,000 occupied bed days 2008–09 to 2013–14



As shown in Figure 21, there were 545 episodes of restraint used in 2012–13 and 631 episodes of restraint in 2013–14. This reflects a significant decline (42 per cent in 2012–13 and 32 per cent in 2013–14) in the use of mechanical restraint from the peak of 934 episodes in 2007–08.

Figure 21: Trend in use of mechanical restraint 2007–08 to 2013–14

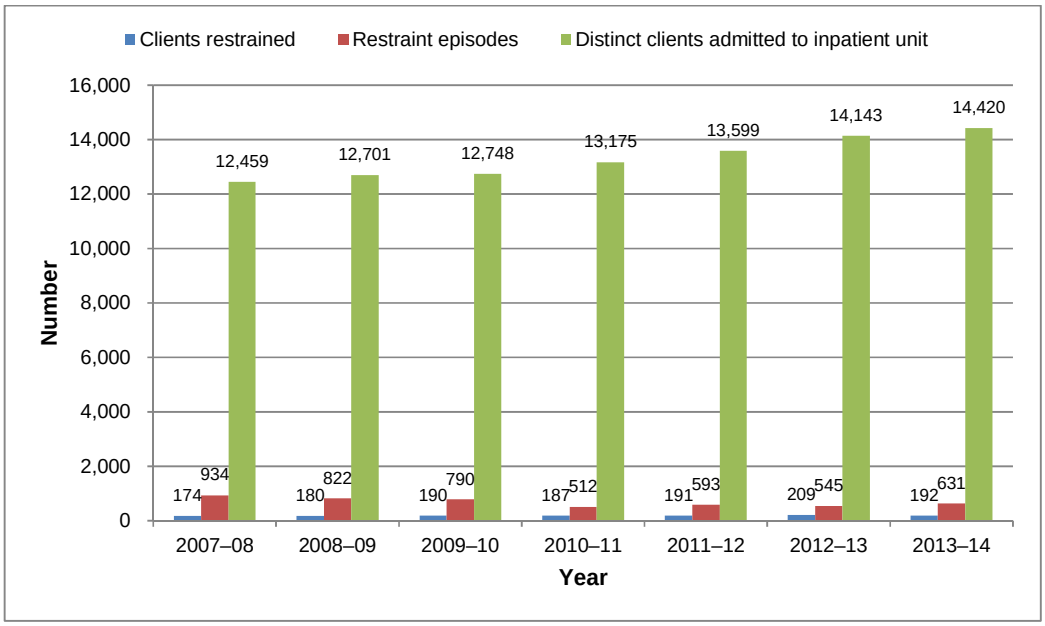


Figure 22 shows that in both 2012–13 and 2013–14, around 80 per cent of restraint episodes were less than four hours in duration. This is a slight increase on the 77 per cent of episodes in 2011–12 and 76

per cent in 2010–11. The average duration of restraint was just 3.3 hours in 2012–13, down from over 6 hours in the previous year (2011–12). In 2013–14, the average duration rose to 5.9 hours.

Figure 22: Duration of restraint episodes 2007–08 to 2013–14

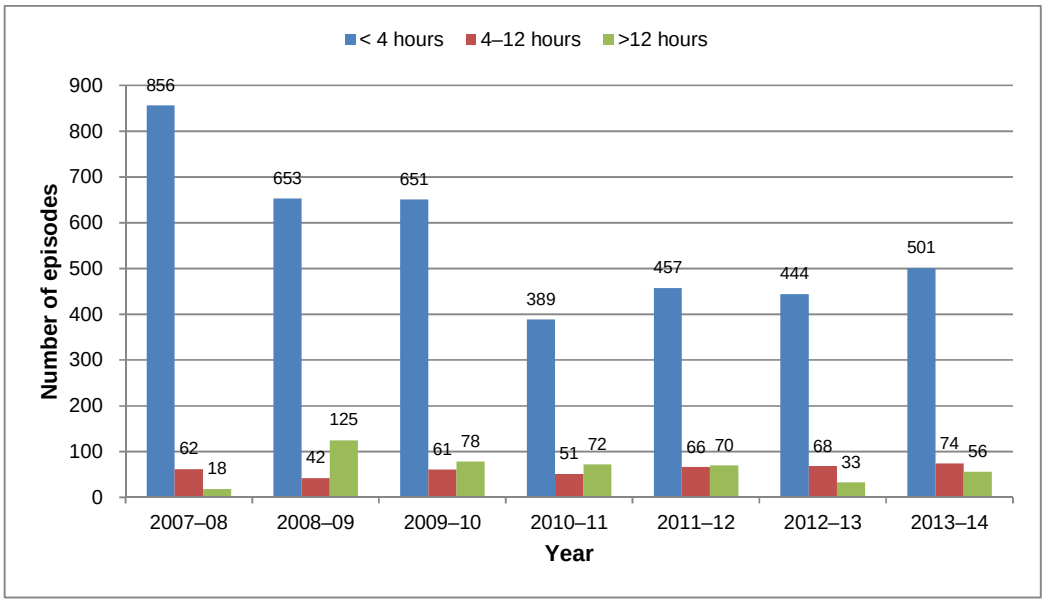
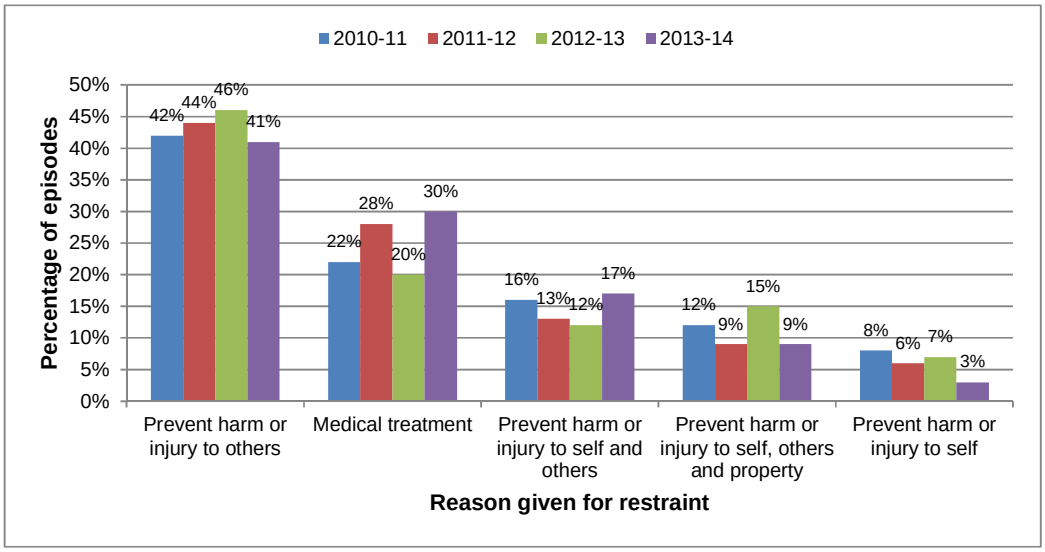


Figure 23 shows that the primary reason given for the use of restraint in 2012–13 and 2013–14 was to prevent harm or injury to others (46 and 41 per cent respectively). The second most common reason for using mechanical restraint was to enable the person to receive medical treatment; this represented 20 per cent of episodes of restraint in 2012–13 and 30 per cent in 2013–14.

Figure 23: Reasons for mechanical restraint 2010–11 to 2013–14



Persons restrained

In 2012–13, 209 people were restrained in public mental health services; in 2013–14, 192 people were restrained. For both years, the number of people restrained represents less than 1.5 per cent of all people admitted to an inpatient unit. This small group of patients presents significantly disturbed, complex and challenging behaviours.

As shown in Figures 24a and 24b, most episodes of restraint involved males aged between 20 and 39 years.

Figure 24a: Mechanical restraint by age and gender 2012–13

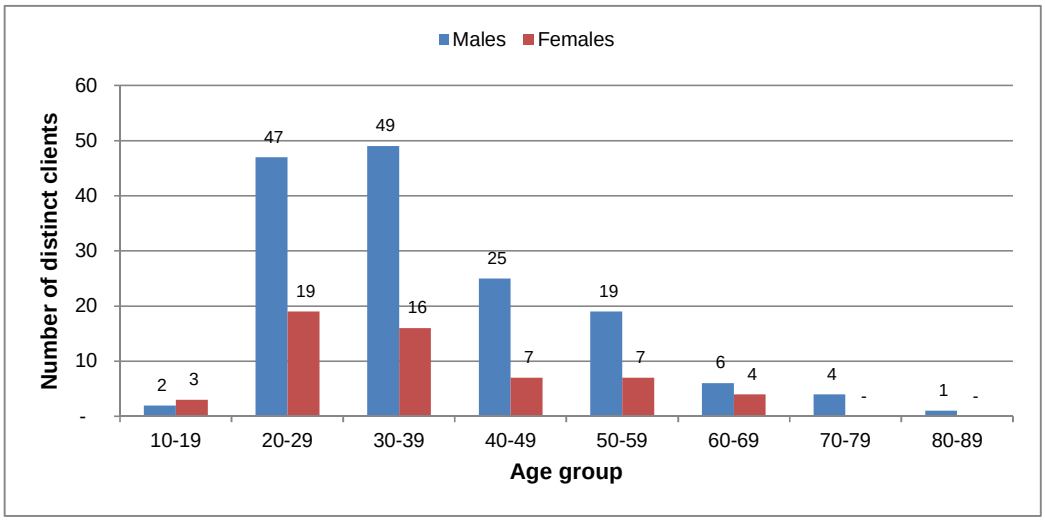
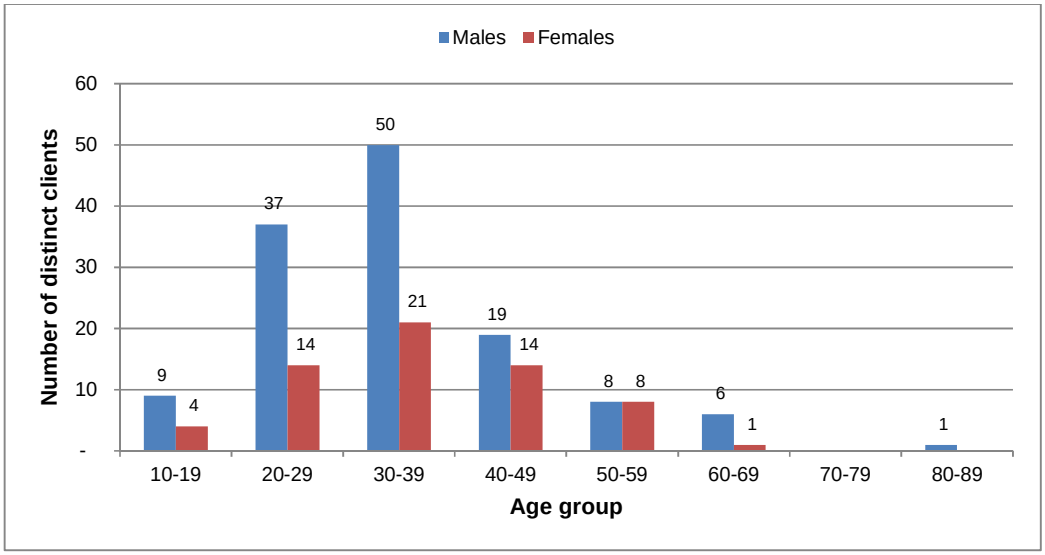
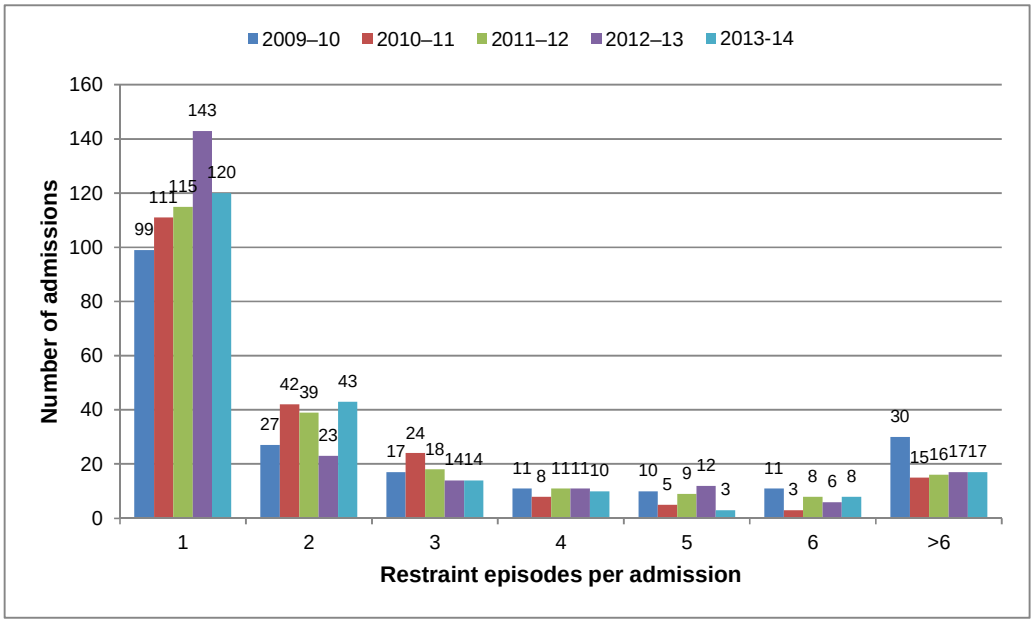


Figure 24b: Mechanical restraint by age and gender 2013–14



During the reporting period 2012–13 and 2013–14, less than 1.5 per cent of people admitted were restrained. As Figure 25 shows, this small cohort experiences only a single episode of restraint (63 per cent in 2012–13 and 56 per cent in 2013–14). Of the small cohort that was restrained, less than eight per cent experienced more than six episodes of restraint in the same hospital admission. This small group of patients with significantly disturbed behaviours accounts for a high proportion of all restraint administered.

Figure 25: Number of restraint events in the same hospital admission 2009–10 to 2013–14



Forensic mental health

Security patients

Security patients are those who are admitted to a mental health service to receive treatment for a mental illness as part of their sentence (s. 93A *Sentencing Act 1991*)[39] or they may be transferred from a prison, remand centre or youth justice centre to receive treatment for a mental illness by order of the Secretary of the Department of Justice (s. 16(3)(b) *Mental Health Act 1986*)[40].

In Victoria, security patients receive treatment and care for their mental illness in Thomas Embling Hospital, a secure, specialist forensic mental health facility, until they can be safely returned to prison or to the community.

During the reporting period, the Chief Psychiatrist was responsible for approving a security patient's discharge back to prison[41]. In granting discharge, the Chief Psychiatrist needed to consider the person's current mental condition, medical and psychiatric history and social circumstances.

The Secretary to the Department of Justice was required to consult with the Chief Psychiatrist when allowing a security patient to be absent from an approved mental health service.[42] The Secretary had to be satisfied that the leave would not seriously endanger the safety of the patient or the public.

During the reporting period the Chief Psychiatrist also had the power to authorise special leave for security patients for specifically defined purposes, usually medical treatment or to attend court[43]. The Chief Psychiatrist was 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 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* establishes a regimen of leave that assists forensic patients and residents in their rehabilitation and return to life in the community. Forensic

[39] From 1 July 2014 the relevant section of the *Sentencing Act 1991* is s. 94B.

[40] Under the *Mental Health Act 2014* the order is known as a Secure Treatment Order and the relevant s. is 276.

[41] This is no longer a requirement under the *Mental Health Act 2014.*

[42] This is no longer a requirement under the *Mental Health Act 2014*.

[43] This is no longer a requirement under the *Mental Health Act 2014.*

patients and residents can apply for on-ground leave, limited off-ground leave and special leave of absence.

The Forensic Leave Panel is an independent tribunal that hears and determines applications for leave of absence and appeals in relation to refusal of special leave of absence and transfers from one mental health facility to another.

In granting leave, the Forensic Leave Panel considers whether the leave will contribute to the person's rehabilitation, the safety of the forensic patient or resident and the safety of members of the public.

The Chief Psychiatrist (or delegate) is a member of the Forensic Leave Panel, which also comprises representatives from the judiciary, psychiatry and psychology, and the general community.

Restricted involuntary treatment orders, hospital orders and restricted community treatment orders

Prior to the commencement of the *Mental Health Act 2014* on 1 July 2014, a person with a mental illness who was found guilty of non-serious offences could be made subject to a restricted involuntary treatment order (RITO) by a court under the *Sentencing Act 1991*. Under the RITO, the person had to be taken to and detained in a mental health service as an inpatient. An RITO could be made for a maximum of two years.

When the person's condition had improved and they could be treated and managed safely in the community, the authorised psychiatrist could make a restricted community treatment order (RCTO) under the *Mental Health Act 1986*[44]. The authorised psychiatrist had to notify the Chief Psychiatrist of the making of an RCTO.

In 2012–13, two RITOs and three RCTOs were made, while in 2013–14 no RITOs or RCTOs were made[45].

[44] Section 15A

[45] There are no longer RITOs and RCTO's under the *Mental Health Act 2014*

Conclusion

The two year period from 1 July 2012 to 30 June 2014 saw significant change occurring in Victoria's public mental health service system and in the OCP. Within the office key changes included staffing changes in the Chief Psychiatrist and Deputy Chief Psychiatrist roles and a departmental restructure which brought the Office of the Chief Mental Health Nurse into the folds of the OCP branch. Across the department preparations increased for the commencement of the *Mental Health Act 2014* and the OCP had a key role in contributing to these efforts.

During the reporting period, the activities of the Chief Psychiatrist covered statutory, advisory and education responsibilities and focused on improving the quality of services and the outcomes for consumers and carers.

Key highlights of 2012–13 and 2013–14 are summarised below.

- The OCP developed guidelines; monitored the outcomes of clinical reviews, audits and investigations; and, conducted education and training to address treatment and system issues and enhance clinical practice.
- We participated in a broad range of committees and working groups across the department, other government agencies and the health system, to provide advice on clinical issues for consideration in policy development and service planning.
- The Chief Psychiatrist's Clinical Leaders Meeting was established to foster excellence and align clinical practice with the directions of the Mental Health Act 2014.
- We had the final meeting of the Quality Assurance Committee and the ECT subcommittee. Both forums had an important role in overseeing and monitoring standards of treatment and care in Victorian public mental health services under the Mental Health Act 1986. I thank all members who contributed to these committees.
- The Reducing Restrictive Interventions Project was established to support services to reduce the use of restrictive interventions and promote recovery-oriented practice. Additionally, the variance reporting pilot commenced which is a new process of reviewing restrictive interventions data.
- My office responded to 1,281 contacts in 2012–13 and 1,019 in 2013–14 from consumers, carers, service providers, health professionals and members of the public. The OCP facilitated the resolution of complaints with mental health services and provided information on complex issues in relation to accessing mental health services, treatment and care.
- In fulfilling my statutory responsibilities the OCP monitored the performance of ECT, the use of seclusion and mechanical restraint and the deaths of persons receiving treatment in public mental health services. This monitoring identifies trends and highlights opportunities to address systemic clinical issues.

This is the last Chief Psychiatrist's annual report under the *Mental Health Act 1986*. The next annual report for 2014–15 will outline activities that reflect the Chief Psychiatrist's role and functions in the *Mental Health Act 2014*.

Reference list

McKenna et al.: The effectiveness of specialist roles in mental health metabolic monitoring: a retrospective cross-sectional comparison study. BMC Psychiatry 2014 14:234.