Chief Psychiatrist's annual report 2005

A Victorian Government initiative

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January 2007 (061209)

Foreword

January 2007

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

Dear Minister,

I am pleased to enclose the annual report of the Chief Psychiatrist for the period 1 January 2005 to 31 December 2005. This report reflects my commitment to ensuring the Victorian community continues to be informed of the functions and key activities of the Chief Psychiatrist in relation to the treatment and care of persons with a mental illness in public mental health services.

Yours sincerely,

Associate Professor Amgad Tanaghow
Chief Psychiatrist
MB CH B. FRC PSYCH (U.K.), FRANZCP

Contents

1 Chief Psychiatrist's summary

It is with great pleasure that I present the Chief Psychiatrist's annual report 2005. This report also serves as the annual report of the Quality Assurance Committee.

Purpose of annual report

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

Key achievements and future directions

We are committed to responding to the needs of, and protecting the rights of, consumers and carers and improving their access to high quality, responsive public mental health services. To achieve this, my office has continued to contribute to improving standards of treatment and care through service monitoring, quality improvement activities, and the production of clinical guidelines to promote quality care and clarify aspects of legislation and mental health policy.

We also continued to receive complaints and enquiries from consumers, carers and families on a wide variety of issues. Most consumer concerns related to involuntary treatment, while carer concerns focused mainly on access to treatment and information, and their desire for greater involvement in decision-making related to the treatment and care of relatives. Managing the dynamic tension between a family's need to know and an individual's rights, including privacy regarding their health information and their right to treatment, is an ongoing challenge for mental health services.

Improving the ways in which services work with families and carers, particularly the areas of communication and discharge planning, continued to be a focus in 2005. Working with mental health providers to facilitate consumer access to mental health beds and services and improving service outcomes for consumers with complex needs were also areas of key activity.

How to optimally provide treatment and care for individuals with aggressive behaviour is a major challenge confronting mental health services locally and internationally. Workforce skill development, management of acutely disturbed consumers, and creating physical and therapeutic environments that support best practice will be a major focus over the coming years. Assisting clinicians to formulate targeted, meaningful and user-friendly treatment plans and proactively engage consumers in the formulation and implementation of their treatment plan remains an area of ongoing activity.

I am committed to working with the Victorian Government, consumers, carers and mental health services to address these and other key challenges impacting on the public mental health service system in order to continue to improve clinical outcomes for people with a mental illness in Victoria.

My office continues to be supported by senior clinicians and administrative staff who assist me in the performance of statutory functions. I am grateful to the staff who have worked with a high level of dedication and skill throughout 2005. I also wish to acknowledge the support and assistance of the Deputy Chief Psychiatrist (Aged), Dr Kuruvilla George, who has continued to actively engage the aged persons mental health service sector in a range of service delivery and standards matters.

I trust this report informs the Victorian community on the activities of my office during 2005.

Associate Professor Amgad Tanaghow
Chief Psychiatrist

2 Overview of statutory responsibilities

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

Statutory framework

Secretary, Department of Human Services Chief Psychiatrist appointed by the Secretary under *s.105 Mental Health Act 1986*

Provide expert clinical advice to the Mental Health Branch and input into policy

Supported by senior clinicians and administrative staff. Key tasks:

- Complaints management and resolution
- Clinical advice to mental health practitioners and services
- Quality improvement activities and projects

***Mental Health Act 1986* - Chief Psychiatrist**

The Chief Psychiatrist has broad powers of investigation, inspection and enquiry under s.106 of the Act including:

- authority to facilitate treatment and care for high-risk consumers
- powers of inspection to investigate a mental health service and direct the service to alter, discontinue or carry out a practice, procedure or treatment or direct that a person be provided with treatment
- power of delegation – the Chief Psychiatrist can appoint authorised officers to assist in the performance of statutory functions.

Quality Assurance Committee

Established under s.106AC of the Act, the Committee provides expert advice to the Chief Psychiatrist and oversees service quality and standards including statutory practices

Authorised officers s.106 of the Act

Authorised officers can make extensive inquiries about the admission, detention, care and treatment of persons with a mental illness on behalf of the Chief Psychiatrist

Other core functions

- Monitor and improve service standards
- Work with clinicians to improve service quality and safety

Core statutory and other functions

Investigate treatment related issues as deemed warranted by the Chief Psychiatrist	Act on behalf of, and improve service outcomes for consumers and carers	Monitor and improve service standards and consistency of clinical practice	Work with clinicians to improve service quality and safety

Outcomes

• Protect the rights of people with a mental illness to be provided with appropriate treatment and care • Ensure consumers receive the most appropriate treatment and care in the least restrictive environment • Facilitate treatment and care for high risk consumers with complex needs	• Investigate and resolve consumer and carer complaints • Resolve conflict between mental health services and consumers and carers • Improve access to services • Contribute to the education of consumers, carers and others regarding their rights and appropriate standards of care	• Contribute to enhanced practice • Value-add to the mental health service system • Improve service practice by producing statutory reports • Undertake clinical reviews of approved mental health services	• Ensure the application of the Act to clinical practice • Investigate and resolve issues raised by practitioners • Provide support to services through quality improvement initiatives, such as clinical guidelines

3 Core programs and activities in 2005

3.1 Monitoring and improving service standards

Monitoring statutory practices

The Act requires mental health services to report monthly to the Chief Psychiatrist on clinical interventions of seclusion, mechanical restraint and electroconvulsive therapy (refer to Table 1 for a description of these interventions). It also requires services to report on the annual medical examination of involuntary patients who have been in continuous care for 12 months, and the death of any patient that is a 'reportable death' as defined by the *Coroners Act 1985*. These reports are known as statutory reports.

Table 1: Overview of statutory practices

Clinical intervention	Description	Circumstances of use	Policy and practice standards
Seclusion For more information on minimum practice standards on seclusion: *Clinical guideline on seclusion* (Department of Human Services, 2004)	Seclusion of a mentally-ill person can only occur in an approved mental health service and is defined as the 'sole confinement of a person at any hour of the day or night in a room in which the doors and windows are locked from the outside'.	Only used as an intervention of last resort to protect the person or others when the person is highly disturbed and unable to be treated in a less restrictive manner.	A registered nurse must review the secluded person at not more than 15 minutes intervals and a medical practitioner must examine the person at intervals of not more than four hours (unless varied by an authorised psychiatrist).
Mechanical restraint For more information on minimum practice standards on the use of mechanical restraint: *Practice guidelines on mechanical restraint* (Department of Human Services, 1996)	Mechanical restraint of a mentally-ill person can only occur in approved mental health services and is defined as 'the application of approved devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted to their arms) that restrict the person's capacity to get off the furniture'.	Only applied as a protective intervention of last resort to protect the person or others, or to allow the person necessary medical treatment.	A person who is mechanically restrained must be continuously observed by a registered nurse or medical practitioner, and reviewed at no more than 15 minute intervals. A medical practitioner must examine the restrained person every four hours at a minimum (unless varied by an authorised psychiatrist).
Electroconvulsive therapy (ECT) For more information on minimum practice standards on ECT: *ECT manual: licensing, legal requirements and clinical practice guidelines* (Department of Human Services, 2000)	ECT can be administered as a course (a number of consecutive treatments) or as a continuation or maintenance treatment after the acute phase of illness.	ECT is most commonly administered for the treatment of severe depression but may be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric disorders. It is most often prescribed as part of a treatment plan in combination with other therapies.	ECT can only be provided in premises licensed by the Secretary of the Department of Human Services and is strictly regulated under ss.72-80 of the Act. Licenses are granted for up to five years.

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

Seclusion

Between 1 January 2005 and 31 December 2005, 59,261 mental health consumers received assessment, treatment or care from public mental health services. Most of these consumers were treated in the community, with only 20.1 per cent (11,941 patients) admitted for acute hospital care during this period. There were 7,993 episodes of seclusion of 2,167 patients during the reporting period. This means 18.1 per cent of admitted patients were secluded at some time during an inpatient stay (down from 22.5 per cent in 2004), with most episodes being for periods of less than four hours (70 per cent). On average, consumers who were secluded experienced 3.7 episodes of seclusion each, which is lower than the preceding two years. The vast majority of seclusion episodes occurred in adult mental health services (92.7 per cent) and involved a male consumer (62.9 per cent).

Figure 1 shows the use of seclusion from 2003-2005.

Figure 1 Use of seclusion 2003-2005

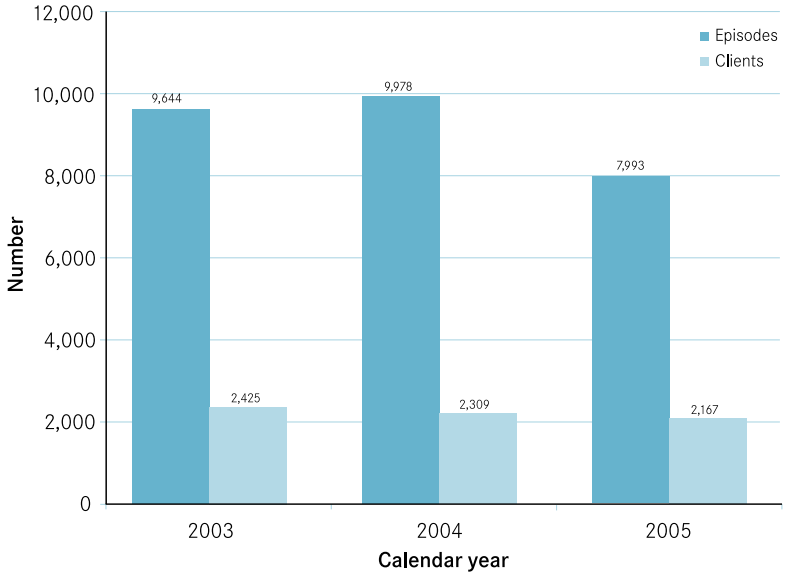
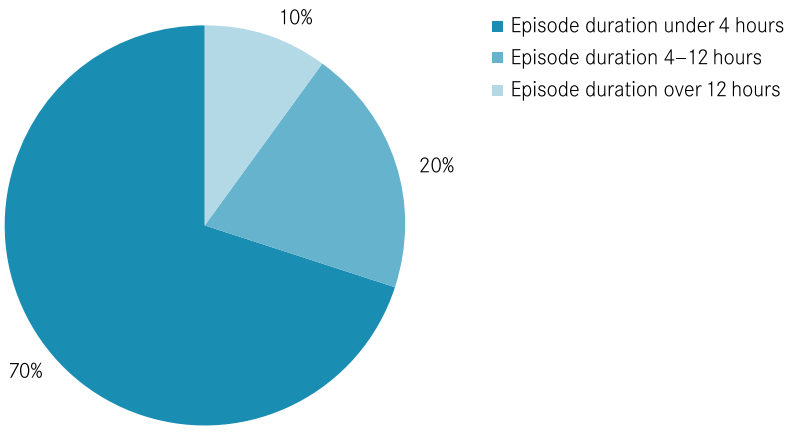


Figure 2 Proportion of seclusion episodes by episode duration 2005



Mechanical restraint

During the reporting period, there were 1,035 episodes of mechanical restraint of 144 individuals. This means 1.2 per cent of the total number of consumers admitted to a public mental health service for acute inpatient care were mechanically restrained at some time during their hospital stay. The majority of mechanical restraint (86.6 per cent) occurred in aged persons mental health services.

In 2005, the average number of episodes of mechanical restraint per person (7.2 per person) increased relative to 2003 and 2004 (an average of 6.7 and 6.6 episodes per person respectively).

Figure 3 Use of mechanical restraint 2003-2005

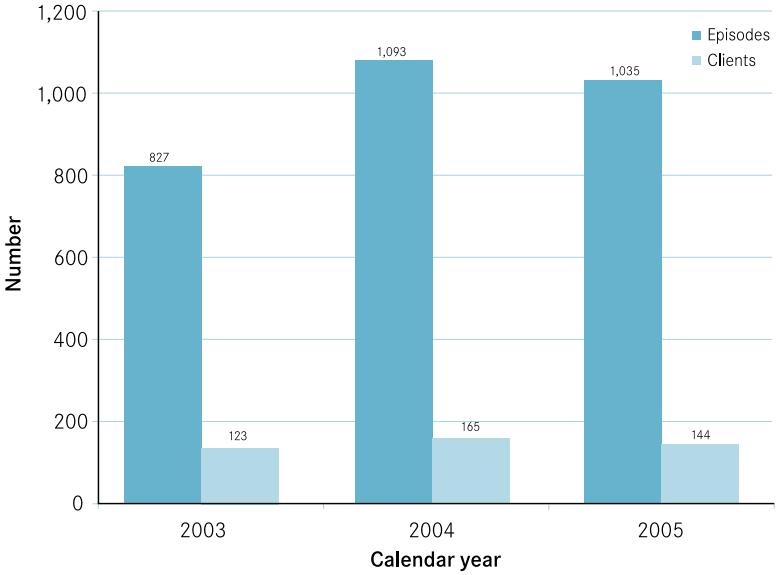
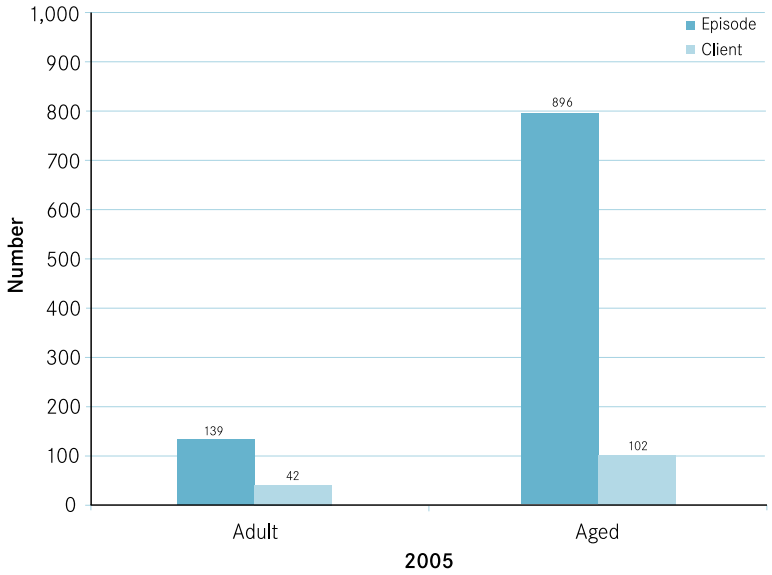


Figure 4 Use of mechanical restraint by age group – 2005



Electroconvulsive therapy

During 2005, 15,842 electroconvulsive therapy (ECT) treatments were given. The number of individual consumers who had electroconvulsive therapy was 1,623 and the average number of treatments per person was 10. These treatments were predominantly administered in the public mental health sector (69.3 per cent). Females received 66.5 per cent of electroconvulsive therapy treatments. This finding is consistent with international figures and might reflect the higher incidence of depression in women. Consumers with a diagnosis of major affective disorder (depression and mania) were the largest single group for whom ECT treatment was given (25 per cent).

Figure 5 Use of ECT 2003-2005

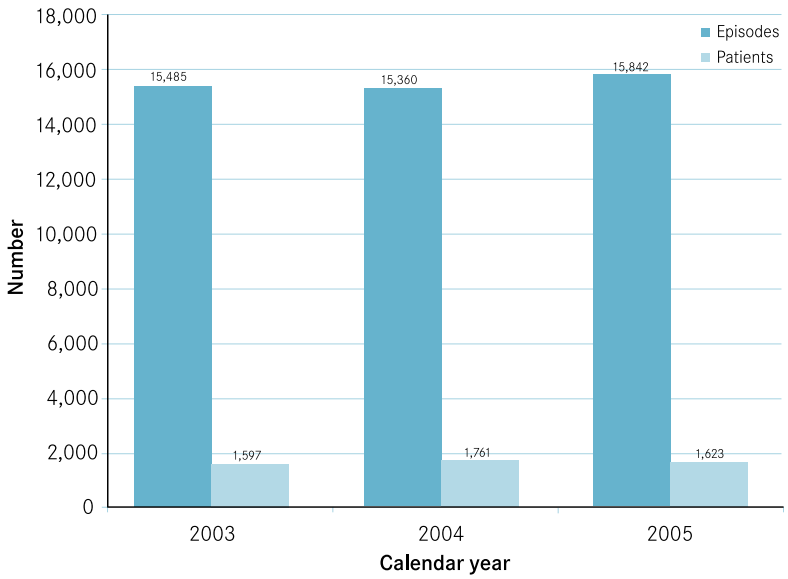


Figure 6 ECT treatment by gender 2003-2005

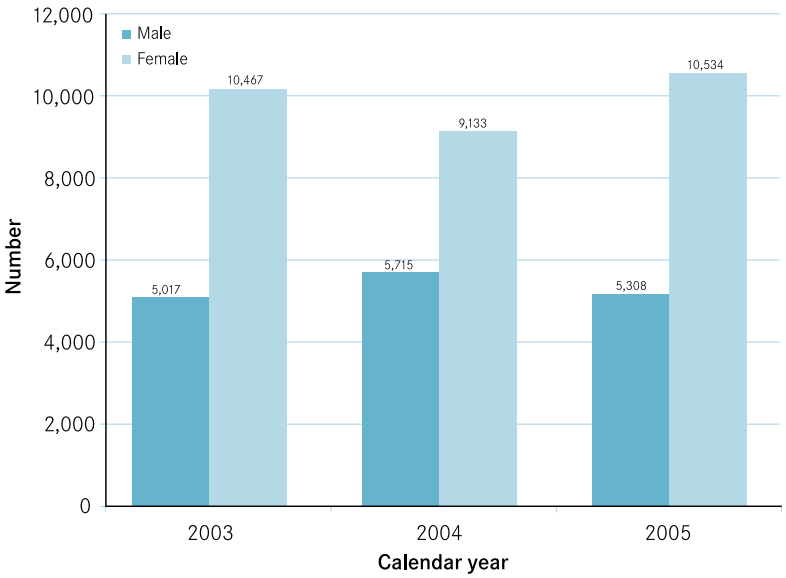
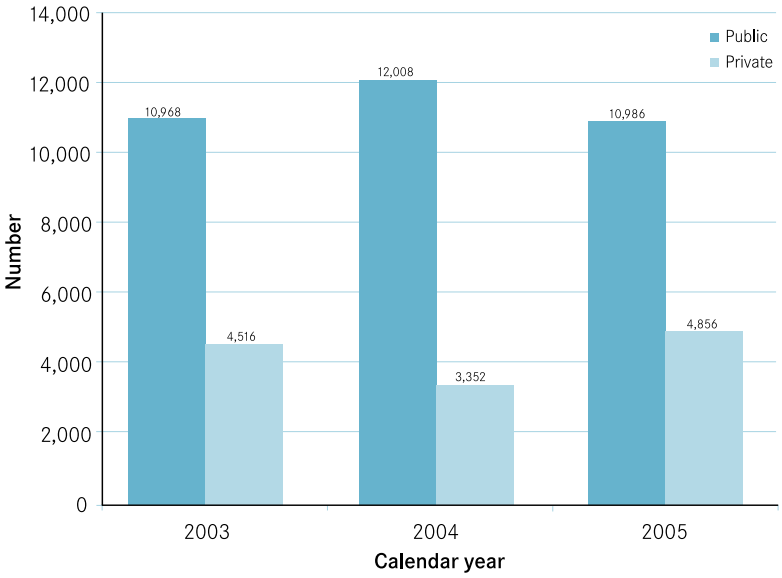


Figure 7 Administration of ECT by sector 2003-2005



Annual examinations

Guidelines for mental health services have been formulated to inform practitioners of their responsibilities: *Physical examination, the annual examination and attention to clients' general medical health needs* (Department of Human Services, 2002)

Section 87 of the Act requires that consumers who have been involuntary patients for a period of 12 months must have their mental and general health examined, and that a report of this examination be sent to the Chief Psychiatrist for review. While there has been an increasing trend for consumers to be linked to general practitioners for ongoing monitoring, the authorised psychiatrist of each approved mental health service remains responsible for ensuring consumers have a general examination at least once a year in recognition of the high level of co-morbid health problems in people with a mental illness.

Reportable deaths

Clinical guideline *Reportable deaths* clarifies the reporting requirements of all area mental health services (Department of Human Services 1999; revised May 2004)

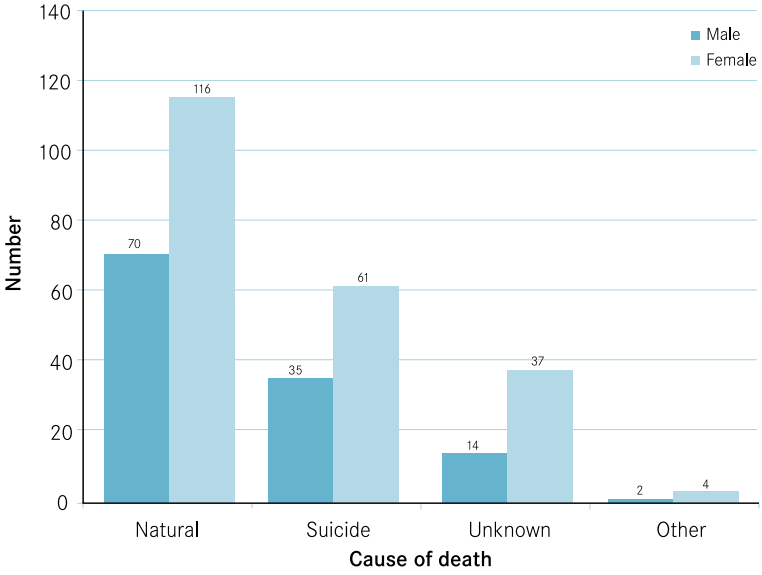
The death of any involuntary, security or forensic patient from any cause, and the unnatural, unexpected or violent death of any current or recent consumers (voluntary, involuntary, inpatient or outpatient of any mental health service) must be reported to the Chief Psychiatrist, in addition to the Coroner, in accordance with the Act. On receipt of a completed notice of death form, the Chief Psychiatrist reviews the information and might seek additional information from the service. If the circumstances surrounding the death cause concern, the Chief Psychiatrist can conduct an investigation. No investigations of this nature were undertaken in 2005.

The Chief Psychiatrist registers an interest with the Coroner for most reportable deaths to ensure his office receives any comment or recommendations following a coronial investigation. The Chief Psychiatrist also collates relevant coronial reports, recommendations and practice themes and disseminates this information to all area mental health services to facilitate ongoing practice improvement. Coronial recommendations relating to observation levels of persons in seclusion, risk assessment practices, supervision of clinical staff, environmental issues in inpatient facilities, record keeping and documentation of care were communicated to all services for consideration with respect to local practice. The Chief Psychiatrist is a member of the Coroner's Medical Advisory Committee and is represented on the Department of Human Services Coroner's Inquest Working Group.

Between 1 January 2005 and 31 December 2005, the deaths of 349 individuals were reported to the Chief Psychiatrist. Of these, 218 (62.5 per cent) were males and 121 (34.7 per cent) were females.[2] The majority of deaths reported were attributed to natural causes (54.9 per cent) and 28.3 per cent attributed to suicide.

2 Ten consumers had no gender specified

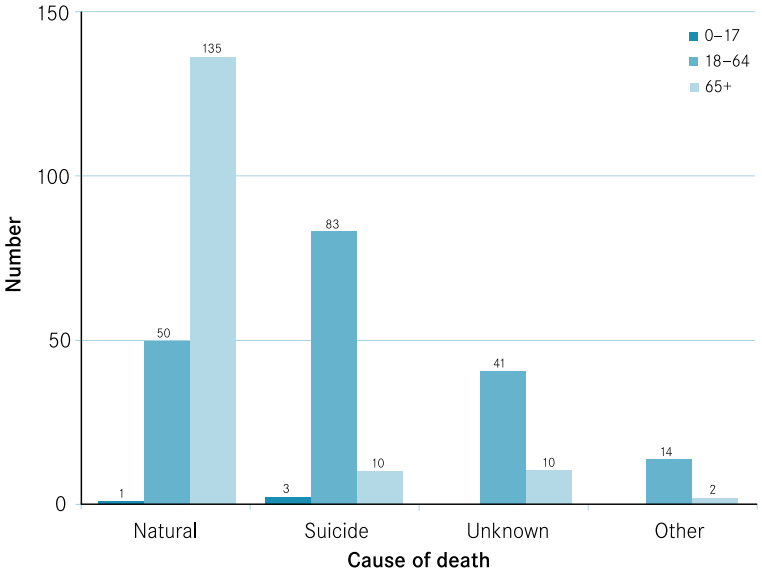
Figure 8 Reportable deaths, by gender and cause of death – 2005



The 'other' category includes deaths by motor vehicle accidents. The 'unknown' cause of death includes those where the Coroner has not yet made a finding or the finding has not been notified.

As shown in Figure 9, for people aged over 65 years, death due to natural causes was the most common cause of death (86 per cent), while for adults, suicide was the most common cause of death (44.1 per cent) followed by natural causes (26.6 per cent). Adults accounted for 53.9 per cent of all reportable deaths while older persons accounted for 45 per cent.

Figure 9 Reportable deaths, by age group and cause of death – 2005



The primary diagnosis of all notifications provided to the Chief Psychiatrist is presented in Table 2. Just under a third of all reportable deaths in 2005 were of people with a psychotic disorder, followed by people with a mood disorder (28.7 per cent) and dementia or other organic brain disorder (25 per cent).

Table 2 Reportable deaths in 2005 by diagnostic group

Diagnostic group	Number of deaths	Percentage
Psychosis	111	31.8
Mood disorder	100	28.7
Dementia and organic brain disorder	87	24.9
Other diagnosis	17	4.9
Personality disorder	13	3.7
Substance-related disorders	11	3.1
Anxiety disorder	3	0.9
Not stated	7	2.0
Total	**349**	**100**

Authorised psychiatrists

Under s.96 of the *Mental Health Act 1986* each approved mental health service must have an authorised psychiatrist who is a qualified psychiatrist. The authorised psychiatrist has specific powers, duties and functions under the Act and is responsible for its application and the treatment and care of persons in the mental health service. The authorised psychiatrist can formally delegate any powers, duties and functions to a qualified psychiatrist employed in the approved mental health service except the power of delegation or the duty to provide the Forensic Leave Panel with information as outlined in s.96 of the Act. The authorised psychiatrist of an approved mental health service is appointed by the board of management of the relevant employing health service.

The Mental Health Review Board and the Secretary of the Department of Human Services must be notified of each authorised psychiatrist's appointment within five days. In practice, the Secretary delegates this function to the Chief Psychiatrist who maintains a register of all authorised psychiatrists. The Chief Psychiatrist convenes a quarterly meeting with authorised psychiatrists to provide education, peer support and a forum in which matters of clinical service delivery, medico-legal issues, the role and function of authorised psychiatrists and other issues of common interest can be discussed.

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

Clinical review program

The Chief Psychiatrist's clinical review program, using the Chief Psychiatrist's powers under s.106 of the *Mental Health Act 1986*, has been a significant quality improvement activity. The purpose of a clinical review is to support and promote continuous quality improvement in public mental health services by evaluating the service's current clinical practice and procedures and their consistency with the requirements of the Act, published policy and clinical practice guidelines, and service agreements. Clinical reviews of mental health services also assist the Chief Psychiatrist to monitor standards of treatment and care provided to individual consumers.

Clinical reviews are conducted within a quality improvement framework and use a peer review methodology to examine standards of treatment and care provided to clients of public mental health services. All area mental health services have been reviewed at least once since the inception of the program in 1997.

The support for the clinical review program by mental health service clinicians and health service management has been considerable, and there is similar interest in continuing the process in another cycle of reviews. The approach has also attracted the interest of other states in developing their own local methods for monitoring standards at a systemic level.

While the clinical review process evolved over the life of the program, a wide range of other quality improvement activities have emerged over this time. Public mental health services are now subject to a number of internal and external quality and safety requirements. Modern approaches to quality improvement also demand greater transparency in their processes and public interest in the dissemination of findings. Any future clinical review program needs to be considered in this contemporary context so that these various initiatives work together to pursue better outcomes for consumers of public mental health services.

Key achievements and advances in 2005 included:

- final feedback meetings with service management of the last four area mental health services reviewed. These meetings examined the action plans developed by these services in response to the review recommendations, and provided an opportunity for mutual discussion of practice issues and the utility of the clinical review process itself in assisting services to improve their quality of care.
- the presentation of a paper on the clinical review program by the Chief Psychiatrist at the Royal Australia and New Zealand College of Psychiatrists National Congress in Sydney (May 2005).
- preliminary work on a framework for considering a second clinical review cycle. This included the development of a draft protocol, which was piloted in a voluntary review of a mental health service. These activities will inform the further development of the clinical review program in conjunction with the Quality Assurance Committee and consultation with relevant stakeholders.

3.2 Responding to consumers and carers

Responding to complaints and enquiries

The Chief Psychiatrist, in his statutory capacity, provides an avenue of complaint and enquiry for consumers, carers, members of the public and interested others on a wide variety of issues and concerns.

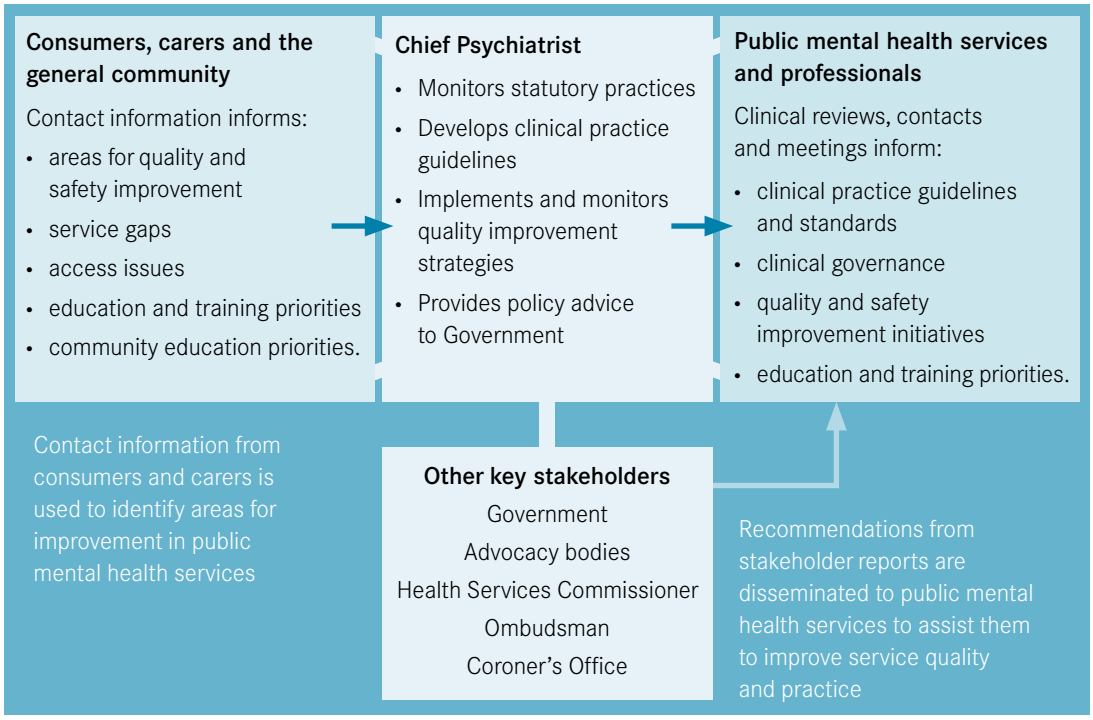
Service providers and clinicians also contact the Chief Psychiatrist's office seeking clinical advice on aspects of practice or service delivery issues. Other agencies such as the Health Services Commissioner, the Office of the Public Advocate, the Ombudsman, the Minister for Health and other areas of government also refer enquiries and issues to the Chief Psychiatrist.

Under the Act, the Chief Psychiatrist is in a unique position to receive and investigate complaints from any source and provide support, assistance and advice to individuals in responding to their issues or concerns. The Chief Psychiatrist and clinical advisers regularly liaise with mental health services in both an advocacy and complaints resolution role to facilitate better outcomes for consumers and carers.

Complaints and enquiries are an important source of information about consumer and carer concerns, service gaps and access issues, areas for quality improvement and service development, clinician education and training, and community education. This information is used in a variety of ways to improve standards of treatment and care.

Clinical advisers assist the Chief Psychiatrist in responding to complaints, enquiries and correspondence within the framework and provisions of the *Mental Health Act 1986*. Administrative staff provide initial telephone contact and overall correspondence management.

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



Case study: Responding to concerns related to involuntary treatment

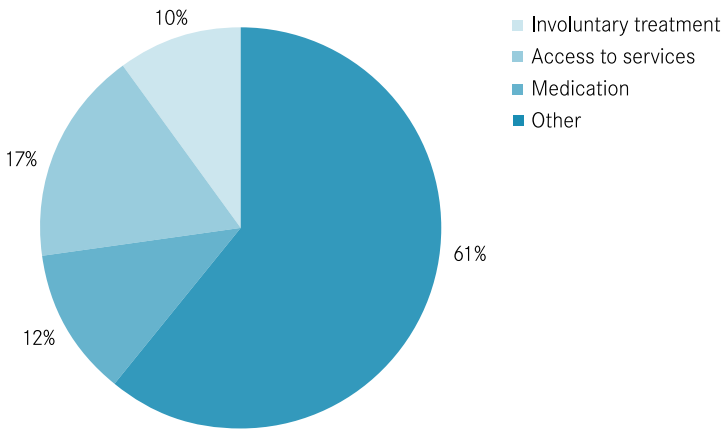
An involuntary patient in an acute inpatient unit contacted the Chief Psychiatrist's office because he was unhappy about being admitted to hospital and being placed in the locked high dependency unit. He wanted to be discharged home. A clinical advisor spoke with him and explained about involuntary treatment and the relevant criteria under the Act. Information was given on the avenues of appeal against involuntary treatment, and the consumer was encouraged to continue to discuss their concerns with the treating clinicians. While patient rights information is routinely provided in inpatient units as required by the Act, some consumers wish to discuss their concerns with someone outside the service. The Chief Psychiatrist's office provides another avenue for consultation, support and advice. Calls about involuntary detention or treatment are among the most common received through the Chief Psychiatrist's enquiry line.

Volume and focus of complaints and enquiries in 2005

During 2005, the Chief Psychiatrist received 758 enquiries and complaints about mental health service delivery, of which 183 were written complaints. Consumers of public mental health services and their carers or relatives were the most frequent callers to the office, followed by clinicians in area mental health services.

Overall, the major topics of complaint were difficulty accessing services (17 per cent), the medication prescribed (12 per cent) and involuntary treatment (10 per cent). The majority of complaints regarding access were from carers (62.5 per cent), followed by other service providers (22 per cent). A total of 37 complaints were received from involuntary patients, which includes people on a Community Treatment Order. Four complaints were about the use of seclusion and mechanical restraint). While these are the main complaint categories, most complaints are not readily grouped and therefore fall into the category of 'other' in Figure 11.

Figure 11 Type of complaints as a proportion of all complaints – 2005



Many of the complaints regarding involuntary treatment were from consumers who believed they had been wrongfully detained. In such circumstances consumers are advised of their appeal rights under the Act and given the relevant contact details for the Mental Health Review Board or Mental Health Legal Service, for example. Consumers were also concerned with various aspects of their treatment, clinician-consumer communications, access to appropriate services, and the side-effects of medication.

Carers and relatives who contacted the Chief Psychiatrist's office expressed concerns about access to appropriate levels of treatment and information. An ongoing issue is the desire for greater involvement in decision-making related to the treatment and care of relatives, particularly in respect to discharge planning. Sometimes carers or members of the public do not know where to start to seek help for an ill relative or to discuss their concerns about an individual's behaviour. A large number of calls are from people who are seeking advice on how to access a service and which is the most appropriate service.

Case study: Improving outcomes for carers

The husband of an 84-year-old woman telephoned questioning the right of the mental health service to take his wife to the local area mental health service. He was also concerned about their finances and future accommodation options and that VCAT had requested (on the instigation of the area mental health service) an investigation by an officer from the Office of the Public Advocate into her care needs. The clinical advisor was able to describe the different mechanisms in the service system and discuss the risk issues associated with caring for an older person in the community. Legal appeal mechanisms were also explained. The local mental health service was contacted, with the caller's consent, and a clinician was appointed to meet regularly with the husband to work through the short and longer-term issues. Understanding and negotiating the mental health service system can be daunting for carers, and contact with the Chief Psychiatrist's office can often help in destigmatising their perceptions and enlisting appropriate support.

Mental health service clinicians principally contacted the Chief Psychiatrist's office about the application of the Mental Health Act in complex or uncommon situations, access to particular service elements such as acute and secure extended care beds, limited accommodation options for people being discharged from acute inpatient settings and follow up of consumers who are homeless or who move frequently between area mental health service catchment areas. Clarification of cross-border arrangements (especially between Victoria and New South Wales) and clinical advice regarding people with particularly complex needs were also common areas in which mental health service clinicians sought the assistance of the office.

Private psychiatrists and other health professionals and agencies contacted the Chief Psychiatrist's office predominantly to clarify aspects of the Act, difficulties accessing services, shared care arrangements, and information about the mental health service system and how to contact relevant services.

Written complaints were predominantly received from consumers and carers and covered a wide range of issues. Most commonly, they related to treatment and care (28 per cent, including a small number related to seclusion, restraint and electroconvulsive therapy), dissatisfaction with services (26 per cent) and access to services (22 per cent). Some complainants are repeat correspondents who have found it difficult to accept that they have a mental illness that requires treatment.

Case study: Responding to complaints about service responsiveness

A carer telephoned the Chief Psychiatrist's office to express concern about her 21-year-old son's threatening behaviour and self-harming. While a previous assessment by the crisis assessment and treatment team did not indicate immediate concerns (her son had been co-operative with assessment and denied any intention to harm himself or others), his carer felt the assessment had not taken into account the family's concerns about his behaviour that led to the request for assessment. A clinical advisor, after discussion with the Chief Psychiatrist, contacted the relevant triage service, and a further assessment was undertaken which took into account the history from the family. The individual was subsequently admitted to hospital for further observation. The Chief Psychiatrist continues to emphasise with mental health clinicians the importance of family and carer concerns as an vital source of information in all aspects of clinical care.

Investigating incidents

Under section 106 of the *Mental Health Act* 1986, the Chief Psychiatrist and authorised officers have special powers to visit a psychiatric service and carry out investigations where this is deemed necessary by the Chief Psychiatrist. This includes inspecting premises and records held by the service and interviewing staff. In 2005, two such investigations were carried out by the Chief Psychiatrist and authorised officers in response to two individual complaints received. The Chief Psychiatrist also attended a number of mental health services to meet consumers jointly with service representatives to attempt to resolve complaints.

Working with families and carers

Families and carers play a critical role in the lives of a relative who has a mental illness. This includes both providing day-to-day support and care to involvement in the treatment and care process. Families and carers need access to information to fulfil their caring role. Families also have support needs of their own and the concept of family burden is well documented.

A series of training workshops between the Bouverie Centre and the Chief Psychiatrist's office, were completed during the first half of 2005. The workshops entitled *Being confident with confidentiality: private and family business* focussed on helping mental health clinicians work more collaboratively with families and carers within the confidentiality provisions of the Act. The dynamic tension between a family's need to know and an individual's right to privacy of their health information is an ongoing challenge for mental health clinicians.

The workshops also provided opportunity for consultation and feedback on the draft guidelines *Working together with families and carers*, which were developed during 2004 with the help of a representative working party and published in April 2005.

Case study: Responding to complaints about service responsiveness

A carer telephoned the Chief Psychiatrist's office concerned about a perceived lack of attention from the mental health service because her daughter has a dual diagnosis of substance use and mental illness. The carer felt the service was reluctant to engage with her daughter because her repeated substance use was complicating her mental health treatment. A clinical advisor liaised with the mental health service to review her daughter's management plan and mental health treatment needs. The advisor also recommended that the case management staff be assisted to access further training in the management of people with co-morbid substance use, and that the dual diagnosis service now available to all area mental health services be more closely involved.

Informing the public

Members of the public often call with general queries about mental illness or seeking advice on how best to help family members, friends or work colleagues who appear in need of assistance. Such contacts provide opportunities to inform the public about mental illness and avenues of assistance, including the role of specialist public mental health services.

Increasingly, people have access to the internet and are referred to the Chief Psychiatrist and mental health websites for information on available services, standards documents, patient rights brochures, relevant legislation, and a range of publications of general interest. The website will continue to be developed as a source of public information about the role of the Chief Psychiatrist and issues and activities of public interest. The Chief Psychiatrist has also given a number of talks at public forums.

Freedom of information

The Department of Human Services receives a variety of requests for information through its freedom of information processes, the majority of which are from consumers requesting access to their records. Where these pertain to mental health clinical information or mental health consumer records[3] held by the department, the Chief Psychiatrist is required to examine the records as part of the freedom of information process. This includes providing advice to the Freedom of Information Unit located within the Department of Human Services prior to the release of documents as per existing protocol arrangements.

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

Facilitating access to mental health beds and services

The Chief Psychiatrist has an ongoing role in assisting mental health services to locate an acute mental health inpatient bed for people when the local service has no vacancies and all avenues to secure a bed in a neighbouring service have been exhausted.

The availability of acute mental health beds remains a system wide pressure. However, growth in core service capacity, the implementation of a range of initiatives designed to manage some of the pressures on acute inpatient services (including hospital emergency departments) and the introduction of further efficiencies into the service system, has helped ease this situation. Examples include admitting rights for the Outer East Area Mental Health Service to the newly opened acute beds at Casey Hospital in Berwick; the refinement of the daily statewide bed status report which can be accessed electronically by all area mental health services to locate vacant beds; and local bed management systems which have fostered better collaboration among neighbouring area mental health services.

During 2005, the Chief Psychiatrist's office also received numerous requests from clinicians to assist with accessing a secure extended-care bed for consumers who required a longer period of sustained treatment and rehabilitation in a secure environment.

Case study: Facilitating access to appropriate services

A child and adolescent mental health service psychiatrist contacted the Chief Psychiatrist's office about a difficult-to-manage older adolescent in an acute adolescent inpatient unit. Staff were having great difficulty managing his aggressive and violent behaviour and this was impacting on other consumers and staff in the unit. The Chief Psychiatrist's office liaised with the adult mental health service to arrange for his care to be transferred as it was apparent that he would be more appropriately managed in an adult unit. Additional liaison with a psychiatric disability rehabilitation and support service assisted his eventual transition to community rehabilitation care.

While mental health services are broadly structured around age groups – child and adolescent, adult, aged persons – situations do arise where the needs of a specific individual may be better catered for in another program, especially where the consumer's age is close to the age boundary of the program area. The targeting of services to age groups is intended to facilitate age appropriate service planning and provision, rather than to impede the management of individual consumers whose needs may be better met in a different program.

Consumers with complex needs

A small number of consumers with exceptional service needs continue to come to the attention of the Chief Psychiatrist. These tend to be individuals whose service needs or diagnostic profiles do not fit neatly into a single service sector.

To assist in considering the needs of these individuals and how services might work together to better support them, the Chief Psychiatrist established a close and ongoing relationship with Spectrum, the statewide service for people with severe personality disorder. During 2005, monthly liaison meetings with Spectrum have enabled the early identification of new high needs individuals, and enhanced the coordination of treatment planning and monitoring for people with complex needs who are already known to mental health services and other service sectors.

Liaison also occurred during the year with the department's Multiple and Complex Needs Initiative (MACNI), which commenced taking referrals in August 2004. Some of the complex clients known to the Chief Psychiatrist were referred to MACNI and accepted. During 2005, the Chief Psychiatrist continued to work closely with the MACNI to clarify the respective roles and best way of working together in the interests of consumers with complex needs.

During 2005, the Chief Psychiatrist or a senior clinical advisor attended 10 case conferences in response to the growing number of requests from area mental health services for the Chief Psychiatrist's participation in case conferences to discuss clients with particularly challenging treatment or management needs.

Case study: Improving outcomes for consumers with complex needs

Community concern was expressed about a consumer of a mental health service living in the community whose anti-social behaviour was disruptive for residents in the local neighbourhood. The mental health service approached the Chief Psychiatrist for assistance with a complex consumer and a case conference of all relevant service providers, clinical and non-clinical, was convened to discuss the consumer's management. The Chief Psychiatrist also interviewed the consumer and gave a second opinion on their diagnosis. Spectrum was asked to assess this individual and advise on their management. Spectrum also assisted in providing a referral to the Multiple and Complex Needs Initiative, and access to general welfare support was organised with a non-government organisation. While not all issues have been fully resolved for this consumer, the situation has improved and the impact on the local community is being addressed.

3.3 Working with clinicians and services to improve service quality

Quality Assurance Committee

The Quality Assurance Committee (QAC), established under s.106AC of the Act in 1999 to oversee and monitor standards of mental health services (such as statutory practices) and provide expert input into the ongoing activities of the Chief Psychiatrist, is a consultative body comprised of senior and experienced clinicians currently working in the public mental health service system. The QAC meets quarterly and membership is reviewed every three years. The membership of the QAC in 2005 is provided in Appendix 1.

Key activities undertaken by QAC in 2005 include:

- reviewing sentinel events involving mental health consumers. Sentinel events are defined as serious adverse events that occur in health services. They are relatively infrequent and commonly reflect deficiencies in hospital systems and processes that actually or potentially result in undesirable outcomes for patients. The sentinel event program aims to reduce the likelihood of such events recurring by examining the environment and circumstances in which they occur. Sentinel events include suicide or attempted suicide of an inpatient and medication errors leading to the death of a patient.
- monitoring reportable deaths and statutory practices, including seclusion, mechanical restraint and electroconvulsive therapy.
- reviewing coronial recommendations.
- reviewing draft clinical practice guidelines.

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

Education and training

The Chief Psychiatrist frequently receives requests to provide education and training sessions to mental health services staff, especially regarding the clinical application and interpretation of the Act. Informal opportunities to educate senior clinicians also arise in response to their regular telephone calls to the office seeking clinical advice or information.

During 2005, the Chief Psychiatrist provided a range of presentations and lectures on a variety of topics including mental health legislation, the mental health service system in Victoria, electroconvulsive therapy and the role of the Chief Psychiatrist in protecting the rights of Victorians with a serious mental illness and promoting quality care and treatment. Audiences included:

- public mental health services
- private psychiatric service providers
- Office of the Public Advocate
- legal aid services
- 6th National Conference for carers of people with a mental illness
- International Mental Health Leadership program
- Royal Australian and New Zealand College of Psychiatrists 40th Congress
- University of Melbourne, Department of Psychiatry
- international delegations from Thailand and China.

Clinical guidelines

From time to time, the Chief Psychiatrist issues clinical guidelines and program management circulars in particular areas of practice or service delivery to promote quality care and clarify aspects of mental health policy and legislation. During 2005, the following guidelines were developed:

- *Working together with families and carers* to remind services of the important role families and carers play as partners in providing care to the consumer.
- *Managing persons required to attend police interview or court* to clarify the expectations of area mental health services in supporting consumers in this process.

In addition, the *Community Treatment Orders* guideline was comprehensively reviewed to incorporate a number of significant amendments to the Act. Minor revisions to a number of existing guidelines were also made to ensure their currency with legislative and administrative provisions.

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

Clinical leadership

The Chief Psychiatrist facilitated and chaired quarterly authorised psychiatrist forums and three inpatient unit manager forums during 2005.

The aim of the authorised psychiatrist forums is to provide an opportunity for authorised psychiatrists to meet on a regular basis with the Chief Psychiatrist to discuss their role, function and statutory responsibilities. It also provides peer support and enables matters of common interest to the Chief Psychiatrist and authorised psychiatrists to be discussed, and issues of concern to be identified.

Three clinical practice standards forums for unit managers were hosted in 2005. These focused on the important theme of seclusion practices, observation of patients and maintaining a safe environment. Presenters were drawn from areas that were able to demonstrate examples of good practice as well as presentations from consumers about their experiences of inpatient care. Both forums will be continued in 2006.

In November 2005, the Chief Psychiatrist hosted a forum to discuss community treatment orders and the related amendments to the Act that came into force in December 2004 and August 2005. These amendments introduced involuntary treatment orders and treatment plans into the Act and made significant changes to community treatment order provisions. The revised guideline *Community Treatment Orders* was launched at this event.

3.4 Improving governance and engaging stakeholders

Implementation of Mental Health Act amendments

Clinicians in mental health services were supported in their efforts to implement the amendments to the Act introduced in December 2004. In conjunction with the Legal and Forensic Policy Unit of the Mental Health Branch, this included responding to individual queries and contributing to the development of frequently answered questions for the website to provide an accessible guide to common queries.

Further amendments were made to the Act in August 2005 to clarify the operation of the 2004 amendments. These covered three key areas including involuntary treatment orders (ITOs), treatment plans and special leave of absence for security patients. Details of the amendments are provided in the Program Management Circular, *Amendments to the Mental Health Act 1986* (August 2005).

Department and stakeholder liaison and participation

During 2005, the Chief Psychiatrist and senior clinical advisors contributed to a number of Mental Health Branch working parties and consultation processes including those relating to workforce development, case management, education and training and triage practice.

The Chief Psychiatrist and clinical advisors liaise routinely with a range of government and advocacy bodies including the Public Advocate, the Health Services Commissioner, the Coroner and the Ombudsman and are also involved in a number of departmental and interdepartmental committees.

A memorandum of understanding between the Chief Psychiatrist and the Office of the Public Advocate regarding roles and responsibilities when working with people with a mental illness was developed in 2005.

3.5 Forensic mental health services

Hospital orders and restricted community treatment orders

Hospital orders are dispositions under the *Sentencing Act 1991*. Courts can make various orders in determining the most appropriate disposition for an individual where mental illness has been seen to play a role in the offending behaviour. Instead of a sentence a person may be directed to receive treatment as an involuntary patient in an approved mental health service. Following treatment, such patients may be suitable for a restricted community treatment order (RCTO) (s.15A of the Mental Health Act), subject to conditions made by the Chief Psychiatrist, to enable them to continue their treatment in the community. The Chief Psychiatrist, upon application by an authorised psychiatrist, may make an RCTO not exceeding 12 months. All RCTOs are subject to the approval of the Mental Health Review Board. During 2005, 12 RCTOs were made.

Security patients

Security patients are people detained in an approved mental health service on a court order under the *Sentencing Act* (s.93(1)(e)) as part of their sentence, or by order of the Secretary of the Department of Justice under the *Mental Health Act* 1986 (s.16) where a sentenced prisoner requires involuntary treatment for their mental illness. In Victoria, such patients are almost invariably treated in the secure specialist forensic mental health service, Thomas Embling Hospital, until well enough to be returned to prison or their sentence ends.

The Chief Psychiatrist is responsible for approving the person's discharge back to prison. In doing so, the Chief Psychiatrist must have regard primarily to the person's current mental condition and consider their medical and psychiatric history and social circumstances. People requiring involuntary treatment at the expiry of their sentence may receive treatment under the standard provisions of the Act.

The Chief Psychiatrist has power to authorise special leave for security patients for specifically defined purposes, usually medical treatment or to attend court. Historically, special leave could not exceed 24 hours. However, the *Mental Health Act* 1986 was amended in August 2005 to allow security patients to be granted up to a maximum of seven days special leave for the purposes of medical treatment. This change brought the special leave provisions for security patients into line with those for forensic patients under the *Crimes (Mental Impairment and Unfitness to be Tried) (CMIA) Act 1997*. In approving special leave or discharging a person from security patient status, the Chief Psychiatrist is required to immediately notify the Secretary of the Department of Justice of the leave or discharge.

Forensic Leave Panel

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

The Chief Psychiatrist has power under the CMIA to suspend leave for forensic patients at any time if satisfied that the safety of the person or members of the public is at risk of serious danger. During the reporting period, the Chief Psychiatrist suspended the leave of two forensic patients on extended leave.

4 Future focus

Emerging priorities over 2006 include improving consumer and staff safety in mental health inpatient units and ongoing effort to improve treatment planning.

Improving safety in mental health inpatient units

Seclusion and restraint practices in mental health inpatient units have collectively been identified as one of the four national safety priorities for state jurisdictions to address. Adult mental health inpatient units report increased acuity and challenges in managing acutely disturbed consumers. Co-morbid substance use features prominently in the presentation of some individuals.

Industry standards and occupational health and safety protocols require service providers to maintain safe working environments for their staff. At the same time, mental health services are required to provide treatment and care, often on an involuntary basis, in accordance with the Act and expectations of community safety. How to optimally provide treatment and care for individuals with aggressive behaviour is a major challenge confronting mental health services locally and internationally. Workforce skill development, optimal management of acutely disturbed consumers and creating physical and therapeutic environments that support best practice will be a major focus over the coming years.

Improving treatment planning

The 2004 amendments to the Act introduced the requirement that all involuntary patients have a treatment plan in accordance with the new s.19A. The primary purpose in providing a legislative impetus to treatment planning was to improve communication between treating teams and consumers and, where appropriate, carers about the treatment to be provided. Feedback from consumers and carers had consistently pointed to the need for greater sharing of information and opportunity for increased involvement in the treatment and care process.

Chief Psychiatrist clinical reviews frequently identified treatment planning as an area for practice improvement, and also acknowledged the continuing challenge for clinicians in formulating targeted, meaningful and user friendly plans. The Mental Health Review Board has highlighted the need for ongoing discussion and training to assist clinicians in developing more advanced treatment planning skills. In line with this, the Chief Psychiatrist agreed to hold a treatment planning forum in 2006.

Appendix 1:
2005 Membership of the Quality Assurance Committee

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