Chief Psychiatrist's annual report 2017–18

VICTORIA State Government | Health and Human Services

Chief Psychiatrist's annual report 2017–18

To receive this publication in an accessible format phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email the Office of the Chief Psychiatrist <ocp@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISSN: 2207-1482 (Online)

Available on the Chief Psychiatrist's webpage <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist.

Chief Psychiatrist's message

I am pleased to present the Chief Psychiatrist's annual report for 2017–18.

As Victoria's Chief Psychiatrist, my responsibilities under the *Mental Health Act 2014* include clinical leadership and quality and safety improvements across the Victorian public mental health system.

People experiencing mental illness are often highly vulnerable and may be treated on a compulsory basis. This is why it is so important that the mental health system has strong mechanisms to monitor practices and help service providers continuously improve the safety and quality of their services. Together with the Mental Health Tribunal and the Mental Health Complaints Commissioner, my role is a cornerstone of the Victorian Government's clinical governance framework for mental health services.

The Office of the Chief Psychiatrist (OCP), which includes the Office of the Chief Mental Health Nurse (OCMHN), had another busy and productive year in 2017–18. While it is not possible to capture all the activities of these teams, this report describes some highlights of the year. These include several new guidelines and practice resources for mental health services in areas such as responding to family violence, providing clinical supervision for staff, meeting the needs of people who require intensive mental health nursing and improving sexual safety in mental health inpatient settings. We also continued to rollout the Safewards program, which has proved effective in driving better cultures and practices in inpatient units.

These initiatives are in addition to our day-to-day work, which includes: monitoring restrictive interventions in mental health services; investigating serious clinical incidents; undertaking reviews and supporting mental health services to address issues of concern; liaising with mental health and other services to improve outcomes for individual consumers; and responding to many calls, letters and emails from consumers and carers seeking assistance and advice regarding access to mental health services. This year has seen a marked increase in the number of direct contacts from mental health service providers seeking advice and assistance from my team; this is a clear indicator of our increasingly robust and productive relationships with services, showing the value of our collaborative approach to clinical leadership.

The OCP and the OCMHN are privileged to have strong links and daily contact with mental health clinicians and service users as well as and staff of agencies such as the Mental Health Tribunal, the Office of the Public Advocate and Safer Care Victoria. This gives us access to a wealth of 'frontline' knowledge that informs our policy and quality assurance endeavours. I wish to thank the many clinicians, service leaders, consumers and carers who have shared their expertise and experiences with us.

I am fortunate to lead a multidisciplinary team of skilled and compassionate people who are dedicated to improving Victoria's mental health system. This report highlights the contributions of two new staff members with lived experience of mental illness and mental health services. Through their own work and their advice and support to other team members, these staff remind us to keep the rights and recovery needs of mental health consumers and carers at the forefront of everything we do.

I also take this opportunity to acknowledge and thank the Chief Mental Health Nurse, my deputies, the OCP manager and the clinical advisors, project officers and administrators in my team for their unflagging commitment and support during the year.

Dr Neil Coventry

Chief Psychiatrist

Contents

Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, carers, service providers and members of the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2017–18 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health Act 2014*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The Mental Health Act aims to improve the treatment experiences of people with a mental illness by actively involving and supporting them, and their families and carers, in making decisions about their treatment and exercising their rights.

The Act has a number of core principles and objectives including that:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under s. 119 of the Act, the Secretary to the Department of Health and Human Services ('the department') can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s. 120 of the Act, is to:

- provide clinical leadership and expert clinical advice to mental health service providers in Victoria
- promote continuous improvement in the quality and safety of mental health services
- promote the rights of people receiving mental health services
- provide advice to the designated minister and the departmental Secretary about mental health services.

Under the Act, 'mental health service providers' are designated mental health services (often public or denominational hospitals) and publicly funded mental health community support services. Often referred to jointly as 'public mental health services', these services include a range of hospital and community-based clinical mental health services and the Victorian Institute of Forensic Mental Health (known as 'Forensicare').

Further information about the Mental Health Act and how it relates to the role of the Chief Psychiatrist can be found on the department's website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health services. Supported by the OCP, the role promotes quality and safety in services provided to some of Victoria's most vulnerable people. The Act, under s. 121, summarises the functions of the Chief Psychiatrist as:

- to develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- to develop and provide information or training, and monitor service provision, to promote quality and safety
- to assist mental health services to comply with the Act, regulations made under the Act and codes of practice
- to conduct clinical practice audits and clinical reviews of mental health service providers, and investigations in relation to service provision
- to analyse data, undertake research and publish information about Victoria's mental health services
- to publish an annual report
- to give directions to mental health service providers regarding service provision
- to promote cooperation and coordination between mental health services and providers of health, disability and community support services.

The Office of the Chief Psychiatrist and the Department of Health and Human Services

The Act defines the statutory role of the Chief Psychiatrist, who also holds an executive officer role in the department, as leading the OCP.

As the department's quality and safety 'arm' in the stewardship of clinical mental health services, the OCP supports the Chief Psychiatrist's responsibility to provide clinical leadership to the sector. The OCP undertakes a wide range of activities including:

- monitoring restrictive and invasive interventions, which include seclusion, restraint and electroconvulsive treatment (ECT)
- responding to serious clinical incidents
- working with mental health and other service providers to improve care for individual consumers
- helping to embed new practices and models of care.

The OCP incorporates the work of the OCMHN. The Chief Mental Health Nurse provides nursing leadership and supports mental health nursing through education/training, through promoting best practice and through workforce planning and development. The OCMHN supports the practical implementation of the OCP's work with policy, procedures and workforce development initiatives.

Structure of the report

This annual report outlines the OCP's activities from 1 July 2017 to 30 June 2018 and has been divided into two sections.

Section 1 relates to leadership and quality and safety improvement across Victoria's mental health system. These activities include: providing advice to services and ministers; clinical leadership; and reviews, audits and investigations to promote continuous improvement in quality and safety.

Section 2 covers the OCP's statutory reporting requirements under the Mental Health Act including monitoring ECT, restrictive interventions (use of seclusion and restraint) and reportable deaths.

Section 1: Leadership and quality and safety improvement

The year in review

The OCP, including the OCMHN, undertakes many and varied activities as part of its clinical leadership and quality and safety functions. In 2017–18 our teams:

- completed three major investigations
- wrote two major reports based on data collected by the department
- undertook audits of ECT at three health services and held an education and training forum on ECT quality and safety
- carried out reviews of mental health services and monitored quality and safety actions plans at two health services
- conducted 447 reportable death report reviews
- established a new case and data collation system to improve future reporting and trend analysis
- created and published four new guidelines and reviewed and reissued two existing guidelines
- developed new policy and practice frameworks on clinical supervision and physical health
- conducted 14 health service site visits
- hosted two quality and safety forums – on incident reporting and risk management, respectively – involving more than 100 stakeholders each
- held the third annual Safewards Victoria forum involving 200 delegates, six Safewards Victoria community of practice meetings, six Safewards Victoria faculty meetings, eight Safewards Victoria workshops and one masterclass workshop, as well as Safewards 'train the trainer' programs at five area mental health services
- held quarterly forums for health services' authorised psychiatrists, three meetings of the restrictive interventions committee, two meetings of the morbidity and mortality committee, a meeting of the ECT committee and meetings of the sentinel events review committee every six weeks
- held monthly forums with senior mental health nurses from across the state and two forums each for community nurses, adult acute inpatient nurse units managers, aged care nurses and child and adolescent mental health nurses
- monitored implementation of the Hospital Outreach Post-suicidal Engagement (HOPE) program at six sites.

We also worked in collaboration with other parts of the Mental Health Branch, other areas of the department and other government departments and agencies on a range of government initiatives and programs.

Continuing the trend from recent years, we were busier than ever in 2017–18. Compared with 2016–17 we experienced:

- a 53 per cent increase in overall contacts from mental health services, carers, consumers and members of the public. The largest increase was in contacts initiated by mental health services, which were 139 per cent higher than the previous year
- 58 contacts from departmental colleagues to provide advice to joined-up service strategies for individuals, representing a 263 per cent increase on the 16 contacts in the previous year
- a 72 per cent increase in direct contacts from consumers

- a 44 per cent increase in direct contacts from carers
- a 322 per cent increase in incident reports, due largely to a sexual safety reporting pilot project and changed reporting requirements
- a 40 per cent increase in correspondence prepared on behalf of the Minister for Mental Health.

The box below gives an example of a day in the life of one of our clinical advisors.

A typical day in the life of an OCP clinical advisor

8.30 am: Clinical team meeting

Clinical meetings occur twice a week. The team discusses clinical matters that have been recently brought to the OCP's attention and any other ongoing clinical issues. Team members seek advice from others and work together to plan how to manage presenting issues.

9.30 am: Responding to emails

Emails to OCP advisors come from a range of sources including departmental colleagues and managers, ministerial officers, mental health services and external agencies. Some will require urgent action – for example, arranging for an area mental health service to assess someone who has contacted a statutory agency making threats of self-harm.

10.00 am: Phone duty

Clinical advisors take turns to answer incoming calls to the OCP's enquiry line. Calls come from health services and from consumers and carers seeking assistance with accessing mental health services. For example, a clinician from a mental health service might ask the OCP for help interpreting a provision of the Mental Health Act in a particular clinical situation. OCP clinicians will often seek advice from legal officers in the department to respond to such queries.

12.00 pm: Record keeping

Record actions and status updates from morning work on the OCP's clinical management database.

12.15 pm: Lunch with colleagues in the office kitchen

12.30 pm: Unscheduled case conference with Chief Psychiatrist

The Chief Psychiatrist is often called on to act in clinical matters that require coordination between many different parties. As an example, he could convene an urgent case conference between clinicians from an area mental health service, Forensicare and other service providers involved with a person who has perpetrated an act resulting in harm to members of the public. In a case like this, the clinical advisor may be asked to check the person's records on the department's central mental health service database and write a briefing for departmental executives and/or the Minister for Health.

1.30 pm: Statutory reporting meeting

OCP clinical advisors regularly meet to review all episodes of restrictive interventions in mental health services. They particularly focus on 'outlier' episodes – for example, people who are secluded for longer than usual or who have experienced multiple episodes of restraint – and will contact the relevant services to discuss these events.

As well as looking at individual cases, the team reviews aggregate data to identify any trends for individual services and across the system.

3.00 pm: Sentinel event teleconference

The Chief Psychiatrist convenes regular face-to-face meetings and teleconferences with service providers to discuss sentinel events. The clinical advisor's role in these meetings includes reviewing 'root cause analysis' documentation for all sentinel events reported to the OCP, summarising this information, sending it out in a secure form before the meeting, and presenting the information verbally to meeting participants. Participants include clinical directors and quality/safety managers from mental health services and representatives of Safer Care Victoria and the OCP.

4.30 pm: Desk work

Clinical advisors contribute to the bureaucratic work of the department such as responding to letters on behalf of the Minister for Mental Health, preparing briefings on the progress of key initiatives and reviewing service policies, plans and evaluations.

Highlights

While it is not possible to describe all the work of the OCP/OCMHN, this section details some of our key achievements in 2017–18.

Family violence

The Victorian Royal Commission into Family Violence directed two of its recommendations specifically to the Chief Psychiatrist. It recommended that the Chief Psychiatrist issue a guideline on family violence for mental health services and – in consultation with relevant professional peak bodies – develop a family violence learning agenda.

The *Chief Psychiatrist guideline and practice resource: family violence* was finalised in June 2018. This guideline outlines the Chief Psychiatrist's expectations of Victorian public mental health services about responding to people who experience family violence and improving the way they work with those who perpetrate it. The guideline sends a strong message that effective responses to family violence should be integrated into usual mental health treatment, and provides practice advice, examples and information resources to help mental health services achieve this objective.

While mental health clinicians are not expected to become family violence specialists, they are required to become skilled in recognising, understanding, enquiring about and taking appropriate action in relation to family violence. Together with the new specialist family violence positions funded in the Victorian Government's 2017–18 State Budget, the Chief Psychiatrist's guideline is an important resource for mental health services to use in improving clinicians' family violence knowledge and skills.

The mandate for mental health services to develop their clinicians' skills in this area will be strengthened through the forthcoming release of a joint statement of commitment to a learning agenda by the Chief Psychiatrist, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian and the Royal New Zealand colleges of general practitioners and other professional bodies. This was an outcome of a project advisory group with representatives from these bodies, which the Chief Psychiatrist convened in 2017.

Clinical practice framework and training for mental health intensive care

Another highlight of 2017–18 was the Chief Mental Health Nurse's project to develop a new clinical practice framework and training program for intensive mental health nursing. The purpose of the project was to improve therapeutic engagement and safety for people who require intensive care due to increased needs and vulnerabilities associated with an acute mental illness.

The framework distinguishes mental health intensive care as a specialist care type that is determined by the consumer's need rather than a particular service setting. Consumers may receive this type of care in a dedicated mental health intensive care area (formerly a 'high dependency unit') or in another treatment environment such as a general inpatient unit or an emergency department.

The framework was informed by a review of high dependency units in Victoria, a review of the Chief Psychiatrist's 2002 policy guideline on high dependency units, and the concurrent development of a training and skills development program (see below). It supports decision making about using mental health intensive care, as well as developing local policies and procedures to ensure consistent and high service standards.

The framework emphasises that all decisions and practices regarding mental health intensive care must consider consumers' rights and recovery goals and the risks and anticipated benefits of the care. Seven core practice principles underpin the framework. These principles specify that mental health intensive care should be recovery-oriented, trauma-informed, human rights-focused, family-

inclusive, responsive to diversity and provided in the least restrictive way possible, and should facilitate supported decision making. The framework also describes expectations of services in five interconnected clinical practice domains: therapeutic environment, staffing skills and requirements, collaborative planning, therapeutic interventions and supporting safety.

The OCMHN's senior consumer and carer advisors, in collaboration with clinical advisors, created and delivered an innovative program of training and skills development based on the actual experiences of consumers, carers and clinicians. They were assisted by the Mental Health Intensive Care Working Group, which included:

- consumer and carer representatives
- a director of nursing (project ambassador)
- nurse practitioners specialising in high dependency units and intensive care
- nurse unit managers
- nurse educators
- OCMHN project staff
- an academic from the University of Melbourne's Centre for Psychiatric Nursing.

The training program is delivered via a multimedia platform with videography and face-to-face training modules presenting research-based evidence on attitudes and values, recovery and trauma-informed care principles, and therapeutic engagement foundations.

The training package was piloted at a service where there was an immediate need for developing the skills of nursing staff. Evaluation and feedback on the training has informed how the program will be delivered across the state.

Clinical supervision framework

The OCMHN provides leadership, training and professional development, promoting evidence-based best practice for mental health nurses employed in Victorian public mental health services.

In 2017–18 the OCMHN team launched *Clinical supervision for mental health nurses – the framework for Victoria*. The framework, developed with the support of an expert reference group from across Australia, addresses an identified need for more consistency and clarity about expected standards of clinical supervision.

Released in May 2018, the framework is designed to:

- promote a common understanding of clinical supervision
- enable mental health nurses to negotiate with and have their clinical supervision needs met by mental health services
- ensure that nurses have regular access to safe spaces where they can reflect on practice
- support the government's response to occupational violence, service quality and safety issues as well as workforce retention in mental health services
- communicate information about how dedicated reflective practice can improve outcomes for consumers
- clarify the roles and responsibilities of nurses, supervisors and employers regarding clinical supervision.

A five-year implementation plan will support the framework's implementation. The plan's consultation phase involves a 12-month dedicated clinical supervision training program for senior mental health nurses and mental health nurses involved in clinical supervision across the state. This leadership group will provide key drivers for the remaining four years of the implementation plan. The five-year

plan provides a platform on which to develop standards for clinical supervision and training programs across Victoria, aligned with national peak bodies and expert groups.

Advance statements and nominated persons

The Mental Health Act contains various provisions designed to uphold the human rights and recovery goals of mental health service consumers and their families and carers. These include a statement of rights, a set of recovery principles and requirements for supported decision making.

A central tenant of the Act is the presumption that people receiving compulsory mental health treatment have the capacity to make decisions about their treatment and to give informed consent (unless clinicians can provide evidence to the contrary at the time a treatment decision needs to be made).

Under the Act, consumers have the right to make an 'advance statement' setting out their treatment preferences in case they become unwell enough to need compulsory mental health treatment. They also have the right to elect a 'nominated person' to receive information and to support them if this occurs. These legislative provisions were designed to protect consumers' interests by ensuring they are able to exercise their rights and have their views and preferences about their treatment and recovery taken into account.

As part of a broader focus on consumer rights, OCP staff have reviewed the uptake and impact of advance statements and nominated person provisions. The aim was to improve understanding of the enablers and barriers to implementing the legislative provisions on advanced statements and nominated persons. The review included:

- a literature review
- a desktop review of current tools, resources and promotional materials supporting the legislative provisions
- an analysis of Client Management Interface / Operational Data Store (CMI/ODS) data by service type and region
- consultations with key stakeholders
- an electronic survey (executed via the peak body for mental health consumers, the Victorian Mental Illness Awareness Council).

The project provided a platform for information exchange and dialogue between the department, consumers/carers and clinical service staff on how to use advanced statements and how to apply nominated persons provisions. This included a successful forum to discuss the project findings with stakeholders from across the sector and to showcase actions and initiatives that promote supported decision making.

The recommendations arising from this project will form the basis of a work plan to improve ongoing data collection and practices relating to supported decision making and the use of the advance statement and nominated persons legislative provisions.

Sexual safety

Sexual safety in mental health services remains one of the Chief Psychiatrist's highest priorities.

The OCP initiated a review of the Chief Psychiatrist's guideline *Promoting sexual safety*, which deals with responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units. The OCP undertook this work in collaboration with consumers, carers and sector clinicians and service managers.

The review responded to several incidents of sexual assault in mental health services. The Chief Psychiatrist was also concerned that there were significant variations between services in the threshold for reporting incidents to the Chief Psychiatrist and the content of reports received.

The review led to a new reporting instruction, *Chief Psychiatrist standard operation procedure – sexual safety notification to the Chief Psychiatrist*. The Chief Mental Health Nurse managed a project to clarify and simplify the reporting process for mental health services using a new reporting checklist that was developed with expert researchers from the field. As part of a three-month trial of the checklist, from 1 March to 1 June 2018 mental health services' authorised psychiatrists were required to report all incidents of alleged sexual assault, sexual harassment and sexual activity on their acute psychiatric inpatient units. This is consistent with the Chief Psychiatrist's instruction that sexual activity is not appropriate in acute mental health treatment settings because consumers may be unable to consent in a meaningful way to such activity when they are acutely unwell.

The Monash Alfred Psychiatry Research Centre is currently evaluating the checklist. While awaiting the findings of the evaluation, mental health services have continued to use the checklist to report information to the Chief Psychiatrist and have given positive feedback about this process. The reported data will be analysed to understand patterns of sexual safety incidents across the state and, over time, to monitor services' progress in achieving sexual safety in mental health inpatient units.

The checklist evaluation and analysis of reported data will inform a revised Chief Psychiatrist's sexual safety guideline. The revised guideline will emphasise safety for all people in inpatient units (consumers, visitors and staff), incident prevention (for example, by better orientating consumers to the inpatient unit), early intervention, appropriate responses to incidents, and best practice standards for reporting to the Chief Psychiatrist.

The new reporting process and revised guideline will form part of the department's response to a recent Mental Health Complaints Commissioner review, which examined complaints relating to sexual safety in acute mental health inpatient environments. The commissioner's report, *The right to be safe: ensuring sexual safety in acute mental health inpatient units*, was released in March 2018. It makes several recommendations to the department, the Chief Psychiatrist and health services about improving sexual safety in acute mental health inpatient units.

The OCP is involved in a range of other activities that will contribute to the Chief Psychiatrist's sexual safety agenda and the response to the commissioner's recommendations. These include:

- working with the Victorian Health and Human Services Building Authority on a mental health infrastructure sexual safety audit in 2018–19 (this will include an assessment of women-only areas, safety features such as locks or swipe cards, and the viability of further reconfiguring facilities to establish single-gender areas)
- working with the Victorian Agency for Health Information to integrate reporting of sexual safety incidents into the Victorian Health Information Management System
- revising existing Chief Psychiatrist guidelines on discharge planning and transfers of care
- developing a new Chief Psychiatrist guideline on clinical risk assessment
- implementing the clinical practice framework and training program for mental health intensive care, as discussed on page 11
- developing a framework for Chief Psychiatrist investigations
- promoting best practice through the Chief Psychiatrist's Quality and Safety Forums, Authorised Psychiatrist meetings and service visits.

Safewards

Safewards was originally developed for mental health inpatients units in the United Kingdom. It was based on a broad body of evidence, including several large research studies conducted by the team that developed the model, and a review of more than 1,000 other studies from around the world.

Safewards is designed to reduce levels of conflict that may lead to aggression, violence and absconding and, in response to these events, the use of restrictive practices such as patient seclusion and restraint. It aims to improve safety for both staff and patients by teaching staff to identify, avoid and respond to 'triggers' of conflict. It examines aspects of six domains (patient community, patient characteristics, regulatory framework, staff team, physical environment and outside hospital) that can give rise to 'flashpoints' – that is, situations where conflict could arise. The flashpoints are addressed through 10 practical, evidence-based interventions.

Safewards' implementation in Victoria has so far targeted adult, aged, youth and secure extended care mental health inpatient units. The Chief Mental Health Nurse has overseen the implementation, with support from the Victorian Managed Insurance Authority. This collaborative model of implementation includes a dedicated project team in the OCMHN, a consumer advisor, expert clinicians, the Safewards community of practice, the Safewards faculty and an evaluation team.

The statewide rollout of Safewards, which began in 2016 following a trial in seven services (18 inpatient units), was completed in 2017–18. The OCMHN has now delivered Safewards training and implementation support to all in-scope mental health services. Visual resources have been developed using a unified theme of origami (signifying transformation), enhanced by consumer perspectives and reflections from the trial. Services have also received funding to incorporate sensory modulation items into their recovery model and to improve the physical environment – for example, by creating sensory courtyards and communal spaces.

International evaluations, including a randomised controlled trial conducted by the development team in the United Kingdom, have shown that Safewards is successful in reducing conflicts in mental health inpatient units. Safewards' implementation in Victoria is being subject to intensive evaluation, but early indications are very promising as to its effectiveness.

The OCMHN is planning to build on the foundational work that Safewards is delivering for Victorian mental health staff and patients. It is expected that the model will be extended to a range of non-acute mental health and general medical services over the coming years. Peninsula Health has recently completed a trial of Safewards in a general ward and has reported benefits for both staff and patients. Preliminary work has begun to introduce Safewards to emergency departments in Victorian public hospitals. Workshops have been held with experts, including people with lived experience, and other key stakeholders. Two health services, Peninsula Health and Bendigo Health, will trial Safewards in their emergency departments in 2019.

Responding to and investigating challenging clinical issues

As mentioned in the Chief Psychiatrist's message at the front this report, the OCP/OCMHN has a generally strong and collaborative relationship with mental health services. We regularly receive feedback that services value the assistance of the Chief Psychiatrist, the Chief Mental Health Nurse and other OCP clinicians in helping them work through problems and manage difficult clinical issues.

A practical way in which the OCP helps services is by supporting care planning for consumers with complex needs. OCP clinicians often play a coordination role by bringing together different people involved in consumers' care – including family members in many cases – to understand their needs from multiple perspectives and to promote a shared understanding of the best way forward.

The following case vignette illustrates how the OCP was able to foster communication and trust between a mental health service and a consumer's family, for the benefit of all parties. Details of the case have been changed to protect the privacy of the people involved.

The father of 20-year-old man contacted the OCP to discuss concerns about his son. The young man, who lived at home with his parents, had a physical impairment as well as behaviour that caused significant risk to himself and others. His mental health diagnosis was unclear.

Family members were worried about the young man's medical and psychiatric needs and were unsure about how to get the help they needed. They perceived that there were limited treatments available within their local mental health system and that interventions by the area mental health service were crisis-driven rather than planned.

The OCP facilitated a case conference with the area mental health service regarding assessment and treatment planning for the young man. As a result, the service was able to clarify the next steps for his treatment. The service's clinical team also engaged with specialised support for involving family members in the treatment process and received advice about referral to other supports for the family.

The OCP interacts with a wider range of services and agencies each year as Victoria's health, mental health and community service system continues to expand and develop. The vignette below, again with details changed to protect privacy, is an example of a case referred to the OCP that resulted in involving the new Victorian Fixated Threat Assessment Centre (VFTAC). The centre brings together senior and experienced police and mental health clinicians to assess and respond to people with complex needs who may pose a risk of serious violence. The OCP has communicated with the mental health sector about the role of this new service.

Police found a 25-year-old homeless man with chronic psychotic illness trying to gain access to Parliament House. The police took him to a local hospital emergency department where he was assessed by a mental health clinician and admitted to a mental health inpatient unit for a week under the Mental Health Act.

During his admission the man expressed concerning views about a senior Victorian politician, who he believed had communicated with him over many months, and about his desire to make the 'ultimate sacrifice' for the state. The mental health service contacted the OCP for advice. The OCP discovered that the man had written to the politician several times about his ideas for making the state safe from invasion.

In consultation with the OCP, the mental health service referred the man to the VFTAC. Staff there assessed the risk to the community and looked at previous forensic contact. On discharge from the inpatient unit, the homeless team from the mental health service and the VFTAC worked with the man to monitor his adherence to treatment, his behaviour and signs of escalating psychosis.

As well as providing leadership, advice and support, the Chief Psychiatrist has general powers under the Mental Health Act to give directions to services. General directions must be preceded by an investigation of a particular incident, a pattern of behaviour or a series of complaints. The Chief Psychiatrist also has the option to conduct a clinical review and audits that do not have any particular criteria to initiate (but require the OCP to give the service 20 days' notice). As illustrated by the following de-identified vignette, the investigations and reviews conducted by the OCP may serve to inform government policy directions and investments in mental health services.

A 50-year-old woman with chronic psychotic illness was involved in a violent altercation in the city where a person sustained a severe head injury. The woman was subsequently imprisoned and remains in remand pending a court hearing. Forensicare is providing treatment.

The Chief Psychiatrist appointed an expert panel to conduct a formal investigation (under s. 122 of the Mental Health Act) of the woman's treatment by the area mental health service, where she was a registered client before the incident. The panel examined the case for two days, including a one-day visit to the service and a one-day review of documentation.

The report of the investigation contained recommendations for both the mental health service and the department. A key finding of the investigation was that although the mental health service had managed the woman's psychotic illness well, it had not adequately assessed or responded to her co-existing personality disorder. The findings and recommendations from the investigation have informed a new initiative funded in the 2018–19 State Budget to improve the identification and treatment of people with personality disorders within area mental health services.

Promoting rights and choice through lived experience expertise

Consumers and carers are central to identifying safety, quality and human rights issues in mental health services, as well as possible solutions. The Chief Psychiatrist must access the expertise of people with lived experience of mental health services and support them to participate in OCP/OCMHN work. This leads to more effective engagement and helps the sector move towards genuine co-production with consumers and carers.

In 2017–18 the OCP/OCMHN established new consumer and carer advisor positions, welcoming two full-time staff members with lived experience of mental illness and mental health services. Julie was appointed to the role of senior consumer advisor. Julie is experienced in consulting with people who have a mental illness and has advised the Commonwealth and state governments on mental health policy. Frances is the senior carer advisor. Before joining the team Frances was leading business development and implementation of the National Disability Insurance Scheme, working extensively with consumers, families and carers. She held executive roles in the mental health sector and is recognised for her commitment to family and carer strategy and policy. Kate, a principal clinical advisor and senior mental health nurse in the OCP/OCMHN team, supports the consumer and carer advisors, oversees their work and coordinates their input to the work of other team members.

The work of the consumer and carer advisors in 2017–18 has focused on consumer and carer rights. This pertains to one of the four statutory roles of the Chief Psychiatrist: 'to promote the rights of persons receiving mental health services' (s. 120, Mental Health Act). The OCP has, until recently, focused its consumer rights work on reducing restrictive interventions and promoting gender and sexual safety. While these issues remain high priorities, there is a need for the office to consider ways of promoting rights more broadly.

The consumer advisor is developing a guidance document on consumer rights for the sector and an action plan for the OCP. The consumer advisor has also established the Victorian Consumer Rights Advisory Group, which provides ongoing, expert advice to the Chief Psychiatrist. The aims of this body of work are are to:

- promote a clear, shared understanding of consumer rights in the mental health sector
- promote knowledge and influence values and attitudes about consumer rights
- contribute to monitoring the effectiveness of the Mental Health Act's provisions on consumer rights
- identify barriers and opportunities to better promote consumer rights.

The senior carer advisor is leading the OCP's work on advance statements and nominated persons, as discussed on page 13, to increase awareness of these rights and mechanisms that support decision making about treatment preferences.

The senior carer advisor is also supporting mental health service providers to operationalise key legislative provisions and policy principles to more effectively involve families and carers in consumers' care. In various reviews, the OCP has identified the need for increased engagement with families and carers. The Chief Psychiatrist will shortly release a new guideline, *Working together with families and carers*, which provides key directions and clinical guidance to services on including family, on carer issues and on responding to children.

In addition to leading their own projects, the consumer and carer advisors work as part of the collaborative, multidisciplinary OCP/OCMHN team. They participate in key work undertaken as part of the Chief Psychiatrist's statutory functions, including investigations, clinical reviews and developing practice guidance. Their participation serves to focus the attention of all team members on improving clinical practice in areas of high priority to consumers and carers. In the words of the senior consumer advisor:

> 'Just being present [in the OCP/OCMHN] has brought a heightened awareness of consumer rights and choices.'

The senior consumer and carer advisors also act as a conduit to bringing other consumer and carer voices into the OCP/OCMHN. They maintain regular contact with the Victorian peak agencies for consumers and carers – the Victorian Mental Illness Awareness Council and Tandem, respectively – as well as supervisors of the peer workforce in mental health services, consumer/carer academics and other lived experience staff employed in the department's Mental Health Branch. Both advisors have contributed to the Mental Health Branch's new lived experience engagement framework, which promotes a consistent and well-considered approach to engaging consumers and carers in the branch's work.

Quality and safety forums

The OCP has begun hosting mental health quality and safety forums. These events bring together mental health service administrators and executives, policymakers, clinicians, consumers, carers, researchers and other stakeholders for an open dialogue on current and emerging quality and safety issues.

Two forums were held in 2017–18. Designed in partnership with clinical leaders, consumers and carers, they comprised a mix of presentations from sector leaders and experts, consumer and carer perspectives and practical solutions components.

The inaugural forum in November 2017 was titled 'When things go wrong – how do services respond to serious incidents?' In debating the question, 'Do the current processes for investigating an incident minimise harm?', six speakers, including two consumers, explored the many perspectives, considerations and possible outcomes of reporting incidents. Later in the day, groups of participants discussed possible game-changing ideas to reduce harm and strengthen the therapeutic environment in mental health services.

The second forum, in June 2018, explored risk assessment and management in inpatient units, including the effectiveness of current risk assessment tools and possible alternative approaches to identifying and managing risk. The forum included a presentation by Professor Matthew Large from the University of New South Wales, who is an internationally noted commentator and researcher on methods of risk assessment in psychiatry.

Each of the forums generated great interest and reached full capacity (more than 100 guests each), with representatives from all Victorian mental health services. The feedback from participants has been very encouraging, and new events are planned for 2018–19. A summary of each forum will be made available on the OCP webpage in the coming months.

Section 2: Statutory reports

Under the Mental Health Act, services are required to report to the Chief Psychiatrist about ECT use, about the use of restrictive interventions such as seclusion and bodily restraint, and about reportable deaths. Gathering information in this way offers the opportunity to monitor trends, identify problems and improve clinical practices to enhance the safety and quality of services.

This section of the report provides data and analysis specific to each area for 2017–18.

Electroconvulsive treatment

ECT induces modified seizures by passing an electrical current through the brain while the person is anaesthetised.

It is an effective treatment for a range of mental illnesses including severe depression, mania, schizophrenia and catatonia. It may be recommended when other treatments have not worked, or take too long to work, or cannot be undertaken safely. ECT might also be recommended to people for whom the treatment worked well previously.

This evidence-based treatment is individually tailored to maximise benefit and reduce adverse effects including memory deficits. Side effects are minimised by applying stimulation to one side of the head (unilateral ECT) with the smallest possible dose of electrical stimulation. Treatments are typically administered on two or three occasions per week over a period of two or more weeks.

The Chief Psychiatrist and the Mental Health Tribunal oversee the use of ECT. Services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use.

Electroconvulsive treatment in public mental health services

In relation to ECT, the Chief Psychiatrist's special responsibilities include:

- receiving reports from public mental health services about ECT use
- reporting on the number of young people (under 18 years of age) who receive ECT.

The number of people who receive ECT has remained relatively static since 2013–14 (see Table 1), despite a significant increase over this period in admissions to inpatient units. There has been a modest increase in the number of individual treatments, reflecting a slight increase in the average number of treatments per person from 11.6 in 2013–14 to 12.9 in 2017–18.

Table 1: Number of treatments and people treated by ECT, 2013–14 to 2017–18

Measure	2013–14	2014–15	2015–16	2016–17	2017–18
Number of treatments	12,831	11,509	11,972	12,266	13,281
Number of people treated	1,109	1,025	993	1,031	1,029

Mood disorders accounted for nearly two-thirds of treatments in 2017–18, followed by schizophrenia and other psychoses (Table 2). The increasing percentage of treatments for mood disorders is likely due to better reporting rather than a shift in practice, as suggested by the marked reduction of missing diagnoses.

Table 2: Percentage of ECT treatments by diagnosis, 2013–14 to 2017–18

Diagnosis	2013–14	2014–15	2015–16	2016–17	2017–18
Mood disorders	52%	54%	63%	66%	62%
Schizophrenia and other psychoses	35%	34%	33%	30%	34%
Other conditions	4%	6%	2%	2%	2%
Not reported	8%	6%	1%	2%	2%

Table 3 shows that, overall, more women than men were treated with ECT across the life span. This is consistent with community-wide differences between the genders in the prevalence of mood disorders.

Table 3: Number of ECT treatments by age group and gender, 2017–18

Gender	18–29	30–39	40–49	50–59	60–69	70–79	80+
Men	747	822	1,236	861	1,026	721	213
Women	703	783	1,325	1,129	1,134	1,573	997

Electroconvulsive treatment and young people

The Chief Psychiatrist must collect data on the number of people aged under 18 years who receive ECT and their clinical outcomes. A subcommittee of the ECT Committee oversees this work. In 2017–18 only two people who received ECT were aged under 18 years.

Deaths of people receiving mental health treatment

The death of a person receiving treatment or support for a mental illness is a tragic event. The Chief Psychiatrist collects data from all public mental health services to learn from each incident, with a view to improving safety and reducing the number of preventable deaths.

All publicly funded mental health service providers must inform the Chief Psychiatrist of a client's death in specified circumstances. This requirement is articulated in the Mental Health Act as well as the *Coroners Act 2008*.

The Chief Psychiatrist is required to be notified of the deaths of all mental health inpatients where an inpatient is defined as *any person, regardless of legal status* who*:*

- has been admitted to a mental health inpatient unit
- is on approved leave from an inpatient unit
- has absconded from an inpatient unit
- has been transferred to a non-psychiatric ward during a mental health admission
- has been discharged from a mental health inpatient unit within the previous 24 hours.

In the case of deaths in the community, the Chief Psychiatrist must be notified of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of people in the community who were registered as a mental health consumer within the previous three months or who had sought care from a mental health provider within that period and had not yet received treatment
- all deaths of patients under community treatment orders or non-custodial supervision orders.

The Chief Psychiatrist also requires notification of the deaths of people detained in an emergency department or non-psychiatric ward under the Mental Health Act and those receiving service from a mental health community support service.

People are considered to be mental health consumers until their case is closed and they have been notified of this closure (or the service has made all reasonable efforts to do so).

In addition, the Chief Psychiatrist holds the following role as part of the quality and safety leadership functions under the Act regarding reportable deaths:

- to maintain a database of reportable deaths of clients of public mental health services in Victoria
- to request the findings of coronial investigations and contribute to coronial processes if requested by a coroner
- to review clinical reports provided by services to identify systemic or management issues
- to identify statewide issues and provide guidance to mental health services to help reduce and prevent deaths and provide safe and effective services.

Reportable deaths in 2017–18

In 2017–18 mental health services reported 371 deaths, of which 36 were inpatient deaths. The comparable numbers of reportable and inpatient deaths in 2016–17 were 391 and 36 respectively. This represents a reduction in the rates of reportable deaths per 100,000 Victorian population from 6.34 in 2016–17 to 5.92 in 2017–18 (Table 4). The rate of death of people receiving care in a community setting within the three months prior to death was 5.35 per 100,000 population compared with 5.76 for 2016–17.

Of the 371 notified deaths in 2017–18, 283 were categorised as unnatural or unexpected deaths, 71 as deaths due to natural causes and two as deaths of unknown cause (Table 5). Most unnatural or unexpected deaths arose in the 20–59-year age group. Natural deaths were more frequent in older age groups.

Of the 36 deaths of inpatients, 21 were categorised as having unnatural or unexpected causes, including 12 suicides (compared with 11 suicides in 2016–17). The remaining 15 deaths resulted from natural causes. Five of the 12 suicides occurred within an inpatient unit. Others took place while on leave from an inpatient unit, after absconding from an inpatient unit, while waiting in an emergency department for a bed to become available, or within 24 hours of discharge.

Table 4: Reportable deaths per 100,000 Victorian population, 2013–14 to 2017–18

Reportable deaths	2013–14	2014–15	2015–16	2016–17	2017–18
Community deaths	5.36	4.81	5.70	5.76	5.35
Inpatient deaths	0.34	0.45	0.51	0.58	0.57
All deaths	5.70	5.26	6.21	6.34	5.92

Table 5: Reportable deaths by category, 2013–14 to 2017–18

Reportable deaths by category (%)	2013–14	2014–15	2015–16	2016–17	2017–18
Unnatural, unexpected	78%	75%	58%	71%	76%
Natural	19%	20%	31%	28%	19%
Not established	2%	5%	11%	1%	5%

The OCP views every suicide in care as potentially preventable. Every number represents a person who has suffered and left behind family and loved ones. The Safewards program (described earlier in this report) promotes greater engagement with inpatients from mental health clinicians with a view to addressing the concerns that might prompt thoughts of self-harm. In addition, services now regularly audit mental health inpatient units to identify and remediate physical elements of buildings that present risk. Within the community, initiatives such as the Hospital Outreach Post-suicidal Engagement (HOPE) project seek to reduce the numbers of suicides of people who presented to emergency departments after an episode of self-harm or with suicidal ideation.

Restrictive interventions – adult inpatient units

Restrictive interventions are defined in the Mental Health Act as the use of seclusion or bodily restraint. Seclusion is 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave' (s. 3(1)). Bodily restraint is 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs' (s. 3 (1)).

The Act provides that a person may only be placed in seclusion or restraint to prevent imminent and serious harm to the person or another person or, in the case of restraint, to administer treatment. The principles outlined in the Act specify that people receiving mental health services should be treated in the least restrictive way possible, meaning that seclusion and restraints can be applied only after all reasonable and less restrictive options have been tried or considered and been found unsuitable.

The Chief Psychiatrist and Chief Mental Health Nurse share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services, in alignment with the *Fifth national mental health plan*. A number of Victorian Government initiatives, such as Safewards, aim to encourage alternative clinical practices. Safewards and other initiatives that contribute to these efforts are described in section 1 of this report.

Data on the use of restrictive interventions are shown separately for inpatient and secure extended care units (SECUs). As a result, the numbers of events listed below cannot be compared directly with those listed in reports prior to 2016–17. This change in practice standardises Victorian reporting modalities across a number of formats.

Seclusion

Table 6 lists the numbers of episodes of seclusion in acute inpatient units per 1,000 occupied bed days. Rates have fallen significantly across the adult, child and youth and specialist clinical program areas over the past five years. Rates for these program areas, as well as the aged mental health portfolio, were uniformly below the current statewide maximum benchmark of 15 or fewer seclusion episodes per 1,000 occupied bed days. The high rate of seclusion evident in the forensic program is of concern. The rate, which has been monitored closely throughout the year, has been driven by the high acuity of illness among a small number of people for whom seclusion has been necessary to ensure their own and staff safety. The OCP works closely with Forensicare to develop strategies to reduce the use of restrictive interventions.

Table 6: Seclusion episodes per 1,000 occupied bed days, by clinical program, 2013–14 to 2017–18

Clinical program	2013–14	2014–15	2015–16	2016–17	2017–18
Adult	12.3	10.3	11.9	11.3	10.4
Aged	1.3	0.8	1.0	1.8	1.2

Clinical program	2013–14	2014–15	2015–16	2016–17	2017–18
Child and youth	6.8	5.5	5.5	5.4	8.8
Forensic	12.3	11.7	13.1	28.7	34.1
Specialist	12.2	2.2	0.5	3.1	0.6
All programs	9.8	8.0	9.1	9.9	9.7

Table 7 shows that 64 per cent of the people subject to seclusion in 2017–18 were secluded on a single occasion across their period of admission. Multiple episodes of seclusion were relatively uncommon.

Table 7: Frequency of seclusion episodes within a single admission, 2013–14 to 2017–18

Number of episodes	2013–14	2014–15	2015–16	2016–17	2017–18
1	845	860	903	950	894
2	264	253	260	258	242
3	101	94	118	96	119
4	60	54	61	54	54
5	31	35	52	35	30
6	26	15	20	28	23
7+	81	49	76	77	70

In 2017–18, seclusion episodes that lasted four or fewer hours accounted for 43 per cent of all episodes (Table 8).

Table 8: Duration (hours) of acute inpatient seclusion episodes, 2013–14 to 2017–18

Duration	2013–14	2014–15	2015–16	2016–17	2017–18
Fewer than 4 hours	1,671	1,509	1,735	1,624	1,506
4–12 hours	756	646	730	862	908
More than 12 hours	773	533	660	995	1,065

Restraint

Bodily restraint refers to physical restraint (placing hands on a person to restrict movement) and mechanical restraint (the use of devices, such as belts, for the same purpose). Applying mechanical restraint typically entails the use of physical restraint for very brief periods. The Act requires that mental health services inform the Chief Psychiatrist of both physical and mechanical restraint.

Table 9 shows bodily restraint episodes per 1,000 occupied bed days in acute inpatient units over a four-year period. Rates fell in adult inpatient units (the largest clinical program) and in most other programs. The increased rate in aged mental health units reflects a clearer understanding of, and compliance with, reporting requirements achieved through close engagement with the OCP throughout 2016–17.

Table 9: Bodily restraint episodes per 1,000 occupied bed days, 2014–15 to 2017–18

Program	2014–15	2015–16	2016–17	2017–18
Adult	1.5	10.0	9.8	8.4
Aged	0.0	6.3	5.0	7.3
Child and youth	0.1	29.5	13.9	17.8
Forensic	7.8	84.4	172.4	115.8
Specialist	2.2	1.5	1.8	1.1
All programs	1.9	17.5	25.6	19.0

In 2017–18, 57 per cent of people who were subject to restraint (whether physical or mechanical or both) were restrained on a single occasion within a period of admission (Table 10).

Table 10: Frequency of restraint episodes within the same hospital admission, 2014–15 to 2017–18

Number of episodes	2014–15	2015–16	2016–17	2017–18
1	835	809	843	867
2	214	274	210	276
3	85	98	98	113
4	53	59	69	65
5	29	39	28	34
6	23	17	26	26
7+	126	116	124	133

The number of all types of restraint episodes rose between 2016–17 and 2017–18, most probably reflecting improved reporting of the very brief periods of physical restraint associated almost invariably in the move to seclusion or the administration of injected medications (Table 11).

Table 11: Type of restraint episodes, 2014–15 to 2017–18

Restraint type	2014–15	2015–16	2016–17	2017–18
Physical	5,029	7,380	6,433	8,321
Mechanical	778	1.049	496	350
Physical and mechanical	523	1.062	301	169

Following from this, the number of episodes of any type of restraint in excess of 12 hours has fallen by 63 per cent relative to 2014–15 (Table 12).

Table 12: Duration of physical, mechanical and combined restraint episodes, 2014–15 to 2017–18

Duration	2014–15	2015–16	2016–17	2017–18
Fewer than 3 minutes	2,539	4,978	3,479	4,807
3–14 minutes	2,750	3,825	3,010	3,423

Duration	2014–15	2015–16	2016–17	2017–18
15–59 minutes	597	339	325	339
1 to fewer than 4 hours	223	186	282	163
4 to fewer than 12 hours	107	73	89	66
12 or more hours	114	90	45	42

Appendix: Restrictive interventions in secure extended care units

Data on the use of restrictive interventions in SECUs is provided separately.

Table A1 shows that seclusion episodes per 1,000 occupied bed days in SECUs increased relative to 2016–17 but is still well below the levels reported in 2013–14.

Seclusion

Table A1: SECU seclusion episodes per 1,000 occupied bed days, 2013–14 to 2017–18

Seclusion episodes	2013–14	2014–15	2015–16	2016–17	2017–18
Number of episodes	4.2	2.8	2.0	2.5	2.7

Of the people subject to seclusion within a SECU, 71 per cent were secluded on one or two occasions across the whole period of admission (Table A2).

Table A2: Frequency of SECU seclusion episodes within the same admission, 2013–14 to 2017–18

Number of episodes	2013–14	2014–15	2015–16	2016–17	2017–18
1	20	21	24	19	21
2	10	7	6	9	11
3	7	4	2	4	4
4	4	2	2	2	3
5	2	1	–	–	1
6	–	3	1	1	2
7+	3	4	1	3	3

Well over half of all episodes (68 per cent) of seclusion were for fewer than four hours (Table A3).

Table A3: Duration (hours) of SECU seclusion episodes, 2013–14 to 2017–18

Duration	2013–14	2014–15	2015–16	2016–17	2017–18
Fewer than 4 hours	82	71	47	41	68
4–12 hours	44	32	19	37	28
More than 12 hours	25	9	19	25	26

Restraint

In 2017–18 the use of restraint in SECUs returned to former levels after a reduction in the previous year (Table A4). The frequency of multiple restraint episodes within a single admission period also increased (Table A5). Most episodes involved physical rather than mechanical restraint (Table A6) and just over half (58 per cent) were for fewer than three minutes (Table A7).

Table A4: SECU bodily restraint episodes per 1,000 occupied bed days, 2014–15 to 2017–18

Bodily restraint episodes	2014–15	2015–16	2016–17	2017–18
Number of episodes	2.6	3.0	2.2	2.9

Table A5: Frequency of SECU restraint episodes within the same admission, 2014–15 to 2017–18

Number of restraint episodes within the same admission	2014–15	2015–16	2016–17	2017–18
1	18	14	27	17
2	10	6	2	4
3	2	4	1	8
4	1	2	3	2
5	4	1	–	1
6	2	–	–	1
7+	1	5	4	5

Table A6: Type of SECU restraint episodes, 2014–15 to 2017–18

Restraint type	2014–15	2015–16	2016–17	2017–18
Physical	105	103	85	121
Mechanical	1	19	5	7
Physical and mechanical	–	5	2	–

Table A7: Duration of SECU physical, mechanical and combined restraint episodes, 2014–15 to 2017–18

Duration	2014–15	2015–16	2016–17	2017–18
Fewer than 3 minutes	55	55	40	58
3–15 minutes	47	50	44	58
16–59 minutes	3	20	4	8
1 to fewer than 4 hours	1	1	3	3
4–11 hours	–	1	1	1
12 or more hours	–	–	–	–