Department of Health

health

Chief Psychiatrist's annual report 2010–11

State Government Victoria

Chief Psychiatrist's annual report 2010–11

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June 2012 (1206002)

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June 2012

The Honourable Mary Wooldridge MP
Minister for Mental Health
50 Lonsdale Street
Melbourne Vic 3001

Dear Minister,

I am pleased to enclose the eighth annual report of the Chief Psychiatrist, covering the 2010–11 financial year.

The report describes the activities of the Office of the Chief Psychiatrist in fulfilment of my responsibilities under the *Mental Health Act 1986* in respect to the treatment and care of people with a mental illness in Victoria. I trust the report will inform consumers, carers, the public and others about the role and function of the Chief Psychiatrist and the work undertaken by my office to monitor and improve the quality of treatment and care in public mental health services, and to protect the rights of the mentally ill.

Yours sincerely,

Dr Ruth Vine
Chief Psychiatrist
MB BS, LLB, FRANZCP

Foreword

One of the highlights of 2010–11 was the commencement of a new statewide program of clinical reviews of mental health services. These peer reviews are undertaken under the auspices of the Quality Assurance Committee (QAC) and focus on key components of mental health service provision: triage, community case management and inpatient services. The reviews also canvass the perspectives of local consumers and carers. Each is undertaken over a three-day period by a panel of experienced mental health clinicians drawn from services across the state. In the reporting period, reviews were held at Austin Health, Mercy Mental Health and Ballarat Health Services.

Following each site visit, a comprehensive report is completed and considered by the QAC. Once endorsed by the QAC, the report is formally submitted to the mental health service under review. The mental health service is then required to develop an action plan to address the report's recommendations. The clinical review process is unique in that no other quality assurance process is able to examine in such depth so many individual clinical records. Although strong confidentiality arrangements protect the clinical reviews, a de-identified summary of issues that affect a number of services will be published on the website of the Office of the Chief Psychiatrist (OCP).

Improving quality in health services takes time and consistent reinforcement of key messages. I was therefore gratified to see that statutory reports in 2010–11 confirm the continuing improvement in safely reducing the use of seclusion and restraint in mental health services in Victoria. This reporting period saw a further 23 per cent reduction in the use of seclusion and a 35 per cent reduction in the use of mechanical restraint compared with the previous year.

The number of electroconvulsive therapy (ECT) treatments increased by less than one per cent in 2010–11. No ECT treatment was provided to young persons under the age of 18 years.

In 2010–11, mental health services reported the deaths of 275 consumers. These are tragic events that require robust review. Because of strong and understandable community concern, I have decided to include more contextual information in this report, explaining how it is possible for these deaths to occur; and why, despite the best intentions and the dedication of staff, they cannot always be prevented. While this provides little comfort, the literature indicates that mortality trends in Victoria are comparable to those in other jurisdictions.

Another key focus for the year was the intensive work undertaken by the clinical advisers, my deputies and myself, together with mental health services and other providers, to produce viable treatment and care solutions for clients with high risk or complex care needs that straddle several service systems. This quiet, persistent and collaborative work generally happens behind the scenes and makes a major difference in our clients' lives.

The OCP led or participated in a number of strategic initiatives in 2010–11. For example, I worked closely with the Legal Policy and Reform Unit of the Mental Health, Drugs and Regions Division on the development of new legislation governing the provision of mental health services in Victoria. I also contributed to the development of a gender-sensitive practice guideline, secure step-down and bed-coordination initiatives, and national work on safety and quality. The Deputy Chief Psychiatrist, Aged Persons Mental Health, Professor Kuruvilla George, provided support and clinical leadership to the aged persons mental health services sector, worked with services to minimise the use of seclusion and restraint, undertook a program of site visits and provided leadership to the ECT sub-committee of the Quality Assurance Committee. The Deputy Chief Psychiatrist for Child and Youth Mental Health, Dr Sandra Radovini, provided support and clinical leadership to the child and adolescent mental health services (CAMHS) sector, convened several cross-sectoral case conferences regarding

clients with multiple and complex needs, worked with services on a range of systemic issues, undertook a program of site visits and presented at several forums. We all contribute to education and training activities across the mental health sector.

As always, a large and important segment of the work of the office related to statutory activities. This included responding to complaints and enquiries, receiving and monitoring statutory reports pertaining to restraint, seclusion, reportable deaths and ECT; providing high-level clinical advice to the sector and to the department; liaising with service providers, particularly in coordinating services for consumers with complex and high-risk presentations; and undertaking defined responsibilities for mentally ill offenders.

I look forward to further improving clinical practice in Victoria's mental health services through a range of strategic activities. These include contributing to the completion of the new legislation, ongoing development of clinical guidelines and engagement with the sector. The OCP will continue to contribute to policy and service planning within the Mental Health, Drugs and Regions Division, and to engage with consumers, carers, service providers and other key stakeholders in order to help shape and support the provision of accessible, safe, recovery-focused high-quality mental health services.

Dr Ruth Vine
Chief Psychiatrist

The role of the Chief Psychiatrist

Legal mandate

Section 105 of the *Mental Health Act 1986* (the Act) establishes the appointment of a Chief Psychiatrist who is 'responsible for the medical care and welfare of persons receiving treatment or care for a mental illness'.

The Chief Psychiatrist is appointed by the Secretary of the Department of Health and is subject to the Secretary's general direction and control. The Office of the Chief Psychiatrist sits within the Mental Health, Drugs and Regions Division of the department. The Chief Psychiatrist is supported by part-time Deputy Chief Psychiatrists and a small team of departmental staff with expertise in mental health who are appointed as authorised officers to assist in carrying out the functions of the office. Authorised officers can make extensive enquiries about the admission, detention, care and treatment of persons with a mental illness.

The Chief Psychiatrist has a range of powers, duties and functions conferred by the Act:

- the power of delegation. The Chief Psychiatrist can delegate any power, duty or function (other than the power of delegation) to a qualified psychiatrist appointed under s. 95 of the Act or to an authorised officer appointed under s. 106 of the Act to assist in the performance of statutory functions
- the power of inspection and enquiry. If concerned about the medical care or welfare of a person, the Chief Psychiatrist may visit a psychiatric service, inspect the premises, see any person receiving treatment and care, inspect and take copies of any documents, and make enquiries relating to the admission, detention, care, treatment and control of people with a mental disorder in or from a psychiatric service
- the power of direction. Following investigation, the Chief Psychiatrist may direct a psychiatric service to provide or discontinue treatment, and admit an involuntary patient. The Chief Psychiatrist may also direct the transfer of patients from one mental health service to another
- the power to discharge involuntary patients from certain orders
- the power to order that security patients be discharged and returned to prison, and to consider applications for special leave to allow security patients access to the community. The Chief Psychiatrist must be consulted on applications for leave of absence for security patients
- the power to license premises in the public and private sectors to perform ECT
- the power to receive statutory reports on the performance of ECT in licensed premises, seclusion and mechanical restraint in approved mental health services, the death of persons 'held in care' or receiving treatment for a mental illness, and the annual medical examination of those treated as involuntary patients for a period of 12 months or more.

Some of the activities undertaken by the office to fulfil these responsibilities include:

- receiving and reviewing statutory reports relating to seclusion, mechanical restraint, ECT, annual examinations and reportable deaths
- responding to enquiries from service providers, service users and the public
- investigating complaints from consumers, carers, members of the public and others
- providing advice to consumers, carers, mental health practitioners and services
- mediating between and liaising with mental health services to achieve improved individual and service system outcomes, particularly for consumers with complex or high-risk presentations
- working with mental health services to improve standards of treatment and care, and the application of the Act to clinical practice

- providing policy and clinical advice to the Mental Health, Drugs and Regions Division, government and other mental health stakeholders
- providing departmental and ministerial briefings about critical incidents
- examining and providing advice on sentinel events or critical incidents
- reviewing the suitability of ECT licensing in the public and private sectors
- performing statutory functions relating to patients detained under the *Sentencing Act 1991* and *Crimes Mental Impairment (Unfitness to be Tried) Act 1997*
- undertaking and promoting quality improvement initiatives and projects relating to mental health treatment and care
- developing clinical guidelines
- delivering education and training
- participating on working parties and interdepartmental committees about the welfare of persons receiving treatment or care for a mental illness.

Legislative reform

A review of the Act announced in May 2008 examined whether the Act provides an effective legislative framework for the treatment and care of people with a serious mental illness in Victoria. As part of the review, various functions of the Chief Psychiatrist were considered, including monitoring functions and powers and the handling of complaints. The review panel conducted an extensive community consultation process in the course of 2008–09. In 2009–10, an exposure draft Mental Health Bill was prepared for public consultation, which occurred in 2010–11. The draft Bill will be refined in 2011–12 and new legislation is expected to be introduced into parliament in 2012–13.

Working with consumers and carers

Clients with complex needs

The Office of the Chief Psychiatrist (OCP) frequently convenes or participates in case conferences involving clients receiving treatment and care from a public mental health service. The purpose of these case conferences is to identify and implement strategies to best support the treatment and care of clients who have highly complex needs, high service utilisation rates and who are at serious risk. These clients are often referred to as clients with complex needs.

Clients with complex needs are brought to the attention of the Chief Psychiatrist from many sources, including the Executive Director of the Mental Health, Drugs and Regions Division (the division), mental health services, disability services, child and youth services, Forensicare, the Multiple and Complex Needs Initiative (MACNI) in the Department of Human Services and Spectrum, the statewide personality disorder service. The Minister's office often refers matters to the OCP where the issues raised with the Minister are of a clinical nature.

Mental health services are often faced with multiple issues in providing treatment and care to clients with complex needs, including where:

- the treatment and care needs of the client exceed the capacity of a single service and require the coordinated effort of a number of agencies such as Corrections Victoria, housing services and drug and alcohol services
- the client has specialised and particular treatment and care needs
- the services require additional skills and other resources to respond appropriately to the client's needs
- the services find it difficult to determine the client's diagnosis and to provide an effective treatment regime to meet the client's needs
- the client is at serious risk of harm to self or others in the context of limited long-stay secure bed-based services or supported accommodation options.[1]

In recent years requests to assist clients with complex needs have increased. In particular there has been an increase in requests for input with vulnerable adolescents and individuals with mental illness and intellectual disability.

A case conference can be extremely helpful to assist in resolving some of the clinical and planning difficulties that may arise in providing treatment and care to these clients. Case conferences fall into two groups – those initiated by the OCP and those that occur at the request of clinicians or other providers.

Where case conferences are initiated by the OCP, the office invites the various workers and key clinicians to discuss strategies to support services to provide the specialised treatment and care required by clients with complex needs. The OCP encourages an informal, creative and open discussion style at these conferences while adhering to an agenda that generally covers the following issues:

- purpose of the case conference
- client's current treatment and recovery plan
- client's current and future needs
- family concerns and needs
- discussion regarding what interventions would best support these needs

1 The OCP notes that a number of new initiatives are in development, for example, secure step-down and disability supported accommodation.

- potential risks and management
- next steps
- future meetings.

When case conferences are held at the request of clinicians they are usually held at the requesting service and the agenda and organisation are the responsibility of the service convening the conference.

The OCP is well placed to contribute to case conferences because:

- the Chief Psychiatrist has powers of inspection, enquiry and direction in regard to people receiving treatment or care under the Act and is therefore appropriately involved in assisting services to plan and coordinate this care
- OCP clinical advisers have regular direct contact with clinicians across the state and an in-depth understanding of the problems and constraints experienced in the sector informs their advice
- the OCP has a close advisory relationship with other branches of the Mental Health, Drugs and Regions Division, the Office of the Senior Practitioner, the Psychiatric Disability Rehabilitation and Support Service (PDRSS) sector, Child Protection and Disability Services and other stakeholders, and provides input to service improvement and workforce planning initiatives.

The OCP takes a facilitating, advising and guiding role at these conferences as the day-to-day clinical responsibility for client care rests with the health service, the PDRSS and other organisations, as well as the staff they employ.

The powers of direction afforded to the Chief Psychiatrist under the Act are, in practice, used very rarely and instead the OCP aims to assist local networks, clinicians and services to reach agreement through discussion and cooperation. The OCP attempts to steward the process towards resolution and listen to the issues raised so that it can inform the division of any policy or systemic issues that may be impeding the provision of effective treatment and care.

By conducting and participating in case conferences, the Chief Psychiatrist provides an important leadership and coordinating role in bringing together the various services and service elements to ensure effective communication and to help develop an appropriate and coordinated multi-sector service response to address the needs of shared high-need and high-risk clients.

The OCP has prepared an information sheet on case conferences, which can be obtained from the office, to help clinicians or services wishing to convene a case conference.

Families and carers

The OCP receives frequent telephone calls and letters from families and carers. The Chief Psychiatrist recognises the important role of carers and the difficulties they can face in supporting their relative and getting their concerns heard by services and clinicians. The office endeavours to support and guide carers in their interactions with service providers, and also draw the attention of service directors and clinicians to the need for continuing effort in improving carer engagement in the treatment and care process wherever possible.

The Chief Psychiatrist guideline on working together with families and carers can be found at: www.health.vic.gov.au/mentalhealth/cpg/families.htm

Responding to contacts, complaints and enquiries

The OCP receives a large number of letters and telephone calls from consumers, carers, service providers, members of the public and others. Ease of access to the knowledge and advice provided by the office is important, especially for mental health service users and their families. The OCP has a free call telephone number (1300 767 299) and makes every effort to respond promptly to calls and written enquiries and to provide informed and helpful advice.

The administrative staff of the OCP are generally the first point of contact and can deal with some enquiries or refer callers appropriately. Often these are simple queries about finding a mental health service and the person is either given the contact details or referred to the website at: www.health.vic.gov.au/mentalhealth/services

Where the issue is more complex or involves a complaint or a clinical matter, the enquirer or complainant is referred to a clinical adviser. Clinical advisers have experience at a senior level in mental health and an extensive knowledge of mental illness, its treatment and care, and the service system. Clinical advisers are appointed as authorised officers of the Chief Psychiatrist to exercise powers under the Act and to assist the Chief Psychiatrist in carrying out statutory functions.

Complainants are initially encouraged to use the local mental health or health service complaints system to resolve their issue locally where possible. A clinical adviser will assist the person to exercise their rights by providing information regarding the implications of their legal status under the Act, their rights and the options available. Where the complainant has tried local avenues without satisfaction, or for some reason is unable to raise the matter locally, the clinical adviser will try to resolve the issue for the person in consultation with the Chief Psychiatrist, as necessary. Often this will involve contact (with the consent of the complainant) with the treating service or others involved in providing care to the person to better understand their situation.

Service providers and clinicians often contact the office seeking advice on aspects of clinical practice or service delivery. The Minister for Mental Health and other government departments also refer matters to the Chief Psychiatrist for advice and action. This diversity of contacts to the office gives the Chief Psychiatrist valuable information about issues of concern for consumers, carers and service providers, and the quality of services delivered.

Contacts

Profile of contacts received by the office

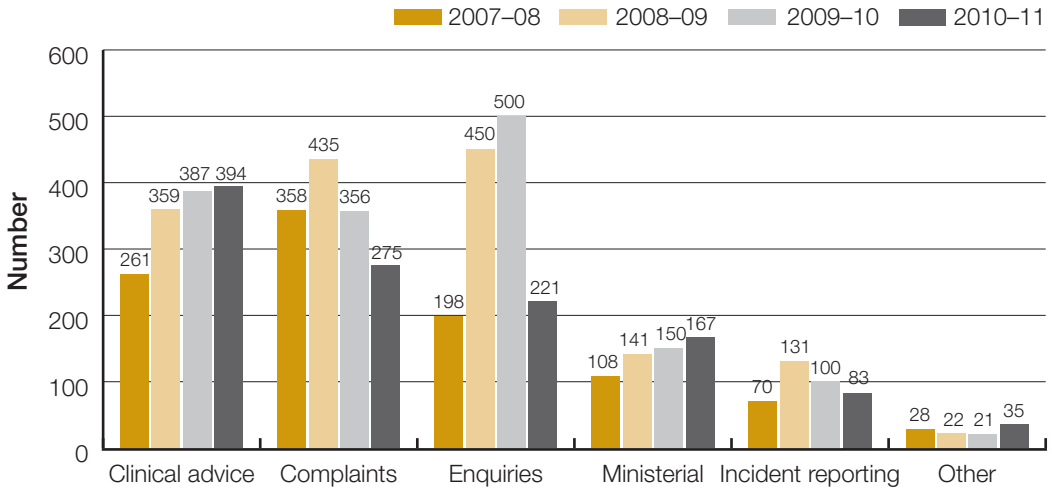
The OCP responded to 1,175 recorded contacts in 2010–11. These contacts are categorised according to the type of contact, the person making the contact, the method of contact (telephone or written) and the primary issue raised.

Figure 1 shows the breakdown of contacts by type since the current data collection system was introduced in 2007. A number of significant shifts appear to have occurred over the reporting period: the provision of clinical advice was the most common type of contact; the OCP received fewer complaints than in the previous year; and the number of enquiries fell by more than half.

These ‘trends’ have to be treated with caution as the contacts and complaints database developed for the OCP in 2007 grew in size and has also become progressively more unreliable. Furthermore, there is a level of incompatibility between the database software and the department’s network environment. As a result, the database has been unavailable at times during the reporting period,

with some data lost or unable to be entered. In addition, under current business rules only the first contact is recorded for each episode. This means that the contacts and complaints data for 2010–11 cannot be regarded as a complete record of OCP activities. Work commenced in January 2011 on planning a new database for the OCP. The aim of the new database is to better capture information pertaining to contacts, complaints and reportable deaths.

Figure 1: Number and type of contacts from 2007–08 to 2010–11



Area mental health services and regional offices of the Department of Health reported a number of incidents to the OCP. These reports were typically for information only, with follow-up action in the wake of the incident being progressed through established internal processes in the health service. The 'other' category contained primarily freedom of information (FOI) requests, as well as five compliments.

Most contacts were made by carers and families (32 per cent–up from 23 per cent in 2009–10), followed by consumers (29 per cent – up from 22 per cent in 2009–10) and service providers (24 per cent – down from 31 per cent in 2009–10). Eight per cent of contacts were made by members of the public – half the level of the previous reporting period.

Seventy per cent of contacts were made by telephone and 30 per cent in writing.

Complaints

Effective complaints management systems in mental health services are important to safeguard the rights of persons with mental illness. They provide an accessible mechanism for consumers and carers to raise issues relating to treatment and care and also inform service providers of issues to improve the quality of services. While the Act does not define a specific complaints function for the Chief Psychiatrist, it provides that the Chief Psychiatrist 'is responsible for the medical care and welfare of persons receiving treatment or care for a mental illness'.[2] This general function is interpreted broadly to give the Chief Psychiatrist the power to receive and investigate complaints or concerns. The Chief Psychiatrist also has the power to enquire into matters relating to the treatment and care of any individual.[3]

2 Section 105(2)(a) *Mental Health Act 1986*.
3 Section 106(5)(b) *Mental Health Act 1986*.

The Victorian Health Services Commissioner is the principal body for health services complaints, and receives some complaints about mental health services.[4] Complaints to the Commissioner must be from the consumer themselves, or their nominee, and be confirmed in writing. The Health Services Commissioner has legislated powers of conciliation, investigation and enquiry but no powers to make treatment decisions. The Health Services Commissioner may refer a complaint to the Chief Psychiatrist where the Chief Psychiatrist's jurisdiction is more applicable, and vice versa, or they may work together on a complaint to try to reach a resolution for the person. A memorandum of understanding between the Chief Psychiatrist and the Health Services Commissioner was finalised in 2008–09. The document outlines how the two bodies can work most effectively in addressing complaints about mental health services and provides a protocol for the sharing of complaint related information.

Health services are expected to have local complaints systems for all health service users, including mental health consumers. Complainants are encouraged to lodge their complaint at the local level first. If the complainant is dissatisfied with the way in which their complaint has been handled, the Ombudsman or relevant health registration boards governing the conduct of healthcare professionals provide avenues of appeal.

Consumers and carers and peak consumer and carer organisations have frequently expressed concern about the quality and variability of existing complaints mechanisms in Victoria. In 2010–11, the development of a discrete complaints mechanism was being progressed within the context of the new legislative framework.

As stated earlier, work commenced in January 2011 on the development of a new database for the OCP. The aim of the new database is to better capture information pertaining to contacts, complaints and reportable deaths and to facilitate reporting.

Responding to complaints

Every effort is made to resolve complaints by telephone without the consumer or complainant needing to put their complaint in writing. This generally provides a speedier and more personal response for the complainant, especially where the concern is a current treatment matter, as they frequently are. Where the issue is more complex, the complainant is asked to provide written details to enable further investigation. In the current reporting period the proportion of telephone complaints increased from 63 to 76 per cent of all complaints received by the OCP. The proportion of complaints made in writing decreased from 37 to 24 per cent.

Most complaints are addressed through liaison and negotiation with the relevant mental health service or clinician, often to reconnect the consumer or carer and the service or clinician so that their concerns can be discussed and addressed. Many complaints are about differences of opinion regarding the need for mental healthcare, or the manner in which treatment has occurred, with consequent impact on the consumer–clinician relationship. For mental health consumers this relationship is especially important since, unlike the general healthcare system, they are required to receive their treatment from the area mental health service responsible for the catchment area in which they live.

The Chief Psychiatrist may write to the authorised psychiatrist of a service requesting a clinical report to assess the treatment and care provided. In a small number of cases, the Chief Psychiatrist

4 The Health Services Commissioner's annual report can be accessed at: www.health.vic.gov.au/hsc/resources/annualrep.htm#annual.

will personally meet with the patient, review the case and provide recommendations to assist in reaching a satisfactory outcome for the complainant. A formal direction may be made in instances where less formal approaches fail to achieve a resolution or desired action. In practice, this is seldom necessary. A complaint is closed when the Chief Psychiatrist decides that all steps have been taken to resolve the issue. Where the interaction has been protracted or the issues are complex, the Chief Psychiatrist will convey her opinion and decision to the complainant in writing.

Profile of complaints

The OCP received 275 complaints in the course of 2010–11. This is in the context of 61,645 registered consumers of public mental health services in 2010–11.

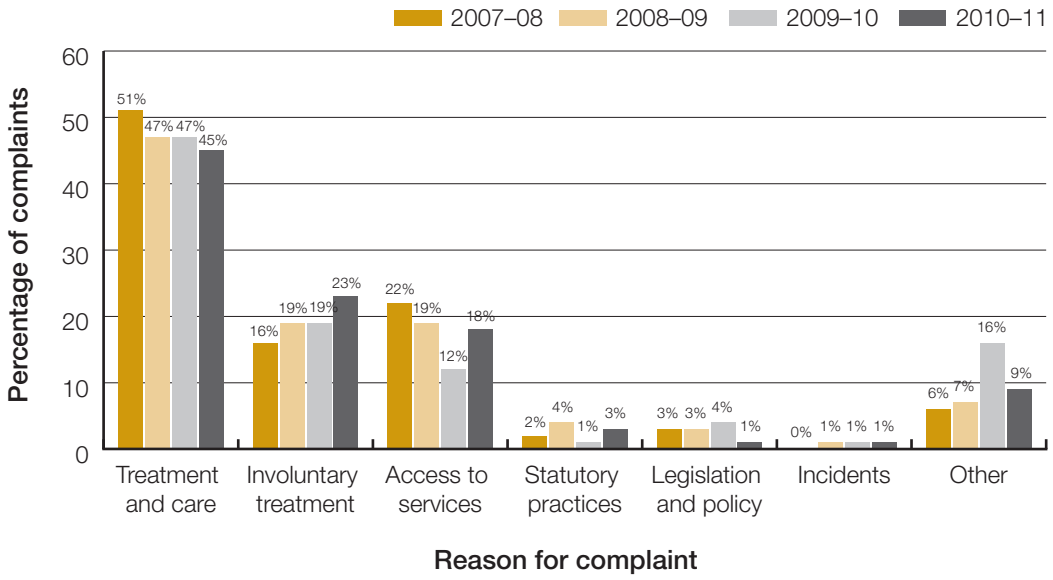
Most complaints were made by consumers (45 per cent – down from 47 per cent in 2009–10) and carers (43 per cent – up from 38 per cent in 2009–10). Other complaints were lodged by members of the public (six per cent), staff and service providers (three per cent) and others. A small number of consumers lodged repeated complaints with the office.

Forty-six per cent of complaints related to a consumer in a community-based service and 41 per cent to a consumer in an inpatient unit.[5]

As in previous years, most complaints (84 per cent) related to adult mental health services, with far fewer complaints relating to child and adolescent mental health services and aged persons mental health services (three per cent each).[6] This distribution may reflect the higher proportion of adult clients on involuntary treatment orders and the relatively greater pressure on bed-based and community-based adult mental health services.

Figure 2 shows complaints grouped according to the primary concern. In practice many complaints straddle several areas and are not easily categorised. Most complaints were broadly about treatment and care, followed by complaints in relation to involuntary treatment and access to services.

Figure 2: Complaints received by the OCP from 2007–08 to 2010–11



5 For a small number of complaints the service type was 'other' (two per cent) or 'not known' (one per cent); and in 11 per cent of records the 'service type' field was left blank.

6 In 10 per cent of complaints, the record did not specify the age group.

Treatment and care

Complaints about aspects of treatment and care made up 44 per cent of all consumer complaints in 2010–11 and 49 per cent of all carer and family complaints. They covered a range of concerns, including complaints about clinicians and requests to change a treating doctor or case manager, communication issues between clinicians and consumers, disagreement about diagnosis, lack of discharge arrangements or effective follow-up care and lack of carer support and involvement. Medication issues were also raised frequently – both the need for it and problematic side-effects. Other issues included accommodation, requests for a second opinion and either perceived poor service responsiveness or the opposite – a wish not to be involved with specialist mental health services.

The OCP's current database has limited capacity to document or track the outcome of complaints. In some instances, however, the office receives direct feedback from a consumer or carer that the complaint has been resolved. For example, in one instance the OCP had helped to arrange a meeting between a consumer and her treating service to discuss the consumer's concerns. The consumer subsequently wrote to the service, thanking them for responding to her concerns 'in a highly professional manner and with sincerity'. The consumer praised the openness and responsiveness of the service and felt that these attitudes reflected 'your genuine interest in the welfare of your clients and in creating a culture that is mutually respectful and dignified'. The consumer also conveyed to the treating staff 'a heartfelt thank you for their care, the people that they are and the professions that they represent.'

Involuntary treatment

Forty per cent of all consumer complaints in 2010–11 related to involuntary treatment. It was also the primary concern for nine per cent of complaints made by families and carers.

Many complaints centred on objections to being placed on an involuntary treatment order or a community treatment order, concerns about the basis for the order and the consequent restrictions. Others concerned the lack of choice in determining treatment options, such as second opinions and changing services, and fears about being admitted to hospital if non-compliant with the order.

Consumers were advised of their appeal rights under the Act and provided with relevant contact details, including the Mental Health Review Board and Mental Health Legal Service. Clinical advisers frequently followed up complaints with the relevant service to verify the circumstances of detention and to convey the consumer's distress to the treating team, with a request that further explanation and support be provided to the person along with all assistance in helping them exercise their rights.

Access to services

Access to services was the second most frequent cause of complaint for families or carers, constituting 29 per cent of their complaints to the office. It was also the primary concern for four per cent of complaints made by consumers.

Concerns included access to appropriate services, including mental health assessment, crisis team and triage response, inter-service transfer, dual-diagnosis services, psychiatric disability and rehabilitation support; and access to bed-based services such as community care units, secure extended care units and other forms of supported residential accommodation. A key theme was gaining access to the desired level of service and support at the time it was needed.

Statutory practices

Complaints about statutory practices included two complaints about ECT treatment, three about seclusion practices and one about mechanical restraint.

Legislation and policy

A small number of complaints were about aspects of the Act or other legislation or departmental policy.

Incidents

Four complaints were classified as ‘incidents’ occurring in a mental health service.

Other

The ‘other’ category included a range of issues including such matters as court and judicial processes, accommodation issues, government policies, other government-funded services and non-specific complaints.

Enquiries

A large number of calls were from people seeking advice on how to access a service, often simply how to contact a public mental health service. Others wanted to discuss potential avenues of treatment and care for an ill relative or employee and were uncertain whether to intervene or how to proceed. Some sought information on various disorders and treatments. Advice provided by clinical advisers or the Chief Psychiatrist often helps to alleviate concerns or clarify possible actions so that the person feels more empowered to assist the individual they are concerned for.

Clinical advice

As shown in Figure 1, mental health service clinicians increasingly contact the office seeking clinical advice. Further detail regarding these contacts can be found in the next section of this report (‘Working with the sector’, see page 11).

Working with the sector

The Chief Psychiatrist works with the mental health service sector to address treatment and service system issues proactively and collaboratively as part of a continuing process of service improvement.

Clinical leadership

Guidelines

The Chief Psychiatrist issues clinical guidelines on appropriate standards of practice and service delivery in a range of areas. A guideline may be required by a change in legislation, to assist services and clinicians to understand the clinical application of the change. At other times a guideline may be developed in response to an identified area of practice, to establish standards and promote more consistent practice as part of quality improvement.

During 2010–11, the Chief Psychiatrist issued a new guideline on *Seclusion in approved mental health services*.[7] Services are required to incorporate these standards and guidelines into their local policy and procedures as a condition of their funding. Copies of all current Chief Psychiatrist guidelines are available on the Department of Health website at: www.health.vic.gov.au/mentalhealth/cpg

New guidelines under development in 2010–11 included:

- *Safe transport of people with a mental illness*
- *Mental health treatment for persons in contact with the criminal justice system (*not yet completed*)*
- *Priority access for out-of-home care*.

Clinical advice

Mental health service clinicians contacted the OCP to seek information and advice on a wide range of issues, the largest single area being the application of the Act.

Other common areas were:

- aspects of treatment
- the process of recommendation for involuntary treatment
- advice about the management of consumers with complex presentations
- negotiation between services regarding who will supervise a community treatment order when a patient moves between areas
- access to secure extended care and forensic beds by rural and metropolitan area mental health services which do not provide this service component
- limited access of forensic mental health services to secure extended care services
- other issues in accessing appropriate services
- Chief Psychiatrist guidelines
- departmental and divisional policies.

Besides providing information, clarification and guidance, the Chief Psychiatrist's capacity to mediate service system issues such as inter-service and interstate transfers, and to facilitate access to specialist services and encourage inter-service cooperation, can improve consumer outcomes by making the best use of available resources in a service system facing high levels of demand.

7 The CPG can be found at: www.health.vic.gov.au/mentalhealth/cpg/seclusion-cpg-1103001.pdf

Authorised psychiatrists

Each approved mental health service must appoint an authorised psychiatrist, who is a qualified psychiatrist employed by the health service.[8] The authorised psychiatrist has specific powers, duties and functions under the Act including overall responsibility for the treatment and care of persons in the mental health service, and the power to consent to treatment on behalf of an involuntary patient. The authorised psychiatrist may also delegate any of their powers, duties and functions under the Act to another qualified psychiatrist (known as a delegated psychiatrist), except the power of delegation or the duty to provide the Forensic Leave Panel with information.

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

The Chief Psychiatrist also provides advice to the Australian Health Practitioner Regulation Agency (AHPRA) on the suitability of psychiatric qualifications obtained by overseas-trained psychiatrists who are seeking registration as specialist psychiatrists in Victoria.

Education and training

The OCP has a broad education and training role in informing mental health service clinicians about the clinical application of the Act and acceptable practice standards. This occurs through formal training sessions, often in response to a specific request from a mental health service for input in a particular area, or more informally through the frequent interactions with mental health service clinicians when they contact the office for clinical advice or to discuss a complaint.

In 2010–11, the Chief Psychiatrist, the Deputy Chief Psychiatrists and the clinical advisers delivered a range of presentations, training sessions and lectures on the Act, the role of the Office of the Chief Psychiatrist, legal and ethical issues in mental health service delivery, complaints management, and the use of ECT. The list below is indicative of the broad range of the presentations delivered by the Chief Psychiatrist, her deputies and advisers:

- presentation at Forensicare for clinical specialists in community forensic mental health, July 2010
- 'Consent: capacity and confidentiality' – Austin Health Child and Adolescent Mental Health Service, August 2010
- youth mental health conference presentation, August 2010
- 'Psychosocial impact and service response to bushfires' – Victorian Bushfire Reconstruction and Recovery Authority, August 2010
- OCP presentations to consumer and carer groups including forensic patients and consumer consultants – August 2010 and May 2011
- presentation for the Office of the Health Safety Commissioner, September 2010
- presentations on the Australian mental health system to departmental and clinical staff in China, September 2010
- opening address at Austin Health ECT training course, September 2010
- presentation at collaborative forum for consumers and staff, Thomas Embling Hospital, September 2010
- Mental Health Week presentation, Department of Justice, October 2010

8 Section 96, *Mental Health Act 1986*.

- ‘Challenges and changes’ – Mental Health Week presentation at Gippsland conference, October 2010
- ‘Leadership and management’ – presentation for senior psychiatry trainees, October 2010
- presentation to the Office of the Public Advocate on restrictive practices, October 2010
- presentation at the Mental Health, Drugs and Regions Division forum, October 2010
- ‘Research in IMYOS: effectiveness, outcomes and long-term follow up’ – Intensive Mobile Youth Outreach Support forum, November 2010
- ‘Recovery in the community’ – presentation to the Disability Action Group Eastern Region (DAGER), February 2011
- presentation at Ballarat conference, March 2011
- ‘Psychosocial recovery’ – community group presentation, April 2011
- ‘Youth Justice Initiative’ – orientation session for new workers, Forensicare, April 2011
- presentation on ECT at Mental Health Legal Centre, April 2011
- ‘Mental health and the media’ – presentation to journalism students at the Royal Melbourne Institute of Technology, May 2011
- ‘Coordination of care’, Austin Health
- mental health cross-departmental forum
- presentations on the Mental Health Act and human rights at Royal Melbourne Hospital, Peninsula Health, Alfred Health and Austin Health
- Community Brain Disorders Assessment and Treatment Services (CBDATS) annual forum at Austin Hospital.

In addition, the OCP hosted a statewide forum in August 2010 on ‘Working with the person with complex needs: optimising engagement with specialist services’, which was attended by around 200 mental health professionals and consumer and carer representatives from across the state.[9]

The office also convened a number of smaller, more specialised, forums including the clinical practice standards forum on ‘Supervision and reflective practice’ (July 2010 – attended by around 60 clinicians including inpatient unit managers and their staff) and the ‘Third annual ECT training providers forum’ (October 2010).

Much of the service-based education in the sector is provided through the education and training clusters, and the Chief Psychiatrist regularly contributes to their training calendars. The Chief Psychiatrist also contributes to other training programs, such as: those provided by Mindful, for clinicians in child and youth mental health; the Master of Psychological Medicine course for psychiatric trainees at St. Vincent’s Hospital; and sessions provided for external agencies such as the Community Visitors Program.

9 Presentations from this forum can be found at: www.health.vic.gov.au/chiefpsychiatrist/forum180810.htm

Fostering dialogue

Committees

As part of the statutory responsibility for standards of treatment and care, the Chief Psychiatrist conducts a range of activities to provide clinical leadership and facilitate practice and service development.

Authorised psychiatrists forum

The Chief Psychiatrist convenes a quarterly forum to assist authorised psychiatrists fulfill their functions, and to provide an opportunity for peer support in dealing with issues of common interest and concern. The forum continues to provide an effective platform for the discussion of complex clinical, legislative and strategic issues pertaining to the provision of public mental health services in Victoria.

During the reporting period, issues discussed included:

- Chief Psychiatrist guidelines
- clinical review program
- cross-border arrangements with South Australia
- cross-cultural mental health practice
- interface between disability and mental health
- implementation of the revised national standards for mental health services
- implementation of the *Severe Substance Dependence Treatment Act 2010*
- inpatient admission upon release from prison or Thomas Embling Hospital
- priority access for children and young people who have been placed in out-of-home care
- reform of the Act
- reportable deaths, sentinel events and the root–cause analysis process
- review of seclusion, restraint and ECT data
- seclusion and restraint practices
- weekend medical cover for acute inpatient units.

Statewide inpatient unit managers forums

Inpatient unit managers have a key role in establishing and supporting quality practice in inpatient mental health services. The office continued to convene regular forums with inpatient unit managers from around the state to discuss common issues.

Topics discussed at the statewide ‘Adult and children and youth unit managers clinical practice standards forums’ included:

- applying the national standards for mental health services to inpatient units
- case studies in reducing seclusion and restraint
- coercion and consent within a compulsory treatment framework
- the concept of humane treatment
- a consumer’s experience of seclusion and restraint
- supervision and reflective practice
- priority access for children and young people who have been placed in out-of-home care

- review of senior nurse positions
- clinical guidelines under development.

These forums facilitate information sharing, foster best practice and innovation and help unit managers to assume a leadership role within their local service.

Aged persons mental health forums

The OCP holds regular forums with clinical directors and senior clinicians from the aged persons mental health sector, with inpatient unit managers, managers of aged residential services and community leaders. The purpose of these forums is to provide education, exchange information and identify systemic issues in addressing the needs of older Victorians who have a mental illness.

Some of the issues covered in the reporting period were:

- assessment of dual-disability clients
- benchmarking
- capital management and planning
- dual-diagnosis training
- implementation of the Mental Health Reform Strategy 2009–2019
- integrated versus specialist teams
- key performance indicators for aged persons mental health
- liaison with the Senior Nurse Advisor
- national standards for mental health services
- reform of the Mental Health Act
- review of seclusion, restraint and ECT data
- role of case management in aged persons mental health
- rollout and evaluation of intensive community teams (ICTs)
- service presentations.

In convening the forums listed above, the OCP works in partnership with the Operations Branch of the division and the Senior Nurse Advisor. A number of child and youth mental health forums attended by the Deputy Chief Psychiatrist for Child and Youth Mental Health were convened by the Operations Branch:

- Child and Youth Program Managers meeting
- Child and Adolescent Mental Health Service Beds Contingency Planning Group
- Mindful project to strengthen collaboration between child and adolescent mental health services (CAMHS) and paediatricians.

Improving service quality

The OCP undertakes a range of activities to monitor and promote continuous improvement in clinical standards across the mental health service system, in addition to responding to identified concerns or problems. Improved service quality leads to improved consumer outcomes.

Quality Assurance Committee

The Chief Psychiatrist chairs the Quality Assurance Committee (QAC), established under s. 106AC of the Act, which is declared to be a consultative council under the *Public Health and Wellbeing Act 2008.*

The function of the QAC is to assist the Chief Psychiatrist in overseeing and monitoring standards of treatment and care in Victorian public mental health services. The QAC meets quarterly and membership[10] consists of senior psychiatrists and mental health clinicians from across the clinical mental health service system. Members are appointed as authorised officers under the Act for their work with the QAC and are subject to the confidentiality provisions relating to authorised officers and consultative councils. All QAC members were reappointed in March 2011 for another three-year term.

The QAC undertook the following activities in 2010–11:

- review of data reports about statutory functions, thematic summaries from coronial reports[11] and Chief Psychiatrist guidelines under development
- commencement of a new program of clinical reviews of public mental health services (see below)
- the QAC ECT subcommittee[12] continued to monitor and oversee ECT practice and training. The subcommittee met four times in 2010–11. This included two regular meetings, an annual training forum for ECT providers and an extraordinary meeting to provide comment on the exposure draft of the new Mental Health Bill. The subcommittee also considered ultra-brief ECT, the provision of ECT on an outpatient basis, the reporting of ECT adverse events; and safeguards for the provision of ECT to young people below the age of 18 years.

Further information about the QAC can be found at: www.health.vic.gov.au/chiefpsychiatrist/qac.htm

10 See Appendix 1 for a list of QAC members in 2010–11.
11 These summaries can be accessed online at: www.health.vic.gov.au/chiefpsychiatrist/coronial.htm
12 See Appendix 2 for a list of QAC ECT subcommittee members in 2010–11.

Clinical review program

The clinical review program is a series of peer reviews that examine clinical practice in public mental health services from the perspective of compliance with legislation and standards, including the *National standards for mental health services*.

Between 1997 and 2003 the OCP undertook a statewide program of 27 clinical reviews of public mental health services under the auspices of the QAC. In 2009–10 the QAC started preparing for a second round of reviews, using a revised methodology in order to ensure that feedback can be provided to clinical services more promptly.

Major accomplishments in 2010–11 included:

- three clinical reviews undertaken:
  - Austin Health (9–11 August 2010; adult mental health services and CAMHS)
  - Mercy Mental Health (25–27 October 2010; adult mental health services)
  - Ballarat Health Services (28–30 March 2011; adult and aged persons mental health services)
- publication of *The clinical review program: manual for review panels*
- further consolidation of process documentation by the creation of an audit tracker, training folders, site-visit kits, web page and a recommendations tracker database.

As the QAC is a consultative council under the *Public Health and Wellbeing Act 2008*, its proceedings, including clinical review reports, are subject to strict confidentiality protections. For quality improvement purposes, the Chief Psychiatrist will occasionally publish de-identified summaries of themes from a number of clinical reviews.

Site visits

In addition to the clinical review program, the Chief Psychiatrist, her deputies and clinical advisers in the OCP also undertake a regular program of site visits. These typically involve meetings with clinical leaders as well as a site visit to the various service components.

Working with departmental and other stakeholders

The Chief Psychiatrist and staff from the office work closely with colleagues in the division. The Chief Psychiatrist is involved in various policy, process and operational matters relating to mental health service delivery, where the office's interface with service providers and service users can bring a practice perspective to the issues being considered. The Chief Psychiatrist and her staff are also involved in a number of departmental and interdepartmental committees.

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

Some key areas of involvement during the reporting period have also been with the Office of the Senior Practitioner in jointly seeking to improve outcomes for dual-disability consumers[13] who come to the attention of either office, and with the Multiple and Complex Needs Panel on care plans for clients with complex needs.

Systemic issues

Children in out-of-home care

In terms of their overall health and wellbeing, infants, children and young people involved with child protection and placed in out-of-home care are a highly vulnerable group. Prior to their placement, they are likely to have been traumatised by significant abuse and neglect. Their complex experiences of loss and trauma frequently impact on many aspects of their development. As a consequence, there is a greater risk of mental health issues or mental illness emerging in this group than in the general community.

The Chief Psychiatrist guideline on *Priority access for out-of-home care* was developed in recognition of these vulnerabilities. The guideline describes arrangements under which mental health services are required to give weighted and preferential consideration to referral requests regarding infants, children and young people (up to the age of 18 years) who are placed by child protection in out-of-home care. It directs area mental health services (child, youth and adult streams) to establish a service response that ensures the most appropriate and timely assistance is either provided or facilitated for this client group. Some mental health assessments and interventions may also require family-focused work to support parents with a mental illness in their parenting role.

Upon publication of the guideline, mental health services started working to implement this new policy direction in collaboration with the regions of the Department of Health and the Department of Human Services. The Deputy Chief Psychiatrist, Child and Youth Mental Health, is supporting mental health services with the implementation process.

Disability services

The OCP has contributed to the development of a joint protocol between mental health and disability services. The aim of the protocol is to improve clients' service access to both areas. The protocol is undergoing consultation processes prior to finalisation.

In the reporting period, the OCP has collaborated with Disability Services to facilitate access to mental health services for clients with a dual disability.

13 People with a learning disability and mental illness.

The OCP has continued to meet with Austin Health and North and West Region Disability Services to discuss the relocation of Austin Health's long-term dual-disability clients from the secure extended care unit (SECU) to disability services supported accommodation in the community.

Bushfire recovery project

The department led the psychosocial response in the aftermath of the February 2009 Black Saturday fires. This work continued in the reporting period, with the Bushfire Psychosocial Recovery Unit being directly managed by the Chief Psychiatrist. The Deputy Chief Psychiatrist, Child and Youth Mental Health chaired the expert advisory committee of the Children's Recovery Project and provided advice to the sector on training needs and other issues. The bushfire recovery project ended in April 2011.

Contributions to working parties

Staff from the office contributed to the development of the new draft legislation.

The Deputy Chief Psychiatrist for Child and Youth Mental Health also worked with the child and youth team in the division on a number of policy issues, including early psychosis, the perinatal and infant mental health initiative; and priority access to mental health services for children and young persons in out-of-home care.

In addition, OCP staff participated on several projects and committees:

- Austin Health reference group on transition to community accommodation from secure extended care
- Child and Adolescent Mental Health Service Beds Contingency Planning Group
- Child Protection Practice Standards and Compliance Committee
- Justice Health, Clinical Advisory Committee
- a number of initiatives, including
  - Child and Youth Partnership Subcommittee
  - SECU Diversion and Substitution initiative
  - Evaluation of the Forensic Clinical Specialists Program
- Multiple and Complex Needs Initiative, central and regional meetings
- Office of the Health Services Commissioner, regular liaison meetings
- Office of the Public Advocate, regular liaison meetings and meetings with Community Visitors
- Office of the Senior Practitioner, regular liaison regarding common issues and shared clients
- Protecting Victoria's Vulnerable Children Inquiry
- Review of the Mental Health Act – participation on the expert advisory group
- Spectrum, liaison meetings
- TAC/WorkSafe Mental Health Steering Committee
- Victorian Dual Disability Service, regular liaison meetings and ad hoc meetings to discuss client-specific issues
- liaison with the Victorian Women's Health Network.

Freedom of information

The FOI unit of the Department of Health receives a variety of requests for information under the *Freedom of Information Act 1982* (Vic) (FOI Act). Where these records pertain to individual client records held by the department, the Chief Psychiatrist is required to provide an assessment and advice to the FOI unit on the recommended circumstances of release of the documents, taking into consideration the potential impact on the consumer or others of such release.

During the reporting period, the OCP assisted the FOI unit in providing recommendations regarding release of departmental client records and also provided documents under the FOI Act in relation to seven separate FOI requests (compared with 12 in 2009–10). The OCP also provided consultation to departmental FOI staff regarding FOI requests pertaining to clients with child protection and mental health histories.

Statutory roles of the Chief Psychiatrist

Statutory reporting

The Act requires mental health services to report monthly to the Chief Psychiatrist on the use of seclusion, mechanical restraint and electroconvulsive therapy (ECT). These reports are known as the statutory reports and they enable the Chief Psychiatrist to monitor the use of these practices including trends over time.

The Act also requires mental health services to report the annual medical examination of involuntary patients who have been in continuous care for 12 months, as well as the death of any patient that is a reportable death within the meaning of the *Coroners Act 2008*.

Electronic reporting for seclusion and mechanical restraint was introduced in 2006. Services now record each occurrence of these practices on their local client management information (CMI) system and submit data electronically via the statewide mental health information system known as the Operational Data Store (ODS). Electronic reporting of ECT commenced in 2008.

An analysis of statutory reports submitted in 2010–11 can be found in the next section of this report.

Investigations

Under s. 106(5) of the Act, the Chief Psychiatrist and authorised officers have powers to visit a psychiatric service and make enquiries if the Chief Psychiatrist forms the view that such action is necessary. This may include inspecting premises and records held by the service, making enquiries about a person's treatment and see a person who is receiving treatment.[14] The Chief Psychiatrist also has power to formally direct a service to cease or implement a particular treatment or clinical action where deemed appropriate and necessary.

In practice the Chief Psychiatrist more frequently addresses concerns through discussion and negotiation with the relevant mental health service, generally through the authorised psychiatrist or clinical director. As part of this process, the Chief Psychiatrist may seek a written formal report from the service, request and examine a copy of a person's medical record, meet with the relevant clinicians and interview the consumer and their carer to assist in determining the most appropriate action. The Chief Psychiatrist will also discuss issues raised by statutory reporting and complaints or contacts during service visits.

The Chief Psychiatrist is notified of critical incidents such as alleged homicides or serious assaults, including sexual assaults, where the victim or the perpetrator is a client of mental health services or believed to have a mental illness, or a forensic patient absconding. The Chief Psychiatrist will gather relevant information and provide briefings as required to keep the Minister for Mental Health and the Secretary informed. Most critical incidents of this kind will also be investigated by other agencies such as the Coroner or Victoria Police. The Chief Psychiatrist arranges for the relevant service to provide a detailed report regarding the care and treatment provided to those involved in a critical incident, and the response of the service following the incident.

The Chief Psychiatrist conducted no formal investigations in the reporting period. It should be noted, however, that inpatient deaths reported to the Chief Psychiatrist in the first six months of the reporting period were part of the *Chief Psychiatrist investigation of inpatient deaths 2008–2010* (see page 28).

14 Section 106(5) *Mental Health Act 1986*

Forensic mental health

Security patients

Security patients are those detained in an approved mental health service for treatment of their mental illness, either on a court order under the *Sentencing Act 1991* (s. 93A) as part of their sentence, or by order of the Secretary of the Department of Justice under the Act (s.16[3][b]). In Victoria, security patients receive treatment and care for their mental illness in Thomas Embling Hospital (a secure specialist forensic mental health facility) until it is appropriate for them to be returned to prison or to the community if they have reached the end of their sentence.

The Chief Psychiatrist is responsible for approving a security patient's discharge back to prison if satisfied that the criteria for being a security patient are no longer met. 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 continuing involuntary treatment at the expiry of their sentence may receive treatment under the civil involuntary provisions of the Act.

The Secretary to the Department of Justice must consult with the Chief Psychiatrist when allowing a security patient to be absent from an approved mental health service. The Secretary must be satisfied that the leave will not seriously endanger the safety of the public or the safety of the consumer.

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

Forensic Leave Panel

The Forensic Leave Panel (the panel) is an independent tribunal established under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA) with jurisdiction to consider applications from forensic patients and residents for:

- on-ground or limited off-ground leaves of absence
- appeals against refusal of special leave
- appeals in relation to transfers from one mental health facility to another.

The leave of absence regimen established by the CMIA aims to assist the rehabilitation of patients and residents and facilitate their ultimate reintegration into the community. The CMIA provides a transparent, accessible and responsive system that supports the application of procedural fairness.

All leave granted by the panel is done so on the basis that the safety of the forensic patient or resident or members of the public will not be seriously endangered as a result of the person being allowed leave.

The panel comprises representatives from the judiciary, the professions of psychiatry and psychology, and the general community. The Chief Psychiatrist is a member of the panel, and may also appoint nominees to attend panel hearings.

Further information on the operations of the panel can be found in its annual reports.[15]

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

Persons found guilty of non-serious offences can be made subject to a restricted involuntary treatment order (RITO). The RITO can be made for a maximum of two years. When the court makes a person subject to a RITO, the person must be taken to and detained in a mental health service as an inpatient. When the person's condition has improved to the extent that they can be treated and managed safely in the community, the authorised psychiatrist may make a restricted community treatment order (RCTO), enabling the person to continue their treatment in the community. The authorised psychiatrist must notify the Chief Psychiatrist of the making of a RCTO.[16]

In 2010–11, three RITOs and two RCTOs were made under these provisions (compared to 10 RITOs and six RCTOs in 2009–10).[17]

15 See: www.health.vic.gov.au/mentalhealth/forensic

16 For further information see the Chief Psychiatrist's guideline on *Restricted involuntary treatment orders and restricted community treatment orders* at: www.health.vic.gov.au/mentalhealth/cpg/index.htm

17 CMI/ODS dataset of 26 August 2011.

Statutory reports for 2010–11

To provide some context for the data, the total number of consumers treated by public mental health services was 61,645 in 2010–11 and 61,076 in 2009–10. Consistent with contemporary practice, the majority of these consumers received their treatment in the community. Only 21 per cent of these consumers (n = 13,175)[18] had a hospital admission during 2010–11 – the same percentage as in the two previous years.

Reportable deaths

What is a reportable death?

Under the Act an authorised psychiatrist of an approved mental health service or a person in charge of any other 'psychiatric service' must report the death of any person receiving treatment or care for a mental disorder, which is a reportable death within the meaning of the *Coroners Act 2008* (Vic).

The Chief Psychiatrist's *Reportable deaths* guideline (2010) also requires that services report the death of the following persons[19] to the Chief Psychiatrist:

- inpatients
- persons who are patients under the Act
- persons on non-custodial supervision orders
- other persons in care (this includes unregistered clients in the process of assessment as well as those who were previously registered clients and who have been in contact with psychiatric services within six months of their death, where the service becomes aware of the consumer's unexpected death).

It is the coroner's role to determine the cause of death and any contributing factors. The Chief Psychiatrist registers an interest with the State Coroner to ensure the office receives the coroner's findings and any recommendations.

Understanding the reporting requirements

When a patient dies in care, the Chief Psychiatrist needs to be notified of the death within 24 hours. The health service will also report the death to the Department of Health's sentinel event program if the death is an inpatient suicide or falls under the 'other catastrophic event' category.

In formally reporting a death, services submit the information available to them at the time they are notified of the death. This may vary depending on when the deceased person last had contact with the service or what details are known about the circumstances of the death. Services are required to describe the manner of death and identify whether a death appears to be:

- 'unexpected, unnatural or violent'
- due to 'natural causes' related to a medical condition or old age
- of unknown cause.

Suspected suicide was discontinued as a reporting category in 2008–09. Suspected suicides are now effectively included under the 'unexpected, unnatural or violent' category, together with deaths that, while 'unexpected, unnatural or violent', are not demonstrably indicative of suicide. Examples of the latter include deaths in a road-traffic accident, by drowning or in a house fire. The change to

18 As there were repeat admissions, these 13,175 individual clients accounted for 19,726 admissions.
19 For further detail please refer to the guideline: www.health.vic.gov.au/mentalhealth/cpg/reportable_deaths2010.pdf

reporting is a result of advice that only a coroner of the State Coroner's Office of Victoria can legally determine the underlying cause of a death, including a finding of suicide;[20] and such determination may be made some time after the year in which the death occurred.

The following review mechanisms may be triggered by the report of a patient's death:

- The health service reviews the unexpected death of a mental health inpatient under internal critical incident review mechanisms.
- Upon notification of a reportable death, the Coroner's Court will arrange for the deceased person to be conveyed to a mortuary. An investigation into the death is commenced. Not all investigations will result in an inquest. An inquest is a court hearing into a death that is heard by the coroner and is generally open to the public. Once the coronial investigation has been completed, the coroner must make written findings about the identity of the deceased, what caused the death and in certain cases, the circumstances in which the death occurred. The coroner may also make recommendations about matters connected with the death. These recommendations are aimed at preventing similar deaths from occurring in the future.
- The Department of Health will record the death in its Victorian Health Incident Management System (VHIMS) and may review it within the context of its sentinel event program. There are eight nationally defined sentinel events, one of which is 'suicide in an inpatient unit'. Victoria is unique in having added an additional 'other catastrophic' category to its sentinel events program. This category covers near misses, as well as deaths of mental health patients who have absconded from the inpatient unit with adverse outcome, or where the cause of death may not be suicide.
- The Chief Psychiatrist receives notification of the death of a person under treatment as an inpatient within 24 hours by telephone, followed by the *MHA33 – Notice of death* form. All deaths involving inpatients or persons being treated under the Act or under the CMIA also require a detailed clinical report from the authorised psychiatrist, to be forwarded to the Chief Psychiatrist within 14 days of knowledge of the death. In a number of instances the Chief Psychiatrist seeks further information from the authorised psychiatrist about the patient's treatment and care to enable the Chief Psychiatrist to undertake a more considered judgement on the appropriateness of the treatment and care provided. The death may also be reviewed by the Chief Psychiatrist's Sentinel Event Review Committee. This committee meets quarterly and includes nominated senior psychiatrists and mental health clinicians who review all root-cause analyses and risk-reduction action plans involving mental health–related events submitted to the department's sentinel event program. In special circumstances the Chief Psychiatrist will convene a panel and conduct an investigation of a reportable death.
- Victoria Police need to be advised of any reportable death immediately in accordance with the protocol.[21] Police may decide to investigate if there are suspicious circumstances or indications that a crime has been committed.

20 Suicide refers to the deliberate taking of one's life. To be classified as a suicide, a death must be recognised as due to other than natural causes and it must be established by a coronial inquiry that the death has resulted from a deliberate act of the deceased with the intention of taking his or her own life. See: Australian Bureau of Statistics 2008, *Suicides 2006*, cat. no. 3303.0, Australian Bureau of Statistics, Canberra.

21 Department of Health and Victoria Police 2010, *Protocol for mental health*, State Government of Victoria, Melbourne, p. 25.

Changes to reporting requirements in 2010

In April 2010, aged persons mental health residential services[22] (APMHRS), such as psycho-geriatric nursing homes and hostels, were removed from the proclamations of Victoria's approved mental health services.[23]

The original model for proclamations under s. 94(1) of the Act was to proclaim only specialised psychiatric inpatient facilities. When these stand-alone facilities were mainstreamed with public hospitals, it became typical to proclaim the entire campus of a public hospital with an acute mental health inpatient service. This practice resulted in some proclamations including APMHRS as part of the approved mental health service. This inadvertently had the effect that these APMHRS were considered to be inpatient services for the purposes of providing involuntary treatment under the Act.

Aged persons mental health residential services are operated as community-based services and consumers residing at these services who require involuntary psychiatric treatment should be placed on community treatment orders. However, the effect of the proclamations was that consumers living at these services could not be placed on community treatment orders. This had a flow-on effect on the models of treatment, support and rehabilitation able to be provided. It was also at odds with consumers' preference of being treated 'in the community' and difficult to reconcile with the requirements in the Act regarding least restrictive treatment. The removal of APMHRS from the proclamations of Victoria's approved mental health services in April 2010 resolved these anomalies.

As anticipated, the number of deaths of aged persons reported to the Chief Psychiatrist has decreased as a result of the removal of APMHRS from the proclamations of Victoria's approved mental health services (see page 28). This is because the death of an APMHRS resident of natural causes is no longer regarded as a reportable death. However, in cases where a resident is also being treated pursuant to a community treatment order, the reporting requirement still exists, in accordance with the Act. The Chief Psychiatrist guideline on *Reportable deaths*[24] provides full details about reporting requirements.

How is it possible that clients die while in care?

The *Chief Psychiatrist investigation of inpatient deaths 2008–2010*[25] examined 41 deaths of inpatients over the three-year period and found that most of these deaths could be attributed to suicide.

Most of these suicides occurred in the community; either while the client was on leave from the inpatient unit, or after the client had absconded from the inpatient unit.

Under the Act there is a general principle that treatment and care should be provided in the 'least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment'.[26] The Act also requires that 'any restriction upon the liberty of patients' and 'any interference with their rights, privacy, dignity and self respect are kept to the

22 Aged persons mental health residential services provide a range of specialist bed-based services to aged consumers who cannot be managed in mainstream aged care residential services due to their level of persistent cognitive, emotional or behavioural disturbance. Some APMHRS are collocated with public hospitals.

23 An approved mental health service is any premise or service that is proclaimed by the Governor in Council to be an approved mental health service under s. 94 of the Act. Approved mental health services are places where involuntary inpatient treatment may be provided to persons with a mental illness.

24 See www.health.vic.gov.au/mentalhealth/cpg/reportable_deaths2010.pdf

25 See http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrists-investigation-of-inpatient-deaths-2008-2010

26 Section 4(2)(a), *Mental Health Act 1986*.

minimum necessary in the circumstances.'[27] These contextual, policy and legislative requirements have been interpreted as requiring mental health inpatient units to be managed as unlocked units whenever possible. This emphasis on the least restrictive environment is further supported by the requirement under the *Charter of Human Rights and Responsibilities Act 2006* that any limitation of human rights must be reasonable and demonstrable.[28]

The investigation found that a number of deaths occurred in the inpatient unit and about half of these were suicides. For some of the other deaths, the cause of death is not known or under police investigation at the time of writing.

The unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers and staff. This is especially so where the person commits suicide.

Inpatient deaths are a relatively rare occurrence: the 41 deaths that fell within the scope of the Chief Psychiatrist's investigation represented 0.08 per cent of the 53,244 hospital admissions in 2008–2010. This appears to be lower than the experience of some other jurisdictions. For example, a US literature review reported research indicating that inpatient suicides constituted between 0.1 and 0.4 per cent of all psychiatric admissions.[29] The authors also concluded that the current ability to predict who will commit suicide while in hospital is poor.

What is being done to prevent client deaths?

The Chief Psychiatrist reviews death reports submitted by services to identify any clinical, service or system issues of concern. The Chief Psychiatrist may ask for further information from the service or, if the circumstances surrounding the death cause concern, may conduct a formal investigation under the Act.

The Chief Psychiatrist also reviews sentinel events referred from the department's sentinel event program.[30] Sentinel events referred to the Chief Psychiatrist are de-identified (by patient and by service) and include suicide in an inpatient unit (general hospital or specialist mental health unit) and any other catastrophic event relating to a mental health consumer in an inpatient service. The Chief Psychiatrist provides advice on any service system and quality issues arising from these reviews to the sentinel event program, which, in turn, gives feedback to the relevant services.

The principal purpose of reporting a death to the Chief Psychiatrist is to enable the Chief Psychiatrist to identify and address any systemic clinical issues. For example, if deaths appear related to treatment from a particular service component, or occur in greater numbers at a particular service, it may lead to a reconsideration of clinical practice in areas such as risk assessment or discharge. In some cases an inquiry may be indicated, such as following an inpatient death. This is particularly important as the coronial process may take some time before a final outcome is achieved and recommendations are made.

The *Chief Psychiatrist investigation of inpatient deaths 2008–2010* is an example of a systemic review. The report made recommendations in a number of areas, including policy and procedures, staffing, training and unit design.

27 Section 4(2)(b), *Mental Health Act* 1986.
28 Section 7(2), *Charter of Human Rights and Responsibilities Act 2006.*
29 Combs H and Romm S 2007, 'Psychiatric inpatient suicide: a literature review', *Primary Psychiatry,* vol. 14, no. 12, pp. 67–74.
30 Further information on the sentinel event program can be found at: www.health.vic.gov.au/clinrisk/sentinel/ser.htm

It is proposed that follow-up reviews be undertaken every three years. In the interim, reportable deaths will continue to be reviewed as part of the clinical review program and additional ad hoc investigations may be required.

The Chief Psychiatrist also continuously examines and collates coronial findings and recommendations, identifying practice themes and disseminating an annual summary to area mental health services to promote quality improvement.

In 2010–11, quality improvement themes from coronial recommendations received by the Chief Psychiatrist were:

- annual audit of potential ligature points
- risk assessment processes
- medically compromised psychiatric patients
- the appropriateness and adequacy of clinical documentation.

The OCP sent a summary of themes raised by coronial inquiries to the clinical directors and managers of all mental health services, with a request to consider the information and recommendations in the context of their local policies and practices.

Copies of recent circulars can be found on the Office of the Chief Psychiatrist website at: www.health.vic.gov.au/chiefpsychiatrist/coronial.htm

In addition, Chief Psychiatrist guidelines pertaining to the issues listed above – and in some cases developed in direct response to a coronial recommendation – can be found at: www.health.vic.gov.au/mentalhealth/cpg/index.htm

Profile of deaths reported in 2010–11

Mental health services reported the death of 275 consumers to the Chief Psychiatrist in 2010–11. This significant decrease[31] was foreshadowed in last year's annual report[32] because of the changed reporting requirements for residents of aged persons mental health residential services that were introduced in April 2010. Residents who die of natural causes are no longer regarded as reportable deaths (see previous section for details).

As a consequence of these changed reporting requirements, the proportion of deaths categorised as 'unexpected, unnatural or violent' (UUV) proportionally increased from 55 per cent of all reportable deaths in 2009–10 to 86 per cent in the reporting period. Conversely, the proportion of deaths attributed to natural causes fell from forty-five per cent of reported deaths in 2009–10 to 13 per cent in 2010–11.

Figure 3 confirms that the level of UUV deaths was virtually unchanged since the previous year and that the overall decrease can be attributed to the reduced reporting of reportable deaths due to natural causes.

31 In 2009–10 mental health services reported 432 deaths.
32 Department of Health 2011, *Chief Psychiatrist's annual report 2009–10*, State Government of Victoria, Melbourne, p. 27.

Figure 3: Reportable deaths by cause, 2008–09 to 2010–11[33]

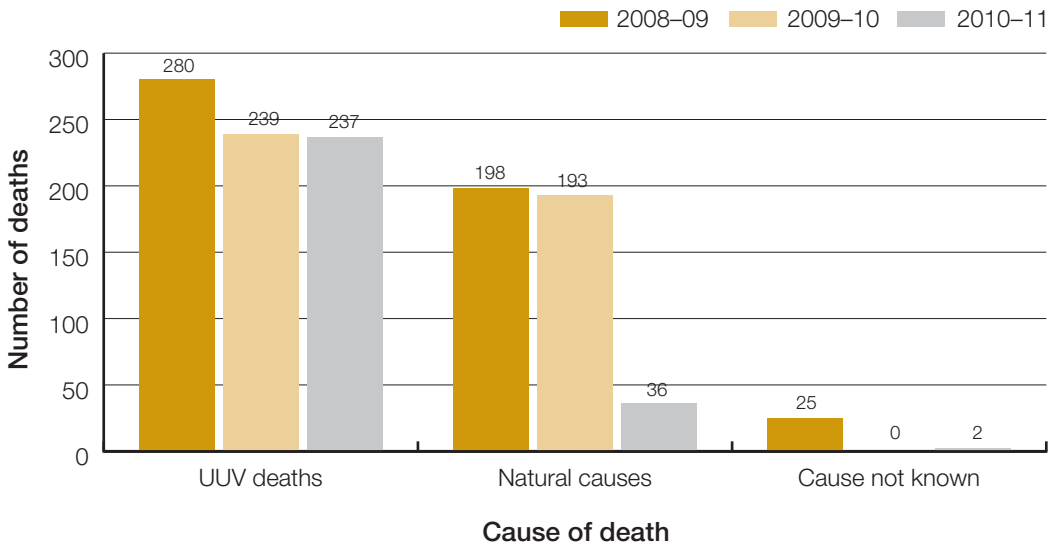
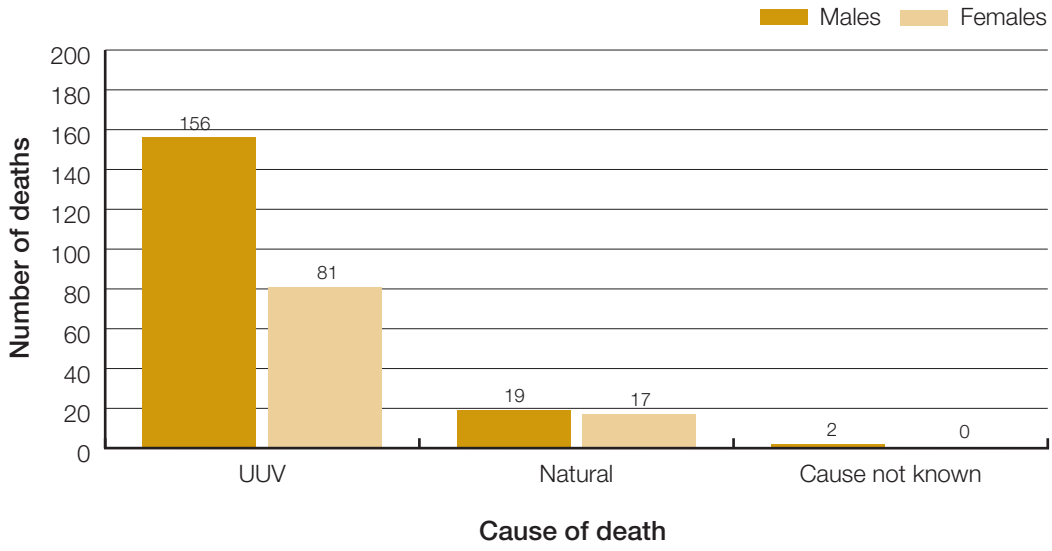


Figure 4 shows reportable deaths by cause and gender. Males outnumbered females by almost two to one in the UUV category. They accounted for 64 per cent of all reportable deaths in 2010–11 (66 per cent in 2009–10) and 66 per cent of unexpected, unnatural or violent deaths (70 per cent in 2009–10).

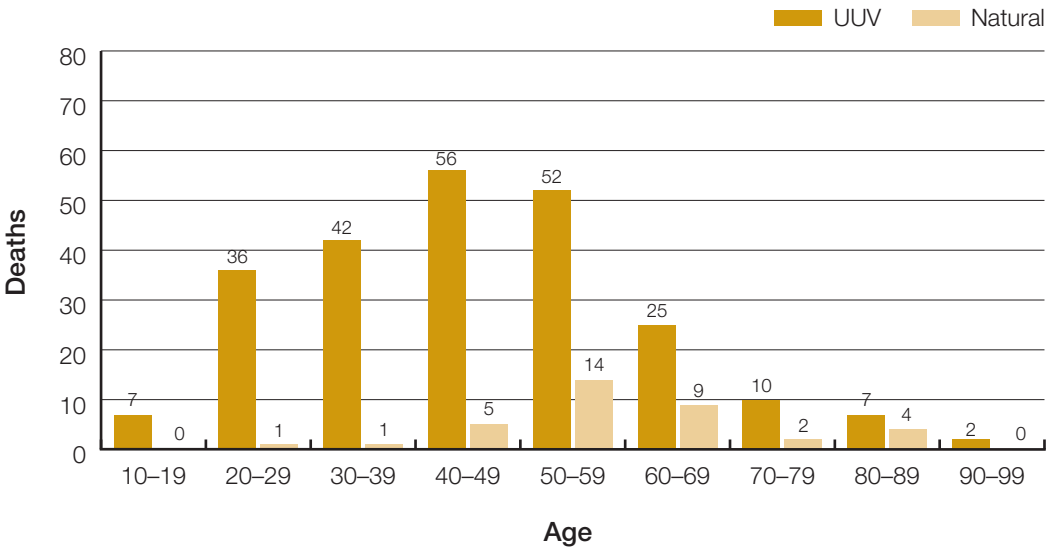
Figure 4: Reportable deaths by cause and gender, 2010–11



33 As a new classification for reportable deaths was introduced in 2008–09, only three years of trend data can be reported.

Figure 5 shows the distribution of reportable deaths by age group and cause of death. All reportable deaths for consumers under 20 years of age were classified 'unexpected, unnatural or violent'. These included two deaths of 14-year-olds. The highest peak of mortality not attributable to natural causes was among clients, or former clients, aged in their 40s.

Figure 5: Reportable deaths by age and cause of death, 2010–11



A clinical diagnosis was recorded for 262 of the 275 reportable deaths recorded in 2010–11 (95 per cent). As shown in Table 1, the most frequent mental illnesses associated with a reportable death were, as in previous years, psychosis (schizophrenia or other psychotic disorders) and mood disorder. This reflects the profile of consumers treated by public mental health services, which tends to be those with a serious mental illness.

Table 1: Reportable deaths in 2010–11 by diagnostic group[34]

Diagnosis	Deaths	Percentage
Schizophrenia, schizotypal and delusional disorders	119	43%
Mood [affective] disorders	81	29%
Neurotic, stress-related and somatoform disorders	24	9%
Mental and behavioural disorders due to psychoactive substance use	14	5%
Disorders of adult personality and behaviour	13	5%
Organic, including symptomatic, mental disorders	9	3%
Other	2	1%
Not known or not available	13	5%
Total	**275**	**100%**

34 Diagnostic grouping based on the *ICD-10-AM Mental Health Manual* (National Centre for Classification in Health 2002)

Electroconvulsive therapy (ECT)

ECT is a procedure performed under general anaesthetic in which modified seizures are induced by the selective passage of an electrical current through the brain. Representations of ECT in popular culture have tended to generate negative public perceptions of the treatment despite significant advances in ECT technology, knowledge and evidence[35] over recent years.

ECT is most commonly prescribed for severe depression but may also be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. It may be life-saving for some patients who have not responded to other treatments and is most often prescribed as part of a treatment plan in combination with other therapies.

Ultra–brief pulse ECT is a new method of delivering ECT and there is some evidence of its potential to minimise possible side-effects of ECT, such as temporary memory loss. This method of providing ECT was again discussed by the ECT subcommittee of the QAC in 2010–11. The majority view remained that the method has not yet been adequately evaluated and needs a stronger evidence base before it can be accepted for routine use in the public sector.

The Act contains specific provisions requiring informed consent to ECT. Where an involuntary patient is incapable of giving informed consent, the Act regulates the circumstances in which the authorised psychiatrist can provide substitute consent to ECT for involuntary patients.[36] The Act also requires any public or private mental health service administering ECT to comply with specified procedures and standards, and report monthly to the Chief Psychiatrist on ECT use.

The Act establishes a framework for the licensing of premises. ECT can only be provided in premises licensed by the Secretary to the Department of Health. In practice this power is delegated to the Chief Psychiatrist.[37] Licences may be granted for up to five years.

ECT can be administered as a course (a number of consecutive single treatments) or as a periodic continuation or maintenance therapy following an acute phase of illness.

See the *Electroconvulsive therapy manual: licensing, legal requirements and clinical guidelines* (Department of Health 2009) for more information on practice standards for ECT.

The data provided in the next section of this report shows that on a per-capita basis, Victorians are now less likely to be given ECT as part of the treatment for their mental illness than a couple of years ago. Those who are given ECT are likely to receive more treatments than in the past; and are increasingly likely to receive ECT treatment on a voluntary basis in a private mental health facility. These trends will be closely monitored by the Chief Psychiatrist.

Number of ECT treatments in 2010–11[38]

Public and private mental health services in Victoria provided a total of 19,912 ECT treatments in the reporting period, 149 more than the previous year (an increase of less than one per cent). Sixty-two per cent of all ECT treatments were provided by public mental health services and thirty-eight per cent by private psychiatric hospitals. This distribution is similar to previous years.

35 See, for example, publications of the National Institute for Health and Clinical Excellence (NHS, UK) and of the American Psychiatric Association.
36 See Part 5, Division 2.
37 See ss. 72–80 of the *Mental Health Act 1986*.
38 Unless otherwise indicated, all data pertaining to the use of ECT cited in this report was derived from the annual report dataset for ECT prepared by the Policy, Planning and Strategy Branch (MDHR) of the Department of Health on 13 January 2012.

Figure 6 shows that, while the number of ECT treatments has increased by 17 per cent since 2004–05, the number of persons receiving ECT has increased by only two per cent. This may reflect the increased use of ultra-brief ECT in private settings.

Figure 6: Use of ECT from 2004–05 to 2010–11 (public and private)

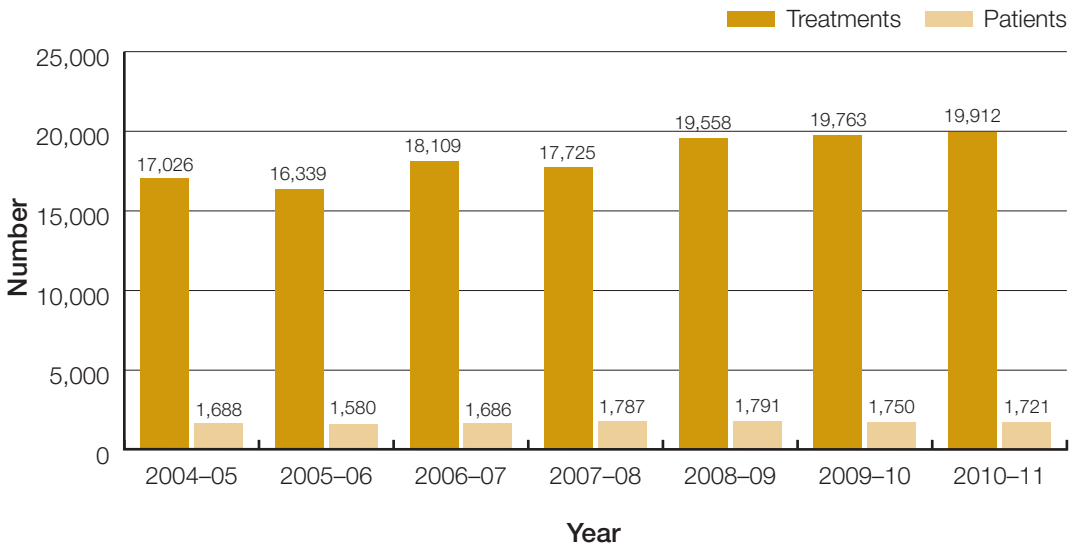
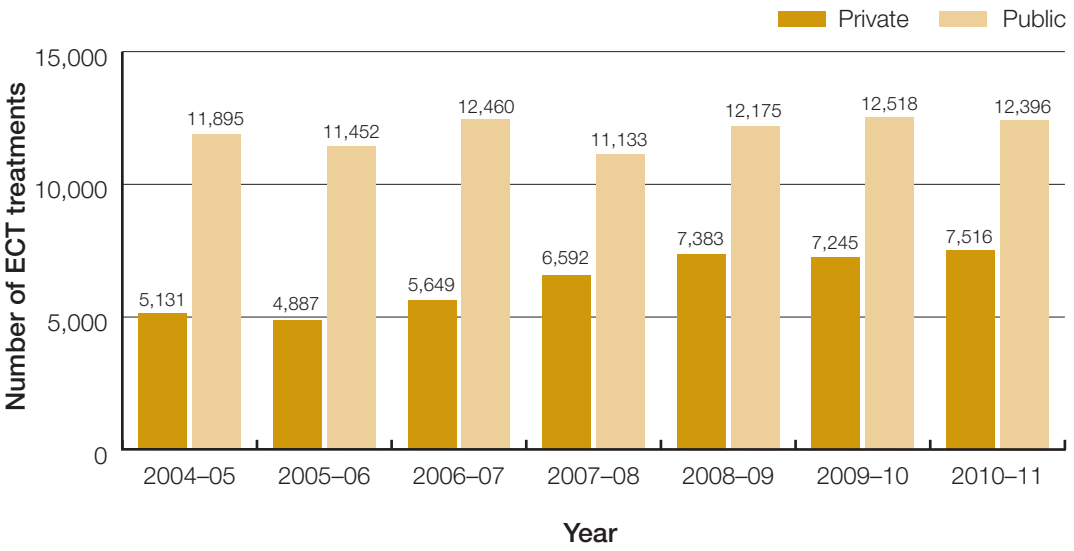


Figure 7 shows that the increase in the provision of ECT treatments since 2004–05 has been uneven across the sectors. The use of ECT in public mental health services has increased by four per cent since 2004–05. In the private sector, the use of ECT increased more significantly over the same period, from 5,131 treatments in 2004–05 to 7,516 in 2010–11. This may reflect an increase in the number of beds in the private sector, combined with a growing tendency in private psychiatry to use ultra-brief and maintenance ECT. The Chief Psychiatrist is closely monitoring this trend and seeking clarification from private providers.

Figure 7: Administration of ECT by sector from 2004–05 to 2010–11



Persons receiving ECT treatment

In 2010–11 a total of 1,721 people received ECT treatment, 29 fewer than in the previous year. The number of patients receiving ECT in a public mental health service decreased marginally, from 1,111 patients in 2009–10 to 1,050 in 2010–11. The number of persons receiving ECT in a private mental health service increased, from 639 patients in 2009–10 to 671 in 2010–11.

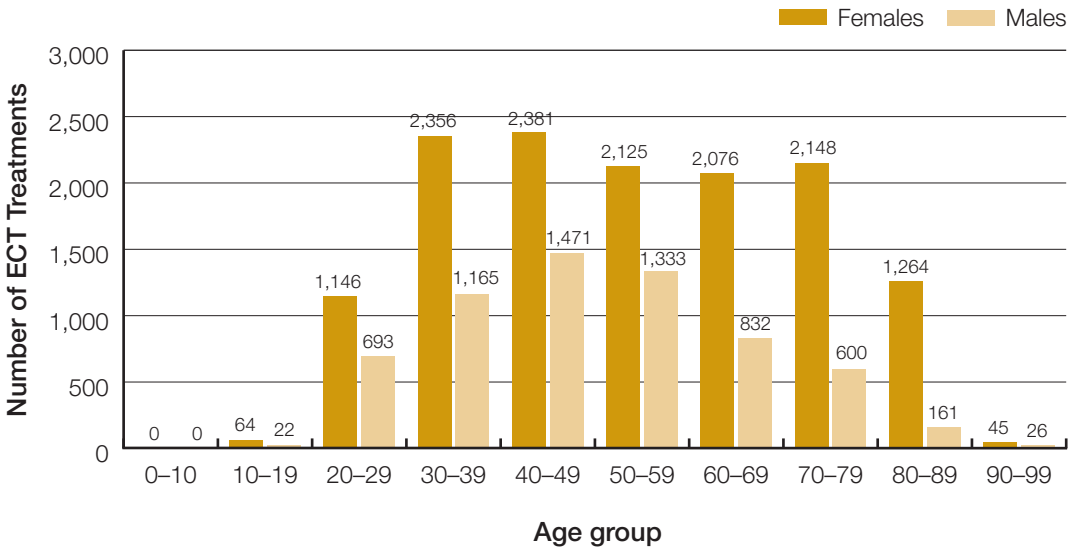
While the total number of ECT treatments has increased over the past few years (see Figure 6), fewer people received ECT in the reporting period than in 2004.[39] The fall in the number of persons receiving ECT since 2004 runs counter to population growth[40] and service utilisation trends[41] over the same period. The 1,721 people who received ECT treatment in the reporting period represent less than three per cent of the total number of patients treated in the public mental health system annually.

The average number of treatments per person has increased over that period – reflecting an increase in the use of maintenance ECT[42] – and currently stands at 11 treatments per client, which is unchanged from the previous year.

Sixty-five per cent of all ECT treatments in 2010–11 were administered to patients who had consented to their own treatment; and 35 per cent to involuntary patients, where the authorised psychiatrist consented on their behalf. Involuntary treatment can only occur in a public mental health service proclaimed under the Act.

Women received 68 per cent of all ECT treatments in 2010–11. This finding remains consistent with previous years and international findings on ECT usage patterns by gender. As in previous years there was a marked difference across sectors, with women receiving 76 per cent of ECT treatments in the private sector and 63 per cent in public mental health services.

Figure 8: ECT treatments by age and gender in 2010–11



39 The *Chief Psychiatrist's annual report 2004* shows that 1,761 individual consumers received an average of 8.72 ECT treatments each in that year (p. 24).

40 The Victorian population increased by 13 per cent between 2004 and 2011 (source: Australian Bureau of Statistics 2011, *Australian demographic statistics*, June 2011, cat. no. 3101.0, ABS, Canberra).

41 The number of consumers admitted to an inpatient unit rose by 16 per cent between 2004–05 and 2010–11 (source: Department of Health 2011, Client Management Interface/Operational Data Store, State Government of Victoria, Melbourne).

42 Maintenance ECT, which is provided on an outpatient basis, will generally be administered fortnightly or monthly.

Figure 8 shows that women aged 40 to 49 received more ECT treatment (2,381 procedures) in 2010–11 than women in other age groups although the number of procedures broadly remains within the same range across five decades. ECT procedures provided to males form a more traditional distribution curve. The peak decade for males receiving ECT was between 40 and 49 years (1,471 treatments), followed by males in their 50s (1,333 treatments).

No ECT was provided to young persons under 18 years of age in 2010–11. In April 2011 the ECT subcommittee of the QAC proposed a new guideline, requiring mental health services to notify the Chief Psychiatrist and to seek a second opinion from a child psychiatrist before providing ECT to a person under the age of 18 years. The QAC endorsed this recommendation at its meeting of 15 June 2011. As this guideline was issued towards the end the reporting period, its introduction does not explain the reversal of the previous trend. Some clinical leaders believe that the difference may stem from the changing clinical profile of the young persons presenting in any given year; others hold the view that mental health services may be changing their practice in this area in anticipation of the new legislation, which is expected to introduce more stringent controls and safeguards regarding the provision of ECT. In the absence of clear evidence, either of these possible explanations must, for the time being, be regarded as conjectural.

Seventy-one ECT procedures were provided to persons over 90 years of age.

Diagnosis

ECT treatment was given most often for a diagnosis of major affective disorder followed by schizophrenia and other affective and somatoform disorders, reflecting the generally accepted clinical indications for its use.

Table 2: Number of ECT treatments by diagnosis, 2010–11[43]

Diagnosis	Treatments	Percentage
Mood [affective] disorders	14,187	71%
Schizophrenia, schizotypal and delusional disorders	3,796	19%
Other (including neurotic illness)	221	1%
Not known or currently not available	1,708	9%
Total	**19,912**	**100%**

Licensing

Victoria's ECT licensing regime enables the Chief Psychiatrist to inspect premises, regulate the suitability of licence holders, regulate the standards and conditions of premises and equipment and check the level of training of clinicians providing ECT. In 2010–11, 34 premises were licensed to provide ECT in Victoria: 27 are public hospital services and seven private. Of these, 24 are located in metropolitan Melbourne and 10 in regional areas.

43 Diagnostic grouping based on National Centre for Classification in Health 2002, *ICD-10-AM Mental Health Manual*, NCCH, Sydney.

During 2010–11 the Chief Psychiatrist inspected six licensed ECT premises:

- Four premises were scheduled for a regular licence renewal inspection. All four premises met the criteria and had their licence to provide ECT extended for a further five years. For two of these premises, the Chief Psychiatrist attached special conditions to the licence renewal, requiring the service to submit a compliance report to the Chief Psychiatrist within six months.
- Two licensed premises requested a special inspection and an amendment to their licence following structural improvements to their ECT suite. Having inspected both premises, the Chief Psychiatrist approved the amendments to the two licences.

Training and quality improvement

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

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

It is a requirement of ECT training certification that training providers submit an annual report to the Chief Psychiatrist.

The Chief Psychiatrist hosted the annual ECT Training Providers Forum in October 2010.

Seclusion and restraint

In 2010–11 the Office of the Chief Psychiatrist continued to work with mental health services as part of the national effort to reduce the use of seclusion and restraint. An audit tool was developed and implemented as part of the clinical review program. In addition, the office monitored seclusion and restraint reports submitted by mental health services. On occasions this involved discussion of seclusion and restraint practices, including case-specific decision-making, with the treating service.

Seclusion

Section 82(1) of the Act defines seclusion as 'the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside'.

Under the Act a person receiving treatment in an approved mental health service can be placed in seclusion if it is necessary to protect them or others from an immediate or imminent risk to their health or safety or to prevent the person from absconding. Seclusion should only be used as an intervention of last resort when a person is unable to be treated less restrictively. Seclusion is not permitted in a private psychiatric hospital or a non-gazetted public mental health service.

A registered nurse must review the secluded person at least every 15 minutes and a medical practitioner must examine the person at least every four hours (unless this is varied by an authorised psychiatrist). Each seclusion episode must be recorded and reported to the Chief Psychiatrist.

The Chief Psychiatrist guideline on *Seclusion* (Department of Health 2011) provides more information on practice standards for seclusion.

Seclusion episodes[44]

A total of 4,694 seclusion episodes were reported in 2010–11, a decrease of 23 per cent compared to the previous financial year (6,059 episodes). The number of individual clients secluded decreased by nine per cent (from 1,828 to 1,656) even though the number of registered clients increased by one per cent in 2010–11.

There were 61,645 registered clients of public mental health services in Victoria in 2010–11, of whom three per cent experienced seclusion at some time in the course of their treatment. Of those admitted to hospital[45] during the reporting period, 13 per cent (1,656 consumers) were secluded at some time during their admission. The statewide seclusion rate in 2010–11 averaged 9.2 events per 1,000 occupied bed days (down from 11 in 2009–10).

Figure 9: The use of seclusion from 2004–05 to 2010–11

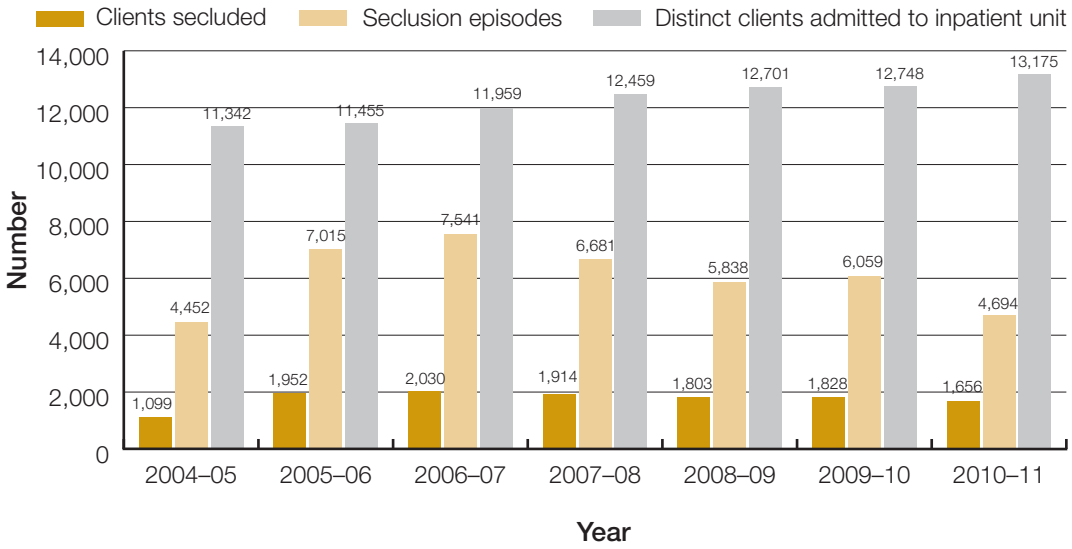


Figure 9 shows that the number of individual clients secluded peaked in 2006–07 and has declined by 18 per cent since, even though bed capacity in public mental health services expanded over this period[46] and the number of distinct clients admitted to an inpatient unit increased by 10 per cent.

44 Unless otherwise indicated, all data pertaining to the use of seclusion cited in this report was derived from the annual report dataset for seclusion and restraint prepared by the Policy, Planning and Strategy Branch (MDHR) of the Department of Health on 20 September 2011.

45 Across all inpatient units, including child and adolescent, adult, aged, general specialist, forensic and secure extended care.

46 Additional short-stay beds in psychiatric assessment and planning units (PAPUs) came online over this period.

Figure 10: Duration of seclusion episodes from 2004–05 to 2010–11

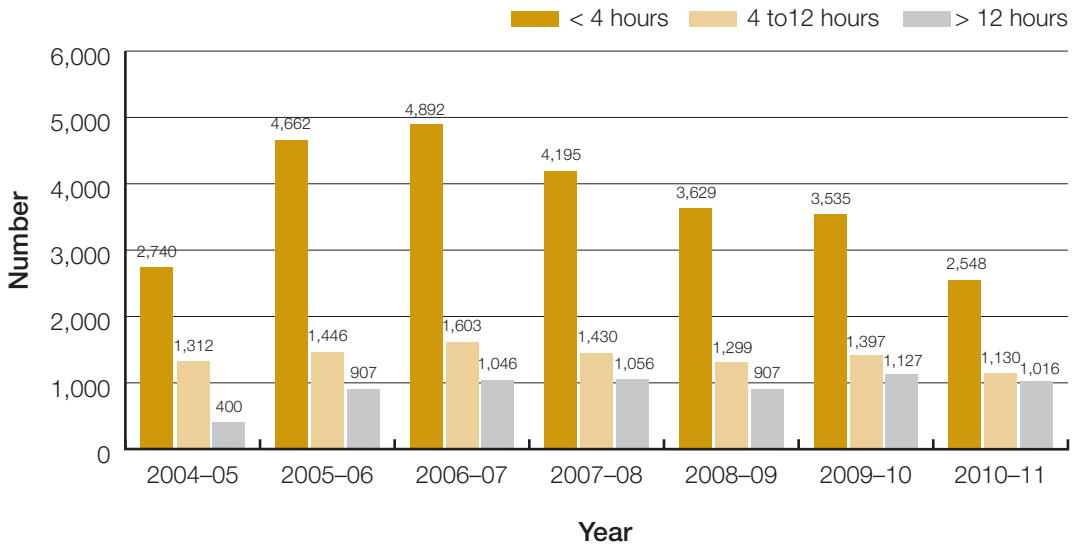
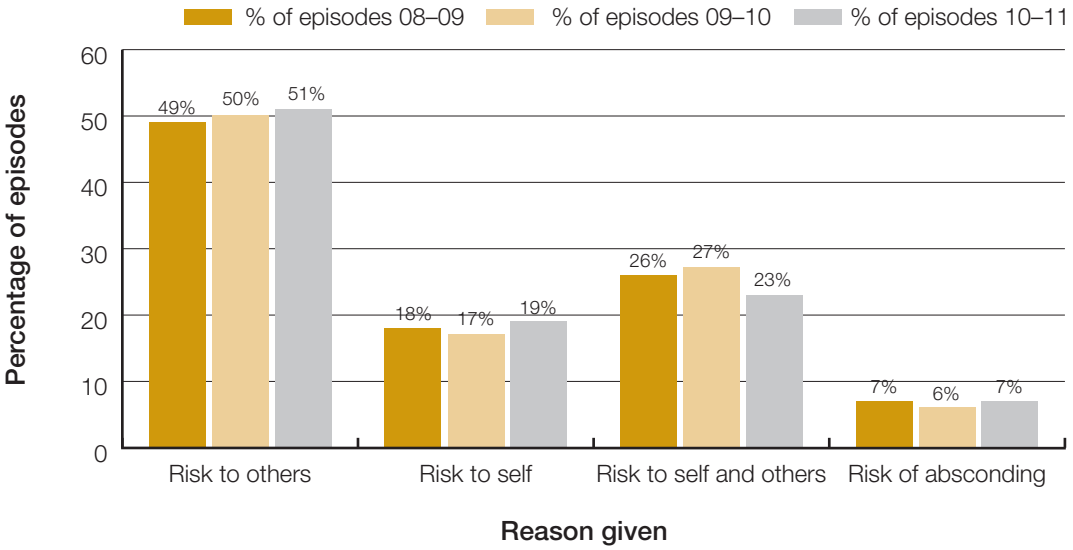


Figure 10 shows the changes in the use of seclusion since 2004–05. In 2010–11, short episodes constituted 54 per cent and medium episodes (between four and 12 hours) 24 per cent of all seclusion episodes. The remaining 22 per cent were seclusion episodes lasting longer than 12 hours (1,016 episodes – 110 fewer than in 2009–10).

Figure 11 shows that, as in previous years, the primary reasons for secluding a patient were to prevent an immediate or imminent health or safety risk to the consumer or to others.

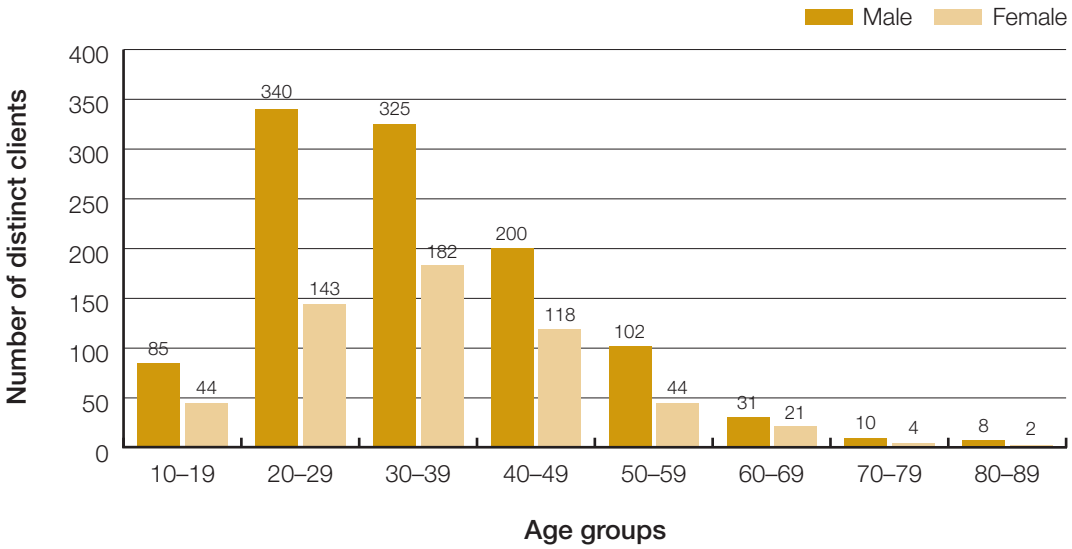
Figure 11: Reason for seclusion, 2008–09 to 2010–11



Persons secluded

Sixty-six per cent of seclusion episodes involved a male consumer. Figure 12 shows that males accounted for most episodes of seclusion across all age groups and that male consumers in their 20s and 30s were most likely to be secluded.

Figure 12: Seclusion episodes by age and gender, 2010–11



In the reporting period, the majority (94 per cent) of all seclusion events occurred in adult inpatient units. Adult mental health services reported 4,694 seclusion events in 2010–11, a decrease of 17 per cent (932 episodes) compared with the previous year.

Seclusion was used relatively rarely in child and adolescent inpatient units (189 episodes, constituting four per cent of the total).

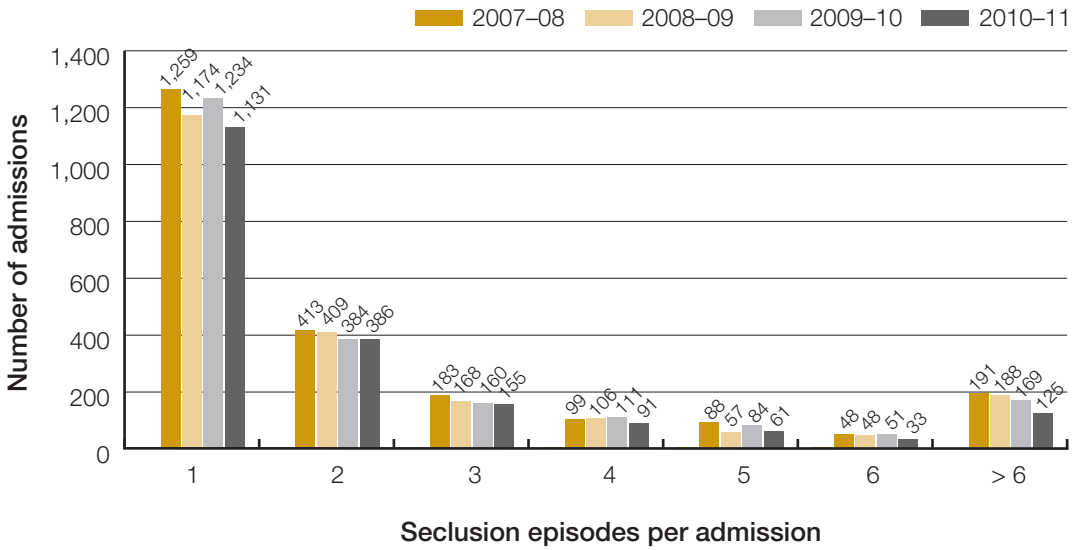
Aged inpatient units, which had accounted for a 40 per cent reduction in the number of seclusion episodes in 2009–10, further reduced their use of seclusion in the reporting period.[47] With a total of 109 episodes, they accounted for two per cent of seclusion episodes in 2010–11 compared to 206 episodes, or three per cent of the total, in 2009–10. The following strategies underpinned the significant reduction in the use of seclusion in aged persons mental health services (APMHS):

- clinical leadership provided by the OCP
- seeking acceptance from the clinical leaders and managers of the 17 APMH services that the reduction of seclusion was a priority for their service
- regular feedback of statutory data to the services
- regular discussion with managers and clinical leaders
- sharing of information and strategies between the 17 services.

Thirteen per cent of patients hospitalised during the reporting period were secluded. As Figure 13 shows, in more than half (57 per cent) of the hospital admissions that involved seclusion in 2010–11, the client was secluded on one occasion in the course of their admission. In more than a quarter of inpatient admissions where seclusion was used the patient was secluded twice or three times in the course of the admission; and in a small number of inpatient admissions (six per cent) that involved the use of seclusion patients were secluded on more than six occasions in the course of their admission. This small group of patients with complex presentations and highly disturbed behaviours accounts for a high proportion of all seclusion episodes.

47 See Sivakumaran H, George K and Pfukwa K 2011, 'Reducing restraint and seclusion in an acute aged persons mental health unit', *Australasian Psychiatry*, vol. 19, no. 6, pp. 498–501 for an account of how this was achieved in one Victorian health service.

Figure 13: Number of seclusion events within the same hospital admission



Mechanical restraint

Section 81(1A) of the Act defines mechanical restraint as 'the application of devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted to their arms) that restricts the person's capacity to get off the furniture'.

Mechanical restraint can only be applied if necessary for the person's medical treatment, to prevent a person causing injury to themselves or any other person, or to prevent a person from persistently destroying property. Like seclusion, mechanical restraint should be an intervention used only when all alternative options have been tried or considered and excluded.

A registered nurse or medical practitioner must continuously observe a restrained person and a registered nurse must review the person at least every 15 minutes. A medical practitioner must examine the restrained person at least every four hours (unless varied by an authorised psychiatrist).

Each restraint episode must be appropriately recorded and reported to the Chief Psychiatrist.

The Chief Psychiatrist guideline on *Mechanical restraint* (2006) provides more information on practice standards for the use of mechanical restraint.

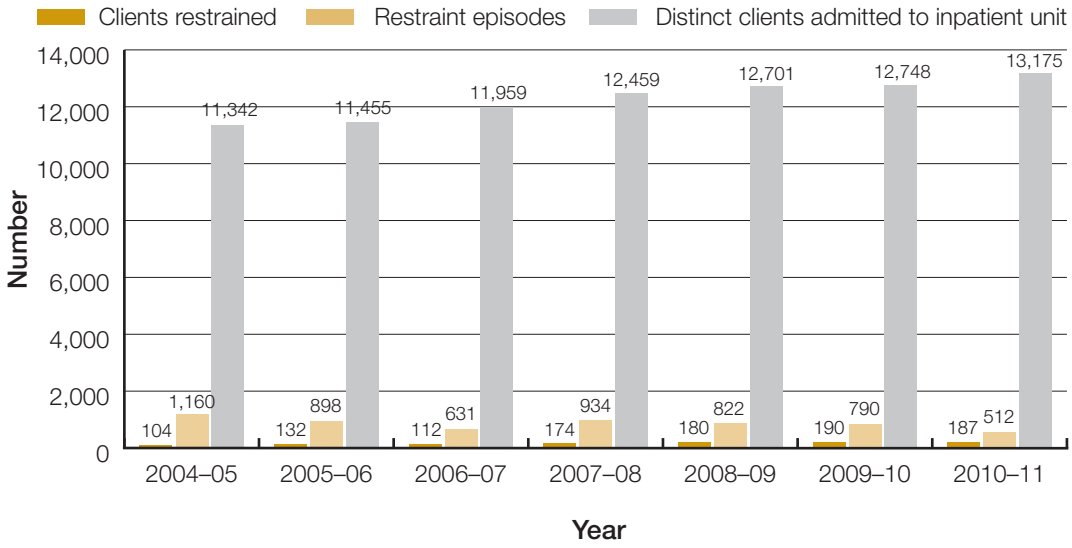
Restraint episodes[48]

There were 512 episodes of mechanical restraint in 2010–11; a decrease of 35 per cent compared with 2009–10 (790 episodes).

Figure 14 shows that the use of mechanical restraint declined from a peak of 1,160 episodes in 2004–05 to 512 episodes in 2010–11. This constitutes a 56 per cent reduction in the use of mechanical restraint, whereas the number of distinct clients admitted to an inpatient service increased by 16 per cent over the same period.

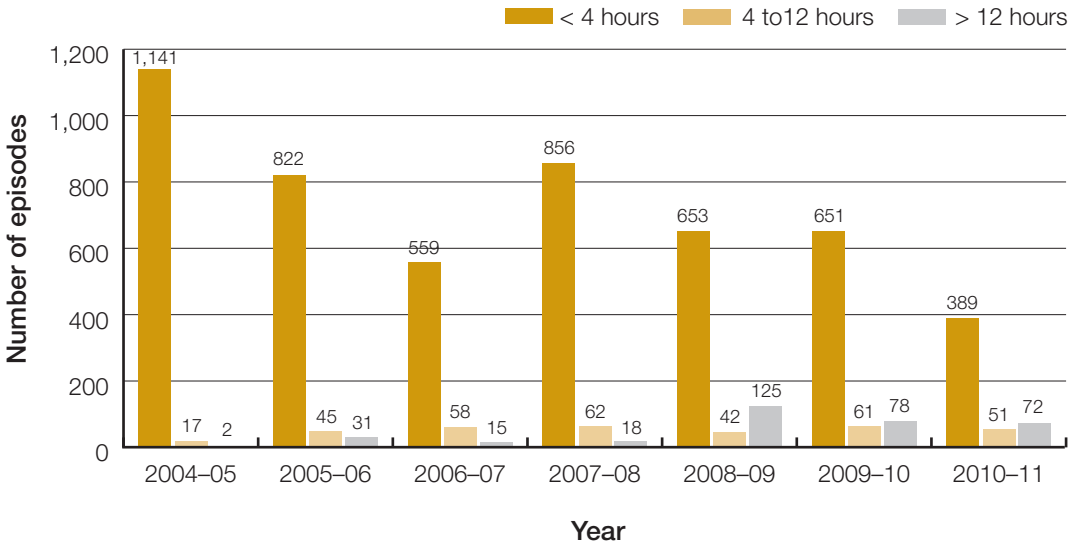
48 Unless otherwise indicated, all data pertaining to the use of restraint cited in this report was derived from the annual report dataset for seclusion and restraint prepared by the Policy, Planning and Strategy Branch (MDHR) of the Department of Health on 20 September 2011.

Figure 14: Trend in use of mechanical restraint from 2004–05 to 2010–11



As shown in Figure 15, most restraint episodes were under four hours in duration (76 per cent of episodes in 2010–11 – a six per cent decrease compared to 2009–10). Ten per cent of episodes lasted between four and 12 hours (up from eight per cent in 2009–10). The proportion of episodes of restraint exceeding 12 hours in duration increased from 10 per cent of all episodes in 2009–10 to 14 per cent in the reporting period.

Figure 15: Duration of restraint episodes, 2004–05 to 2010–11

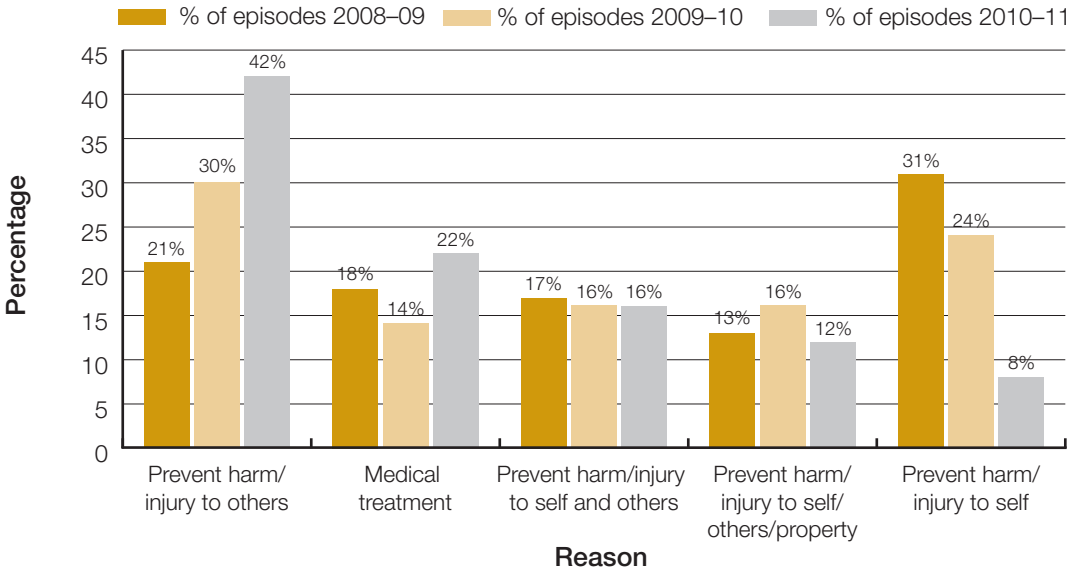


The average duration of a restraint episode in 2010–11 was just over six hours. Episode duration ranged from one minute to 113 hours. The duration of restraint episodes varied significantly across age groups, averaging more than six hours in adult mental health services and almost three hours in aged persons mental health services.[49]

49 Because of the low numbers involved in the reporting period, the corresponding figure for child and adolescent mental health services lacks statistical validity.

Figure 16 shows that in 2010–11 the primary reason for restraining an inpatient was to prevent harm or injury to another person. This reason was cited in 42 per cent of episodes (up from 30 per cent in 2009–10). The second most common reason for using mechanical restraint was to facilitate medical treatment of the inpatient. This rationale was cited in 22 per cent of episodes (up from 14 per cent in 2009–10). Preventing harm or injury to the person themselves was the primary reason in eight per cent of restraint episodes and part of the rationale for the remaining episodes, where concern for the client's safety was intertwined with concerns for others and property.

Figure 16: Reasons for mechanical restraint



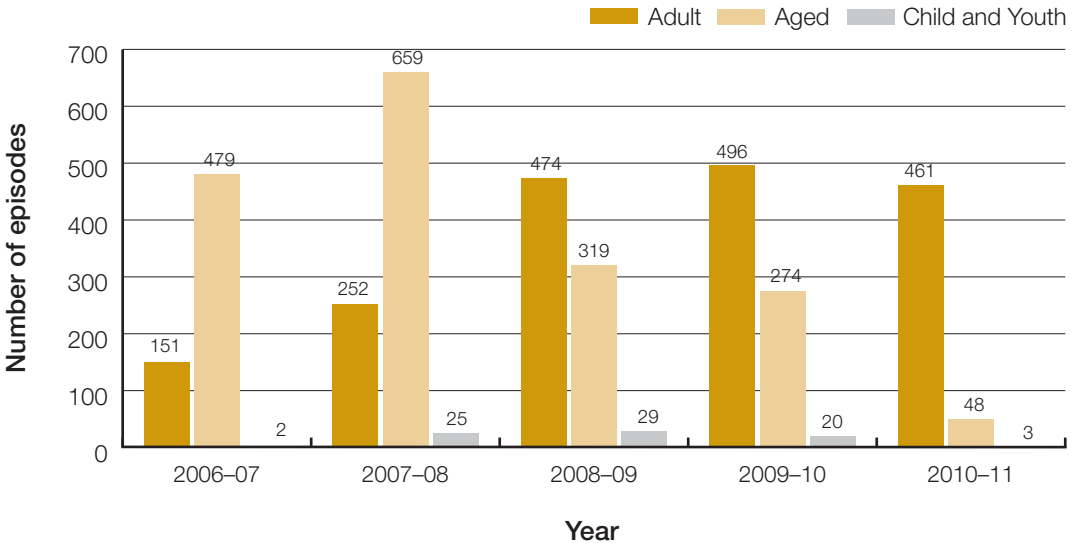
Persons restrained

One hundred and eighty-seven persons were restrained in public mental health services in 2010–11, a slight decrease compared to 2009–10, when 190 persons were restrained.

Seventy per cent of restraint episodes involved a male consumer (up from 66 per cent in 2009–10) and 90 per cent of restraint is now occurring in adult mental health services. Aged persons mental health services accounted for nine per cent and child and youth services for less than one per cent of all restraint episodes in the reporting period. This constituted a further significant reduction (24 per cent) in the use of restraint in aged persons mental health.[50] While these reductions in the use of restraint are encouraging, Figure 17 shows that these patterns can change over time, depending largely on the clinical presentation and treatment issues of individual patients in the age cohort.

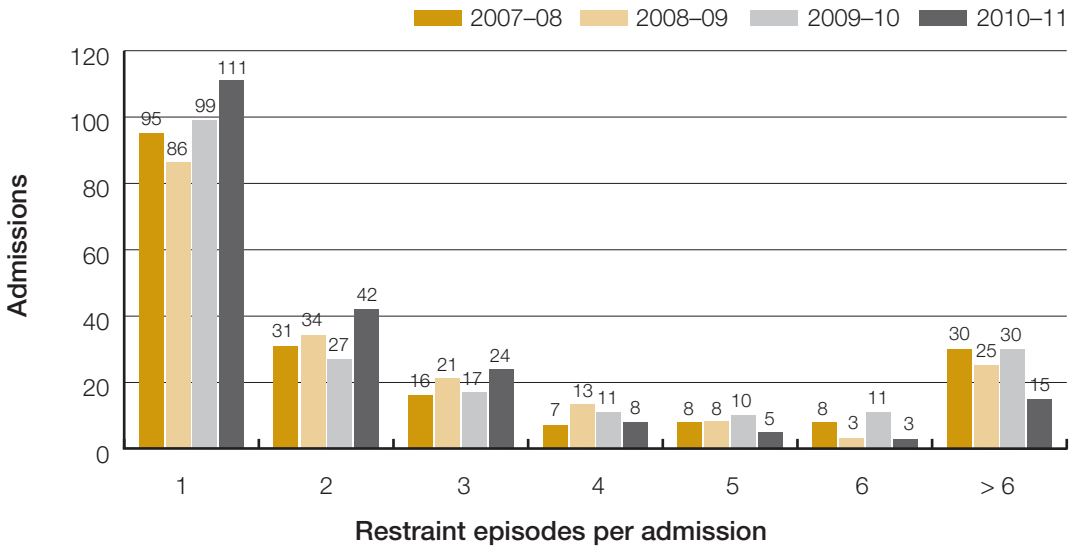
50 See Sivakumaran H, George, K and Pfukwa K 2011, 'Reducing restraint and seclusion in an acute aged persons mental health unit', *Australasian Psychiatry*, vol. 19, no. 6, pp. 498–501 for an account of how this was achieved in one Victorian health service.

Figure 17: Trends in the use of mechanical restraint by age group, 2006–07 to 2010–11



Fewer than one and a half per cent of patients hospitalised during the reporting period were mechanically restrained. As Figure 18 shows, in more than half of the hospital admissions (53 per cent) that involved restraint in 2010–11, the patient experienced a single episode of restraint in the course of their admission. In 47 per cent of admissions involving restraint the patient experienced multiple episodes of mechanical restraint in the course of their admission. This includes a small group (seven per cent) of hospital admissions involving restraint in which the patient experienced more than six episodes of restraint in the course of the same admission.

Figure 18: Number of restraint events within the same hospital admission



This small group of patients with significantly disturbed behaviours accounts for a high proportion of all restraint administered in the state. For example, in the reporting period the five longest episodes of restraint exceeded 75 hours each and together accounted for 19 per cent of the total statewide duration of restraint. Reviews of the data undertaken by the OCP identify these 'outliers' for clinical discussion with the relevant mental health service. This ensures that appropriate reviews occur, including seeking a second opinion, so that treatment and care are provided in the least restrictive manner possible, in accordance with the Act and the *Victorian Charter of Human Rights and Responsibilities Act 2006*.

Annual examinations

Section 87 of the Act requires that every patient must have a mental and general health examination at least once a year. The authorised psychiatrist must submit a report of the examination to the Chief Psychiatrist.

Increasingly, mental health consumers attend a local general practitioner for their physical health needs as would any other member of the community. However, given the known increased morbidity of consumers with a mental illness and tendency to poorer health status, the authorised psychiatrist of each approved mental health service has a responsibility for ensuring each consumer's health status is appropriately reviewed.

The Chief Psychiatrist reviews all *Annual examination of patient* forms submitted and may request further information from a service if necessary.

For further information relating to the responsibilities of mental health services under s. 87 of the Act, see: Department of Health 2008, *General medical health needs, annual examination, non-psychiatric treatment, special procedures and medical research procedures*, State Government of Victoria, Melbourne.

Appendices

Membership of the Quality Assurance Committee

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Mental Health, Drugs and Regions Division
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Aged Persons Mental Health
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Associate Professor Richard Newton
Medical Director
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Austin Health

51 From September 2010 to March 2011
52 QAC member for the full year but from March 2011 to June 2011 in his capacity as Deputy Chief Psychiatrist
53 Until December 2010
54 From November 2010

Professor Daniel O'Connor
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Aged Persons Mental Health
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Dr Bob Salo
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55 From August 2010