health

Chief Psychiatrist's annual report 2011–12

State Government Victoria

Department of Health

Chief Psychiatrist's annual report 2011–12

If you would like to receive this publication in an accessible format, please phone 03 9096 7571 using the National Relay Service 13 36 77 if required.

This document is available as a PDF on the internet at: www.health.vic.gov.au/chiefpsychiatrist

Authorised and published by Victorian Government, 50 Lonsdale Street, Melbourne.

Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

2012

Contents

November 2012

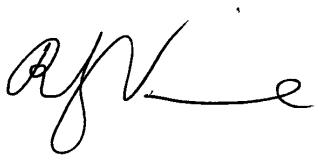
The Honourable Mary Wooldridge MP
Minister for Mental Health
50 Lonsdale Street
Melbourne Vic 3001

Dear Minister,

I am pleased to enclose the ninth annual report of the Chief Psychiatrist, covering the 2011–12 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 hope the report will inform consumers, carers 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

In September 2011, a series of newspaper articles drew public attention to the death of consumers in public mental health acute inpatient services. The reports focussed on three individual clients and the impact of their deaths on their families and carers. In the context of concerns raised by reporters, relatives, advocacy groups and members of the public, the former Premier of Victoria, the Hon Ted Baillieu MP and the Minister for Mental Health, the Hon Mary Wooldridge MP, asked me to conduct a formal investigation into how services responded in the event of the unexpected, unnatural or violent death of an inpatient.

The scope of the investigation was limited to deaths of mental health clients that occurred between 1 January 2008 and 31 December 2010. The investigation was undertaken by an expert panel that included interstate clinicians. The report of the *Chief Psychiatrist's investigation of inpatient deaths 2008–2010* was submitted to the Minister for Mental Health and publicly released. The inquiry found that, of the 41 deaths that were in scope, 29 most likely occurred as a result of suicide, though at the time of the review a cause of death had only been formally ascertained by a coroner for 13 of the 41 deaths. The investigation made a number of recommendations for improving systems and clinical practice. These are currently being addressed by health services and the department.

On 22 September 2011 the Minister for Mental Health formally launched the new Chief Psychiatrist guideline on *Priority access for out-of-home care*. 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. The guideline was developed in recognition of the particular vulnerabilities of infants, children and young people involved with child protection and placed in out-of-home care.

Other milestones in 2011–12 included the development of a new Chief Psychiatrist guideline on *Safe transport of people with a mental illness*, the completion of two clinical reviews, at Outer East Area Mental Health Service (August 2011) and Inner West Area Mental Health Service (May 2012) and 21 licence reviews of ECT service providers.

Throughout the reporting period 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. 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. It is intended to focus future effort on reduction in the use of restraint, especially in light of the changes proposed to our mental health legislation.

In 2011–12, mental health services reported the deaths of 211 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 to those affected, 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.

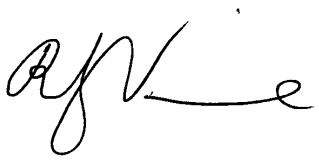
The OCP led or participated in a number of strategic initiatives in 2011–12. For example, I worked closely with the Legal Policy and Reform Unit of the Mental Health, Drugs and Regions Division on the development of new legislation governing the provision of mental health services in Victoria. I also

contributed to the development of a gender-sensitive practice guideline, secure step-down and bed-coordination initiatives, and national work through the Safety and Quality Partnership Subcommittee (SQPS). This included work on development of a Recovery Framework, a review of the Rights and Responsibilities document, and accreditation against the National Standards for Mental Health Services (NSMHS) and the National Safety and Quality Health Service Standards (NSQHSS).

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 Psychiatrists for Child and Youth Mental Health, Dr Sandra Radovini and her successor, Dr Neil Coventry, 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.

As this is the last annual report I will be presenting, I take this opportunity to thank the administrative and clinical staff who have worked with me in the Office of the Chief Psychiatrist, and especially Gilbert Van Hoeydonck, who has shepherded the annual report over the past three years. We are looking forward to new challenges and opportunities under renewed mental health legislation in 2013 and beyond. This will also entail 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 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.

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 was refined in 2011–12 and new legislation is expected to be introduced into parliament in 2013.

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
- potential risks and management
- next steps

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

- 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 frequently receives 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 encouraged to initially 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.

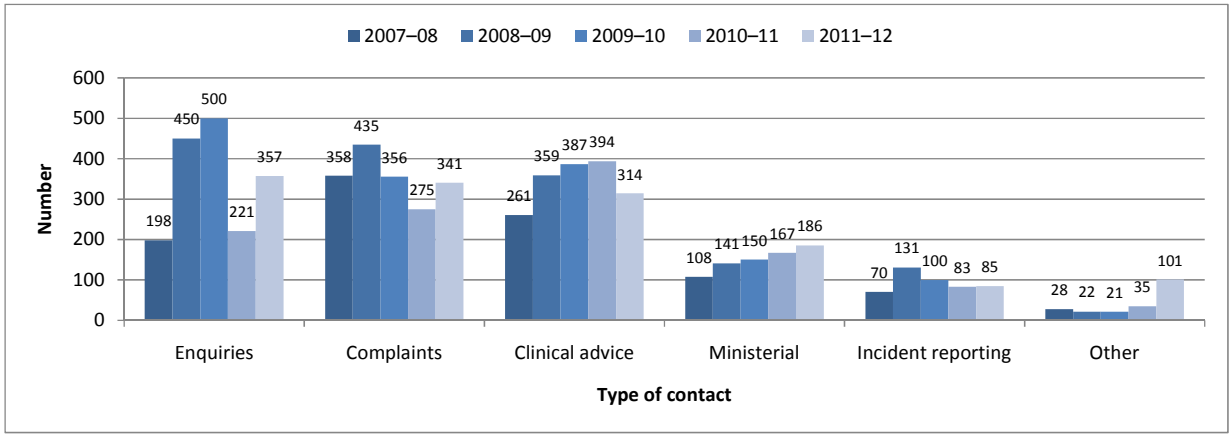
Contacts

Profile of contacts received by the office

The OCP responded to 1,384 recorded contacts in 2011–12. This was 209 more than in the previous year—an increase of 18 per cent. 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 received by the OCP by type since the current data collection system was introduced in 2007. Enquiries were the most common type of contact in the reporting period (26 per cent of all contacts), followed by complaints (25 per cent) and requests for clinical advice (23 per cent). There was an increase in the number of complaints received by the OCP in 2011–12 and a decrease in the number of requests for clinical advice.

Figure 1: Number and type of contacts from 2007–08 to 2011–12



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 six compliments.

Most contacts were made by service providers (31 per cent—up from 24 per cent in 2010–11), followed by carers and families (28 per cent – down from 32 per cent in 2010–11), followed by consumers (25 per cent – down from 29 per cent in 2010–11) and members of the public (11 per cent – up from eight per cent in 2010–11)[2].

Sixty-three per cent of contacts were made by telephone and 37 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'.[3] 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.[4]

The Victorian Health Services Commissioner is the principal body for health services complaints, and receives some complaints about mental health services.[5] 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.

2 For the remaining five per cent of contacts, the initiator field was coded as 'other', 'unknown', or left blank.

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

4 Section 106(5)(b) *Mental Health Act 1986*.

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

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 2011–12, the development of a discrete complaints mechanism was being progressed within the context of the new legislative framework.

Work continued in 2011–12 on the development of a new database for the OCP. The new database will enable the office to better capture information pertaining to contacts and complaints 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 fell from 76 to 55 per cent of all complaints received by the OCP. The proportion of complaints made in writing increased from 24 to 44 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 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 341 complaints in the reporting period — a 24 percent increase compared to 2010–11 but lower than the level of complaints received in previous years (see Figure 1). Most complaints were made by consumers (45 per cent – as in 2010–11) and carers (39 per cent – down from 43 per cent in 2010–11). Other complaints were lodged by staff and service providers (seven per cent) or members of the public (seven per cent). A small number of consumers lodged repeated complaints with the office.

Forty-six per cent of complaints related to a consumer in an inpatient unit (up from 41 per cent in 2010–11) and 40 per cent to a consumer in a community-based service (down from 46 per cent in 2010–11).[6]

As in previous years, most complaints (78 per cent) related to adult mental health services, with far fewer complaints relating to aged persons mental health services (six per cent) and child and adolescent

[6] For a small number of complaints the service type was ‘other’ or ‘not known’ and in nine per cent of records the ‘service type’ field was left blank. Three complaints related to private service providers,

mental health services (four per cent).[7] 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 about service access and involuntary treatment.

Figure 2: Complaints received by the OCP from 2007–08 to 2011–12

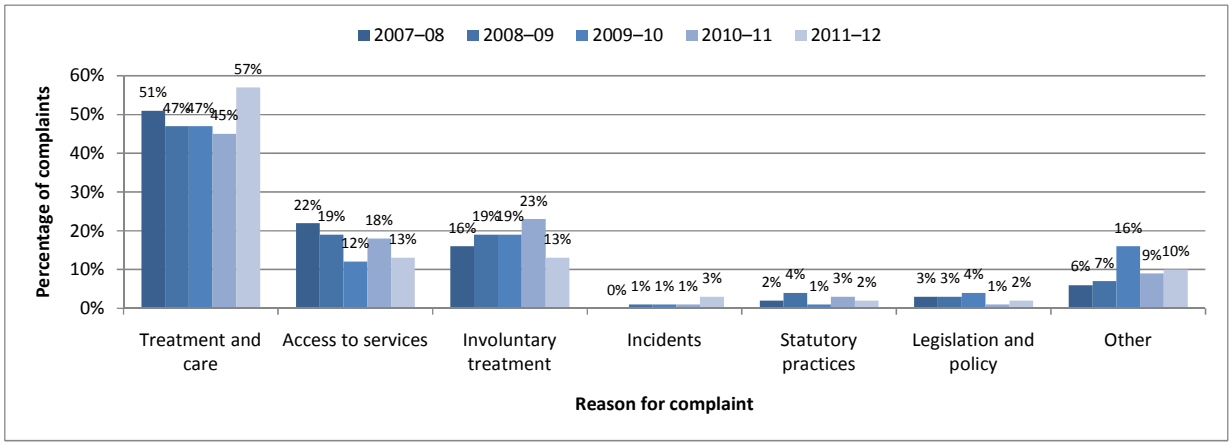
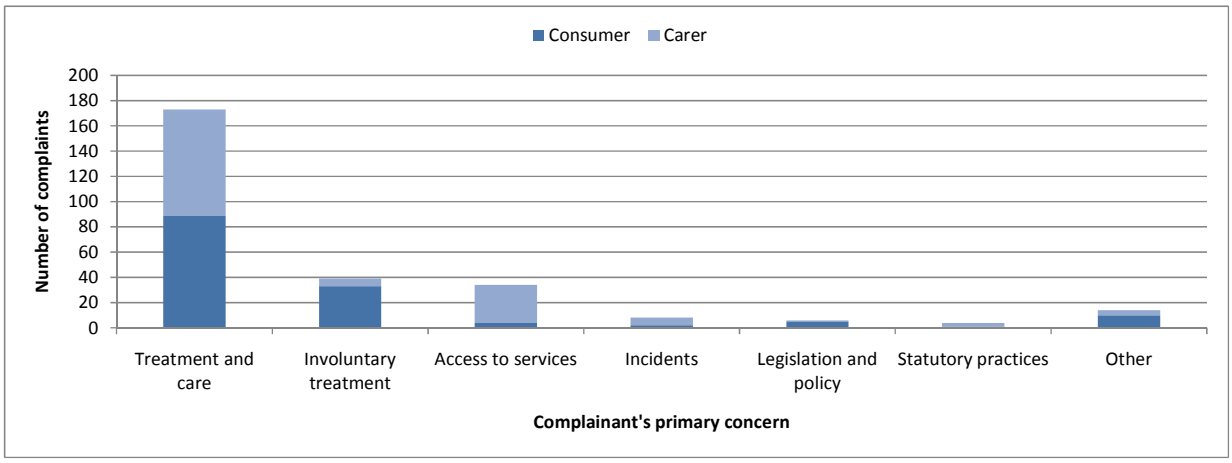


Figure 3 shows that the primary issues for consumers lodging a complaint with the OCP were aspects of treatment and care and involuntary treatment. For carers or family members lodging a complaint, the primary concerns were aspects of treatment and care and access to services.

Figure 3: Primary concern for complaints initiated by consumers and carers in 2011–12



Complaints about aspects of treatment and care made covered a range of issues, including complaints about smoking bans, the behaviour of individual clinicians, 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 consumers' physical health and accommodation, and either perceived poor service responsiveness or the opposite – a wish not to be involved with specialist mental health services.

Complaints about involuntary treatment 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

[7] In 12 per cent of complaints, the record did not specify the age group.

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.

Concerns about service access included the availability of appropriate services including criteria for admission, mental health assessment, crisis team and triage response; international, interstate and inter-service transfers, 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 recurrent theme was gaining access to the desired level of service and support at the time it was needed.

Nine complaints were classified as 'incidents' occurring in a mental health service. These included three client deaths, three alleged assaults and three alleged sexual assaults. Complaints about statutory practices included four complaints about ECT treatment, two about mechanical restraint practices and one about seclusion. A small number of complaints pertained to aspects of the Act or other legislation or departmental policy.

The 'other' category included a range of issues including such matters as catchment areas, court and judicial processes, power of attorney, FOI applications and government-funded services.

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 frequently 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').

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 2011–12, the Chief Psychiatrist issued two new guidelines:

- *Safe transport of people with a mental illness (August 2011)*
- *Priority access for out-of-home care (September 2011).*

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 2011–12 included:

- *Mental health treatment for persons in contact with the criminal justice system* (not yet completed)
- *Criteria for searches to maintain a safe environment for consumers, visitors and staff* (not yet completed)
- *The physically deteriorating patient* (not yet completed).

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.

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 2011–12, 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:

- presentations on the Victorian mental health system and mental health legislation to delegations from India, Japan, Korea and Qatar
- presentation to the *Queensland Mental Health Collaborative* on seclusion and restraint reform in Victoria
- presentation to the *National Seclusion and Restraint Forum* in Adelaide
- presentation on young people and the use of ECT for the Mental Health Review Board
- presentation at the aged persons mental health *Elder Abuse Workshop* at Victoria University
- presentations to a number of health services on care coordination
- presentations at a number of forums on the proposed new mental health legislation
- participation in a public forum at Kinglake within the context of the department's psycho-social response to the 2009 bushfires
- presentation at the Monash University Law Faculty's conference on *Implementing human rights in closed environments*
- whole day workshop about triage across the age spectrum for managers, clinicians and triage coordinators
- whole day workshop on adolescent mental health for child protection and youth justice case managers

[8] Section 96, *Mental Health Act 1986*.

- meeting with consumer and carer organisations at Warrnambool.

In addition, the OCP hosted a national conference and two statewide forums in 2011—12:

- under the banner of *Coordinating care: smoothing the path or adding more twists?* (25 October 2011) the 'complex care forum' sought to provide staff from clinical mental health services with an opportunity to explore how the role and function of care coordination are evolving, especially in areas where there is shared care or transition between services.[9] More than 150 participants attended this forum.
- the *Inpatient leadership forum* (13 June 2012) aimed to provide psychiatrists, nurse unit managers and allied health staff working in an inpatient setting with an opportunity to explore how clinical leadership can help ensure better outcomes for consumers admitted to an inpatient unit and their families. [10] More than 150 participants attended this forum.
- the *Inaugural national mental health recovery forum* was held at the Melbourne Convention and Exhibition Centre (21–22 June 2012). Three renowned international guest speakers, Mr Gareth Edwards, Dr Ken Thompson and Professor Mike Slade gave presentations and shared their ideas and experiences of recovery. The aim of the Forum was to promote and adopt a recovery-oriented culture within mental health services nationally, which is a key deliverable of Action 4 of the *Fourth national mental health plan*. The work is being led by Dr Ruth Vine as Chair of the Safety and Quality Partnership Subcommittee. Conference participants included consumers, carers, clinicians, mental health community sector and peak bodies; and other key stakeholders including Commonwealth agencies and departments. More than 600 participants attended the first day of the conference.

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] Selected presentations can be downloaded from www.health.vic.gov.au/chiefpsychiatrist/forum251011.htm
[10] Selected presentations can be downloaded from www.health.vic.gov.au/chiefpsychiatrist/forum130612.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 fulfil 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:

- activity-based funding
- bed coordination and patient flow project
- Chief Psychiatrist's investigation of inpatient deaths
- Chief Psychiatrist guidelines
- clinical review program
- criteria for patient searches in inpatient units
- maintaining patient confidentiality when using email
- Mental Health Review Board: new template for review processes
- reform of the Act
- responding to allegations of sexual assault
- secure extended care (SECU) access and distribution
- SECU referral processes: admission and transfer during an acute episode
- review of seclusion, restraint and ECT data
- seclusion and restraint practices
- waiting times in emergency departments.

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 clinical standards forums for managers of child and youth inpatient units and adult inpatient units included:

- bed coordination and patient flow project
- clinical guidelines under development
- clinical risk management in inpatient units
- community visitors program
- effective limit setting strategies
- inpatient treatment and care of persons withdrawing from alcohol and other substances
- nursing observations
- recognising and responding to clinical deterioration in inpatients
- recovery in mental health
- releasing time to care: the productive mental health ward project
- responding to the needs of families and carers following the death of an inpatient

- seclusion and restraint practices
- updates from the Chief Psychiatrist and the Senior Nurse Advisor.

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:

- aged persons mental health strategy
- bed coordination and patient flow project
- bed day rates
- benchmarking
- catchment areas
- dual-diagnosis training
- elder abuse forum
- elder abuse prevention strategy professional evaluation program
- future directions
- ICT guidelines
- key performance indicators for aged persons mental health
- meetings with the Ministers for Health and Mental Health
- model of care
- reform of the Mental Health Act
- residential support programs
- review of seclusion, restraint and ECT data
- supported residential service (SRS) protocol
- transition from adult to aged persons mental health services
- updates from the Chief Psychiatrist and the Senior Nurse Advisor.

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:

- bi-monthly Infant, Child and Youth Forum for clinical directors and managers
- Child and Adolescent Mental Health Service Beds Contingency Planning Group.

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[11] 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.

The QAC undertook the following activities in 2011–12:

- review of data reports about statutory functions, thematic summaries from coronial reports[12] and Chief Psychiatrist guidelines under development
- monitored progress of the clinical review program (see below), including consideration of action plans submitted by area mental health services in response to clinical reviews undertaken in 2010–11
- the QAC ECT subcommittee[13] continued to monitor and oversee ECT practice and training. The subcommittee met twice in 2011–12 and also convened the annual forum for ECT training providers. The ECT subcommittee considered a range of issues in the reporting period including:
  - ECT incident reporting
  - feedback from ECT licence review visits
  - replacement of Thymatron ECT machines of public mental health ECT providers
  - monitoring the use of ECT in the private sector
  - the new Mental Health Bill and possible implications for the prescription and administration of ECT
  - paucity of data about ultra brief ECT
  - RANZCP competency-based fellowship program.

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

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* and the *National safety and quality health service standards*. The reviews are undertaken under the auspices of the 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 and examine any reportable deaths that occurred during the period under review.

The core activity of each clinical review is a three-day on-site audit of clinical records undertaken by a panel of experienced mental health clinicians drawn from services across the state. Following the site visit the OCP collates the panel's findings and compiles a comprehensive report, which is considered by the QAC. Once endorsed by the QAC, the report is formally submitted to the mental health service under

[11] See appendix 1 for a list of QAC members in 2011–12.
[12] These summaries can be accessed online at: www.health.vic.gov.au/chiefpsychiatrist/corep.htm
[13] See appendix 2 for a list of QAC ECT subcommittee members in 2011–12.

review. The service is then required to develop an action plan that addresses the report's recommendations and to periodically report to QAC on implementation progress. The clinical review program is unique in that no other quality assurance process is able to examine in such depth so many individual clinical records.

Between 1997 and 2003 the OCP conducted 27 clinical reviews of public mental health services across the state under the auspices of the QAC. In 2010–11 the QAC commenced a second round of reviews. Three clinical reviews were undertaken in 2010–11 and two further reviews in 2011–12:

- Central East Area Mental Health Service (8–10 August 2011). An expert panel comprising ten senior clinicians and a project manager audited 347 triage and clinical records from selected child and youth mental health services and adult mental health services.
- Inner West Area Mental Health Service (28–30 May 2012). An expert panel comprising ten senior clinicians and a project manager audited 237 triage and clinical records from selected adult mental health services.

In addition, a statewide 'recruitment' campaign conducted by the OCP in January 2012 resulted in around 60 experienced mental health clinicians expressing an interest in participating in a clinical review. This response reflected the high regard in which the review program is held—and almost doubled the pool of prospective panel members in the OCP 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. The first of these thematic summaries can be found at appendix 3.

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[14] 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

Implementing the recommendations of the review of inpatient deaths

The report of the Chief Psychiatrist's investigation of inpatient deaths 2008–10, which is discussed in more detail on page 29, was published in February 2012.[15]

The report made 15 recommendations, of which the Government accepted 12. Three other recommendations (4, 5 and 6) were accepted in principle. While the Government supports the intent of these three recommendations, their implementation will require further consideration and discussion with health services.

Following the report's release the office of the Chief Psychiatrist developed a project brief and a project plan to help drive and monitor implementation of the recommendations that had been accepted by government. An internal MHDR project management group was established to track the implementation of recommendations addressed to the department. In addition, the then Executive Director of the MHDR division wrote to the CEOs of all Victorian health services that deliver public mental health services, requesting that they prepare an action plan for implementing the report's recommendations. The plans submitted by the health services were reviewed and collated by the OCP and submitted to the QAC.

At the time of writing, implementation work had progressed in several areas. For example:

- the Government immediately provided $500,000 to respond to urgent capital improvements in mental health inpatient units. This included measures such as identifying and removing ligature points wherever possible and improving the design of hinges and door handles
- the OCP is developing a Chief Psychiatrist guideline to provide better guidance for searching clients in an inpatient unit in order to provide a safe environment for patients, visitors and staff
- the development of a new *Victorian Mental Health Act* is intended to further drive positive change in the delivery of mental health services. The new legislation will have stronger regulation and greater scrutiny in areas of patient safety and protection.

It is anticipated that implementation of the majority of the recommendations will be in place by December 2013.

[14] People with a learning disability and mental illness.
[15] For a copy of the report, go to www.health.vic.gov.au/chiefpsychiatrist

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.

The Minister for Mental Health formally launched the new guideline on 22 September 2011.

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.

Bed coordination and patient flow project

High levels of demand for mental health inpatient beds frequently translate into high occupancy rates, long waits in emergency departments and a high level of out-of-area admissions.

One of the government's election commitments was to establish a capacity for the central coordination of mental health beds to ensure rapid access to inpatient beds. To this end, the 2011–12 state budget committed $1 million over four years to establish a central coordination system for mental health beds in public hospitals to ensure greater responsiveness and more rapid access to inpatient services for Victorians with a mental illness.

In November 2011 the OCP appointed a project manager to implement the initiative, which has become known as the bed coordination and patient flow project (BCPFP). The BCPFP aims to:

- develop information systems that will improve access to mental health information
- establish ongoing central bed monitoring systems
- establish statewide bed coordination processes and protocols that will facilitate access to out-of-area public mental health beds
- promote effective patient flow processes that use 'all of service'[16] resources to minimise unnecessary acute inpatient admissions.

In 2011–12 the project focused on establishing or enhancing information systems. The CMI[17] bed status enquiry (BSE) has been updated, improving its functionality and performance. It now provides fast access to public mental health occupancy and throughput information. In addition, the Victorian Critical Care Access Webpage (VCCAW)—a component of the Ambulance Retrieval Service webpage—will include data about mental health acute beds from early 2013. This is a critical new initiative that will require the participation of all mental health acute inpatient services. The web page will include

[16] Area mental health services provide a comprehensive range of services. When used judiciously, well-targeted community-based mental health services can provide timely and effective treatment in a less restrictive setting and may be able to prevent admission to an acute inpatient service.
[17] Client management interface, a component of the statewide database for public mental health services.

information about bed availability and about persons in emergency departments or the community who are waiting for admission and will be accessible by relevant AMHS and emergency department staff.

In its development phase, the BCPFP will focus on beds in acute mental health inpatient services for all age groups (children and young persons, adults and aged persons). Subsequent work will incorporate inpatient beds in statewide specialist and PDRSS bed-based services. The project will build on locally established pathways to develop broader statewide protocols and systems to improve overall patient flow and bed coordination.

OCP/MHCC database development

Work commenced in January 2011 on planning new databases for the OCP and for the Mental Health Complaints Commissioner (MHCC), a new role expected to be established under new mental health legislation. There are synergies in developing the two databases together, as they are expected to have a similar architecture.

The aim of the new OCP database is to better capture information pertaining to contacts, complaints and reportable deaths and to support improved data retrieval and reporting. In addition, both new databases aim to support the respective functions of the OCP and the MHCC under the new legislation.

The following project milestones were attained in 2011–12:

- business analyst services funded
- database business requirements specifications developed
- privacy assessments completed[18]
- security assessments completed[19].

In 2012–13 quotes will be sought for the development of the databases, user acceptance testing and hosting. The databases need to be operational for the expected commencement of the new Act in 2013–14.

Disability services

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

The OCP 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. These clients have now been relocated to more appropriate accommodation with continuing input and support from mental health services. In December 2011 the OCP also followed up on clients identified in the Long Stay Project undertaken by the Community Visitors Program auspiced by the Office of the Public Advocate.

[18] Department of Health information owners must demonstrate compliance with legal, regulatory and policy requirements for data protection and information risk management.

[19] A separate information security assessment to provide a system security plan for the databases needed to be undertaken following the privacy assessment.

Contributions to working parties

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 and practice issues, including early psychosis, the perinatal and infant mental health initiative, youth suicide 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:

- Aged Care Quality Improvement Unit, regular liaison meetings
- Child and Youth Partnership Subcommittee
- Child Protection Practice Standards and Compliance Committee
- Dementia Referral Pathways Project
- ECT Nursing Project Advisory Committee
- Evaluation of the Forensic Clinical Specialists Program
- development of the Framework for Recovery Oriented Practice
- Gender Sensitivity Steering Group
- Justice Health, Clinical Advisory Committee
- Mental Health Resource Centre: participation in multicultural 'round table'
- 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
- Older persons mental health plan: scoping workshops
- Psychiatric Illness and Intellectual Disabilities Donations Trust Fund (PIIDDTF) reference group
- Review of the Mental Health Act – participation on the expert advisory group
- SECU Diversion and Substitution initiative
- 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 provided documents under the FOI Act in relation to discrete FOI requests. The OCP also assisted the FOI unit in providing consultation regarding release of departmental client records and 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 2011–12 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.[20] 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 inform the Minister for Mental Health and the Secretary. Most critical incidents of this nature 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 one formal investigation in the reporting period. In September 2011, a series of newspaper articles drew public attention to the death of consumers in public mental health acute inpatient services. The reports focussed on three individual clients and the impact of their deaths on their families and carers. In the context of concerns raised by reporters, relatives, advocacy groups and members of the public, the former Premier of Victoria, the Hon Ted Baillieu MP and the Minister for Mental Health, the Hon Mary Wooldridge MP, asked the Chief Psychiatrist to conduct a formal investigation into how services responded in the event of the unexpected, unnatural or violent death of an inpatient.

[20] Section 106(5) *Mental Health Act 1986*

The scope of the investigation was limited to deaths of mental health clients that occurred between January 2008 and December 2010. The investigation was undertaken by an expert panel that included interstate clinicians. The report of the *Chief Psychiatrist's investigation of inpatient deaths 2008–2010* was submitted to the Minister for Mental Health and publicly released. The inquiry found that, of the 41 deaths that were in scope, 29 most likely occurred as a result of suicide, though at the time of the review a cause of death had only been formally ascertained by a coroner for 13 of the 41 deaths. The investigation made a number of recommendations for improving systems and clinical practice. These are currently being addressed by health services and the department. The findings of this major investigation are described in more detail elsewhere in this report (see page 29).

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.[21]

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.[22]

In 2011–12, five RITOs and four RCTOs were made under these provisions (compared to three RITOs and two RCTOs in 2010–11).[23]

[21] See: www.health.vic.gov.au/mentalhealth/forensic
[22] 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
[23] CMI/ODS dataset of 25 July 2012.

Statutory reports for 2011–12

As part of industrial action undertaken in public mental health services within the context of negotiations for a new Enterprise Bargaining Agreement (EBA), a ban was in place on data entry from 14 November 2011 until the end of the financial year. While the ban primarily affected non-clinical data entry, it also led to delays in the reporting of statutory activities, such as seclusion, restraint and ECT. The OCP made clear to services that industrial action does not obviate the need to comply with licensing and legislative requirements; and that statutory activities needed to be reported to the OCP, retrospectively if necessary. In spite of this, the OCP regrets that it cannot guarantee that seclusion and restraint data for 2011–12 are complete.

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[24] 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.

[24] For further detail please refer to the guideline: www.health.vic.gov.au/mentalhealth/cpg/reportable_deaths2010.pdf

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 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;[25] 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.[26] Police may decide to investigate if there are suspicious circumstances or indications that a crime has been committed.

How is it possible that clients die while in care?

The *Chief Psychiatrist investigation of inpatient deaths 2008–2010*[27] examined 41 deaths of inpatients over the three-year period and found that most of these deaths could be attributed to suicide.

[25] 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 2012, *Suicides, Australia, 2010*, cat. no. 3309.0, Australian Bureau of Statistics, Canberra.
[26] Department of Health and Victoria Police 2010, *Protocol for mental health*, State Government of Victoria, Melbourne, p. 25.
[27] See http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrists-investigation-of-inpatient-deaths-2008-2010

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'.[28] 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 minimum necessary in the circumstances.'[29] 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.[30]

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.[31] 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.[32] 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.

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

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.

A follow-up review will be undertaken every three years. In the interim, reportable deaths were 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 2011–12, quality improvement themes from coronial recommendations received by the Chief Psychiatrist were:

- management of inpatients (including clearer protocols for the searching of patients on admission or return from leave)
- discharge and transfer of patient care
- risk assessment processes (with particular reference to clients who are facing custody issues and present as suicidal)
- trans-cultural issues (including culturally sensitive practice and the use of interpreters)
- referrals by general practitioners and across catchment areas
- services for patients with dual diagnosis or personality disorders.

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 2011–12

In 2011–12 mental health services reported the death of 211 consumers[33] to the Chief Psychiatrist—64 fewer than the previous year (a decrease of 23 per cent).

Figure 4 shows that, while the number of deaths attributed to natural causes was virtually the same, the number of UUV deaths decreased by 28 per cent in comparison to the previous year.

The proportion of deaths categorised as 'unexpected, unnatural or violent' (UUV) was 81 per cent of all reportable deaths in the reporting period (down from 86 per cent in 2010–11). The proportion of deaths attributed to natural causes increased from 13 per cent in 2010–11 to 18 per cent in 2011–12.

Figure 4: Reportable deaths by cause, 2008–09 to 2011–12[34] [35]

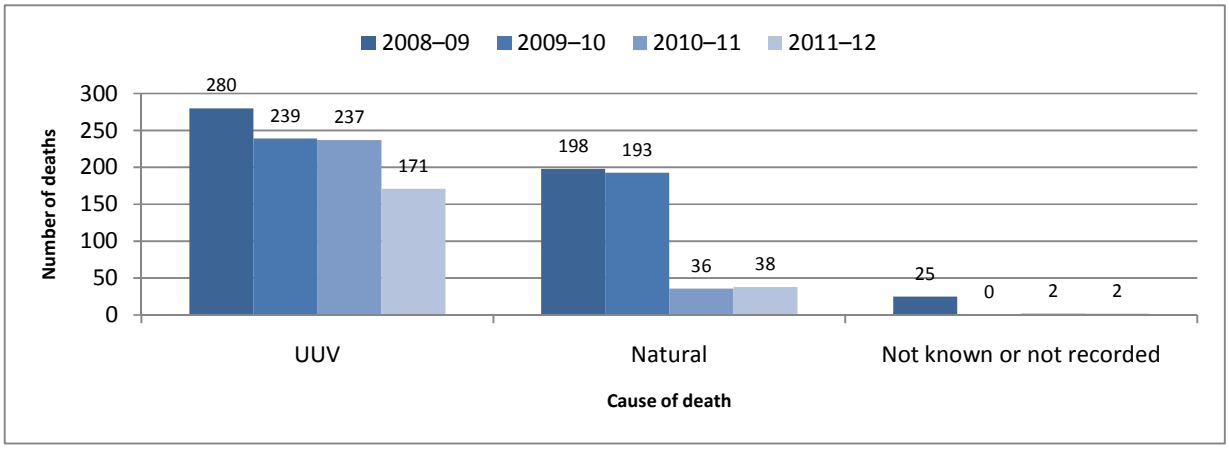
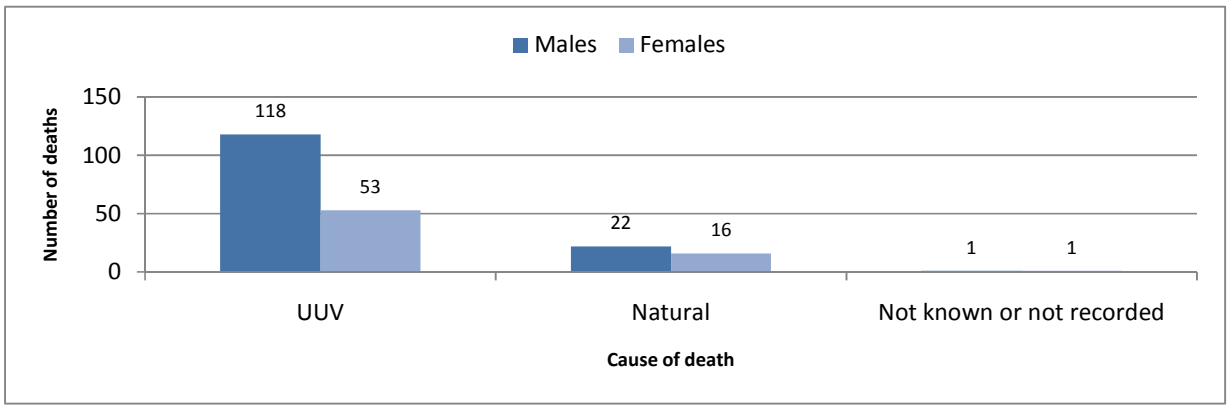


Figure 5 shows reportable deaths by cause and gender. Males outnumbered females by more than two to one in the UUV category. They accounted for 67 per cent of all reportable deaths in 2011–12 (64 per cent in 2010–11) and 69 per cent of unexpected, unnatural or violent deaths (66 per cent in 2010–11).

Figure 5: Reportable deaths by cause and gender, 2011–12



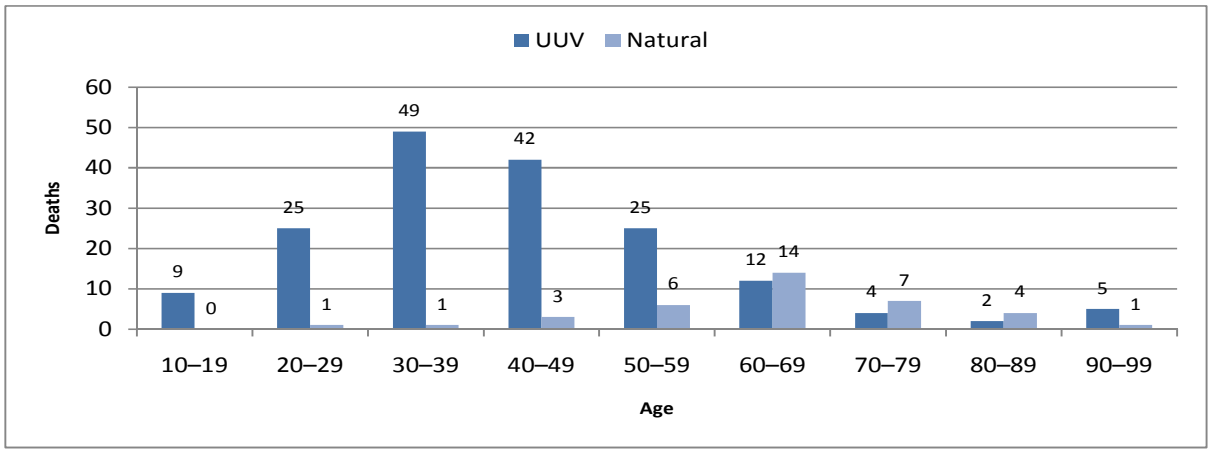
[33] Data source: OCP reportable deaths database, 31 October 2012.

[34] As a new classification for reportable deaths was introduced in 2008–09, only four years of trend data can be reported.

[35] The significant decrease in reportable deaths due to natural causes since 2010–11 is attributable to the changed reporting requirements for residents of aged persons mental health residential services that were introduced in April 2010. These changes were described in detail in the *Chief Psychiatrist's annual report 2010–11*, p. 26.

Figure 6 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 the deaths of five children and young persons under the age of eighteen (a two–year–old, a six–year–old, a 16–year–old and two 17–year–olds). The highest peak of mortality not attributable to natural causes was among clients, or former clients, aged in their 30s.

Figure 6: Reportable deaths by age and cause of death, 2011–12



A clinical diagnosis was recorded for 196 of the 211 reportable deaths recorded in 2011–12 (93 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 2011–12 by diagnostic group[36]

Diagnosis	Deaths	Percentage
Schizophrenia, schizotypal and delusional disorders	86	41%
Mood [affective] disorders	57	27%
Neurotic, stress-related and somatoform disorders	18	9%
Disorders of adult personality and behaviour	17	8%
Mental and behavioural disorders due to psychoactive substance use	8	4%
Organic, including symptomatic, mental disorders	7	3%
Other	3	1%
Not known or not available	15	7%
Total	**211**	**100%**

[36] 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[37] 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 2011–12. 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.[38] 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.[39] 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 show 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.

Number of ECT treatments in 2011–12[40]

Public and private mental health services in Victoria provided a total of 18,803 ECT treatments in the reporting period, 1,109 fewer than the previous year (a decrease of six per cent). As in the previous year, sixty-two per cent of all ECT treatments were provided by public mental health services and thirty-eight per cent by private psychiatric hospitals. Figure 7 shows that, while the number of ECT treatments has increased by 15 per cent since 2005–06, the number of persons receiving ECT has increased by only seven per cent. This may reflect the increased use of ultra-brief ECT in private settings.

[37] See, for example, publications of the National Institute for Health and Clinical Excellence (NHS, UK) and of the American Psychiatric Association.

[38] See Part 5, Division 2.

[39] See ss. 72–80 of the *Mental Health Act 1986*.

[40] 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 19 October 2012.

Figure 7: Use of ECT from 2005–06 to 2011–12 (public and private)

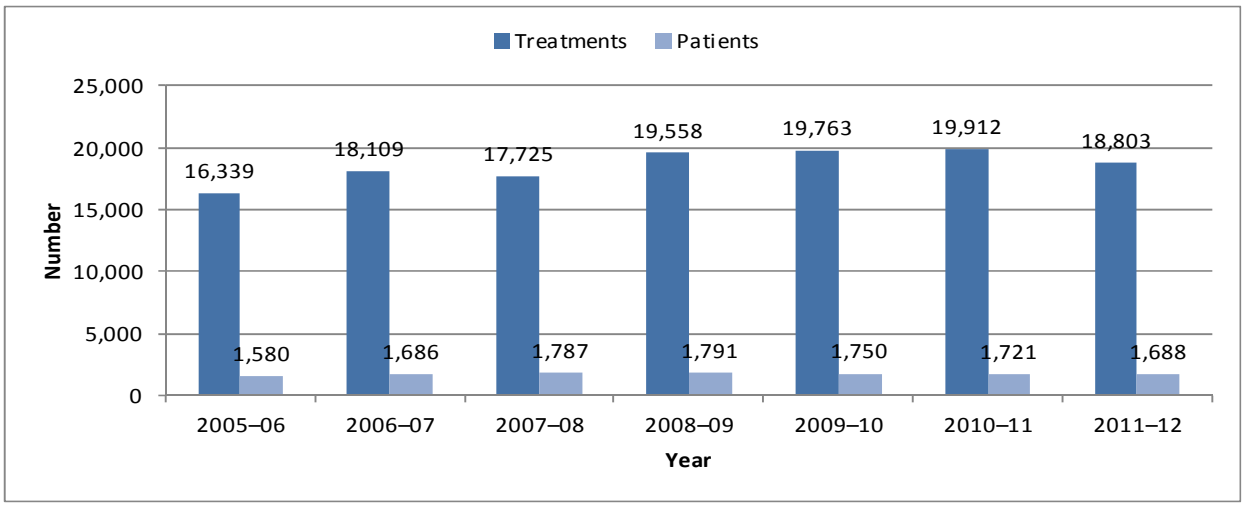
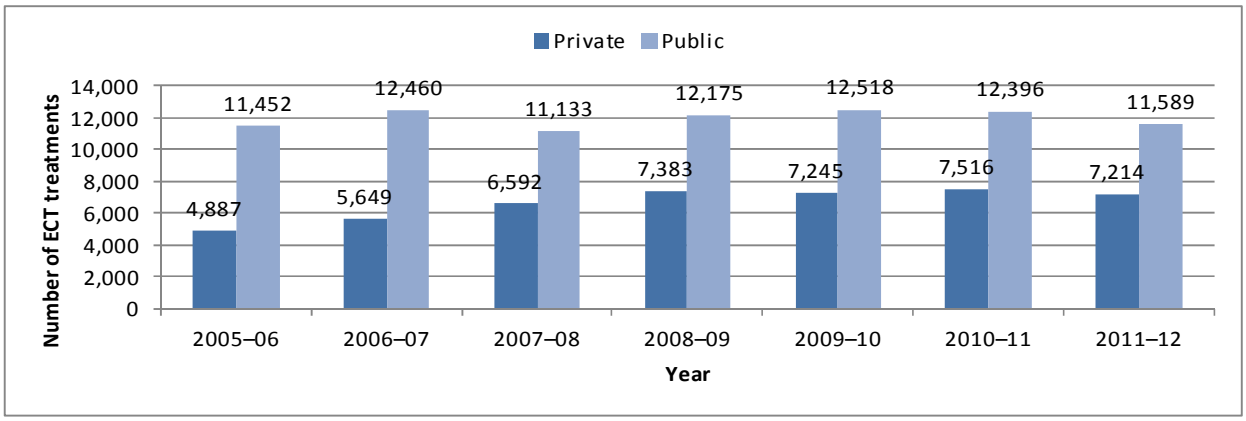


Figure 8 shows that the increase in the provision of ECT treatments since 2005–06 has been uneven across the sectors. The use of ECT in public mental health services has increased by just one per cent since 2005–06. In the private sector, the use of ECT increased by 48 per cent over the same period, from 4,887 treatments in 2005–06 to 7,214 in 2011–12. 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 contacted all private providers to review their processes for audit and second opinions. Private providers were keen to be involved and have indicated a willingness to continue closer involvement with the OCP.

Figure 8: Administration of ECT by sector from 2005–06 to 2011–12



Persons receiving ECT treatment

In 2011–12 a total of 1,688 people received ECT treatment, 33 fewer than in the previous year. The number of patients receiving ECT in a public mental health service increased marginally, from 1,050 in 2010–11 to 1,056 in 2011–12. The number of persons receiving ECT in a private mental health service decreased, from 671 patients in 2010–11 to 632 in 2011–12.

While the total number of ECT treatments has increased in recent years (see Figure 7), fewer people received ECT in the reporting period than in 2004.[41] The fall in the number of persons receiving ECT since 2004 runs counter to population growth[42] and service utilisation trends[43] over the same period.

---

41 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).

42 The Victorian population increased by 13 per cent between 2004 and 2012 (source: Australian Bureau of Statistics 2011, *Australian demographic statistics*, *March 2012*, cat. no. 3101.0, ABS, Canberra).

43 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).

The average number of treatments per person has increased over that period – reflecting an increase in the use of maintenance ECT[44] – and currently stands at 11 treatments per client, which is unchanged from the previous year.

As in 2010–11, sixty-five per cent of all ECT treatments 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 65 per cent of all ECT treatments in 2011–12. 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 72 per cent of ECT treatments in the private sector and 61 per cent in public mental health services.

Figure 9: ECT treatments by age and gender in 2011–12

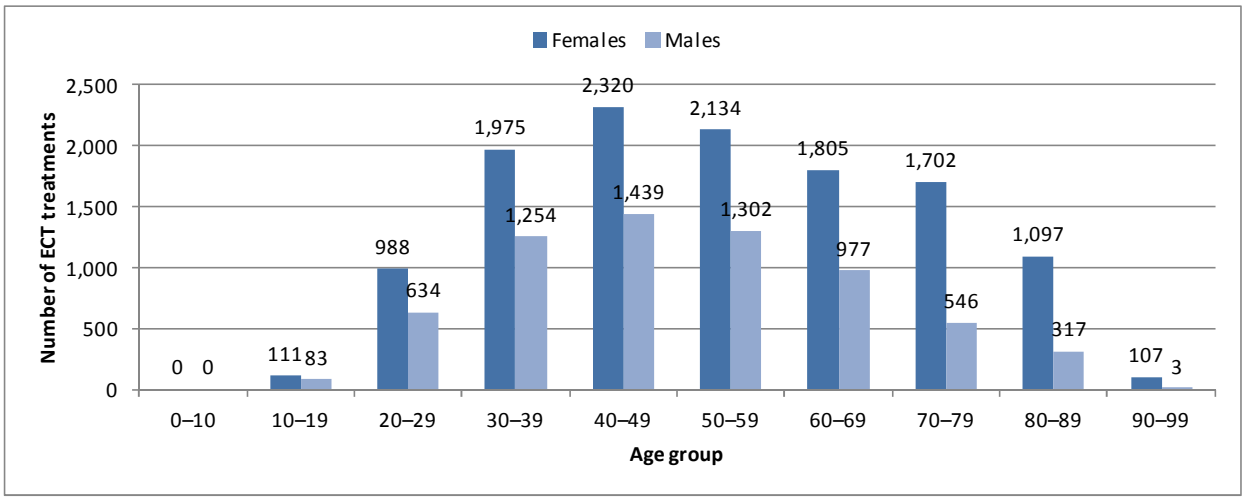


Figure 9 shows that for both genders, 40 to 49 was the peak decade for those receiving ECT treatment in 2011–12.

Forty ECT treatments were provided to three 17–year–old inpatients in the reporting period. All other treatments in the 10–19 age group were provided to patients who were 18 or 19 years old.

More than a hundred ECT procedures were provided to persons over 90 years of age. This reflects the safety and effectiveness of ECT in elderly persons who may be on multiple medications such that oral antidepressants may be relatively contraindicated.

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

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, 2011–12[45]

Diagnosis	Treatments	Percentage
Mood [affective] disorders	13,368	71%
Schizophrenia, schizotypal and delusional disorders	3,565	19%
Other (including neurotic illness)	234	1%
Not known or currently not available	1,636	9%
Total	**18,803**	**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 2011–12, 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.

During 2011–12 the Chief Psychiatrist inspected 21 premises providing ECT treatment. During these inspections, the Chief Psychiatrist makes a number of recommendations to the licence holder and the local director and coordinator of ECT to ensure standards of care are satisfactory. Recommendations usually pertain to patient amenities or quality improvement activities.

Of the 21 premises inspected in 2011–12:

- one service was provided with a new ECT provider licence for one year subject to the submission of a compliance report within six months, demonstrating it had met four conditions attached to the licence
- 20 premises were scheduled for a regular licence renewal inspection
- 15 of these met all criteria and had their licence renewed for a further five years
- for four premises, the Chief Psychiatrist attached special conditions to the licence renewal, requiring the service to provide a report of compliance
- one service was decommissioned as it was unable to comply with licence conditions.

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

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

- 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 2011.

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[46]

A total of 4,265 seclusion episodes were reported in 2011–12, compared to 4,694 episodes during the previous financial year. The number of individual clients secluded decreased from 1,656 to 1,584.

Of the 13,599 mental health clients admitted to hospital[47] in 2011–12, 12 per cent (1,584 consumers) were secluded at some time during their admission. The statewide seclusion rate in 2011–12 averaged 13 events per 1,000 occupied bed days (up from nine in 2010–11).

Figure 10: The use of seclusion from 2005–06 to 2011–12

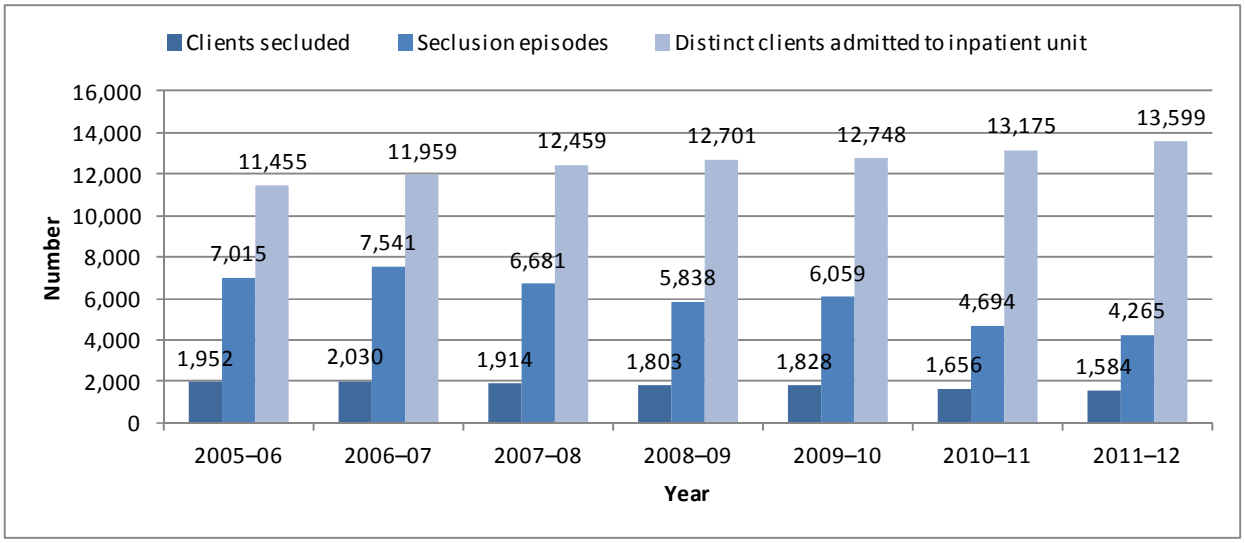
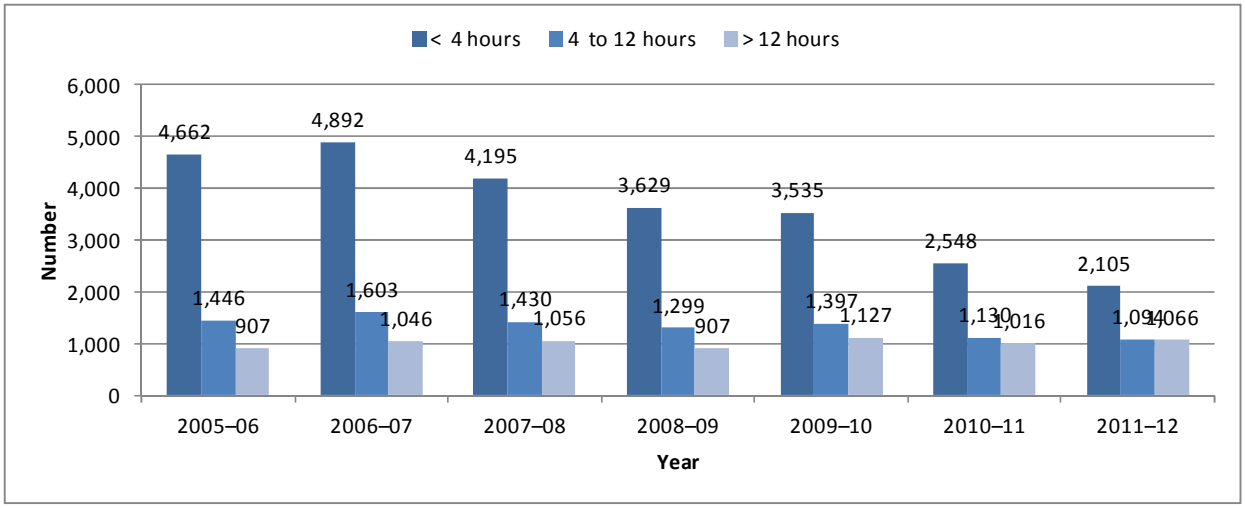


Figure 10 shows that the number of individual clients secluded peaked in 2006–07 and has declined by 22 per cent since, even though bed capacity in public mental health services expanded over this period[48] and the number of distinct clients admitted to an inpatient unit increased by 14 per cent.

[46] 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 7 September 2012.
[47] Across all inpatient units, including child and adolescent, adult, aged, general specialist, forensic and secure extended care.
[48] Additional short-stay beds in psychiatric assessment and planning units (PAPUs) came online over this period.

Figure 11: Duration of seclusion episodes from 2005–06 to 2011–12

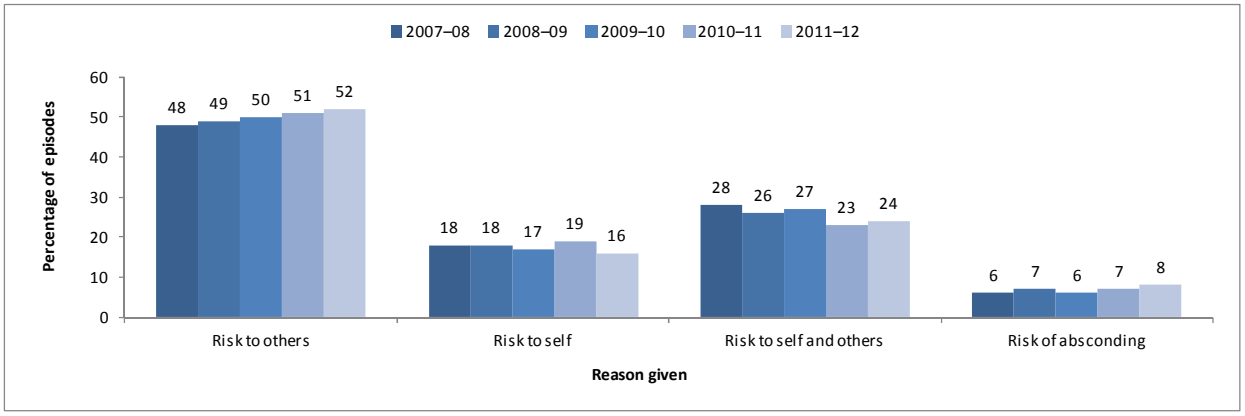


While the use of seclusion has reduced since its peak in 2006–07 (see figure 10), the duration of seclusion episodes has increased since that time.

Figure 11 illustrates those changes: in 2006–07 'short' episodes of seclusion (those lasting less than four hours) made up 65 per cent of all seclusion episodes; in 2011–12 the proportion of short episodes had fallen to 49 per cent (down five per cent from the previous year). A quarter of all seclusion episodes now lasts between four and twelve hours; and one in four seclusion episodes lasts longer than 12 hours.

Figure 12 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.

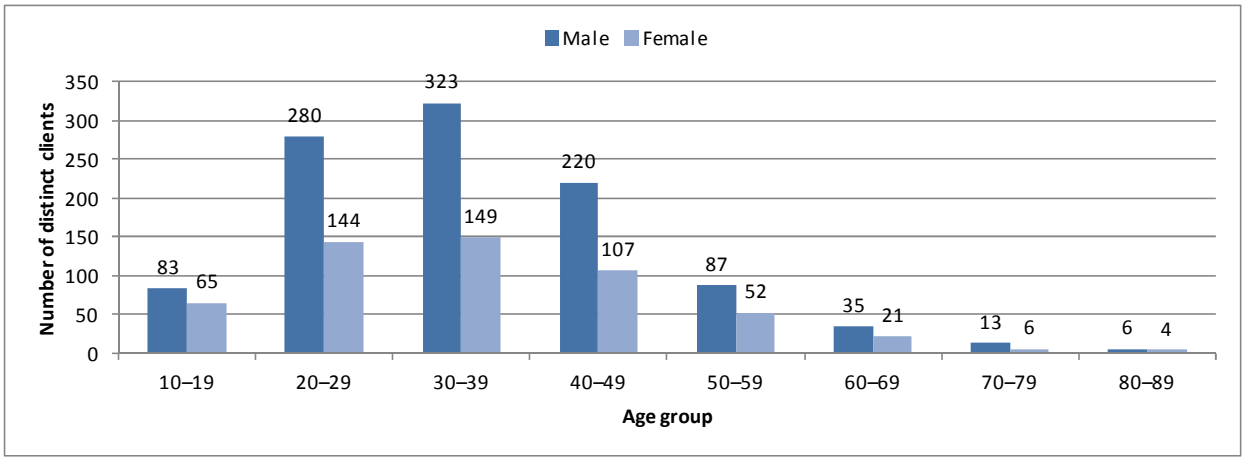
Figure 12: Reason for seclusion, 2007–08 to 2011–12



Persons secluded

Sixty-six per cent of seclusion episodes involved a male consumer. Figure 13 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 13: Persons secluded by age and gender, 2011–12



In the reporting period, the majority (92 per cent) of all seclusion events occurred in adult inpatient units. Adult mental health services reported 3,923 seclusion events in 2011–12, a decrease of 16 per cent (771 episodes) compared with the previous year.

There was a noticeable increase in the use of seclusion in child and adolescent inpatient units, from 189 episodes in 2010–11 to 251 episodes in 2011–12. Seclusion in child and adolescent mental health now accounts for six per cent of all seclusion episodes (up from four per cent in the previous year).

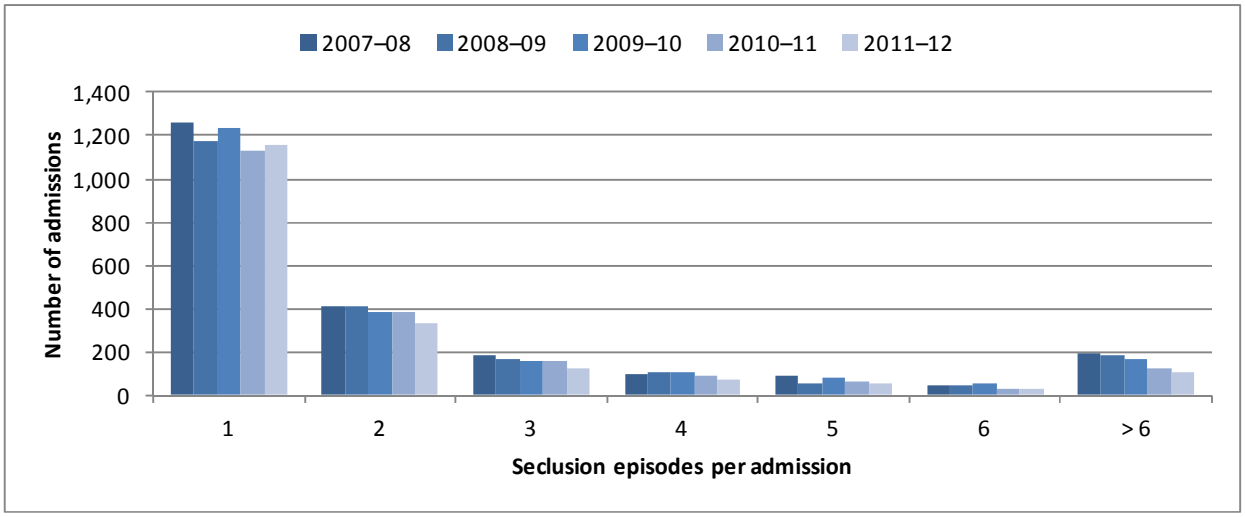
Aged inpatient units continued to reduce their use of seclusion in the reporting period. With only 91 episodes across the entire program (down from 109 episodes in 2010–11), aged persons mental health services accounted for two per cent of all seclusion episodes.

The following strategies underpinned the significant reduction in the use of seclusion in aged persons mental health services (APMHS) over the past two years:

- 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.

Twelve per cent of patients hospitalised during the reporting period were secluded. As Figure 14 shows, in the majority (61 per cent) of the hospital admissions that involved seclusion in 2011–12, the client was secluded on one occasion in the course of their admission. In 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.

Figure 14: 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.

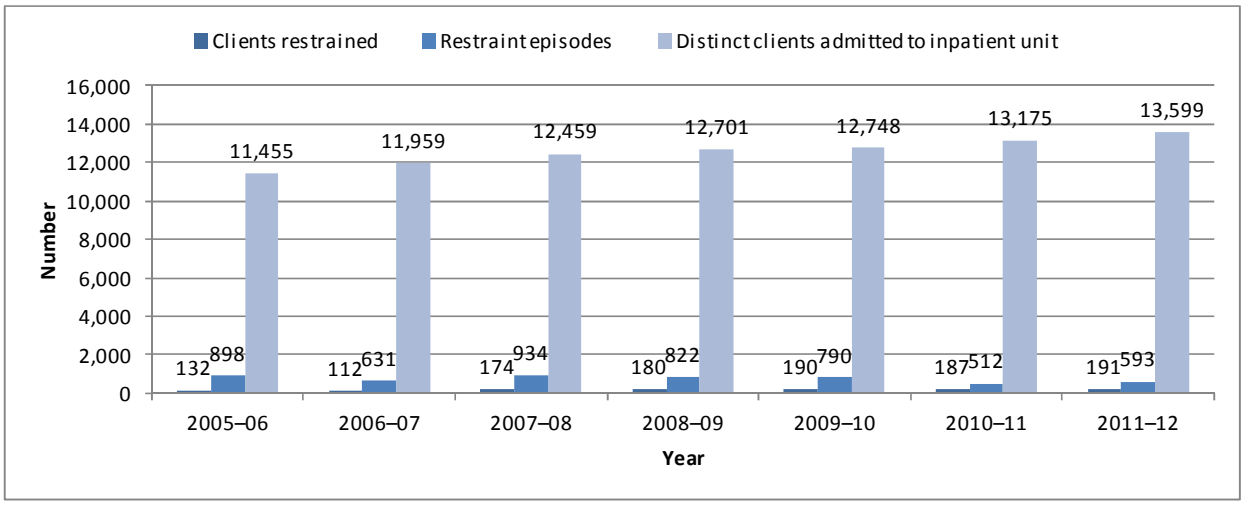
The Chief Psychiatrist guideline on *Mechanical restraint* (2006) provides more information on practice standards for the use of mechanical restraint.

Restraint episodes[49]

There were 593 episodes of mechanical restraint in 2011–12; compared with 512 episodes during 2010–11. However, 123 of these episodes (24 per cent) had a duration of just one minute and a further 23 episodes lasted between two and five minutes. Past practice reviews have shown that restraint episodes of extremely short duration indicate that the patient was briefly restrained at the start of a seclusion episode. Reporting these ultra short restraint episodes has the unintended effect of distorting statewide data by suggesting that the use of restraint is more widespread than is the case.

Figure 15 shows that the use of mechanical restraint declined from a peak of 934 episodes in 2007–08[50] to 593 episodes in 2011–12. This constitutes a 37 per cent reduction in the use of mechanical restraint, whereas the number of distinct clients admitted to an inpatient service increased by nine per cent over the same period.

Figure 15: Trend in use of mechanical restraint from 2005–06 to 2011–12

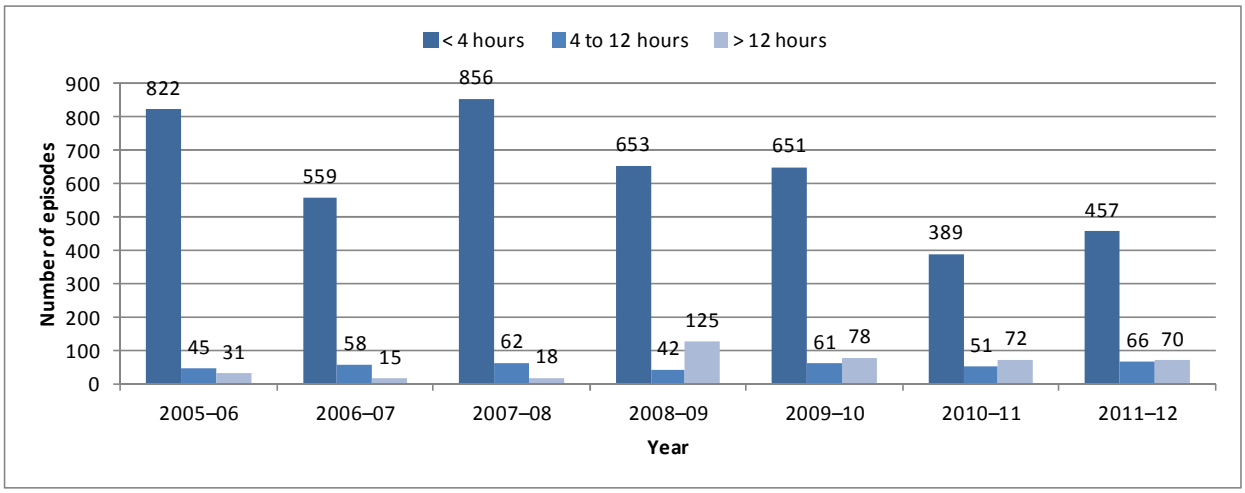


[49] Unless otherwise indicated, all data pertaining to the use of restraint cited in this report was derived from the annual report dataset for seclusion and restraint prepared by the Policy, Planning and Strategy Branch (MDHR) of the Department of Health on 7 September 2012.

[50] The previous high of 1,160 episodes in 2004–05 is no longer shown in this seven-year time series.

As shown in Figure 16, most restraint episodes were under four hours in duration (77 per cent of episodes in 2011–12) – an increase compared to 2010–11 yet still showing a reduction over the last 6 years.

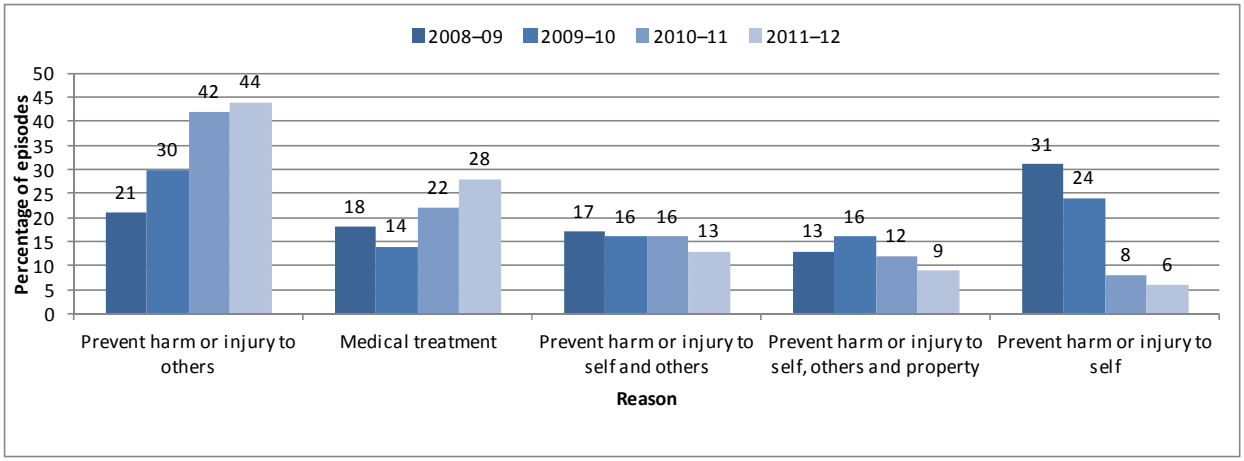
Figure 16: Duration of restraint episodes, 2005–06 to 2011–12



The average duration of a restraint episode in 2011–12 was just over six hours. Episode duration ranged from one minute to 134 hours. The duration of restraint episodes varied across age groups, averaging six hours in adult mental health services and eight hours in aged persons mental health services.[51]

Figure 17 shows that in 2011–12 the primary reason for restraining an inpatient was to prevent harm or injury to another person. This reason was cited in 44 per cent of restraint episodes. The second most common reason for using mechanical restraint was to facilitate medical treatment of the inpatient. This rationale was cited in 28 per cent of episodes (up from 22 per cent in 2010–11). Preventing harm or injury to the person themselves was the primary reason in six 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 17: Reasons for mechanical restraint



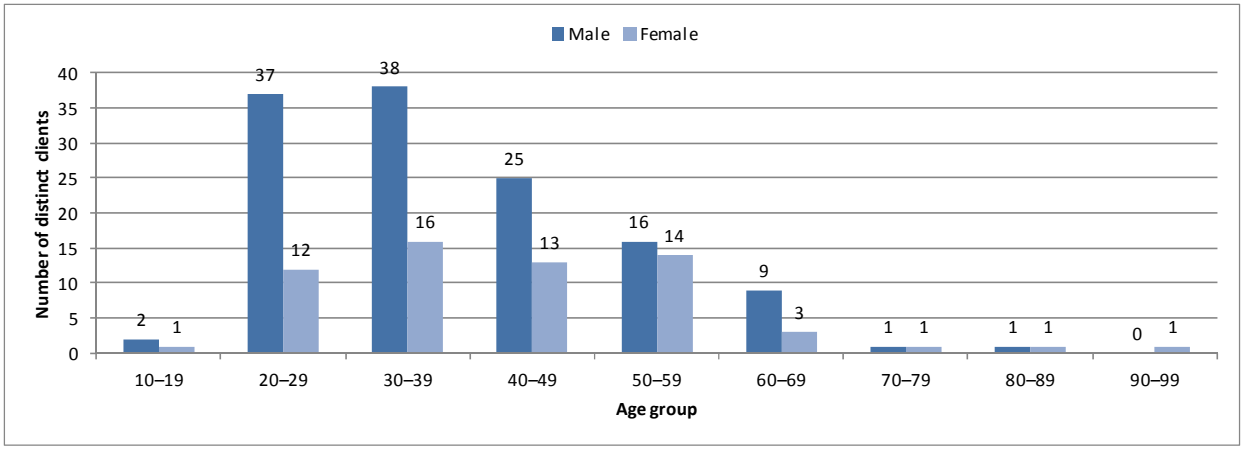
[51] Because of the low numbers involved in the reporting period, the corresponding figure for child and adolescent mental health services lacks statistical validity.

Persons restrained

One hundred and ninety-one persons were restrained in public mental health services in 2011–12, a slight increase compared to 2010–11, when 187 persons were restrained.

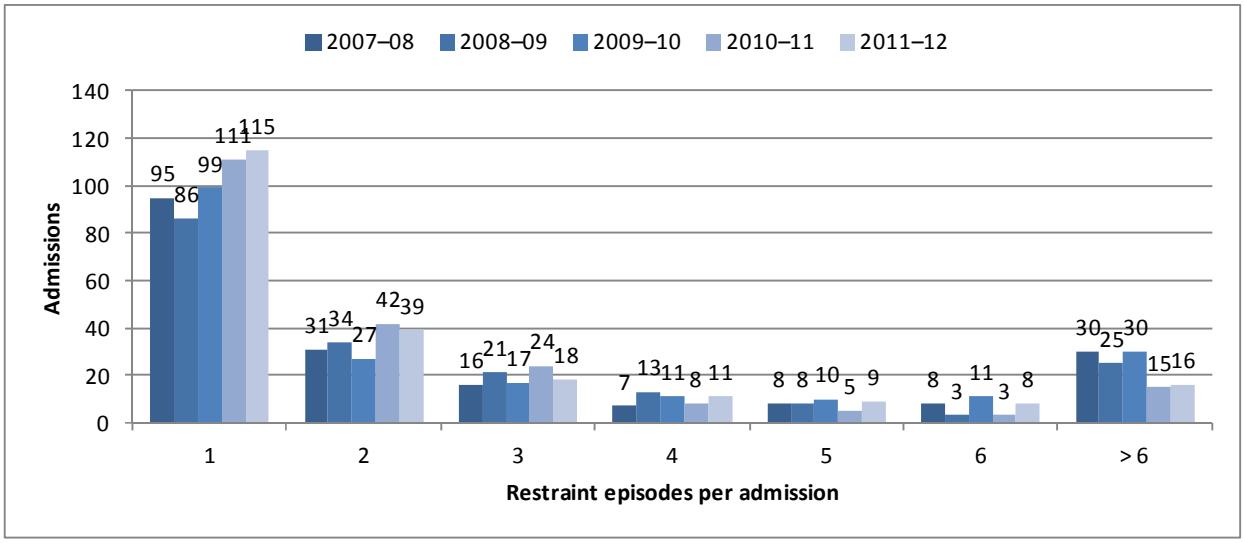
Sixty-eight per cent of restraint episodes involved a male consumer (down from 70 per cent in 2010–11) and figure 18 shows that most restraint occurred in adult mental health services.

Figure 18: Mechanical restraint by age and gender, 2011–12



Fewer than one and a half per cent of patients hospitalised during the reporting period were mechanically restrained. As Figure 19 shows, in more than half of the hospital admissions (53 per cent) that involved restraint in 2011–12, 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 19: 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. 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

Dr Ruth Vine (Chair)
Chief Psychiatrist
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Professor Kuruvilla George
Deputy Chief Psychiatrist, Aged Persons Mental Health
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Dr Sandra Radovini[52]
Deputy Chief Psychiatrist, Child and Youth Mental Health
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Dr Neil Coventry[53]
Deputy Chief Psychiatrist
Child and Youth Mental Health
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Dr Peter Burnett[54]
Director Clinical Governance
North Western Mental Health

Ms Tracy Beaton
Senior Nurse Advisor
Mental Health, Drugs and Regions Division
Department of Health

Associate Professor Ravi Bhat
Director of Psychiatry
Goulburn Valley Area Mental Health Service

Ms Lesley Chisholm[55]
Manager, Sector Quality Workforce Development
Mental Health, Drugs and Regions Division
Department of Health

Dr Paul Denborough
Director
Child and Adolescent Mental Health Service
Alfred Psychiatry

Mr Peter Kelly
Operations Director
Mental Health Services
Melbourne Health

Ms Sandra Keppich-Arnold
Associate Director of Nursing
Alfred Psychiatry

Ms Shannon Lang
Associate Director AMHS Strategy and Access
Eastern Health

Ms Bee Mitchell-Dawson
Senior Clinical Adviser
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Ms Claudia Mulder
Clinical Adviser
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Associate Professor Richard Newton
Medical Director
Mental Health Clinical Services Unit
Austin Health

Professor Daniel O'Connor
Director of Clinical Services
Aged Persons Mental Health
Southern Health

[52] Until November 2011
[53] From December 2011
[54] QAC member for the full year but until mid–July 2011 in his capacity as Deputy Chief Psychiatrist
[55] From September 2011

Dr Bob Salo
Director
Child and Adolescent Mental Health Services
Royal Children's Hospital

Ms Cathie Seccombe
Executive Director
Community Operations
Forensicare

Associate Professor Dean Stevenson
Director, Clinical Services
Mercy Mental Health

Ms Kate Thwaites
Clinical Adviser
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Mr Gilbert Van Hoeydonck
Project Manager
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Membership of the Quality Assurance Committee's ECT Sub-committee

Professor Kuruvilla George (Chair)
Deputy Chief Psychiatrist
Aged Persons Mental Health
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Ms Sheridan Ayton
ECT Coordinator
Barwon Health

Associate Professor David Barton
Director
North West Aged Persons Mental Health
Melbourne Health

Dr Peter Bosanac
Director Clinical Services/Director of ECT
St. Vincent's Mental Health

Dr Sathya Rao
Clinical Director, Spectrum/Director of ECT
Eastern Health

Associate Professor Simon Stafrace
Program Director
Alfred Psychiatry

Ms Kate Thwaites
Clinical Adviser
Office of the Chief Psychiatrist
Mental Health, Drugs and Regions Division
Department of Health

Professor John Tiller
Director of ECT
Albert Road Clinic

Dr Dennis Velakoulis
Director, Neuropsychiatry Unit
Melbourne Health

Thematic summary of clinical review findings 2010–2012

Purpose

To provide an overview of clinical reviews undertaken by the Office of the Chief Psychiatrist (OCP) under the auspices of the Quality Assurance Committee (QAC) between 2010 and 2012 and to help inform quality improvement initiatives by making available de-identified review findings to public mental health services across Victoria.

Background

The Quality Assurance Committee was established by law to 'oversee and monitor standards of mental health services'. [56] To this end, the QAC conducted a program of clinical reviews of public mental health services between 1997 and 2003. In 2010 the QAC commenced a new program of clinical reviews, using a revised methodology (see below).

As the QAC is a consultative council under the *Public Health and Wellbeing Act 2008* its activities, including the clinical review program, are accorded a high level of confidentiality. While this is conducive to mental health services freely sharing information with the review panel, the confidentiality restrictions placed upon review reports make it difficult to share the learning from clinical reviews with the sector at large. To counteract this, the OCP has produced this de-identified thematic summary, which outlines themes emerging from the five clinical reviews conducted between 2010 and 2012.

Clinical reviews 2010–2012

Reviews undertaken

Table 3: Clinical reviews undertaken since August 2010

Review held	Health service	Age groups in scope	% of records reviewed
August 2010	Austin Health	Adult and CYMHS[57]	21%
October 2010	Mercy Mental Health	Adult	16%
March 2011	Ballarat Health Services	Adult and Aged	15%
August 2011	Central East Area Mental Health Service (Eastern Health)	Adult and CYMHS	15%
May 2012	Inner West Area Mental Health Service (Melbourne Health)	Adult	18%

Methodology

The objective of a clinical review is to evaluate the consistency of clinical practices and procedures in selected components of the mental health service under review with the requirements of the *Mental Health Act 1986* ('the Act') and current standards, guidelines, legislative and policy requirements, in order to contribute to continuous improvement in the quality of the mental health service.

Services were reviewed from three complementary perspectives, each focusing on a particular component of the continuum of services:

- how responsive is the service to persons who present with mental health issues?

[56] S.106AC (3), *Mental Health Act 1986*.

57 Child and Youth Mental Health Services.

- how effective is community case management?
- what do seclusion and restraint practices tell us about the quality of treatment and care in inpatient services?

In addition, each review also examined any reportable deaths that had occurred in the period under review.

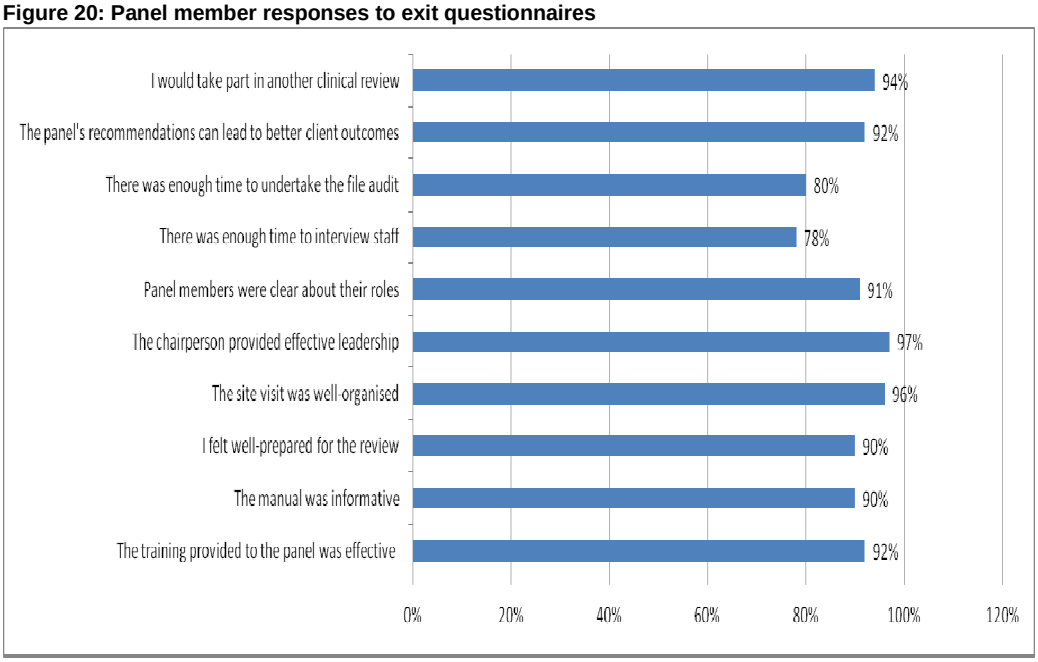
For each area, the OCP developed three audit tools. The first of these listed the national and Victorian standards that were applicable to the area under review; the second provided reviewers with a guide for interviewing staff and the final audit tool comprised a matrix for auditing clinical records against the standards.

The OCP continued the peer review methodology that had proved so successful in the first round of reviews. Each clinical review was undertaken by a large multi-disciplinary panel comprising experienced clinicians from mental health services across the state. In all, 39 clinicians from 17 services participated in the five most recent reviews.

Panel members are vetted for conflict of interest, appointed as QAC authorised officers and receive training about their role, with particular reference to confidentiality obligations and protections and the use of the audit tools. They also receive extensive background information about the services to be reviewed. This includes policy and procedure documentation provided by the service and statistical data provided by the Department of Health.

The centrepiece of the clinical review is a three-day site visit, during which the review panel examines clinical practice at the service using the suite of audit tools. Every clinical review exceeded its target of reviewing at least ten per cent of client records that were in scope. Following the site visit, separate feedback questionnaires were provided both to the service and to panel members. Only one service availed itself of the opportunity to provide feedback upon the review process. Figure 20 shows that panel members were very positive about the review process.

Figure 20: Panel member responses to exit questionnaires



Panel members are not remunerated but the clinical review is widely regarded as a valuable professional development opportunity.

Costs and benefits

The Mental Health, Drugs and Regions (MHDR) Division spent approximately $22,000 on overheads to cover the costs of the five clinical reviews undertaken since August 2010. This included primarily the purchase of encrypted laptops, the publication of the clinical review manual and payment of panel members' travel and accommodation costs. In addition, each review is estimated to have cost around $35,000 in OCP staff salaries[58], taking the total cost to approximately $40,000 per review.

The primary strengths and benefits of the clinical review program are:

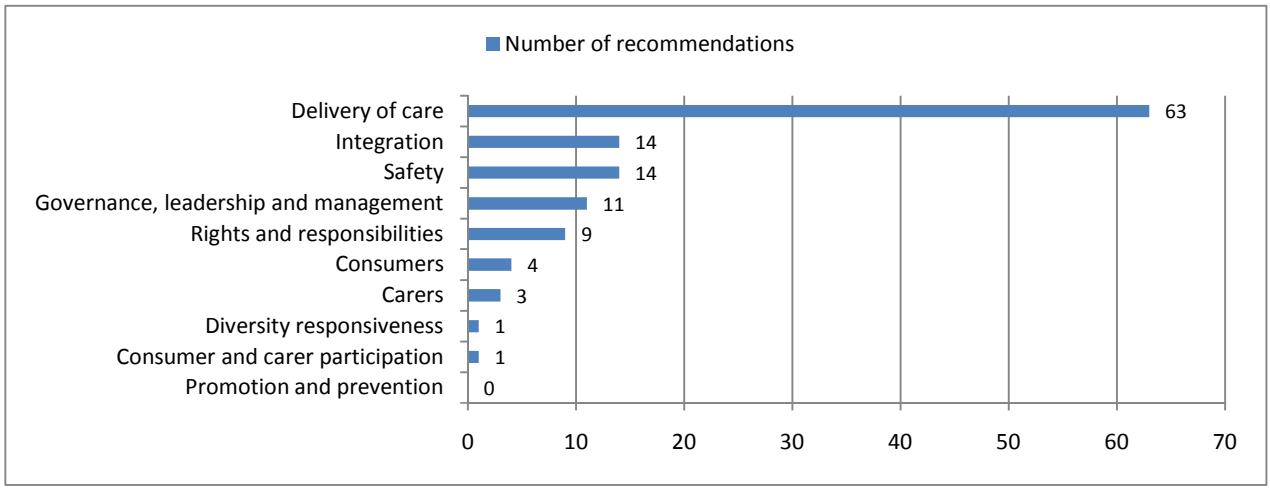
- no other quality improvement activity examines individual clinical records in such depth
- the program is underpinned by a strong project management approach including a manual and a training program for panel members; and audit tools based on the national standards
- the decision to review at least ten per cent of clinical records of service elements that are in scope means that the panel's recommendations are underpinned by a strong evidence base
- reviews are undertaken by a multi-disciplinary team of experienced mental health professionals who are familiar with the Victorian service delivery context
- the 115 recommendations made in the five most recent reviews are specific and provide services with a framework and a mandate for improving service delivery and consumer outcomes
- a number of the review recommendations were potentially life-saving
- services are required to develop an action plan in response to the review's recommendations and those action plans are followed up by the OCP and the QAC until implementation is complete.

The section below provides more details on the reviews' findings.

Findings

Figure 21 shows that most recommendations made by the five clinical reviews pertained to national standard 10—delivery of care. Issues pertaining to service integration and safety[59] issues ranked second. Standard 8 (governance, leadership and management) ranked high because several recommendations related to the training of staff (standards 8.6 and 8.7).

Figure 21: Clinical review recommendations by national standard



[58] Not counting the time of external panel members.
[59] A decision was made to count recommendations relating to the use of seclusion and restraint against the Victorian Seclusion CPG, which provides more detail than national standard 2.2. See figure 4 for details.

Figure 22 shows a further breakdown of clinical review recommendations by each of the areas that constitute standard 10.

Figure 22: Clinical review recommendations by subsets of standard #10 (delivery of care)

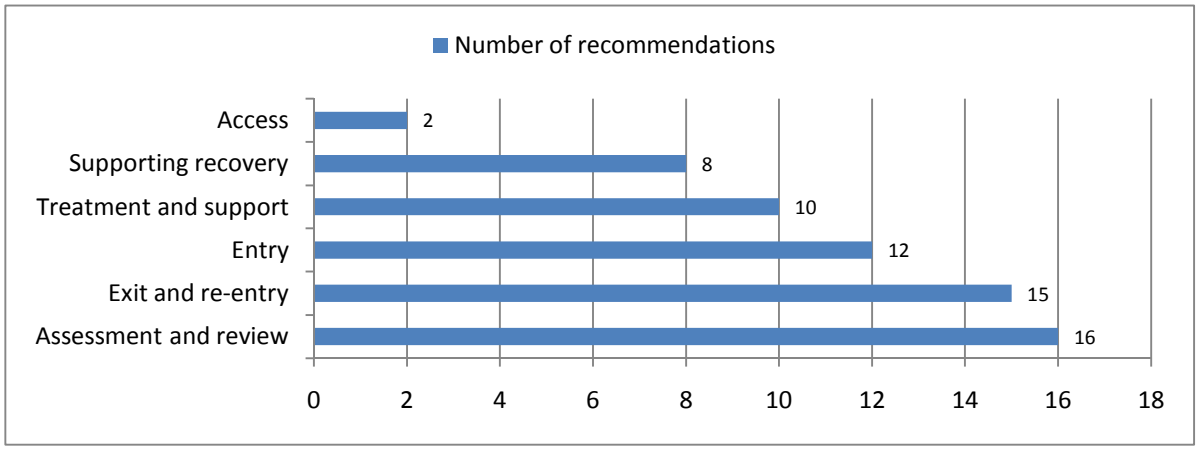
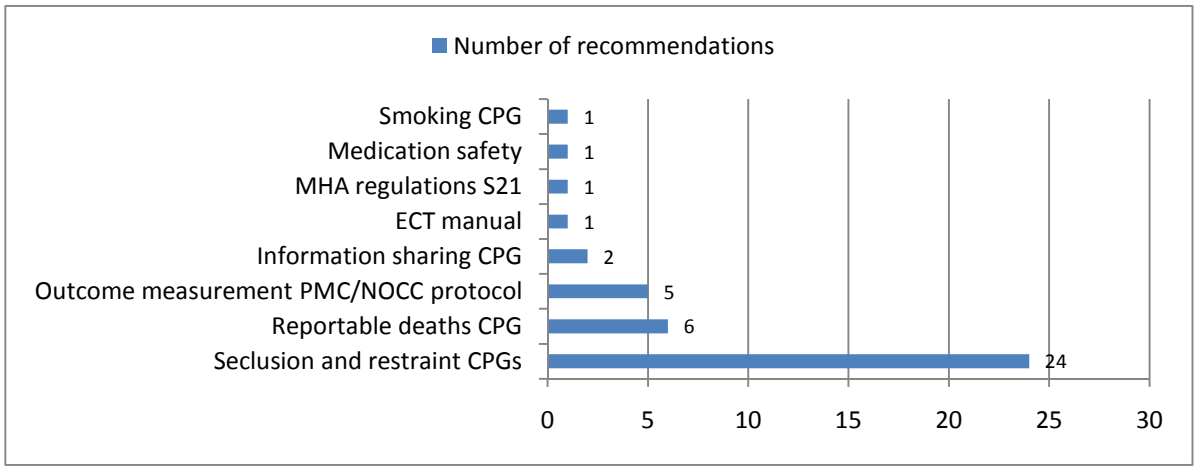


Figure 23 provides a breakdown of clinical review recommendations that related to Chief Psychiatrist guidelines (CPGs) and other regulations, guidelines or policy documents. It shows that most recommendations related to the use of seclusion and restraint in inpatient services; and to service responses following the reportable death of a consumer. This is not surprising, as both areas were a standard feature of the clinical review; and neither is covered in detail in the national standards.

Figure 23: Clinical review recommendations pertaining to other standards and guidelines



In reviewing clinical practice, the review panels found numerous examples of excellence in individual clinical care. Strengths across most of the services reviewed were:

- most services had experienced and committed staff who had been with the service for a long time and had an in-depth knowledge of the local service context
- consumer and carer participation processes were generally embedded in the culture of the organisation
- most services had made a sustained effort to reduce the use of seclusion and restraint in the inpatient unit.

Most services met most of the national standards most of the time, though there was considerable variability across and even within area mental health services. This sometimes came down to the practice of individual clinicians. For example, it was not unusual for reviewers to cite treatment planning practices as both an area of excellence and an area of concern within the same team. It was important in such cases to have recourse to the standardised audit tools, so that reviewers' perceptions could be quantified and conclusions refined as appropriate following the collation of all audit results.

For most of the services reviewed, a significant amount of work remains to be done in the following domains to ensure that standards are consistently met:

- provide regular refresher training to triage staff
- promote a recovery-based approach to treatment that is reflected in the clinical record through, for example, entries that reflect the consumer's perspective, or engagement with consumer-defined goals
- ensure that consumers of mental health services are regularly screened for physical health issues and referred to a GP as necessary
- improve treatment planning by:
  - formulating specific, individualised and realistic objectives
  - more consistently involving consumers and carers
  - regularly reviewing treatment plans in order to reflect the consumer's changing needs, to monitor therapeutic progress and to underpin work towards recovery
- provide senior medical review or a second opinion for patients having prolonged or repeated episodes of seclusion or restraint
- conduct a regular audit of clinical records to ensure that seclusion and restraint practices comply with all applicable standards and statutory requirements
- review all episodes of seclusion and restraint with a view to identifying common factors involved in these events in order to help inform the development or refinement of strategies that can safely reduce the use of these restrictive interventions
- involve consumers and, with the consumer's informed consent, their carers, in the development of discharge plans and ensure that all relevant parties are provided with a copy of the plan
- follow up recently discharged clients to ensure that proposed discharge arrangements have been put into effect
- regularly review and remove potential ligature points in inpatient units
- ensure that adequate debriefing and support are provided to families, staff and fellow patients following the death of a inpatient
- use outcome measurement data in clinical review processes and to review progress with the consumer.

The road ahead

The MHDR Division is currently preparing for the implementation of the new mental health act. This is a major undertaking which requires a review of work priorities across the division, including the OCP. As the clinical review program is a labour-intensive process, it has been decided to pause the program to help free up staff resources that can be redirected to the implementation of the act. Therefore no clinical review is being scheduled for 2013. The OCP and the QAC will continue to monitor the implementation of the recommendations of reviews completed since 2010.

Gilbert Van Hoeydonck
Project Manager, Clinical Review Program
12 September 2012