

Annual Report 2003

Office of the Chief Psychiatrist

Annual Report 2003

Office of the Chief Psychiatrist

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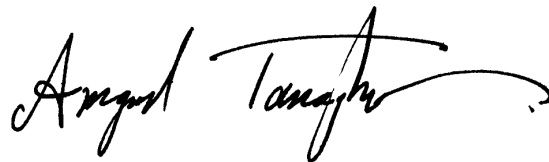
8/12/04

The Honourable Bronwyn Pike MP
Minister for Health
555 Collins Street
MELBOURNE VIC 3000

Dear Minister

In the interests of increasing the public transparency and accountability of mental health services in Victoria, I present the first annual report of the Chief Psychiatrist for the period 1 January 2003 to 31 December 2003.

Yours sincerely

A handwritten signature in black ink, reading "Amgad Tanaghow". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Associate Professor Amgad Tanaghow
Chief Psychiatrist
MB CH B. FRC PSYCH (UK) FRANZCP

Introduction

It is with great pleasure that I present the Chief Psychiatrist's annual report 2003, the first publicly available report of this office. The report also serves as the first annual report of the Quality Assurance Committee established under s. 106AC of the *Mental Health Act 1986* (Vic). It covers the period 1 January 2003 to 31 December 2003.

Under the general direction and control of the Secretary of the Department of Human Services, the Chief Psychiatrist has statutory responsibility for the medical care and welfare of persons receiving treatment or care for a mental illness. This report acknowledges the increasing demand for the Office of the Chief Psychiatrist to describe its operations and to report to the Victorian community and stakeholders on key activities of the office.

In publishing this first report, it is important to acknowledge my predecessors in this role and their contributions to overseeing and monitoring mental health service delivery in Victoria. Dr Carlyle Perera was appointed as Victoria's first Chief Psychiatrist in 1987 and faced the challenging task of establishing and developing the role, defining its relationship with mental health services, consumers, stakeholders and the broader community. Dr Perera oversaw a period of great change in mental health service provision during the 1990s, and his dedication and commitment to the role and sensitivity to the needs of people with mental illness are well known.

Following Dr Perera's retirement in 1998, Associate Professor Norman James showed a similar dedication to the Chief Psychiatrist's responsibilities. During the period of his appointment, Professor James also oversaw a significant increase in systemic quality assurance activity through the Office of the Chief Psychiatrist. This occurred principally through statewide clinical review of all area mental health services.

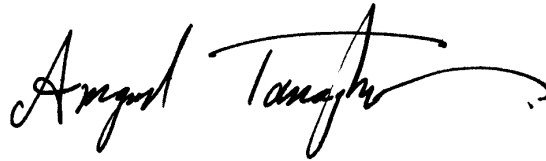
As Victoria's third Chief Psychiatrist, I express my gratitude to Dr Perera and Associate Professor James for their work and for establishing administrative systems for effectively managing statutory responsibilities.

Since its inception, the office has been served by senior clinicians and administrative staff who have assisted the Chief Psychiatrist in performing the role's statutory functions. I am grateful to the current staff of the office for their high level of commitment and skill: without such commitment, the office could not fulfil its statutory functions.

It is also appropriate in this report to acknowledge the contribution of a number of psychiatrists who have either acted in the role of Chief Psychiatrist for brief periods or acted as assistants to the Chief Psychiatrist. All have brought particular expertise and areas of interest which have enriched the office in a range of ways. These include Dr Ruth Vine, Dr Basil Pinkey, Dr Richard Zimmerman, Dr Ric Yeatman, the late Dr Peter MacCallum, the late Dr Tony Chandrasakera, Dr Kathy Hall, Dr Peter Doherty, Dr Rob Shields, Dr Dhushan Illesinghe, and Dr Paul Hantz.

Information presented in this report is a combination of descriptive and statistical information. As this is the first report, it seeks to describe significant recent activity of the office in some detail and provide additional historical information where relevant. It is anticipated that data analysis will be more detailed in future reports.

I am committed to the continued development of the Office of the Chief Psychiatrist, with the central aim of achieving improved clinical outcomes for persons with a mental illness in Victoria and working with services to continuously improve the quality of mental health services. I am hopeful this report provides a valuable insight into the operations of the office at this point in its continuing development.

A handwritten signature in black ink, reading "Amgad Tanaghow". The signature is written in a cursive style with a large, sweeping flourish at the end.

Associate Professor Amgad Tanaghow
Chief Psychiatrist

1. Overview

1.1 Objectives of the annual report

The objectives of this report are to:

- inform mental health consumers, carers, service providers and members of the public about the role, functions and activities of the Office of the Chief Psychiatrist
- provide information about specific clinical practices which must be reported to the Chief Psychiatrist under the Mental Health Act
- report on the activities of the Quality Assurance Committee
- contribute to the education of members of the public about mental health service delivery and mental health issues
- assist the continuing increase in standards of treatment and care for persons with a mental illness.

1.2 Statutory framework for the Office of the Chief Psychiatrist

Section 105(1) of the Mental Health Act provides for the appointment of a chief psychiatrist by the Secretary of the Department of Human Services. Section 105(2) states that subject to the general direction and control of the Secretary, the Chief Psychiatrist is responsible for the medical care and welfare of persons receiving treatment or care for a mental illness. The Chief Psychiatrist undertakes a range of statutory and quality monitoring functions in fulfilling these statutory responsibilities.

To perform these functions, the Chief Psychiatrist has broad powers of investigation, inspection and enquiry contained in s. 106 of the Mental Health Act. Following an investigation, the Chief Psychiatrist can direct a mental health service to discontinue or alter practice, procedure or treatment, direct it to observe or carry out a practice, procedure or treatment specified, or direct a person be provided with treatment. The Chief Psychiatrist can also direct a person be admitted to an approved mental health service as an involuntary patient.

The Chief Psychiatrist can appoint authorised officers to assist in performing statutory functions. Under s. 106 of the Act, authorised officers can make extensive enquiries about admission, detention, care and treatment of persons with a mental illness or disorder. Staff and service management are required to provide reasonable assistance to authorised officers to enable them to effectively conduct these functions.

1.3 Role of the Chief Psychiatrist

In fulfilling the statutory responsibilities described, the Chief Psychiatrist and staff of the office:

- investigate treatment-related issues where the Chief Psychiatrist determines such an investigation is warranted
- conduct statewide clinical review of approved mental health services to examine the standard, quality and consistency of clinical practice provided
- receive and investigate complaints from consumers and carers
- manage enquiries and correspondence from members of the public, service providers and other organisations
- develop clinical guidelines and circulars about applying and interpreting the Mental Health Act and establishing and maintaining practice standards. Clinical guidelines set out service requirements, relevant policy and legislation and a range of other useful information related to particular areas of practice. Program management circulars provide additional guidance on specific matters to services and practitioners
- provide expert advice and consultation to mental health services, divisions of the Department of Human Services, other government departments and statutory authorities
- participate on working parties and committees about the welfare of persons receiving treatment or care for a mental illness.

1.4 Other statutory and related functions of the Chief Psychiatrist

In addition to the broad statutory functions already described, the Chief Psychiatrist has a number of additional statutory responsibilities. These include:

- receiving statutory reports on performance of electroconvulsive therapy in licensed premises, seclusion and mechanical restraint in approved mental health services, and annual medical examinations of all involuntary patients under the Mental Health Act
- receiving reports on all reportable deaths (as defined by the *Coroners Act 1985* (Vic) and required by the Mental Health Act)
- licensing premises in the public and private sectors to perform electroconvulsive therapy
- assessing patients detained pursuant to s. 93(1)(d) of the *Sentencing Act 1991* (Vic) for restricted community treatment orders, and making recommendations to the Mental Health Review Board about such assessments

- discharging patients detained pursuant to s. 93(1)(d) of the Sentencing Act
- being a member of the Forensic Leave Panel, which oversees limited leave for forensic patients pursuant to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)
- considering applications for special leave for security patients
- providing advice to the Ministerial Correctional Advisory Committee about leave for persons detained under s. 16(3)(b) of the Mental Health Act and s. 93(1)(e) of the Sentencing Act.

These functions are described in more detail in the report.

1.5 Brief history of the Office of the Chief Psychiatrist

Dr Carlyle Perera became the first Chief Psychiatrist following commencement of the Mental Health Act in 1987, and occupied the position until his retirement in November 1998. In the latter part of his term, Dr Perera was assisted by Associate Professor Norman James, who took up the Chief Psychiatrist's role following Dr Perera's retirement. In 1999 the position of Deputy Chief Psychiatrist was created and was filled by Dr Ruth Vine on a full time basis until 2002. Associate Professor James returned to South Australia in February 2002 to contribute to reforming that state's mental health services and Associate Professor Amgad Tanaghow took up the position of Chief Psychiatrist in September 2002. An additional part time position of Deputy Chief Psychiatrist, Aged Persons Mental Health, was established in 2002 in recognition of the growing need for specific attention to be paid to aged persons' mental health issues with the increasing ageing population. Dr Kuruvilla George was appointed to, and remains in, this position.

Since the Office of Chief Psychiatrist was created, the focus of work has altered. While managing consumer and carer concerns and complaints has remained a principal function, there have been shifts and changes in associated activity, driven by particular service or consumer needs. In its earliest days, when the Department of Human Services directly managed services, the focus was on recruiting psychiatrists and being involved in training psychiatrists and rotation of registrars. At the time, the office promoted development of an innovative compulsory rotation for registrars to rural services, which were experiencing significant difficulties in recruiting psychiatrists.

Other significant early activities include involvement in inquiries into standards of treatment and care at Ararat and Lakeside Hospitals in the late 1980s and early 1990s and the statewide audit of standards of treatment and care in state psychiatric hospitals in Victoria in 1991. These were watershed events in the history of Victorian mental health services and were catalysts for reform of mental health services in the state.

Following the mainstreaming of mental health services with the general hospital system in 1995, the responsibilities of the Chief Psychiatrist broadened, as did the scope of activities undertaken. In particular, monitoring functions which examined standards of treatment and care were expanded and strengthened.

During this period, the office was also engaged in continuous development of internal systems and processes to support its statutory and associated functions.

Two senior clinical advisor positions were established, one in 1995 and another in 1997, adding to an existing small group of administrative staff. Creating these positions enabled extensive development of clinical practice guidelines and establishment of the clinical review program. The current incumbents of these positions are Deanna Clancy and Bee Mitchell-Dawson. Previous clinical advisors include Elizabeth Croke and Alicia Evans.

In addition, the Chief Psychiatrist took over responsibility for licensing premises to perform electroconvulsive therapy. The then Acute Health Division of the Department of Human Services formerly conducted this licensing.

In 1999, the Quality Assurance Committee was established under the Mental Health Act with the statutory function of overseeing and monitoring standards of mental health services. In establishing the Quality Assurance Committee under the Act, a greater level of focus was given to systemic quality assurance activity. Prior to the committee's establishment, the focus of statutory provisions had been on incident-driven investigations. This increased focus on systemic approaches to quality assurance activity in health services was consistent with increased national and international views on how best to improve health service delivery. Around this time, the office also became more involved in providing clinical advice and education to public mental health services to assist clinicians in applying the Act and other complex clinical areas of practice.

1.6 Staff of the Office of the Chief Psychiatrist

The Office of the Chief Psychiatrist functions within the Department of Human Services' Mental Health Branch. During the 2003 calendar year, the staff comprised:

Chief Psychiatrist	Associate Professor Amgad Tanaghow, MB CH B. FRC PSYCH (UK), FRANZCP
Deputy Chief Psychiatrist (Forensic)	Dr Ruth Vine, MBBS, FRANZCP, LLB, DPM, DipCrim
Deputy Chief Psychiatrist (Aged Persons Mental Health)	Dr Kuruvilla George, MBBS MPhil, DPM, FRC Psych, FRANZCP
Senior Clinical Advisor	Ms Deanna Clancy, Clinical Psychologist, BA (Hons), MA, MAPS
Senior Clinical Advisor	Ms Bee Mitchell-Dawson, Registered Psychiatric Nurse
Project Officer	Dr Cameron Wallace, PhD, MAPS
Executive Personal Assistant	Ms Zeza de Carvalho
Executive Services Officer	Ms Rose Nero, MA
Executive Assistant	Ms Margaret Turner
Administration Assistant	Ms Frances Jacovou

1.7 Policy context for service delivery in Victoria

Role of the Mental Health Branch

The department's Mental Health Branch is responsible for the overall planning of mental health services in the state. The branch implements government policy, sets key priorities, develops policy and monitors service delivery and effectiveness. The Office of the Chief Psychiatrist plays a significant role in this process.

International and national policy – some historical background

In 1991, the General Assembly of the United Nations adopted *Principles for the protection of persons with mental illness and for the improvement of mental health care*.

In 1992, Commonwealth, state and territory health ministers agreed on a *National mental health policy and National mental health plan* (the *National mental health strategy*), consistent with the United Nations Principles, with the goal of reforming and developing Australian mental health services. Central to these reforms was providing services which uphold consumer rights to receive safe, effective and dignified mental health care of a high quality.

In 1998, the second *National mental health plan* was published, building on the reforms of the first strategy through three key areas: promotion and prevention, development of partnerships in service reform, and quality and effectiveness of service delivery. By 2003, in the third plan, the *National mental health plan 2003–2008*, four broad priority areas were considered central to consolidating existing reform activities and strengthening focus in these areas of particular significance:

- promoting mental health and preventing mental health problems and mental illness
- increasing service responsiveness
- strengthening service quality
- fostering research, innovation and sustainability.

All states are required to work towards these goals and progress continues to be monitored annually through the *National mental health report*. The *National Standards for Mental Health Services*, endorsed by the Australian Health Ministers' Advisory Council's National Mental Health Working Group on 3 December 1996, also provide an important benchmark which all services are expected to progressively meet.

Victorian reforms 1994–2003

Victoria's reform goals were initially contained in *Victoria's mental health service: a framework for service delivery* (Department of Human Services, 1994). The framework stated services must:

- provide standards and conditions of treatment and care for persons who are mentally ill which are, in all possible respects, at least equal to those provided for persons with other forms of illness
- take into account the religious, cultural and language needs of persons who are mentally ill
- minimise the adverse effects of mental illness in the community
- be comprehensive and accessible
- be designed to reduce the incidence of mental illness in the community
- provide for intervention at an early stage of mental illness
- support people who are mentally ill in the community and coordinate with other community services.

Victoria's mental health service: improved access through coordinated client care (Department of Human Services, 1995) built on the framework. It requires that all people receiving public mental health services have a case manager who is responsible for coordinating treatment and care. Treatment must be undertaken according to an individualised treatment plan, which is developed with the mentally ill person and regularly reviewed. This is intended to ensure continuity of treatment and care, which is tailored to a person's needs. Mandatory obligations for service providers are also articulated as part of the above policies and require that:

- services be targeted to people with serious mental illness and be provided in a manner consistent with the requirements of the Mental Health Act
- initial assessment and treatment be provided routinely through community mental health services, including a crisis assessment and treatment service, a community mental health service or an intensive mobile treatment service
- area mental health services have a single point of management and accountability.

In support of these policies, public mental health services in Victoria were divided into catchment areas in 1994–95. These areas are defined by geographical boundaries and form area mental health services. There are 21 area mental health services in Victoria, each with three core programs: adult mental health services, child and adolescent mental health services, and aged persons mental health services.

Each area mental health service has a range of inpatient and community-based services aimed at providing general mental health services to their local community. Additionally, there are a number of statewide programs providing a range of specialist services and functions. General information about area mental health services, including their catchment areas, a list of statewide services, and contact details for accessing services, is available from the Department of Human Services web site at www.health.vic.gov.au/mentalhealth/accessingservices.

New directions for Victoria's mental health services 2002

In late 2002, the Minister for Health launched *New directions for Victoria's mental health services*. The policy stated that while Victoria had laid the foundations of a comprehensive public mental health system, further improvements were required to better meet the needs of people with severe and ongoing mental health problems and those with more complex needs. *New directions* stated improvements would be directed at:

- managing the growing demand for mental health services
- responding to increasingly complex consumer needs, particularly the needs associated with increasing drug use among young people with mental illness
- developing improved responses to consumer and carer needs, including developing new models of care, particularly for people with high needs
- establishing and maintaining an appropriate balance between inpatient and community-based services
- addressing workforce challenges, including education, training, recruitment and retention
- ensuring the future sustainability of services.

The *National mental health plan 2003–2008* and *New directions* form the broad policy basis for service development and current Mental Health Branch monitoring and review activity.

1.8 Legislative context for service delivery

In addition to the specific powers of the Chief Psychiatrist and authorised officers, the Mental Health Act contains objects and principles which govern service delivery. Services are required to provide treatment and care in a manner which is consistent with these objects and principles. The objects and principles also provide a foundation for the work of the Chief Psychiatrist.

The objects require the Act be interpreted so that:

- People with a mental disorder are given the best possible care and treatment appropriate to their needs.
- Care and treatment are provided in the least possible intrusive manner, consistent with the effective giving of that care and treatment.

- In providing for the care and treatment of people with a mental disorder and the protection of members of the public, any restriction on the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances.

The Mental Health Act principles are consistent with the United Nations principles, the third *National mental health plan* and the National Standards for Mental Health Services. The principles in the Act state people with a mental disorder should:

- be provided with timely and high quality treatment and care in accordance with professionally accepted standards
- wherever possible, be treated in the community
- be provided with appropriate and comprehensive information about their mental disorder and proposed and alternative treatments (including medication and services to meet their needs)
- be treated near their homes or the homes of relatives or friends wherever possible
- have their age, gender, religious, cultural, language and other special needs taken into consideration.

In addition:

- Prescription of medication should meet the best health needs of the person and should be given only for therapeutic or diagnostic purposes and never as a punishment or for the convenience of others.
- Treatment and care should be designed to assist people to live, work and participate in the community and should promote and assist self-reliance.
- Treatment and care should be provided by appropriately qualified people within a multidisciplinary framework.
- Every effort that is reasonably practicable should be made to involve a person in developing an ongoing treatment plan. Treatment and care should be based on this plan and the plan should be reviewed regularly and revised as necessary.

1.9 Key activities and achievements in 2003

Some of the key achievements and activities of the office during 2003 include:

- completing the clinical review of all area mental health services
- ongoing development of quality improvement activities through the Quality Assurance Committee
- the Quality Assurance Committee's involvement in the Department of Human Services Clinical Risk Management Program, including root cause analysis for sentinel events

- developing and updating clinical guidelines in the areas of:
 - cross border services: Victoria and New South Wales
 - apprehension of mentally ill persons by a member of the police force under the Mental Health Act
 - non-psychiatric treatment and special procedures
- completing major enhancements to statutory return databases to enable improved collection and analysis of data about electroconvulsive therapy, seclusion, mechanical restraint and reportable deaths
- developing and implementing a new annual examinations database to provide for more effective monitoring of service reports, together with guidelines to improve the quality of data and reporting
- appointing the Deputy Chief Psychiatrist (Aged Persons), who attended all regional and rural aged persons mental health services to make recommendations on service delivery
- commencing regular aged persons mental health program meetings
- commencing ongoing liaison with SPECTRUM Personality Disorder Service for Victoria about complex clients
- collaborating in revising the protocol between Victoria Police and the Department of Human Services Mental Health Branch
- developing a contacts database and monitoring framework to enable improved analysis of complaints and feedback of aggregated information to services as part of quality improvement
- commencing revisions to the *ECT Manual: Licensing, Legal Requirements and Clinical Practice Guidelines*
- completing a major review of the reportable deaths data and developing recommendations to improve service reporting and data analysis.

1.10 Key objectives for 2004

Key objectives for 2004 include:

- synthesising statewide clinical review findings and considering methodology for a second cycle of reviews
- establishing an expert committee to review ECT practice and revise the *ECT manual*
- providing training to area mental health services and developing guidelines and forms for the amendments to the Mental Health Act made by the *Mental Health (Amendment) Act 2003 (Vic)*, including the new requirement for treatment plans
- providing education and training to service providers on applying the confidentiality provision in s. 120A of the Mental Health Act and working with families and carers.

2. Quality Assurance Committee

The Quality Assurance Committee was established in June 1999 under s. 106AC of the Mental Health Act to oversee and monitor standards of mental health services. At the time, it was considered that greater statutory provision was required to support systemic quality assurance activities, such as clinical review, and that a body such as the Quality Assurance Committee should be established to auspice these activities. In addition, it was considered that systemic quality assurance activities should be the subject of stronger confidentiality controls than those contained in the Mental Health Act. As such, the Quality Assurance Committee was prescribed as a consultative council and identifiable data obtained by the Quality Assurance Committee as part of its functions are now governed by strict confidentiality controls in s. 24A of the *Health Act 1958 (Vic)*, in addition to those contained in the Mental Health Act.

The Quality Assurance Committee has been in operation since July 2000 and meets quarterly. It comprises the Chief Psychiatrist and all authorised officers appointed by the Chief Psychiatrist pursuant to s. 106 of the Act. As described, authorised officers are senior and experienced clinicians selected from area mental health and statewide services. In their capacity as authorised officers, and under the direction of the Chief Psychiatrist, these officers undertake a range of specific activities requested by the Chief Psychiatrist.

Authorised officers appointed to the Quality Assurance Committee at its commencement are identified at section 2.3 of this report. These officers were appointed for the period June 1999 until 31 December 2003. It should be noted that in addition to those identified, the Chief Psychiatrist also appoints additional authorised officers solely for the purpose of conducting clinical reviews or investigations under s.106 of the Act. These appointments are usually for a short period to enable these clinicians to undertake the clinical review or investigation.

2.1 Terms of reference

The Quality Assurance Committee's terms of reference state that subject to the direction of the Chief Psychiatrist, members of the Quality Assurance Committee might be required to:

- participate in clinical review of area mental health services
- collect and interpret information about treatment and care of mentally ill people in Victorian mental health services
- provide advice and assistance to the Chief Psychiatrist concerning clinical standards in mental health services
- identify and promote best practice in mental health service delivery
- develop and disseminate clinical guidelines and quality improvement information.

The work of the Quality Assurance Committee is also linked to the department's Metropolitan Health and Aged Care Division program, Improving Patient Safety in Victorian Hospitals – Clinical Risk Management Strategy. This program reviews the analysis (root cause analyses) and risk reduction action plans for sentinel events in acute hospitals. The Quality Assurance Committee reviews the sentinel event of all inpatient suicides.

2.2 Key activities

Since inception, the Quality Assurance Committee has considered a number of issues and, like all new entities, continues to develop its method of operation and key tasks. Part of its role is to provide expert input and comment on continuous activities, such as statutory practices, but also to consider ad hoc matters relating to quality improvement as they arise.

Throughout 2003, activities of the Quality Assurance Committee included:

- referring various practice matters to the ECT Reference Group for consideration in revising the *ECT manual*
- developing a reporting format to feedback trends in statutory practices as a preliminary step in developing practice benchmarks
- giving input to the Reportable Deaths Project being conducted by the Office of the Chief Psychiatrist
- considering its role in analysing the reportable deaths data and potential links with the Coroner's Office on matters of joint interest
- establishing links with the Victorian Quality Council regarding safety and quality matters of common concern in Victorian health care services
- reviewing specific sentinel events as part of the department's Clinical Risk Management Strategy in Victorian hospitals.

2.3 Members of the Quality Assurance Committee

Members of the Quality Assurance Committee during the reporting period were:

Ms Ann Arnott
Senior Psychologist
Dandenong Area Mental Health Service

Mr Peter Borthwick
Area Manager
Goulburn Valley Area Mental Health Service

Dr Tom Callaly
Chief of Services, Barwon Health
Community and Mental Health Program

Professor Ed Chiu
Director, Geriatric Psychiatric Services
St Vincent's Mental Health Services

Dr Neil Coventry
Director of Child Psychiatry
Austin and Repatriation Medical Centre

Dr Peter Doherty
Associate Professor, Director of Psychiatry
The Alfred Hospital

Professor Helen Herrman
Professor and Director of Psychiatry
St Vincent's Mental Health Services

Professor Fiona Judd
Professor for Rural Mental Health
Bendigo Health Care Group

Ms Barbara Keeble-Devlin
Manager, Integrated Clinical Team
Peninsula Mental Health Care

Ms Sandra Keppich-Arnold
Assistant Director of Nursing
Caulfield Aged Persons Mental Health Service

Dr Noel Renouf
Senior Social Work Advisor
North Western Mental Health, and Adjunct Senior Lecturer
School of Social Work and Social Policy La Trobe University

3. Clinical review program

3.1 Introduction

Developing the clinical review program commenced in 1995–96 as a means of establishing a proactive quality improvement process for public mental health services. Prior to this, reviews were largely incident-specific, convened in response to particular clinical issues that arose in services, and were undertaken by staff of the Office of the Chief Psychiatrist who were appointed as authorised officers under the Mental Health Act.

During 1996 a leading senior clinician, the late Dr Peter McCallum, proposed to the Mental Health Branch that clinical reviews be conducted on a systematic, quality-oriented basis through the Office of the Chief Psychiatrist and using senior clinical advisors from that office, together with clinicians nominated by services across the state. It was considered that such a process could provide an effective tool to monitor and improve the quality of care provided to consumers. The process also provided a mechanism to assist the Chief Psychiatrist in monitoring standards of treatment and care. It was also considered that a systematic statewide clinical review process would enable participating clinicians to critically reflect on their own practice by reviewing other public mental health services.

The Mental Health Branch committed at that time to undertake detailed clinical review of each area mental health service. Developing a protocol commenced in 1997, prior to the first detailed clinical review. The protocol was intended as a guide for services in preparing for the clinical review process, and for reviewers while undertaking reviews, and has been continuously refined since then. The clinical review program was unique in Australia with its scope, methodology and application across all public mental health services in the state. Other states and territories have since used the protocol as a template in developing their own clinical review process.

3.2 Terms of reference and methodology for clinical review

The clinical review terms of reference describe the purpose of clinical review as evaluating the consistency between service clinical practice and procedure and the requirements of the Mental Health Act, service agreements and published policy, to ensure continuous improvement in service quality. The terms of reference are in full at Appendix A.

Clinical reviews assess standards of treatment and care of persons with a mental illness in all approved mental health services. The program differs from other accreditation processes in that it focuses on the treatment and care delivered to individual patients.

Clinical reviews are conducted within a peer review quality improvement framework and are undertaken by a multidisciplinary team of senior mental health practitioners drawn from across the public mental health service system, led by a senior consultant psychiatrist. Reviewers appointed as authorised officers under s. 106(1) of the Mental Health Act have all the powers of inspection and enquiry specified in the Act.

Review teams comprise between six and 12 members depending on the size of the service to be reviewed. Each review typically takes place over three days.

Reviewers apply their extensive clinical knowledge and experience to assessing the standard and consistency of clinical practices and procedures with reference to published standards, such as the Mental Health Act, the National Mental Health Services Standards, health service agreements, published departmental policies, and accepted contemporary practice.

The review methodology includes detailed examination of both selected and random clinical records. All treatment components of the service are sampled. The review team consults with service staff and management, attends relevant clinical meetings, and examines policy and procedure manuals and statutory registers. The team seeks feedback from representatives of external agencies, services and consumer and carer organisations about their interactions and satisfaction with the service. It compiles a detailed confidential report for the Chief Psychiatrist and a copy is subsequently forwarded to the chief executive officer of the relevant health service. The service is required to provide a written response, including an action plan to address any recommendations made in the report.

Clinical reviews are conducted in accordance with the *Protocol for Clinical Review of Area Mental Health Services 1997-2003* (Department of Human Services, 2004). The practice areas examined include entry and assessment, treatment and support, documentation of treatment and care, discharge and case closure, patient rights, statutory registers and returns, policy and procedures, and statutory functions of the authorised psychiatrist.

3.3 General findings

By the end of 2003, all area mental health services had been reviewed. These reviews covered adult, aged persons, and child and adolescent mental health services programs within these services. The Victorian Institute of Forensic Mental Health was also reviewed as part of the program.

Across the service system, the review process identified impressive examples of good practice delivered by committed and caring staff. Services were targeted at persons with the most severe and disabling forms of mental illness and mental disorder. Standards of treatment and care were found to be generally within acceptable standards, with areas of high quality work. Equally, however, practice varied significantly both within and across services, and all services attracted recommendations for service improvement. These are identified in sections 3.4 to 3.8 of this report.

Systemwide, a noticeable improvement observed over time is the way in which services approach clinical management of patients with multiple needs and disabilities, such as severe personality disorders and substance abuse and mental illness. These practice improvements might be attributed to the introduction of a

number of statewide specialist services over recent years, which have provided direct care services and training and consultation on effective treatment interventions to area mental health services.

The clinical review program yields significant information to inform practice and service development. The Office of the Chief Psychiatrist intends to evaluate the program's methodology and review findings during 2004. This is part of the ongoing process of seeking effective mechanisms to bring about quality improvement within mental health services. The office will also consider a second cycle of clinical reviews.

Some of the key themes from completed reviews are summarised in the following sections.

3.4 Documentation of treatment and care

Services are increasingly adopting comprehensive documentation formats to describe a person's clinical presentation, treatment needs, proposed treatment, and key decisions and actions taken during the course of treatment and care. The standard of documentation has improved across the lifespan of the clinical review program as services recognise the need for clearer documentation and accountability. Clinical documentation is a critical ingredient in the provision of care, and various bodies, including the Coroner and the Victorian Auditor-General, have commented on the need for better documentation.

A key issue has been the promotion of a single mental health clinical record which can follow the patient across service components within an area mental health service. The Chief Psychiatrist's position is that information pertaining to a person's mental health treatment and care should be consolidated in one record which follows the patient across components of a given mental health service.

Prior to the mainstreaming of mental health services, a single mental health record was able to follow the patient across the state, no matter where they presented for treatment. Now that the mental health services are mainstreamed with general health services, patient records do not move beyond the immediate health service. While there are presently no provisions for transferring files between services, it is important that all available information is consolidated within a service so patients do not have to unnecessarily repeat their story. Such an approach also provides a treatment history over time, which promotes continuity of care and effective communication of key information.

3.5 Entry and assessment

All services have a defined intake process, although some are complex to navigate. The process, variously known as a 'triage', 'intake' or 'a duty system', is organised differently across the service system. Supervision and review of decision making about service eligibility at the point of entry to services was generally absent at the commencement of the clinical review cycle in 1997; however, improvement has been noted over time. The Mental Health Branch has commenced a review of triage

functions and practice to promote more consistent practice across the state and to enhance responsiveness to consumers, carers and others in contact with mental health services. It is anticipated this review will be completed in 2004.

In response to referrals, decisions about service eligibility were generally appropriate and timely, with priority given to persons with serious mental illness. Persons who contacted services generally received an assessment identifying their immediate issues. Some assessments were excellent, providing a sound basis for continuing work with the patient. The quality of assessments in many services varied, however, and sometimes omitted information, such as personal and family history, psychosocial context, and a concise clinical formulation of the patient. Several services had a standardised format to guide the assessment process and where this was in place the quality of assessment benefited.

Assessment of clinical risk (risk of harm to self, to others or by accident) occurred in widely different ways and requires further refinement in most services, including consideration of more widespread use of standardised assessment instruments. It is recognised that assessment of clinical risk is a complex area of practice and there is no universally agreed approach.

Comprehensive psychiatric assessment should also include a physical assessment. The physical health status of a person is an important component of clinical management in view of the increased co-morbidity of mental and physical illness. This area of practice needs to be strengthened, either directly by the mental health service or in closer collaboration with a patient's general practitioner.

3.6 Treatment and support

Statewide clinical reviews reflected that area mental health services generally deliver an acceptable and effective standard of treatment and care. Most patients had a management plan or individual service plan to guide their treatment, although standards of treatment planning differed within and between services. In some cases this appeared to lead to a lack of focus in treatment and care, despite the level of clinical skill and often considerable effort expended. Almost every patient currently in contact with mental health services had a designated case manager.

New medications were extensively and appropriately used, and patients were generally monitored and followed-up with respect to their treatment response and potential side effects. Clinical reviews detected very few instances of polypharmacy or unacceptable drug dosages. It is a fact many medications have unpleasant side effects which pose problems for patients, particularly when they have to take the medication long term. This continues to present a challenge for clinicians to find ways of working sensitively around medication adherence issues with patients.

Access to other interventions, including family and individual psychoeducation, early warning symptom identification, relapse prevention strategies, education about medication and other psychological approaches aimed at improving individual

functioning and reducing vulnerability to relapse, was variable across the service system. These important therapies require ongoing development, including opportunities for staff to acquire the necessary skills in applying these techniques.

Structured systems of case review were evident in most services, enabling the treating team to comprehensively review each patient's treatment plan and treatment strategies. This process aims to evaluate progress towards the identified treatment objectives, whether the specific strategies are working or need changing and whether new needs have emerged which need to be addressed. Case review by the treating team is a key mechanism for monitoring the practices of individual clinicians who are often required to make complex decisions on a day-to-day basis in collaboration with their patients. Clinical reviews found that case review processes varied in their formality and structure, with the result that it was sometimes unclear whether the process occurred, who participated, the outcome of the treating team's deliberations and its recommendations for ongoing treatment and care.

Involving family members in treatment and care is an important factor in clinical practice and an area of dissatisfaction for carers. The extent of involvement of carers and family members varied widely. Often family members appeared to be told about aspects of their relative's clinical care, but were not actively involved or consulted at key points, such as discharge from inpatient treatment. Notwithstanding this, the clinical review process noted increasing recognition of the role of families in the ongoing care of persons with a mental illness and services' and clinicians' efforts to engage more with families. The Mental Health Act contains exemptions within its confidentiality provision to facilitate appropriate communication with families and carers, and services need to ensure clinicians are fully informed about them.

Most consumers of public mental health services have complex needs. Some of these needs are clinical while others are more practical, such as accommodation, lifestyle and financial concerns. Addressing such wide-ranging issues requires services to have effective partnerships with other service providers, particularly psychiatric disability and rehabilitation support services, which have the lead role in providing psychosocial rehabilitation programs, supported residential services and recreational activities. Most area mental health services demonstrated solid links with psychiatric disability and rehabilitation support services, although there is scope to further develop the coordination of the various inputs and communication between the various agencies.

3.7 Staff training and development

A skilled workforce is critical to providing high quality mental health care. The clinical review process does not directly evaluate staff training and development, but several of the areas it identified for quality improvement reflect training and development needs across all professions to ensure staff have the necessary skills and competencies.

Specific areas identified as a priority for staff training and development include mental status assessment, risk assessment, treatment planning, preventing and managing aggression, psychosocial interventions such as psychoeducation, relapse prevention, and psychological therapy skills.

Clinical supervision processes were well established for some professions, usually medical and allied health, but were underdeveloped for nursing, the largest discipline in the mental health workforce. This is being addressed through the implementation of senior nurse training and support positions in all area mental health services.

3.8 Insights from the clinical review program

The clinical review program has proved to be an effective mechanism for the Chief Psychiatrist to directly examine standards of treatment and care delivered to patients. At the completion of a review, the Chief Psychiatrist provides a report to the service outlining areas for improvement and service development. Issues identified during a review that warrant more immediate attention are brought to the notice of the service's authorised psychiatrist at the time of the review.

Since its inception, the clinical review program has brought systemic and policy issues identified in the process to the attention of the department's Director, Mental Health. This has provided an important feedback loop into broader mental health policy and service development activities.

The program has continued to evolve and develop over the period through experience and identification of emerging practice trends and issues. The program is well accepted by service providers who see it as useful for identifying areas for improvement at all levels of service delivery, from the individual case to the design of clinical service systems. The program has fostered active collaboration between the Office of the Chief Psychiatrist and service clinicians and managers in seeking to address issues.

The quality improvement framework within which reviews are conducted has enabled services to engage in the process in a constructive and open manner. Using respected and experienced peer clinicians, external to the service under review, has contributed to the credibility and acceptance of the process. Other states have recognised the value of this approach to monitoring standards and have either commenced or are looking to develop similar systems based on the Victorian experience.

In addition to those authorised officers on the Quality Assurance Committee identified at section 2.3 of this report, 112 authorised officers were appointed from across the Victorian mental health service system for limited periods during 2003 to participate in clinical reviews. This has meant a large number of clinicians have been able to participate in this systemic quality improvement program. Review team members report participation has offered a unique opportunity to work with senior clinicians from other services, to share and learn from the experience and to apply their learning to systems and practices in their own service.

4. Contacts, complaints and enquiries

The Office of the Chief Psychiatrist receives a wide variety of contacts from consumers, carers, relatives, members of the public, health care professionals and other bodies. Contacts are a key source of information about issues of consumer and carer concern, service gaps and matters relating to clinical standards and practice. Analysing contacts identifies areas for quality improvement, service development, clinician education and training, and community education.

The Chief Psychiatrist's contact details are included in all patient rights information brochures as an avenue of complaint and information. In addition, other agencies, such as the Health Services Commissioner, the Office of the Public Advocate, the Ombudsman, the Minister for Health and other areas of the Department of Human Services, bring enquiries and issues to the Chief Psychiatrist.

The powers of the Chief Psychiatrist under the Mental Health Act place the Chief Psychiatrist in a unique position to receive and investigate complaints from any source. Further, the Chief Psychiatrist is able to provide support, assistance and advice to mental health consumers, carers, clinicians and other service providers.

4.1 How contacts, complaints and enquiries are managed

The Office of the Chief Psychiatrist is committed to providing assistance to persons who make contact, to resolving issues as they arise and to improving the standard of treatment and care for consumers of mental health services. Contacts received by the Office of the Chief Psychiatrist come predominantly by telephone or letter.

Administrative staff in the office screen telephone contacts. If the call is relatively straightforward (for example, the caller wants to find out how to access a service) the administrative staff will provide the necessary assistance and advice.

Some people who contact the office are acutely unwell or distressed at the time and might feel powerless to effectively communicate their concerns or feel they are not being heard. If the person making the contact is unwell or the subject of the request is complex, the administrative staff will transfer the contact to a senior clinical advisor or the Chief Psychiatrist. These clinicians have detailed knowledge of the service system and can respond to the caller's concerns or provide advice on the most effective course of action.

4.2 Resolution by the Chief Psychiatrist or clinical advisor

When an enquiry or contact is referred to a senior clinical advisor or the Chief Psychiatrist, they assess the issue with a view to assisting the person as quickly as possible. Often the matter can be dealt with by giving the person the appropriate information and support to resolve the issue. Frequently, clarifying the processes of admission with the person and informing them of their rights and avenues of review and appeal will be sufficient.

Many callers wish to discuss various aspects of their treatment or specific clinical issues or experiences and are satisfied by the opportunity to talk these through and obtain information, support and advice. Where appropriate, the Office of the Chief Psychiatrist will contact the service provider on behalf of the person to seek additional information or articulate an issue for them and how it might be resolved. The office might request that the service address the issue with the person or provide a written report to the Chief Psychiatrist.

Sometimes a caller will be asked to put their complaint or issue in writing so the details can be examined more fully and the necessary information can be obtained. From either a written or telephone contact, the Chief Psychiatrist might conduct an investigation if he believes it is warranted.

4.3 Contacts, complaints and enquiries

One of the key activities for 2003 was developing a database for collecting and analysing data about telephone and written contact with the Office of the Chief Psychiatrist. This database was trialled during the year and will enable a detailed report of contacts to be provided in the next annual report. Although specific data are not available for 2003, telephone enquiries made to the office tend to reflect a range of common themes.

The majority of telephone enquiries related to one of the following categories:

- access to services: persons trying to access a mental health service
- Mental Health Act: persons seeking information about the Mental Health Act
- complaint: an expression of dissatisfaction with a service, treatment or clinician
- clinical information request: persons seeking information about clinical treatments, mental illness or clinical discussions
- departmental policy: persons requesting information about departmental policy, clinical guidelines or program management circulars.

Registered clients of public mental health services and their carers or relatives were the most frequent callers. Area mental health service clinicians were the next most frequent callers.

Many complaints from registered clients were from patients who believed they had been wrongfully detained. In such circumstances, callers were often assisted to recall the circumstances of their admission and were provided with an explanation of the admission process and their rights. The other most common patient concerns related to medication side effects, communication difficulties with clinicians and general service system inadequacies.

Carers and relatives who rang the office most often expressed concern about the nature and quality of communication with area mental health services, difficulties with access to services generally and in crisis situations, lack of assertive follow-up and inadequate discharge planning. The office staff achieved resolution in most cases by communicating with the service involved.

These calls highlight the difficulty mental health clinicians experience with the confidentiality provisions of the Mental Health Act and the requirements of the *Health Records Act 2001*. The Health Records Act restricts the disclosure of information without the consent of the individual to whom it relates, while the Mental Health Act, which takes precedence, makes provision under s. 120A for relevant information to be provided to carers in limited circumstances. The Office of the Chief Psychiatrist is arranging continuing education for clinicians in this area.

Although calls to the Office of the Chief Psychiatrist about electroconvulsive therapy represented a small proportion of the total calls, these predominantly came from carers of persons for whom electroconvulsive therapy had been prescribed. In all instances, carers had been provided with information by treating clinicians and were seeking further information and reassurance about electroconvulsive therapy as a treatment option. These calls highlight the continuing stigma and fear that surrounds electroconvulsive therapy treatment and psychiatric treatment generally, and point to the need for continuing efforts in community education.

Service clinicians principally contacted the Office of the Chief Psychiatrist about aspects of the Mental Health Act, particularly community treatment orders, confidentiality, and statutory procedures, such as reportable deaths. Other common queries related to departmental policy and practice guidelines and access to specialist consultation and input for complex clinical situations. These calls indicated the need to ensure all clinicians are familiar with existing departmental program management circulars, clinical guidelines and other published policy, and further emphasise the need for ongoing clinician education in applying the Mental Health Act to clinical practice.

General practitioners, private psychiatrists, other health professionals and agencies contacted the Office of the Chief Psychiatrist predominantly for advice on how to access appropriate mental health services for their clients or to complain about difficulties accessing services. They also sought information about applying the Mental Health Act.

The Office of the Chief Psychiatrist received written correspondence from a variety of persons and organisations during 2003, with consumers, carers and relatives representing the greatest proportion. Most correspondence related to complaints about mental health services and the people working in them. Most of these were resolved through communication with the relevant service. The office was not able to resolve a small number of correspondents' complaints to the complainant's satisfaction. Where resolution was not achievable, no substantive evidence supporting the allegations could be found after extensive enquiry. Some complainants were referred to the Health Services Commissioner to seek a resolution, especially where formal conciliation could be considered.

4.4 Freedom of Information

The Department of Human Services receives a variety of requests for information through its Freedom of Information processes. Where these pertain to mental health clinical information or mental health patient records held by the department, the Chief Psychiatrist is required to examine the records as part of the Freedom of Information process for the release of information. At the time of the mainstreaming of mental health services with general hospitals in August 1995, inactive patient records, which were the property of the department, were archived and are held by the department. The Freedom of Information officers of the relevant general hospitals manage Freedom of Information requests relating to current patient records.

5. Departmental enquiries

The Chief Psychiatrist is able to make enquiries into the admission, detention, care, treatment and management of people with a mental disorder and to conduct investigations in accordance with s. 106 of the Mental Health Act. These enquiries and investigations can involve visits by the Chief Psychiatrist and/or authorised officers to psychiatric services and can relate to the overall functioning of a service, to an individual incident or to a series of incidents or concerns about practices. The Chief Psychiatrist can initiate the process or it can be at the request of a service or an external body.

A number of enquiries and reviews of services were conducted or completed in 2003. Following the Auditor-General's 2002 report, Mental Health Services for People in Crisis, the department's Director, Mental Health requested the Chief Psychiatrist re-examine the intake and service responsiveness of public mental health services in light of the difference between the Auditor-General's audit findings and those of the clinical reviews. Latrobe Regional Mental Health Service, one of the services audited by the Auditor-General, was selected for review. This review was undertaken in November 2002 and the recommendations were implemented in 2003.

In the vast majority of cases, the level of response was considered clinically appropriate, the clinical decision making was generally sound, and the service was generally responding in a timely manner. However, consistent with the Auditor-General's findings, the documentation of the entry and intake process and related decision making was often difficult to track and the standard and degree of completion of documentation was highly variable. This was the most likely source of the considerable variation between the Auditor-General's findings and those of the clinical reviews. The other major basis for discrepancy was the Auditor-General's adoption of an arbitrary standard of mandatory assessment. The review found there was scope to strengthen a range of processes related to perceived responsiveness. A range of recommendations was made to achieve this and were implemented by the service.

The Chief Psychiatrist also conducted a review of standards of treatment and care at the Aged Acute Psychiatry Inpatient Unit, Peter James Centre at Eastern Health. The service requested the Chief Psychiatrist conduct the review following a complaint. The review commenced in December 2002 and the report documenting the review outcomes was sent to the Peter James Centre in February 2003.

Standards of treatment and care generally were found to be consistent with contemporary standards; however, a range of recommendations was made for practice improvement in particular areas. These recommendations concerned the documentation and frequency of medical review, risk assessment and treatment planning procedures, pain management and the use of restraint. The inquiry also identified the need to strengthen the internal complaints and incident reporting mechanisms and to further develop policy and procedures to guide staff in their work and to promote more consistent practice.

The Deputy Chief Psychiatrist (Aged Care) visited all the rural and regional aged persons mental health services in 2003 and was impressed by the commitment and hard work of the staff; however, he was concerned about the clinical governance of the aged psychiatric residential care facilities. He believed the roles and responsibilities of the authorised psychiatrists at these units were sometimes unclear. Several units had limited psychiatric input as a result. He recommended that clinical governance issues and the role of the authorised psychiatrist be clarified to strengthen the specialist mental health aspects.

Following his visit to the Dandenong Aged Persons Mental Health acute inpatient unit, the Deputy Chief Psychiatrist (Aged Care) concluded the physical environment had a number of limitations and relocation to a purpose-built facility should be considered.

6. Mental Health Act statutory reports

The Mental Health Act provides the legislative framework for the treatment and care of persons with a mental illness. This includes the provision for services to be proclaimed as approved mental health services for the treatment of involuntary patients and for the appointment of an authorised psychiatrist for each approved mental health service.

The Act requires that the clinical interventions of seclusion, mechanical restraint and electroconvulsive therapy be reported to the Chief Psychiatrist on a monthly basis. It also requires services to report on the annual medical examination of involuntary patients who have been in continuous care for 12 months and the death of any patient, which is a 'reportable death' as defined by the Coroner's Act. These are known as the statutory reports.

The statistics that appear in sections 6.1 to 6.5 of this report are based on information provided by services to the Chief Psychiatrist in statutory reports.

As a point of reference, in the period 1 January 2003 to 31 December 2003, the profile of service delivery in mental health services across Victoria was:

- There were 57,923 registered clients.
- Hospital inpatient admission episodes numbered 17,782 for 11,323 individual clients.
- Involuntary admissions accounted for 50.8 per cent of all admissions to inpatient beds.
- A total of 4,252 community treatment orders were made for 2,797 clients.
- Seven restricted community treatment orders were made for seven clients.

6.1 Seclusion

Seclusion is defined in the Act 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' (s. 82). Seclusion imposes a significant restriction on an individual's freedom of movement and is only used as a clinical measure to protect the person or others when the person is highly disturbed and unable to be treated in a less restrictive manner. The seriousness of seclusion is reflected in the level of observation and review the Act imposes. A registered nurse must review a secluded person at not more than 15-minute intervals and a medical practitioner must review the person at intervals of not more than four hours. The interval between medical examinations can only be varied if the authorised psychiatrist believes it is appropriate. Seclusion can only occur in approved mental health services.

In addition to the requirements of the Act, the Chief Psychiatrist has developed and published guidelines for using seclusion: *Seclusion Chief Psychiatrist's guideline* (1996, updated 2004). These guidelines are intended to support services and mental health practitioners in appropriately using and managing seclusion. They establish minimum practice standards and criteria, answer some common questions and discuss legal and clinical issues. The guidelines apply to the use of seclusion in all approved mental health services.

The Act requires each approved mental health service to submit a monthly report of seclusion to the Chief Psychiatrist. The report details each episode of seclusion for the period, who was secluded, their legal status, the duration, who approved or authorised the seclusion, why the person was secluded and any variation of medical review procedures. Collection of this data allows the Chief Psychiatrist to monitor trends in the use of seclusion. Seclusion that appears to be of extended duration might be the subject of inquiry by the Chief Psychiatrist.

During the reporting period, there were 9,644 episodes of seclusion for 2,425 patients. The average duration of a seclusion episode was 4.82 hours. The vast majority of seclusion episodes occurred in adult mental health services (90.2 per cent). Of the total number of registered clients, 4.19 per cent were secluded for their own safety or the safety of others during the reporting period.

Seclusion – key statistics	
Episodes of seclusion	9,644
Number of patients	2,425
Average duration of seclusion episode	4.82 hours

6.2 Mechanical restraint

As with seclusion, mechanical restraint can only be applied in approved mental health services. Mechanical restraint is regulated under s. 81 of the Act and is defined as ‘the application of approved devices (including belts, harnesses, manacles, sheets and straps) on the person’s body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person’s capacity to get off the furniture’.

Such restraint is only applied as a clinical intervention of last resort to protect the person or others, or to allow the person to receive necessary treatment. Mechanical restraint is primarily used in aged persons mental health services for patients who are suffering from dementia and behavioural disturbance and are prone to falling and injuring themselves. Mechanical restraint occurring in the acute adult services is comparatively rare and predominantly applies to patients with a mental illness requiring treatment in acute medical or surgical units where restraint might be applied to stop the person removing intravenous infusions or sutures.

Guidelines published by the Chief Psychiatrist in 1996 (*Mechanical restraint*) discuss the provisions of the Act regarding mechanical restraint, answer common questions, consider legal, clinical and treatment issues and define expectations, minimum standards and criteria against which practice standards can be assessed. The guidelines apply to the use of restraint on all persons, regardless of age, who are receiving treatment for a mental disorder in an approved mental health service.

A person who is mechanically restrained must be continuously observed by a registered nurse or medical practitioner, and reviewed at not more than 15-minute intervals. A registered medical practitioner must examine the restrained person every four hours at a minimum, unless the authorised psychiatrist varies this.

The Act requires each approved mental health service to submit a monthly report of mechanical restraint to the Chief Psychiatrist. The report details each episode of mechanical restraint for the period, who was restrained, their legal status, who approved or authorised the restraint, why they were restrained and any variation of medical review procedures. Restraints that appear to be of extended duration might be the subject of an inquiry by the Chief Psychiatrist.

During the reporting period there were 4,320 episodes of restraint in respect of 267 individuals. This represents 0.46 per cent of the total number of registered clients who were restrained. The average duration of restraint was 2.1 hours. The vast majority of mechanical restraint (92.5 per cent) occurred in aged persons mental health services.

Mechanical restraint – key statistics	
Episodes of Restraint	4,320
Number of patients	267
Average duration of restraint episode	2.1 hours

6.3 Electroconvulsive therapy

Electroconvulsive therapy is a valuable and sometimes life-saving psychiatric treatment procedure despite the often negative depictions of it in popular culture and the media. Electroconvulsive therapy is most commonly administered for the treatment of severe depression, but can also be used for other types of serious mental illness, such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. It is most often prescribed as part of a treatment plan in combination with other therapies. It can be administered as a course (a number of consecutive treatments) or as a maintenance treatment after the acute phase of an illness.

Electroconvulsive therapy can only be provided in licensed premises and is strictly regulated under ss. 72–80 of the Mental Health Act. The Act requires that the Secretary of the Department of Human Services license all facilities performing this therapy. The Secretary has delegated this power to the Chief Psychiatrist. Prior to granting a licence, the Chief Psychiatrist visits each facility to determine the suitability of the applicant, equipment, staff and layout to ensure compliance with required standards. Licences are granted for periods of up to five years. In the reporting period there were 36 licensed premises in Victoria, nine of which were private facilities.

All electroconvulsive therapy licences contain a number of conditions. These include compliance with the requirements of the Mental Health Act, the right of the Chief Psychiatrist to visit the licensed premises at any time, and the requirement for staff to have attended a recognised course in the administration of electroconvulsive therapy or be supervised by a clinician who has completed a course. If required, the Chief Psychiatrist can add further conditions to the licence.

The Act requires each licensed facility to submit a monthly report of electroconvulsive therapy treatment to the Chief Psychiatrist. The report details each electroconvulsive therapy treatment for the month, who had the therapy, their legal status, who gave consent, the underlying diagnosis, and the manner of administration (unilateral or bilateral). Collection of data allows the Chief Psychiatrist to monitor trends in the use of electroconvulsive therapy.

In addition to the legislative requirements of the Mental Health Act for electroconvulsive therapy, the Chief Psychiatrist has issued the *ECT manual: licensing, legal requirements and clinical practice guidelines* (2000), which provides minimum standards and information about the prescription, practice and procedures relating to electroconvulsive therapy. The guidelines represent a significant increase in the standards required for the provision of electroconvulsive therapy, and have enhanced the ability of the Chief Psychiatrist to examine information from services and to clarify issues, such as the licence conditions.

Between 1 January 2003 and 31 December 2003, 15,484 electroconvulsive therapy treatments were given. The number of individual patients who had electroconvulsive therapy was 1,597 and the average number of treatments per person was 9.65. These treatments were predominantly (70.8 per cent) administered in the public mental health sector. Females received 67.6 per cent of electroconvulsive therapy treatments. This finding is consistent with international figures and might reflect the higher incidence of depression in women. Just over half of all treatments were given for a diagnosis of major affective disorder (depression or mania).

Electroconvulsive therapy – key statistics			
	Private centres	Public centres	Total
Episodes of electroconvulsive therapy treatment	4,516	10,968	15,484
Number of patients	479	1,118	1,597
Average number of treatments per person treated with electroconvulsive therapy	9.11	9.83	9.65

6.4 Annual examinations

Section 87 of the Mental Health Act requires that every involuntary patient's mental and general health must be examined at least once a year. A report of this examination must be sent to the Chief Psychiatrist. This section of the Act aims to ensure comprehensive physical and mental health care of involuntary patients given the high degree of medical health needs in this patient population and their tendency not to attend general medical services. While there has been an increasing trend for patients to be linked to a general practitioner for ongoing monitoring, the authorised psychiatrist of each approved mental health service remains responsible for ensuring patients have a general medical examination at least once a year.

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

During the reporting period a new database was developed to monitor the occurrence of annual examinations.

6.5 Reportable deaths

The Mental Health Act requires the authorised psychiatrist of each approved mental health service and the person in charge of any other 'psychiatric service' to report to the Chief Psychiatrist 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. This means the death of any involuntary, security or forensic patient from any cause, and the unnatural, unexpected or violent death of any client (voluntary or involuntary, inpatient or outpatient) of any mental health service, must be reported to the Chief Psychiatrist in addition to the Coroner. On receipt of a completed notice of death form, the Chief Psychiatrist reviews the information received and might seek additional information from the service.

The Office of the Chief Psychiatrist has distributed guidelines clarifying the reporting requirements (*Reportable deaths*, December 1999) to all area mental health services. Currently, the minimum information to be reported for each reportable death is:

- names of the relevant treating clinicians, including consultant psychiatrist, treating doctor and case manager
- name of the doctor pronouncing death and their comments
- name of the person who last saw the patient and the time last seen
- observation and action taken on discovery of the body
- detailed description of the patient and their management in the hours or days preceding death
- treatment provided, known side effects or hypersensitivity reactions

- evidence of alcohol consumed or other prescribed/non-prescribed drugs at the time of death
- evidence of violence or any other suspicious circumstances
- contact made with next of kin or close friends
- any other information the authorised psychiatrist considers relevant in the circumstances.

There is considerable variation in the reliability of reporting among services. This is associated with a range of factors, such as greater use of shared care between general practitioners and the area mental health service, which might result in services having less immediate information about patients or being unclear about where reporting responsibilities lie and who is to fulfil them. Deaths in aged persons mental health services, for example, do not always fall clearly within the definitions of reportable death and are variously reported. During 2004, the office will clarify reporting obligations to enhance compliance and the reliability of the data collected.

The Chief Psychiatrist routinely registers an interest with the Coroner for each reportable death to ensure receipt of any comment or recommendations following coronial investigation. The Chief Psychiatrist has the opportunity to collate reports across services and to identify systemic issues. Recommendations relevant to general service provision are disseminated to all area mental health services to facilitate ongoing practice development. If circumstances surrounding a death cause concern, the Chief Psychiatrist can conduct an investigation.

Over time the Chief Psychiatrist has disseminated to mental health services coronial recommendations about issues, such as assessing intoxicated persons expressing suicidal ideation, levels of nursing observation provided to people in seclusion, risk assessment practices, supervising junior clinical staff, record keeping, and documenting treatment and care. Environmental hazards in inpatient facilities and communication of clinical information between staff or agencies have also been highlighted in coronial recommendations. The Chief Psychiatrist is a member of the Department of Human Services Coroner's Working Group and has participated in working parties with the Coroner to form closer links between the services.

Between 1 January 2003 and 31 December 2003, the deaths of 358 individuals (231 or 64.5 per cent male and 127 or 35.5 per cent female) were reported to the Chief Psychiatrist, of which 186 (51.95 per cent) were reported as due to natural causes. Deaths reported as due to natural causes were more common in aged mental health services, while reports of suicide were higher for younger persons.

Table: Cause of death by age group and gender as reported in notice of death

Cause of death	Age group						Total
	< 18 years		18-64 years		65+ years		
	M	F	M	F	M	F	
Natural causes	-	-	26	21	88	51	186 (51.95%)
Suicide	-	1	54	27	10	3	95 (26.54%)
Other*	-	-	6	4	-	1	11 (3.07%)
Unknown**	1	1	36	11	10	7	66 (18.44%)
	1	2	122	63	108	62	358 (100%)

* 'Other' includes deaths from motor vehicle accident.

** 'Unknown' cause of death includes those where the Coroner had not yet made a finding or the finding had not been notified.

The primary diagnosis of all the notifications of death forwarded to the Office of the Chief Psychiatrist is presented in the following table.

Table: Number of deaths by diagnostic group as reported in notice of death

Diagnostic group	Number	Per cent
Psychosis	124	34.64
Mood disorder	97	27.09
Dementia and organic brain disorder	90	25.14
Personality disorder	11	3.07
Anxiety disorder	11	3.07
Substance related disorders	4	1.12
Other diagnosis	14	3.91
Not Stated	7	1.96
Total	358	100

6.6 Authorised psychiatrist data

Every approved mental health service must have an authorised psychiatrist who is a qualified psychiatrist (s. 96 of the Mental Health Act). The Mental Health Review Board and the Secretary of the Department of Human Services must be notified of each appointment within five days. (In practice, the Secretary delegates this requirement to the Chief Psychiatrist). The Office of the Chief Psychiatrist maintains a database of all authorised psychiatrists.

The authorised psychiatrist has specific powers, duties and functions under the Mental Health Act and in general is accountable for the application of the Act and the treatment and care of persons in the approved mental health service. The authorised psychiatrist can formally delegate to a qualified psychiatrist employed in the approved mental health service, any power, duty or function of the authorised psychiatrist other than the power of delegation or the duty to provide the Forensic Leave Panel with information as outlined in s. 96 of the Mental Health Act. Each clinical review examines whether the authorised psychiatrist has been appropriately appointed and has formally delegated the respective powers and duties to all other qualified psychiatrists within the area mental health service.

7. Education and training

The Office of the Chief Psychiatrist has ongoing involvement in the education and training of mental health services, tertiary students and other agencies and stakeholders through a range of activities. These include providing direct sessional training to services, making formal presentations, publishing clinical practice guidelines, and giving individual advice to clinicians and service providers who contact the office. The office has also provided information sessions for carers and other agencies, such as the Health Services Commissioner.

The office gave more than 40 formal presentations during 2003 on topics such as the clinical review process, the Mental Health Act, the role of the Chief Psychiatrist, service responses to people with complex care needs, dual diagnosis, case conferencing, electroconvulsive therapy training, risk management and discharge planning. The office made the presentations to service providers, consumers, students, international delegates and other government authorities, such as the Office of the Public Advocate.

Where appropriate, the office also disseminates findings from judicial decisions, which clarify the interpretation of mental health legislation, to ensure services are informed and adjust their practices accordingly.

8. Responsibilities relating to forensic mental health services

Forensic mental health services are provided to mentally ill offenders or those who present a serious risk of such behaviour. In Victoria forensic mental health services are provided within the prison system, in a specialist forensic mental health hospital (Thomas Embling Hospital) and in the community. The Chief Psychiatrist has a range of responsibilities for mentally ill offenders under the Mental Health Act and the Crimes (Mental Impairment and Unfitness to be Tried) Act, including those outlined here.

8.1 Forensic Leave Panel

The Chief Psychiatrist (or delegate) sits on the Forensic Leave Panel, established under the Crimes (Mental Impairment and Unfitness to be Tried) Act. This panel hears applications for limited off-ground leave by forensic patients who are subject to custodial supervision orders. Leave assists in the rehabilitation process, with gradual development towards a return to community living consistent with the needs of the individual and community safety. The panel also hears appeals of a decision by the authorised psychiatrist to refuse special leave of absence.

The Forensic Leave Panel must submit a yearly report to the Attorney-General, which includes the number and type of leave applications made, the number and type granted and refused by the Panel during that year, the number of leaves suspended and the type of leave suspended. More information can be found in the Forensic Leave Panel annual report.

The Chief Psychiatrist has the power to suspend leave for forensic patients at any time under the Crimes (Mental Impairment and Unfitness to be Tried) Act. This will occur if the Chief Psychiatrist is satisfied on the evidence available that the safety of the person on leave or members of the public will be seriously endangered if leave is not suspended. Within the reporting period, the Chief Psychiatrist suspended leave for two forensic patients.

8.2 Hospital orders and restricted community treatment orders

Hospital orders are dispositions made under the Sentencing Act. A court can make a hospital order for a person who has committed an offence and who requires treatment for a mental illness. Instead of receiving a sentence, these people are directed to receive treatment as an involuntary patient in an approved mental health service. Following inpatient treatment, such patients might be suitable for a restricted community treatment order under s. 15A of the Mental Health Act. Restricted community treatment orders are made by the Chief Psychiatrist upon application by the authorised psychiatrist and approved by the Mental Health Review Board. Restricted community treatment orders generally contain a number of specific conditions tailored to the individual patient's needs, which assist the patient to remain in treatment and to prevent further offending behaviour.

8.3 Security patients

Security patients are patients detained in an approved mental health service by an order of either:

- a court under s. 93(1)(e) of the Sentencing Act. The court can, by way of a sentence, make a hospital security order for a specified period
- the Secretary of the Department of Justice. The Secretary can make an order under s. 16 of the Mental Health Act for a prisoner who has become mentally ill during their sentence or while on remand to be transferred from prison to an approved mental health service. In Victoria, such patients are transferred to the secure specialist forensic mental health service at Thomas Embling Hospital. On completing treatment, security patients are returned to prison to serve out the remainder of their sentence. However, a security patient must be discharged if their sentence has ended.

Under s. 51 of the Mental Health Act, the Secretary of the Department of Justice can, in consultation with the Chief Psychiatrist, allow a security patient to be absent from an approved mental health service in which they are detained for a defined period of up to six months, if satisfied this will not seriously endanger the patient's safety or the public's safety.

A security patient can apply under s. 52 of the Mental Health Act to the Chief Psychiatrist for special leave. Special leave is usually granted for the purpose of accessing medical treatment, often as an emergency, or to attend court. The Chief Psychiatrist must advise the Secretary of the Department of Justice of the leave. The application must specify why the leave is required. If an application for special leave is refused, the patient can appeal to the Mental Health Review Board. Special leave cannot exceed 24 hours and can be subject to conditions.

9. Publications

The Chief Psychiatrist and the department's Mental Health Branch produce guidelines and program management circulars to articulate departmental policy on key aspects of service provision and to inform mental health practitioners and services about the operation and clinical application of the Mental Health Act. Copies of these documents are available on the Department of Human Services web site at <http://www.health.vic.gov.au/mentalhealth>.

The Mental Health Branch also produces information for patients and carers, including patient rights information brochures, which advise patients about their legal rights and other entitlements. Services provide these brochures to patients in accordance with the Act.

Some of the publications available on the department's web site are listed at Appendix B.

10. Participation in working parties and consultations during 2003

During 2003, the Chief Psychiatrist or senior clinical advisors from the Office of the Chief Psychiatrist participated in numerous Mental Health Branch working parties or consultation processes. Issues addressed include cross border issues, proposed amendments to the community treatment order provisions in the Mental Health Act, proposed amendments to the hospital order provisions in the Sentencing Act and the Mental Health Act, and statewide improvements to triage and intake processes.

10.1 Managing people with complex care needs

The office's clinical staff regularly participate in case conferences about people with complex needs or cases which involve multiple service providers. Persons with complex needs are not only those with mental illness; they can be persons who also receive services through other areas of the department and across government.

The Multiple and Complex Needs Panel will be established in 2004. This is an initiative of the Department of Human Services to provide specialist intervention for members of the community with multiple and complex needs as defined in the *Human Services (Complex Needs) Act 2003* (Vic). The Office of the Chief Psychiatrist will work with the panel as requested and will consider whether people who come to the attention of the office would benefit from referral to the panel.

10.2 SPECTRUM – Personality Disorder Service for Victoria

SPECTRUM was established to support the treatment of individuals meeting the criteria for a diagnosis of borderline or severe personality disorder, with a particular emphasis on those at risk of self-harm or suicide. SPECTRUM works closely and collaboratively with area mental health services across Victoria to better support and meet the needs of this client group.

Regular liaison meetings commenced in 2003 between the Office of the Chief Psychiatrist and SPECTRUM to assist in promoting integrated and effective service delivery. Most patients referred to SPECTRUM have complex needs and the office is likely to have had some involvement with them. The Chief Psychiatrist has maintained close links with SPECTRUM to assist in the continuing development and implementation of this service.

10.3 Representation on other committees

The Chief Psychiatrist or senior clinical staff are also involved in a number of departmental and interdepartmental committees, including:

- Ministerial Correctional Advisory Committee
- Department of Human Services Coroner's Inquest Working Group
- Corrections Health Board
- Interdepartmental Police Liaison Committee.

Staff from the Office of the Chief Psychiatrist have also been involved in discussions with the Public Advocate and the Health Services Commissioner on an ad hoc basis about issues of common concern.

11. Financial information

The Office of the Chief Psychiatrist operates within the Metropolitan Health and Aged Care Services Division of the Department of Human Services. The Department of Human Services' audited financial statements include the office's budget and expenses.

Appendix A: Terms of reference for clinical review of area mental health services by the Office of the Chief Psychiatrist

Object

Evaluate consistency of area mental health service clinical practice and procedure with the requirements of the Mental Health Act, service agreements and published policy, in order to ensure continuous improvement in the quality of the area mental health service.

Scope

Examine clinical practice and procedure relating to:

- documentation
- entry and assessment
- treatment and support
- discharge and case closure
- rights relating to treatment and care
- the authorised psychiatrist.

Typical methodology

Clinical reviewers will typically:

- review clinical records selected by the Chief Psychiatrist following a review of service data
- review a random sample of clinical records
- review policy and procedure manuals
- review statutory registers or returns in relation to seclusion, restraint, major non-psychiatric treatment, electroconvulsive therapy, reportable deaths
- consult with area mental health service managers, key service personnel and clinical staff
- consult with consumer consultants, consumer and carer organisations and other key service providers or agencies who interact with the area mental health service.

Review personnel

Clinical review is undertaken by a team of senior mental health practitioners, selected by the Chief Psychiatrist and appointed as authorized officers in accordance with the Mental Health Act. The review team is led by a consultant psychiatrist and includes a senior clinical advisor from the Office of the Chief Psychiatrist and other allied health professionals. The size and composition of the team depends on the nature of the service being reviewed.

Outcome

A comprehensive written report is prepared by the review team addressing the above and forwarded to the Chief Psychiatrist. The report is then forwarded to the service chief executive officer for review, response and action where necessary.

Principles of treatment and care

Clinical review is undertaken in accordance with the following Principles of treatment and care contained in the Mental Health Act, which state that it is parliament's intention that the following principles be given effect in the provision of treatment and care to people with a mental disorder:

- People with a mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards.
- Wherever possible, people with a mental disorder should be treated in the community.
- The provision of treatment and care for people with a mental disorder should promote and assist self-reliance.
- The provision of treatment and care should be designed to assist people with a mental disorder to, wherever possible, live, work and participate in the community.
- People with a mental disorder should be provided with appropriate and comprehensive information about their mental disorder, and proposed and alternative treatments, including medication and services available to meet their needs.
- People with a mental disorder should be treated near their homes or the homes of relatives or friends wherever possible.
- When receiving treatment and care the age-related, gender-related, religious, cultural, language and other special needs of people with a mental disorder should be taken into consideration.
- The prescription of medication should meet the best health needs of the person with a mental disorder and should be given only for therapeutic or diagnostic purposes and never as a punishment or for the convenience of others.
- Treatment and care should be provided by appropriately qualified people and within a multidisciplinary framework.
- Every effort that is reasonably practicable should be made to involve a person with a mental disorder in the development of an ongoing treatment plan. Treatment and care of a person with a mental disorder should be based on this plan. The plan should be reviewed regularly and revised as necessary.

Appendix B: List of publications available on the Department of Human Services mental health web site

The documents listed are available on the Department of Human Services web site at <http://www.health.vic.gov.au/mentalhealth>.

Chief Psychiatrist's guidelines

- *Access to beds* (1997)
- *Appointment of an authorised psychiatrist* (1997)
- *Apprehension of patients without leave* (1997)
- *Assessment of intoxicated persons* (1999)
- *Community treatment order guidelines* (2001)
- *Discharge planning for adult community mental health services* (2002)
- *High dependency unit guidelines* (2002)
- *Illicit substance use in acute inpatient mental health services* (2001)
- *Mechanical restraint* (1996)
- *Non-psychiatric treatment and special procedures* (updated 2003)
- *Patient access to files for Mental Health Review Board hearings* (updated 2001)
- *Reportable deaths* (updated 2004)
- *Seclusion* (updated 2004)

Program management circulars

- *Accessing services across regions and areas* (updated 1999)
- *Accessing forensic psychiatric services* (1996)
- *Apprehension of mentally ill persons by a member of the police force under the Mental Health Act 1986* (2003)
- *Authority to transport without a recommendation* (1996)
- *Cross border mental health services: Victoria and NSW* (2003)
- *Guidelines for the Consumer Consultant Program* (2003)
- *Guidelines on catchment areas in relation to the implementation of the Primary Mental Health and Early Intervention Initiative* (2002)
- *Holding client records: Department of Human Services policy for psychiatric disability support services* (1999)
- *Mental health carer support program* (2003)
- *Ministerial exemption relating to the release of information: persons unfit to possess, carry or use a firearm* (2000)
- *Out of area patients* (updated 2000)
- *Provision of language services* (1996)

- *Psychiatric Illness and Intellectual Disabilities Donations Trust Fund, mental health services, information for case managers* (updated 2003)
- *Responding to allegations of physical and sexual assault* (1995)

Patient rights information brochures

- *Community treatment order and restricted community treatment order*
- *Electroconvulsive therapy (ECT)*
- *Forensic Leave Panel – how it can help you*
- *Forensic Patient – about your rights*
- *Hospital order patient*
- *Involuntary patient*
- *Mental Health Review Board*
- *Psychosurgery*
- *Security patient*

Other publications

- *Ambulance transport of people with a mental illness* (2002)
- *Better outcomes through area mental health services* (1996)
- *Collaborative service arrangements: private psychiatrists and public mental health services* (1996)
- *ECT manual: licensing, legal requirements and clinical practice guidelines* (updated 2000)
- *Guidelines for mental health services: working with people who are deaf or hard of hearing* (2000)
- *High dependency unit guidelines* (2002)
- *Information for families and carers of people with a mental illness* (2004)
- *In partnership: families, other carers and public mental health services* (1996)
- *Resources for case managers: individual service planning* (1996)
- *Resources for case managers: meeting consumer needs for housing and accommodation: a guide for case managers* (1996)
- *Resources for case managers: needs for service assessment and review: a collaborative approach* (1996)
- *Sharing the care: general practitioners and public mental health services* (1996)
- *Protocol between Victoria Police and Department of Human Services Mental Health Branch* (2004)

