

# Chief Psychiatrist's annual report 2004

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Published by the Mental Health Branch, Victorian Government  
Department of Human Services, Melbourne, Victoria, Australia.

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Also published on [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth)

Printed by xxxxxxxxxxxxxxxxx

February 2006 (060204)

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February 2006

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

Dear Minister

I am pleased to enclose the annual report of the Chief Psychiatrist for the period 1 January 2004 to 31 December 2004. This is the second published annual report and I believe it is important that the Victorian community continues to be informed of the activities of my office in relation to the treatment and care of people with a mental illness in public mental health services.

Yours sincerely

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

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



## Foreword

It is with great pleasure that I present the *Chief Psychiatrist's annual report 2004*. This report also serves as the annual report of the Quality Assurance Committee established under s. 106AC of the *Mental Health Act 1986* (Vic) ('the Act').

Under the Act, the Chief Psychiatrist has statutory responsibility for the medical care and welfare of persons receiving treatment or care for a mental illness. In fulfilling this responsibility, my office undertakes a wide range of activities. These range from addressing the needs of individual consumers whose concerns are brought to my attention to examining broader service delivery issues.

Delivery of high quality, responsive mental health services continues to be a challenge for all those involved in providing treatment and support to consumers, carers and their families. The need to keep pace with increasing service demand; rising community, consumer and carer expectations; complexity in consumer presentations; and treatment advances requires a concerted effort from government, policy makers, service planners, service providers and individual clinicians. The office is committed to promoting standards of treatment and care through service monitoring, quality improvement activities, complaint investigation, and the production of clinical practice guidelines to establish standards for clinicians in their work with consumers.

During 2004 much activity was devoted to helping services prepare for the implementation of the amendments to the Mental Health Act, which came into effect on 6 December 2004. A key aim of the amendments was to improve the operation of community treatment orders and to promote greater consumer and carer involvement in treatment planning.

Another key activity was to improve the way in which mental health clinicians work with families and carers, especially in communicating information families and carers need in performing their caring role. A concern carers frequently express is the lack of communication about their relative's treatment, particularly discharge planning. During 2004 a working group was established to develop a clinical practice guideline on working together with families and carers, and clinical advisers from the office joined with The Bouverie Centre in delivering training for mental health clinicians on working more effectively with families using the confidentiality provisions of the Mental Health Act.

The issue of mental health consumer presentations to hospital emergency departments has been subject to considerable public debate. The Department of Human Services has set in train a number of strategies as part of its broader Demand Management Strategy to ease the high demand on emergency departments. The long waiting times experienced by mental health consumers in emergency departments pending location of an acute bed have been of particular concern to my office. In 2004 the office was involved in facilitating access to beds. This included securing a protocol for priority access for patients from the Outer East Area Mental Health Service to beds at St Vincent's and The Alfred hospitals to help alleviate the shortage of acute mental health beds at Maroondah Hospital.

My office also continued to receive complaints from consumers, carers and families about the treatment and care delivered or the lack of access to treatment. Most consumer concerns relate to involuntary treatment, while carer concerns are frequently about access to appropriate treatment and monitoring. These often very different perspectives are a reminder of the ongoing challenge of balancing the individual's rights, including the right to treatment, with the need to provide treatment to minimise the impact of mental illness, not only on the sufferer but those close to them.

A key task for the Chief Psychiatrist's office in the years 1997 to 2003 was a statewide program of reviews examining clinical practice across all area mental health services. The last review was conducted in November 2003, and 2004 saw the first cycle nearing completion, with the finalisation of comprehensive clinical review reports and follow-up meetings with services to discuss their action plans. The clinical review program has been very successful in engaging mental health services and clinicians in external scrutiny of their practice with the express aim of improving service standards and outcomes for consumers. I am delighted other states have expressed an interest in developing a similar activity based on the Victorian experience.

The promotion of service standards also requires consideration of the workforce issues that underpin them. National and state mental health policies recognise the major challenges in ensuring adequate numbers of skilled staff are available to provide quality services. Of particular concern is the shortage of psychiatrists in public mental health services. The other key professions of nursing and allied health whose contribution is crucial in delivering multidisciplinary care face similar recruitment and retention challenges.

My office continues to be supported by senior clinicians and administrative staff who assist me in the performance of statutory functions. I am grateful to the staff who have worked with a high level of dedication and skill throughout 2004. I also wish to acknowledge the support and assistance of the Deputy Chief Psychiatrist (Aged), Dr Kuruvilla George, who has continued to actively engage the aged persons mental health service sector in a range of service delivery and standards matters.

I am committed to the continued development of the work of the Chief Psychiatrist, in the interests of improving clinical outcomes for persons with a mental illness in Victoria. I hope this report provides an insight into the operations of my office.



**Associate Professor Amgad Tanaghow**  
**Chief Psychiatrist**

## Overview

### 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 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
- report on continuing efforts to increase standards of treatment and care for persons with a mental illness.

### Statutory framework

Section 105 of the Mental Health Act provides for the appointment of a chief psychiatrist by the Secretary of the Department of Human Services and 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 responsibilities.

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

The Chief Psychiatrist can appoint authorised officers to assist in the performance of statutory functions. Under s. 106 of the Act, authorised officers can make extensive inquiries about the 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.

### Role of the Chief Psychiatrist

In fulfilling the statutory responsibilities described, the Chief Psychiatrist:

- investigates treatment-related issues where the Chief Psychiatrist determines such an investigation is warranted
- conducts a statewide program of clinical review of approved mental health services to examine the standard, quality and consistency of clinical practice provided
- receives and investigates complaints from consumers and carers
- develops clinical practice guidelines and circulars on the application of the Mental Health Act in order to establish and maintain practice standards
- provides expert advice and consultation to mental health services, the Department of Human Services, other government departments and statutory authorities

- manages enquiries and correspondence from members of the public, service providers and other organisations
- participates on working parties, committees and case conferences about the welfare of persons receiving treatment or care for a mental illness.

### **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 further statutory responsibilities. These include:

- receiving statutory reports on the performance of electroconvulsive therapy in licensed premises, and seclusion and mechanical restraint in approved mental health services
- reviewing reports of the annual medical examination of persons treated as involuntary patients under the Mental Health Act for a period of 12 months or more
- receiving reports on all reportable deaths (as defined by the *Coroners Act 1985* (Vic) and required by the Mental Health Act)
- licensing of 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
- sitting on 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.

## Key activities and achievements in 2004

### Amendments to the Mental Health Act

From time to time amendments are made to the Mental Health Act to improve its operation, clarify its interpretation and introduce legislative changes to strengthen process and practice in the treatment and care of persons with a mental illness. The current Act was first enacted almost 20 years ago and reflected the knowledge and organisation of treatment and care at that time, which was still largely institution-based. A different emphasis has become progressively necessary, reflecting the fact that the vast majority of people with a mental illness now receive their treatment and care in the community rather than in hospital.

### Overview of the changes

The purpose of the *Mental Health (Amendment) Act 2003* (Vic) ('the Amending Act') was to:

- improve the operation of community treatment orders and confidentiality provisions within the Mental Health Act
- improve clinical practice for people on community treatment orders
- clarify and uphold the rights of involuntary patients.

The Amending Act received Royal Assent on 21 October 2003 and became law on that date. The parts concerning confidentiality and a change to the Coroners Act came into operation immediately.

Part two of the Amending Act, which makes changes to the Mental Health Act regarding involuntary admission and community treatment orders, came into effect on 6 December 2004. This delay was built in to allow the department to develop and conduct an implementation and communication strategy. Representatives of stakeholder groups participated on reference groups to help revise documents, guidelines and procedures and to advise the department on training and communication strategies.

### Rationale for the changes

The Mental Health Act provides for community treatment orders, which authorise the involuntary treatment of people with a mental illness while they live in the community. It became apparent over time that central sections of the community treatment order provisions did not provide sufficient guidance for clinicians or consumers. The department undertook a review of the community treatment order provisions and circulated a discussion paper for public consultation in 2003. Submissions received in response to the discussion paper informed the amendments to the community treatment order provisions.

Section 120A of the Mental Health Act establishes a regime for the confidentiality of mental health information. Section 120A was amended by the Health Records Act 2001 (Vic) to regulate the sharing of information between approved mental health services by means of an electronic records system established for the purpose of providing treatment to persons with a mental disorder. There have been practical difficulties with the interpretation of some of the amendments and the Amending Act addresses these issues.

Electronic copies of the Mental Health (Amendment) Act and the amended Mental Health Act are available at [www.dms.dpc.vic.gov.au](http://www.dms.dpc.vic.gov.au).

## Summary of the changes

### Introduction of an involuntary treatment order

The criteria for involuntary treatment in s. 8 of the Mental Health Act were amended to focus more on whether a person needs involuntary treatment for their illness and less on whether they also need admission to and detention in hospital. This change reflects the fact that most people who need involuntary treatment under the Act now have that treatment in the community on a community treatment order. The concept of the involuntary treatment order was introduced and provides the legal basis for giving involuntary treatment.

The amendments clarified the two pathways by which a person may be made subject to an involuntary treatment order and receive involuntary treatment. Following a request and recommendation made by a doctor, a person may be taken to the approved mental health service (usually a hospital) where an involuntary treatment order is completed and the person detained, or a mental health practitioner may place a person on an involuntary treatment order in the community without the person being taken to hospital.

The making of the involuntary treatment order also clarified for services the point at which the 24-hour period commenced within which an authorised psychiatrist must examine a person to decide whether the involuntary treatment order should be confirmed, whether the inpatient or community setting is required for treatment, or whether the person should be discharged from the involuntary treatment order.

### Introduction of treatment plans

The Amending Act provides that each patient under the Mental Health Act must now have a treatment plan. Under the Act, a 'patient' is defined as being a forensic, security or involuntary patient. The treatment plan is intended to give a clear statement of the treatment the consumer can expect and guidance about their obligations under the involuntary treatment order and, where applicable, the community treatment order. The authorised psychiatrist must follow a process in developing the treatment plan, which includes taking into account the wishes of the consumer as far as they can be ascertained and, unless the consumer objects, the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the consumer. The treatment plan must be reviewed regularly and revised, as appropriate, to reflect current treatment needs and goals.

At every appeal or review, the Mental Health Review Board will review the treatment plan for a consumer. The board must be satisfied that the authorised psychiatrist has followed the proper process in developing the treatment plan (in accordance with s. 19A) and that the plan is capable of being implemented by the approved mental health service.

### Changes concerning community treatment orders

A series of amendments were made to the community treatment order sections in the Act to clarify that a person is automatically discharged from involuntary status if their community treatment order expires without extension, to give the Mental Health Review Board power to order the authorised psychiatrist to make a community treatment order for an inpatient, to require the authorised psychiatrist to notify the respective case manager about a scheduled board hearing, and to provide more specific guidance to clinicians in supervising and revoking a community treatment order.

### **Changes to the confidentiality provisions**

Some changes were made to the confidentiality sections in the Act to clarify the relationship between the Mental Health Act and the Health Records Act, to describe the legislative basis for sharing of information in and between approved mental health services by means of an electronic records system for treatment purposes, and to provide the basis for access to some information by the Department of Human Services if it is necessary for the duties, powers or functions of the Secretary to the department, and by delegation, the functions of the Chief Psychiatrist.

### **Miscellaneous amendments**

Miscellaneous amendments were made in respect to the Mental Health Review Board and orders relating to security/involuntary patients.

### **Communicating the changes**

In order to communicate the changes to the sector, the department's Mental Health Branch developed a three-stage community education strategy, which was conducted from July to December 2004.

In the first phase, staff of the Legal and Forensic Policy team and the Chief Psychiatrist's office consulted with area mental health services about local training needs and developed an information and training package.

In the second phase, staff of the Legal and Forensic Policy team and the Chief Psychiatrist's office delivered 35 three-hour training sessions between 4 October and 10 November 2004. The target group for the first round of training events included senior staff (consultant psychiatrists, program managers, discipline seniors and clinical educators), health information managers, and consumer and carer consultants. This training 'road show' also included a statewide session for the psychiatric disability rehabilitation and support services sector, hosted by VicServ, and a separate session for health information managers. In all, more than 1,000 staff attended these sessions.

After the initial training, the focus shifted to providing ongoing information and training to ensure all staff and other stakeholders were able to obtain information about the amendments. The project team supported local facilitators, enabling them to deliver information and training within their service, and made available online training materials and a list of frequently asked questions.

The final phase focused on monitoring implementation of the amendments. Initial feedback from local trainers was promising, with responses suggesting significant levels of local activity in the wake of the amendments. At the same time, further feedback from facilitators involved in local training indicated that knowledge of the Mental Health Act was highly variable across the mental health workforce. The education and training partnership 'clusters' developed in 2004 potentially provide a vehicle for undertaking a more thorough training needs analysis and a more consistent and planned approach to training about the Act.

## Treatment Plan Working Party

During 2004 the Chief Psychiatrist chaired a reference group of service providers, consumers and carers, and staff from his office and the Legal and Forensic Policy team to consider the implementation of treatment plans. A clinical practice guideline on treatment plans and a treatment plan form template were subsequently developed.

## Forms Working Party

Changes to the Act also necessitated changes to the prescribed forms for documenting the process for admission to involuntary treatment. A working party of staff from the Legal and Forensic Policy team and the Chief Psychiatrist's office reviewed all forms associated with treatment and care under the Act. The amendments also provided the opportunity to review and update all forms in use. Updated forms were subsequently made available online.

## Review of the Sentencing Act

Part 5 of the Sentencing Act enables Victorian courts to make hospital orders and hospital security orders for persons found guilty of offences who require involuntary treatment and care for mental illness. These provisions were reviewed as a result of the *Report of the Review Panel Appointed to Consider Leave Arrangements for Patients at the Victorian Institute of Forensic Mental Health* undertaken by the Honourable Justice Frank Vincent, and the *Sentencing Review discussion paper* and *Pathways to justice* report of Professor Arie Freiberg. In addition, stakeholders working in the area have raised operational problems associated with these provisions.

In November 2003 the department published the discussion paper, *Treatment and care of mentally ill offenders pursuant to Part 5 of the Sentencing Act 1991 and Parts 3-4 of the Mental Health Act 1986*. This paper proposed significant changes to the hospital order provisions and was subject to broad public consultation through the early months of 2004. The discussion paper sought input on simplifying and streamlining the current provisions, with the aim of improving their operational effectiveness. The paper proposed that the Chief Psychiatrist retain his current role concerning discharge of patients subject to these orders, but also proposed that the authorised psychiatrist be given greater powers concerning the making of orders for community treatment.

Feedback in response to the discussion paper and direct consultation with key stakeholder groups has shaped the government's policy on these important sentencing options. A bill will be presented to the Victorian Parliament in 2005 to amend Part 5 of the Sentencing Act to implement new policy directions.

## Working with families

As part of the Victorian Psychiatric Services Certified Agreement 2000-2004 between the Victorian Government, the Victorian Hospitals Industrial Association, the Australian Nursing Federation and the Health and Community Services Union, the department's Mental Health Branch agreed to auspice training in a number of key clinical areas in recognition of the need for the mental health workforce to continuously update its skills.

Complaints from carers and enquiries from clinicians had highlighted for some time a level of uncertainty among clinicians in using the confidentiality provisions of the Mental Health Act when dealing with requests for information and involvement from families and carers concerned about their relative. The introduction of the Health Records Act appeared to make practice ambiguous leaving clinicians unclear about the status and application of the respective Acts.

The Bouverie Centre and the Chief Psychiatrist's office provided a series of half-day workshops entitled 'Being confident with confidentiality: private and family business'. The workshops provided training on interpreting the confidentiality provisions (s. 120A) of the Mental Health Act, and developing skills in building more effective relationships with family and carers, especially regarding the communication of information.

During 2004, 201 mental health clinicians attended a total of 12 half-day workshops conducted across the state. Further workshops are scheduled for 2005 to provide an opportunity for clinicians from all area mental health services to participate.

### **Facilitating access to acute inpatient beds**

Considerable publicity and concern were raised during 2004 about the difficulties experienced accessing an adult acute inpatient bed when needed. Reports were received of mental health patients spending lengthy periods in hospital emergency departments awaiting a bed, difficulties locating beds for 'out of area' patients when no bed was available in the local service, and unwell patients having to be managed in the community when admission to hospital may have been more beneficial. Services sought the assistance of the Chief Psychiatrist on occasions when they had exhausted other available avenues to source a bed.

The department's Mental Health Branch acknowledges that the distribution of acute beds has become uneven around the state, with some area mental health services having comparatively fewer beds per head of population to service their needs. A range of initiatives and projects have been implemented or are being trialled through the department's Hospital Demand Management Strategy to help ease the demand on emergency departments, including more optimal management of people presenting with mental health problems.

The Outer East Area Mental Health Service (Eastern Health) experienced particular difficulties due to the shortage of acute beds at Maroondah Hospital. The Chief Psychiatrist oversaw the development of a memorandum of understanding giving priority access for patients from the Outer East Area Mental Health Service to up to eight beds at St Vincent's and The Alfred hospitals. This arrangement commenced on 29 March 2004 and ran for several months pending the opening of 25 new beds at Casey Hospital. An arrangement was then put in place to provide ongoing access for Outer East patients to ten Southern Health beds.

The Chief Psychiatrist also convened quarterly meetings with area-based bed coordinators to monitor and address issues relating to bed access throughout 2004.

## Complex clients

A small number of consumers have particularly complex needs that cannot be adequately met by routine area mental health services, and in these instances the assistance of the Chief Psychiatrist is sought in developing a service system response. Some of these consumers receive time-limited special funding from the Mental Health Branch to support a package of care.

These consumers tend to have needs that require the input of multiple service sectors, often including the criminal justice system. They commonly have a diagnosis of severe personality disorder and long histories of contact with mental health services, and they may have co-morbid substance use, cognitive impairment, and poor adaptive and social skills. All pose significant risk to either themselves or the community and some may have attracted considerable media publicity.

The Chief Psychiatrist works closely with Spectrum, the personality disorder service for Victoria, in coordinating a coherent management plan and service response. Spectrum's Intensive Outreach Program has a lead role in providing clinical expertise through consultation, facilitating close working relations between services and clinicians, and providing direct advice on day-to-day matters, including, where appropriate, direct therapeutic interventions. The Chief Psychiatrist monitors the progress of complex clients through monthly liaison meetings with Spectrum and is also kept informed of significant developments as they occur.

In 2003 the department established the Multiple and Complex Needs Initiative (MACNI) as a new service response targeting individuals 16 years and older with multiple and complex needs. The initiative began taking referrals in August 2004. While some of the complex clients who come to the attention of the Chief Psychiatrist are eligible for the MACNI, others are not. The Chief Psychiatrist looks forward to continuing to work closely with the MACNI and its associated assessment and case management services in the interests of providing a better service response to this small but service-intensive group.

Another group of consumers with complex needs are those with severe psychotic disorders, often complicated by substance use, homelessness, and high levels of aggression, including forensic involvement, who pose particular challenges for area mental health services. During 2004, the Chief Psychiatrist and clinical advisers responded to a number of requests to participate in case conferences to discuss needs for care and the most appropriate mental health response. Requests for the Chief Psychiatrist to become more directly involved in finding solutions to such cases appear to be increasing.

## Objectives for 2005

Key objectives for 2005 are to:

- finalise the *Working with families* guideline
- revise the community treatment order guideline to incorporate 2004 legislative changes
- review the methodology of the clinical review process and commence planning for future clinical reviews
- examine the place of the clinical review process in the context of other national and state developments in safety and quality
- review reporting arrangements for seclusion and mechanical restraint in order to improve data integrity and linkages with other data sources
- convene acute inpatient managers and secure extended care forums.

## 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. The Quality Assurance Committee was prescribed as a consultative council and identifiable data obtained by the committee as part of its functions are 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 meets quarterly, is chaired by the Chief Psychiatrist and comprises all authorised officers appointed by him pursuant to s. 106 of the Act. Authorised officers are senior and experienced clinicians drawn 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.

Members of the Quality Assurance Committee during 2004 are listed below. In addition to those listed, the Chief Psychiatrist also appoints authorised officers to conduct particular clinical reviews or investigations. These appointments are usually for a time-limited period.

### 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 may 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 root cause analysis and risk reduction action plans for sentinel events in acute hospitals. The Quality Assurance Committee reviews the sentinel event of all inpatient suicides.

## Key activities

Since its inception, the Quality Assurance Committee has considered a range of issues, providing expert input to ongoing activities, such as statutory practices, and ad hoc matters relating to quality improvement.

In 2004, activities of the Quality Assurance Committee included:

- establishing links with the Victorian Quality Council regarding safety and quality matters of common concern in Victorian health care services
- reviewing sentinel events as part of the department's Clinical Risk Management Strategy in Victorian hospitals
- monitoring reportable deaths and statutory practices, including seclusion, mechanical restraint and electroconvulsive therapy
- reviewing coronial recommendations
- reviewing draft clinical practice guidelines.

## Membership

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

### **Ms Ann Arnott**

Senior Psychologist  
Dandenong 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

### **Ms Deanna Clancy**

Senior Clinical Adviser  
Mental Health Branch,  
Department of Human Services

### **Dr Neil Coventry**

Director of Child Psychiatry  
Austin Health

### **Associate Professor Peter Doherty**

Associate Professor, Director of Psychiatry  
The Alfred Hospital

### **Dr Kuruvilla George**

Deputy Chief Psychiatrist

### **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 Sandra Keppich-Arnold**

Associate Director of Nursing  
Caulfield Aged Persons  
Mental Health Service

### **Ms Bee Mitchell-Dawson**

Senior Clinical Adviser  
Mental Health Branch,  
Department of Human Services

### **Dr Noel Renouf**

Senior Social Work Advisor  
North Western Mental Health and Adjunct  
Senior Lecturer,  
School of Social Work and Social Policy  
LaTrobe University

### **Associate Professor Amgad Tanaghow**

(Chair)  
Chief Psychiatrist

## Clinical review program

### Background

The clinical review program commenced in late 1997 and the last review in the cycle was conducted in November 2003. An overview of the program and the general practice themes found were included in the Chief Psychiatrist's 2003 annual report.

The purpose of a clinical review is to ensure continuous improvement in service quality by evaluating the consistency of clinical practice and procedures in area mental health services with the requirements of the Mental Health Act, published policy and practice guidelines, and service agreements. Clinical reviews also assist the Chief Psychiatrist in fulfilling his responsibility to monitor standards of treatment and care provided to persons with a mental illness.

Clinical reviews have differed from accreditation processes in their focus on the treatment and care delivered to individual consumers. The clinical review process has been unique in Australia in its scope, methodology and application across all public mental health services.

Clinical reviews are conducted within a quality improvement framework in accordance with the Protocol for Clinical Review of Area Mental Health Services 1997–2003. Practice areas examined include entry and assessment, treatment and support, documentation of treatment and care, discharge and case closure, consumer rights, statutory registers and returns, policy and procedures, and the statutory functions of the authorised psychiatrist.

### Activities in 2004

Activities during 2004 were largely devoted to finalising the comprehensive reports to services and meeting with services to discuss their action plans in response to the review recommendations.

In May 2004 the Queensland Department of Health's Mental Health Branch expressed interest in the process and invited the office to present at a statewide managers' forum.

## Contacts, complaints and enquiries

The Chief Psychiatrist's office 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 consumer 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, 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.

### How contacts, complaints and enquiries are managed

The Chief Psychiatrist's office 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 the Chief Psychiatrist receives come predominantly by telephone or letter. Administrative staff 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 that 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 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.

When an enquiry or contact is passed to a 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 Chief Psychiatrist or clinical advisor 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 may request that the service address the issue with the person or provide a written report to the Chief Psychiatrist (or both).

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 a written or telephone contact, the Chief Psychiatrist might conduct an investigation if he believes it is warranted.

## **Volume and focus of complaints and enquiries in 2004**

During 2004, the Chief Psychiatrist received 556 complaints about mental health service delivery. The major topics of complaint were involuntary treatment (16 per cent), the medication prescribed (14 per cent) and carers having difficulty gaining access to services (9 per cent). Two complaints related to seclusion practice and one to mechanical restraint. In addition, for the same period, the Chief Psychiatrist's office dealt with 436 information requests and 217 general inquiries. Seclusion was the topic of eight information requests and three requests for information pertained to mechanical restraint.

Registered consumers 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. Other common consumer concerns related to medication side effects, communication difficulties with clinicians, and perceived service system inadequacies.

Carers and relatives who rang the office 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. Resolution was achieved in most cases by communicating with the service involved.

Although calls to the Chief Psychiatrist's office 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 surround electroconvulsive therapy and psychiatric treatment generally, and point to the need for continuing efforts in community education.

Service clinicians principally contacted the Chief Psychiatrist's office 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 indicate the need to ensure all clinicians are familiar with departmental program management circulars, clinical practice 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 Chief Psychiatrist's office 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 application of the Mental Health Act.

The Chief Psychiatrist received written correspondence from a variety of persons and organisations during 2004, 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. Some complainants were referred to the Health Services Commission to seek a resolution, especially where formal conciliation could be considered.

## Freedom of information

The department receives a variety of requests for information through its freedom of information processes. Where these pertain to mental health clinical information or mental health consumer 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.

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

The Chief Psychiatrist or Deputy Chief Psychiatrist screen all consumer records held by the department and requested under freedom of information and provide advice to the Freedom of Information Unit prior to the release of documents. A protocol between the Chief Psychiatrist's office and the Freedom of Information Unit formalises this process.

## Incidental enquiries

The Chief Psychiatrist is able to make enquiries into the admission, detention, care, treatment and management of persons with a mental disorder where he has formed a view that such enquiry or investigation is warranted. This process may be initiated by the Chief Psychiatrist or may be at the request of a service, the department or an external body. Enquiries may relate to the overall functioning of a service, to an individual incident or to a series of incidents or concerns about practices.

There were two such enquiries undertaken during 2004.

## 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 services to report monthly to the Chief Psychiatrist the clinical interventions of seclusion, mechanical restraint and electroconvulsive therapy. 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 Coroners Act. These reports are known as the statutory reports.

### 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 that 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 of mentally ill persons can only occur in approved mental health services.

In addition to the requirements of the Act, the Chief Psychiatrist has developed and published a guideline for the use of seclusion, *Seclusion* (1996; updated 2004). It establishes minimum practice standards and criteria, answers some common questions, discusses legal and clinical issues, and applies 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 these data allows the Chief Psychiatrist to monitor trends in the use of seclusion.

During 2004, 58,397 mental health consumers received some form of treatment and care from public mental health services. Most of these consumers were treated in the community, with only 17.5 per cent (10,225) admitted for acute hospital care during this period. There were 9,978 episodes of seclusion for 2,309 patients during the reporting period. This means 22.5 per cent of admitted patients were secluded at some time during an inpatient stay, with most episodes being for periods less than four hours. The vast majority of seclusion episodes occurred in adult mental health services (92.8 per cent) and involved a male consumer (67 per cent).

Figure 1 shows the use of seclusion in 2003 and 2004.

**Figure 1 Use of seclusion 2003 and 2004**

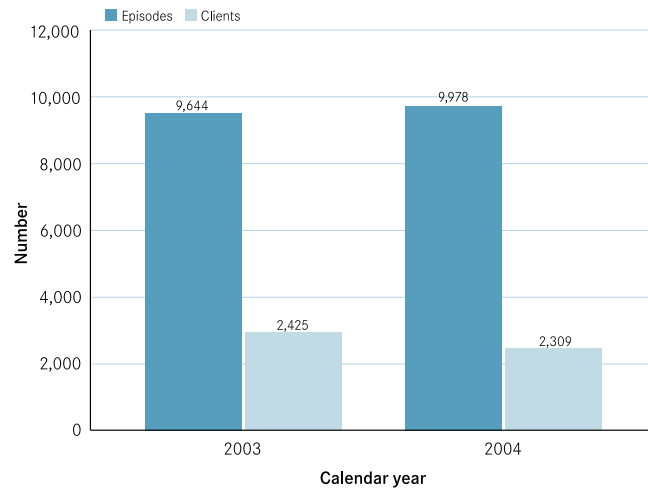
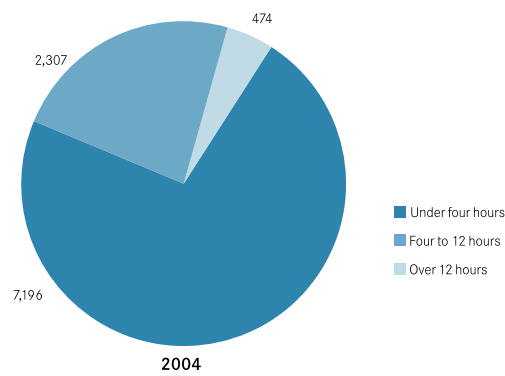


Figure 2 shows seclusion episodes by episode duration for 2004.

**Figure 2 Seclusion episodes by episode duration 2004**



## Mechanical restraint

As with seclusion, mechanical restraint under the provisions of the Act 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'.

Mechanical restraint is only applied as a protective clinical intervention of last resort to protect the person or others, or to allow the person to receive necessary treatment. It 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 in 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, for example, to stop the person removing intravenous infusions or sutures.

A clinical practice guideline published by the Chief Psychiatrist in 1996 (*Mechanical restraint*) discusses the provisions of the Act regarding mechanical restraint, answers common questions, considers legal, clinical and treatment issues, and defines expectations, minimum standards and criteria against which practice standards can be assessed. It applies 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. Restraint that appears to be of extended duration might be the subject of further review by the Chief Psychiatrist.

During the reporting period, there were 1,093 episodes of restraint for 165 individuals. This means 1.6 per cent of the total number of consumers admitted to a public mental health service for acute inpatient care were mechanically restrained at some time during their hospital stay. The vast majority of mechanical restraint (82 per cent) occurred in aged persons mental health services.

The aggregated figures in Figure 3 show a significant increase in the use of mechanical restraint in 2004 compared with 2003. A closer analysis of the data reveals this is almost entirely attributable to the prevailing circumstances in one aged persons mental health service. Routine monitoring of statutory data enabled the Chief Psychiatrist's office to take early action in engaging with the particular service to address the factors contributing to this anomalous increase in the use of mechanical restraint.

Figure 3 compares the number of mechanical restraint episodes with the number of clients for 2003 and 2004.

**Figure 3 Use of mechanical restraint, 2003 and 2004**

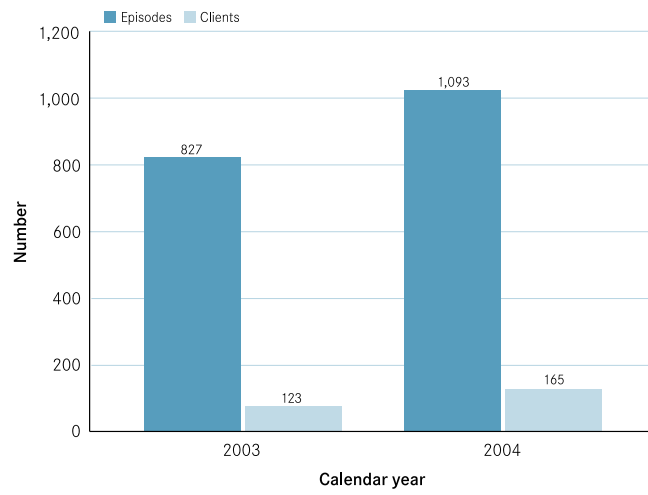
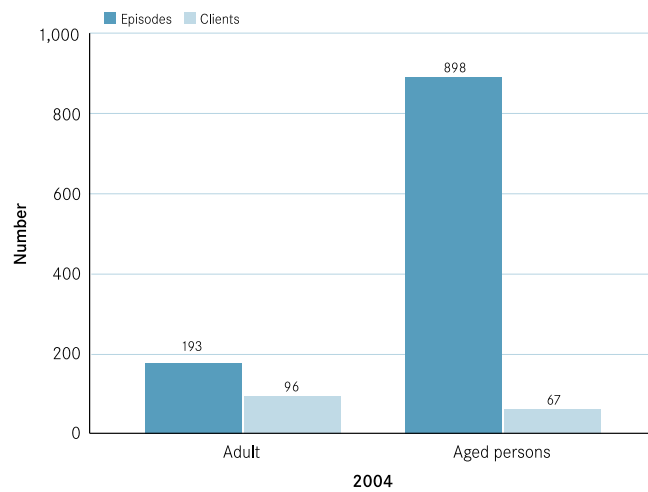


Figure 4 compares the use of mechanical restraint between adult and aged persons mental health services by episode and by client

**Figure 4 Use of mechanical restraint by age group, 2004**



## Electroconvulsive therapy

Electroconvulsive therapy is a valuable and sometimes life-saving psychiatric treatment procedure despite the sometimes 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 continuation or 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 35 licensed premises in Victoria, eight of which were private facilities.

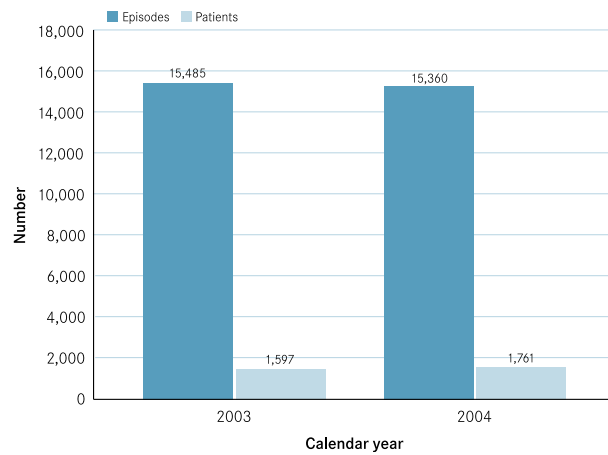
All electroconvulsive therapy licences contain a number of conditions. These include compliance with the requirements of the Mental Health Act, the right of the Chief Psychiatrist to visit the licensed premises at any time, and the requirement for staff to have attended a recognised course in the administration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

The Act requires each licensed facility to submit a monthly report of electroconvulsive therapy to the Chief Psychiatrist. The report details each electroconvulsive therapy treatment for the month, who had the treatment, 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.

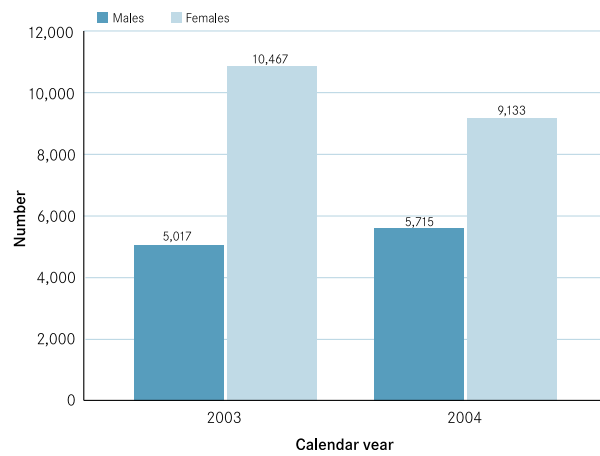
In addition to the legislative requirements of the Mental Health Act for electroconvulsive therapy, the Chief Psychiatrist has issued *ECT manual: licensing, legal requirements and clinical practice guidelines* (2000), which provides minimum standards and information about the prescription, practice 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 Chief Psychiatrist's ability to examine information from services and to clarify issues such as the licence conditions.

Between 1 January 2004 and 31 December 2004, 15,360 electroconvulsive therapy treatments were given. The number of individual consumers who had electroconvulsive therapy was 1,761 and the average number of treatments per person was 8.72. These treatments were predominantly (78.2 per cent) administered in the public mental health sector. Females received 61.5 per cent of electroconvulsive therapy treatments. This finding is consistent with international figures and might reflect the higher incidence of depression in women. The majority of treatments (69.33 per cent) were given for a diagnosis of major affective disorder (depression or mania).

**Figure 5 Use of ECT, 2003 and 2004**

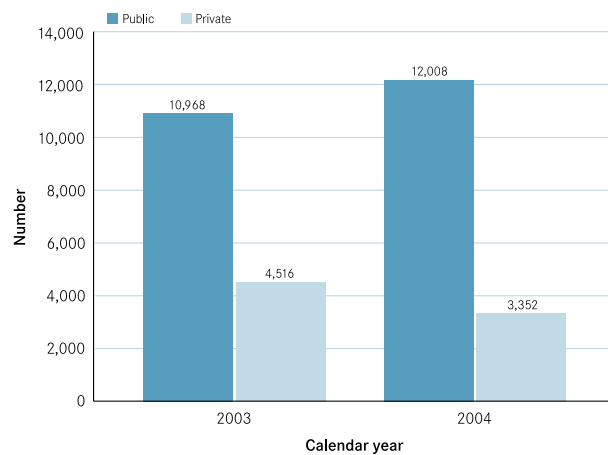


**Figure 6 ECT treatment by \*gender, 2003 and 2004**



*\*Gender not fully reported*

**Figure 7 Use of ECT by sector, 2003 and 2004**



## Annual examinations

Consumers who have been involuntary patients for a period of at least 12 months must have their mental and general health examined. Section 87 of the Mental Health Act requires that a report of this examination 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 population and the difficulties they may have in accessing general medical services. While there has been an increasing trend for consumers to be linked to a general practitioner for ongoing monitoring, the authorised psychiatrist of each approved mental health service remains responsible for ensuring consumers have a general medical examination at least once a year.

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

## 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 that the death of any involuntary, security or forensic patient from any cause, and the unnatural, unexpected or violent death of any consumer (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 Chief Psychiatrist has issued a clinical guideline, *Reportable deaths* (1999; revised May 2004), which clarifies the reporting requirements for 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.

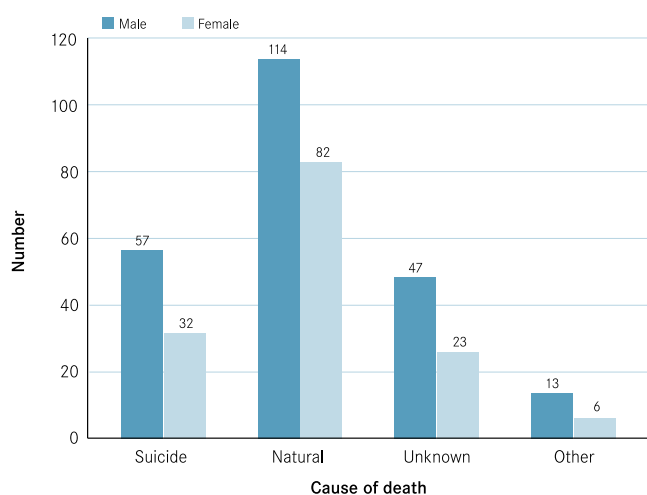
There is considerable variation in the reliability of reporting among services. This is associated with a range of factors, such as greater use of shared care between general practitioners and the area mental health service, which might result in services having less immediate information about patients or being unclear about where reporting responsibilities lie and who is to fulfil them. The revised guideline issued in May 2004 clarifies these matters.

The Chief Psychiatrist registers an interest with the Coroner for most reportable deaths to ensure he receives any comment or recommendations following coronial investigation. The Chief Psychiatrist has the opportunity to collate reports and recommendations 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.

The Chief Psychiatrist has disseminated to mental health services coronial recommendations about a range of issues, including levels of nursing observation of people in seclusion, risk assessment practices, supervision of 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.

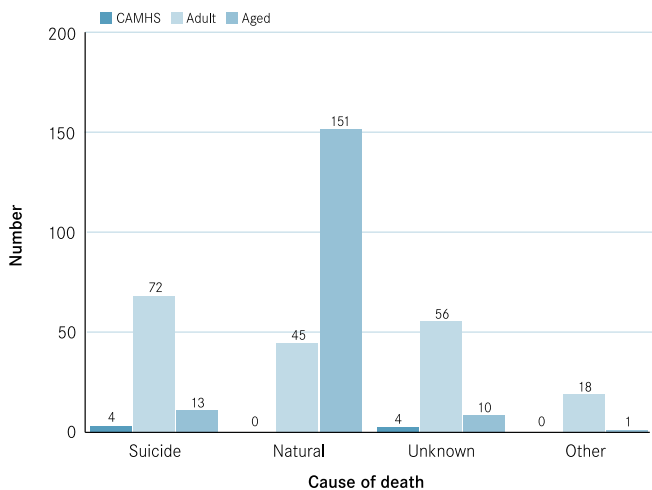
Between 1 January 2004 and 31 December 2004, the deaths of 374 individuals were reported to the Chief Psychiatrist. Of these, 231 (62 per cent) were males and 143 (38 per cent) females, and 196 of these individuals (52.4 per cent) died of natural causes.

**Figure 8 Reportable deaths, by gender and cause of death, 2004**



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

**Figure 9 Reportable deaths, by age group and cause of death, 2004**



As shown in Figure 9, deaths reported as due to natural causes were more common in aged persons mental health services, while reports of suicide were highest for adults.

The primary diagnosis of all the notifications forwarded to the Chief Psychiatrist's office is presented in Table 1.

**Table 1: Reportable deaths in 2004, by diagnostic group**

Diagnostic group	Number of deaths	Percentage
Psychosis	116	31.02
Mood disorder	105	28.07
Dementia and organic brain disorder	99	26.47
Anxiety disorder	17	4.55
Other diagnosis	14	3.74
Personality disorder	9	2.41
Substance related disorders	7	1.87
Not stated	7	1.87
<b>Total</b>	<b>374</b>	<b>100</b>

## Authorised psychiatrists

Under s. 96 of the Mental Health Act every approved mental health service must have an authorised psychiatrist who is a qualified psychiatrist. The authorised psychiatrist has specific powers, duties and functions under the Act and 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.

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

Many overseas-trained psychiatrists are employed across the public mental health system. The Chief Psychiatrist has a role in providing advice as to the suitability of a person's psychiatric qualifications before that person obtains registration with the Medical Practitioners Board of Victoria.

The Chief Psychiatrist convenes a quarterly meeting of authorised psychiatrists to provide education, peer support, and a forum in which matters of clinical service delivery, medico-legal issues, the role and function of the authorised psychiatrist, and other matters of common interest can be discussed.

## 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.

### 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, the number of leaves suspended and the type of leave suspended. More information can be found in the Forensic Leave Panel's 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.

During the reporting period, the Chief Psychiatrist suspended the leave of one forensic patient on extended leave. The patient's leave was reinstated after a brief admission to Thomas Embling Hospital.

### 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 not exceeding 12 months duration 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 consumer's needs, which assist the consumer to remain in treatment and to prevent further offending behaviour. In 2004 the Chief Psychiatrist made 14 restricted community treatment orders.

## Security patients

Security patients are consumers 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. 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 consumer 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 for attending 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 consumer can appeal to the Mental Health Review Board. Special leave cannot exceed 24 hours and can be subject to conditions.

## Education and training

The Chief Psychiatrist's office 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 to carers and to agencies, such as the Health Services Commissioner's office.

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

In 2004, the Chief Psychiatrist, the Deputy Chief Psychiatrist and clinical advisers from the department's Clinical Policy and Standards Unit prepared and delivered 78 training or education sessions. Most of these related to the two major professional education initiatives for 2004: the comprehensive statewide training programs on working with the confidentiality provisions of the Act and the 2004 Act amendments.

The Chief Psychiatrist also presented a paper on electroconvulsive therapy in Australia at the International Congress of Biological Psychiatry held in August in Sydney. In addition to ad hoc presentations to a range of agencies and organisations, he has also contributed to forums and clinical in-service sessions for mental health services staff. The Chief Psychiatrist has a number of standing teaching commitments related to the role and function of the Chief Psychiatrist, the Mental Health Act, statutory reporting and electroconvulsive therapy.

The Deputy Chief Psychiatrist also offers a regular lecture to trainee psychiatrists and has participated in the Mental Health Act amendments and risk assessment training initiatives. He also presented at the Regional Ballarat Mental Health Services Forum in March 2004.

A senior clinical adviser assisted the department's Mental Health Branch in developing an orientation training package for staff commencing work within the Victorian mental health service system. This illustrates the strategic role clinical advisers can play in collaborating with the Mental Health Branch on workforce issues.

## Clinical practice guidelines

The Chief Psychiatrist and the department's Mental Health Branch produce clinical practice 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.

During 2004, a new guideline, *Subpoenas for documents, search warrants or other requests by police for information*, was issued. In addition, a draft guideline, *Treatment plans under the Mental Health Act 1986*, was issued to assist services in complying with amendments to the Act, and the guidelines on seclusion and reportable deaths were revised and updated.

Copies of all current Chief Psychiatrist's guidelines are available on the department's web site at [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth). Some of the publications available on the department's web site are listed at Appendix 1.

## Working parties and consultation

During 2004, the Chief Psychiatrist and senior clinical advisers participated in a number of Mental Health Branch working parties or consultation processes. A key initiative was participating on the working party developing the Orientation manual for Victoria's specialist mental health services.

The Chief Psychiatrist and clinical advisers were also involved in a number of departmental and interdepartmental committees, including:

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

## Financial information

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



## Appendices

### Appendix 1: List of publications

The documents listed below are available on the Department of Human Services' web site at [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth).

#### Chief Psychiatrist's guidelines

- *Access to beds* (1997)
- *Appointment of an authorised psychiatrist* (2005)
- *Assessment of intoxicated persons* (1999)
- *Community treatment order guidelines* (2005)
- *Discharge planning guidelines* (2002)
- *ECT manual: licensing, legal requirements and clinical practice* (2000)
- *High dependency unit guidelines* (2002)
- *Illicit substance use in acute inpatient mental health services* (2001)
- *Managing persons required to attend police interview or court* (2005)
- *Mechanical restraint* (2005)
- *Non-psychiatric treatment and special procedures* (2005)
- *Patient access to files for Mental Health Review Board hearings* (2001)
- *Physical examination, the annual examination and attention to clients' general medical health needs* (2002)
- *Reportable deaths* (2004)
- *Seclusion* (2005)
- *Subpoenas for documents, search warrants or other requests by police for information* (2004)
- *Working together with families and carers* (2005)

#### Program management circulars

- *Accessing services across regions and areas* (1999)
- *Amendments to the Mental Health Act 1986* (2005)
- *Apprehension of mentally ill persons by a member of the police force under the Mental Health Act 1986* (2003)
- *Clinical supervision guidelines* (2005)
- *Cross border mental health services: Victoria and NSW* (2003)
- *Discharge planning and the development of protocols between adult area mental health services and general practitioners* (2005)
- *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)
- *Mental health carer support program* (2003)
- *Mental health triage* (2005)

- *Ministerial exemption relating to the release of information: persons unfit to possess, carry or use a firearm* (2000)
- *Out of area patients* (2000)
- *Psychiatric Illness and Intellectual Disabilities Donations Trust Fund guidelines* (2003)
- *Referral practices to supported residential services* (2003)
- *Rural-metropolitan child and adolescent mental health services: inpatient arrangements* (2003)
- *Section 97 of the Mental Health Act 1986 – reimbursement of claims for super top-up and salary maintenance* (2005)
- *Use of language services in area mental health services – draft for consultation* (2005)

### 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

- *Collaborative service arrangements: private psychiatrists and public mental health services* (1996)
- *General adult community mental health services: guidelines for service provision* (1996)
- *Guidelines for mental health services: working with people who are deaf or hard of hearing* (2000)
- *Guidelines for service provision for people with brain disorders* (1996)
- *In partnership: families, other carers and public mental health services* (1996)
- *Mobile support and treatment services: guidelines for service provision* (1995)
- *Psychiatric crisis assessment and treatment services: guidelines for service provision* (1995)
- *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 psychiatric services* (1995)