The protocol for clinical review of area mental health services

1997-2003

State Government Victoria

The protocol for clinical review of area mental health services

1997-2003

Published by the Metropolitan Health and Aged Care Division,
Victorian Government Department of Human Services, Melbourne, Victoria.

© Copyright State of Victoria, Department of Human Services, 2004.

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968.

This document may also be downloaded from the Department of Human Services web site at: http://

(040303)

Authorised by the State Government of Victoria, 555 Collins Street, Melbourne.

Introduction and historical context

This protocol provides information about clinical reviews conducted between 1997-2003. Part one of the protocol provides a guide to the scope and purpose of clinical reviews, the relevant legislative and policy frameworks and review methodology. Part two contains criteria considered during a review.

This document brings together information about the clinical review process which commenced in 1995-6 via the Office of the Chief Psychiatrist. Prior to this, incident-specific reviews were convened in response to particular clinical issues which 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. When undertaking these reviews, staff relied on procedures developed during the statewide audits of mental health services in the early 1990s.

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, via the Office of the Chief Psychiatrist and using senior clinical advisers from that office together with clinicians nominated by services across the state. In doing so, it was considered that such a process could provide an effective tool to monitor and improve the quality of care provided to consumers. It was also considered that a systematic statewide clinical review process would enable participating clinicians to reflect critically on their own practice through review of other public mental health services.

The branch committed at this time to detailed clinical reviews of each area mental health service. Development of this protocol commenced in 1997, prior to the first detailed clinical review. The document was intended as a guide for services in relation to the clinical review process, and has been continuously refined since that date. In addition, drafts of the protocol have been used as a template by other states and territories in developing their own clinical review processes.

In 1999, the *Mental Health Act 1986* was amended to make explicit provision for systematic quality assurance activities of this nature, and to establish a Quality Assurance Committee chaired by the Chief Psychiatrist and with all authorised officers as members. In 2000, that committee was declared a consultative council by the Minister for Health under s24 of the *Health Act 1958*.

These and other related legislative changes strengthened the powers of the Chief Psychiatrist and authorised officers in relation to clinical reviews. They also enabled senior service clinicians to be appointed as authorised officers for the purpose of participating in clinical reviews, and simultaneously ensured that their activities were governed by appropriate confidentiality and secrecy provisions.

The first cycle of clinical reviews was completed in late 2003. During 2004, it is intended that key statewide review findings will be published by the Office of Chief Psychiatrist. The Branch considers it important that this protocol be published as a record of the guide used for the first cycle of reviews, and as a means of promoting discussion about how the next cycle of clinical reviews should be undertaken. It is likely that aspects of this protocol will form the basic framework for the future of clinical review cycles, though future cycles may target specific areas of practice rather than the generalist approach taken in the first cycle.

Dr Ruth Vine
Director, Mental Health
March 2004

Contents

Introduction and historical context ii

Contents iii

Part One – The protocol 1

- What is a clinical review? 1
- Who conducts clinical reviews? 1
- Why conduct clinical reviews? 1
- How do clinical reviews differ from other evaluations and accreditation processes? 2
- How do clinical reviews examine treatment and care? 2
- How long do clinical reviews take? 2
- What are the outcomes of clinical reviews? 2
- Does the Chief Psychiatrist continue to conduct clinical investigations? 2
- Are services required to collate separate data and information for review? 3
- Clinical reviews in the future 3

The policy context 4

- Victoria 4
- Monitoring and evaluation 5
- National standards and the role of clinical review 5

The legal context 7

- Objects of the Mental Health Act 7
- Principles of treatment and care 7
- How are the objects and principles used in a clinical review? 8

Responsibilities of the Chief Psychiatrist and authorised officers 9

- The Chief Psychiatrist 9
- Authorised officers 9
- Powers of the Chief Psychiatrist and authorised officers under the Act when conducting a review 9
- Powers of the Chief Psychiatrist to give directions 9
- Powers of the Chief Psychiatrist to direct admission of an involuntary patient 10

Service obligations during a review 11

- Responsibilities of service staff 11
- Confidentiality 11

Scope of review 12

A: Clinical record 12

B: Policies and procedures 13

Preparing for a review 14

- Notice 14
- Planning for a review 14

Review liaison officer and departmental executive officer 14
Documentation provided prior to review 14
Documentation collated by departmental executive officer for review 15
Review of records 16
Review methodology 16
Consultations with service managers and key personnel 16
Consultations with clinical staff 16
Consultations with consumer consultants and consumer and carer organisations 16
Consultations with the Mental Health Review Board, public advocate community visitors, Victoria Police, general practitioners and other related service providers 17
Review of seclusion, restraint, non-psychiatric treatment registers, electroconvulsive therapy returns and reportable deaths 17
Policy and procedure manuals 17
Other information considered 17
Following a review 18
Meeting with service 18
Report of review team 18
Report of service 18
Twelve monthly report on action plan 18
Service concerns 19
Part Two: Review guidelines 20
Introduction 20
The response to the review report should be accompanied by an action plan 18
A. Clinical record 20
B. Policies and procedures 30
Appendix 1: Glossary of terms 34
Appendix 2: Current publications relevant to clinical reviews 39
Appendix 3: Terms of reference for clinical review of area mental health services by the Office of the Chief Psychiatrist 42
Appendix 4: Quality Assurance Committee terms of reference 44

Part One – The protocol

What is a clinical review?

Clinical reviews examine whether treatment and care of mentally ill people is consistent with the objects and principles in the Mental Health Act 1986 (Vic) and other applicable policies.

Who conducts clinical reviews?

Clinical reviews are conducted by senior mental health practitioners who are selected by the Chief Psychiatrist and appointed as 'authorised officers' under the Mental Health Act. The process of appointment is set out on page 9 of the Protocol. Authorised officers may only conduct clinical reviews at the direction of the Chief Psychiatrist and do not participate in clinical reviews of services in which they are employed.

All authorised officers are members of the Quality Assurance Committee established under s106AC of the Mental Health Act for the period of their appointment. The role of this committee is to oversee and monitor standards of mental health services and its terms of reference are set out at Appendix 4 of this protocol. The committee is chaired by the Chief Psychiatrist. All authorised officers appointed by the Chief Psychiatrist have substantial expertise in the delivery of treatment and care in Victorian mental health services.

The Quality Assurance Committee is appointed as a consultative council under sections 24 and 24A of the Health Act 1958 (Vic). These sections impose rigorous protections and controls on the disclosure of identifying information by authorised officers, and ensure that any information obtained in the course of clinical reviews is treated in accordance with the statutory controls in the Health Act.

Reviews are typically undertaken by teams of authorised officers selected by the Chief Psychiatrist, led by a consultant psychiatrist and a senior clinical adviser from the Office of the Chief Psychiatrist. Other team members are drawn from professions such as nursing, occupational therapy, social work, and psychology. Specialist clinicians form part of review teams for child, adolescent and aged services.

The diversity in professional background of authorised officers is intended to reflect the multi-disciplinary nature of treatment and care provided by Victorian mental health services. Consideration in formulation of teams is given to team members' expertise in the delivery of community-based and hospital-based treatment and care. This process is intended to promote the broadest possible sharing of expertise and knowledge amongst mental health practitioners.

Why conduct clinical reviews?

Clinical reviews are undertaken to ensure continuous improvement in the quality of mental health services. Clinical reviews are an effective means of examining and improving the quality of treatment and care, and enable services to critically evaluate the ways in which they carry out their clinical responsibilities.

Clinical reviews are not simply about the detection of problems - they enable excellence in treatment and care to be acknowledged and allow for the sharing of knowledge and expertise amongst mental health practitioners.

How do clinical reviews differ from other evaluations and accreditation processes?

Clinical reviews are based upon consideration of the way treatment and care is provided to individual consumers.

In considering whether treatment and care is being provided consistent with the objects and principles in the Mental Health Act and associated policies, authorised officers consider a range of treatment and treatment-related issues. Clinical reviews are not intended, however, to review every aspect of mental health care. Clinical mental health services currently participate in external accreditation processes and quality activities, which consider a broader range of issues. These activities continue to be strongly supported by the department.

How do clinical reviews examine treatment and care?

Treatment and care is reviewed through a range of different methods, including review of clinical records, consultation with service staff, management, consumer consultants, consumer and carer organisations and other service providers who interact with the service.

Authorised officers also consider a range of other information, including registers and returns provided by services to the Chief Psychiatrist concerning treatments such as electroconvulsive therapy. A more detailed description of the way reviews are conducted is on page 16 of this protocol.

How long do clinical reviews take?

The length of a review varies, depending on the size and nature of the service. Most reviews are completed in three to four days.

What are the outcomes of clinical reviews?

On completion of a review, a report is prepared by the review team for the Chief Psychiatrist. Following examination of the report by the Chief Psychiatrist, it is then forwarded to the chief executive officer of the service. Where necessary, recommendations in relation to any issues of concern are addressed and best practice examples are identified. Services are requested to respond in writing to reports. (See Following a review on page 18 for further information in relation to reports).

During 2004–05, it is intended that the Chief Psychiatrist publish key findings and review recommendations and best practice examples relevant to all services.

Does the Chief Psychiatrist continue to conduct clinical investigations?

Where necessary, the Chief Psychiatrist will conduct investigations in relation to specific incidents which have arisen concerning treatment and care of mentally ill people in approved mental health services. This may or may not be in the context of clinical review of a service.

Are services required to collate separate data and information for review?

Services are only required to collate a small amount of existing information prior to a review, and authorised officers attempt to avoid any disruption to consumers and staff when conducting a review. Authorised officers attend at services to conduct reviews, and clinical records are not removed from the service environment.

Prior to the review, representatives of the service participate in a review orientation, at which information concerning the service structure and organisation is presented to the review team.

Clinical reviews in the future

The process described above may be modified in the future to focus on particular clinical issues, or to address particular aspects of service provision. Services will be advised concerning any such developments as they occur.

The policy context

In 1991, the General Assembly of the United Nations adopted the *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, for reform and development of Australian mental health services. Central to these reforms was the provision of services which uphold consumer rights to receive safe, effective and dignified mental health care of a high quality.

In July 1998, the *Second National Mental Health Plan* was released, which was intended to build on the reforms of the first strategy, through three key areas:

- promotion and prevention
- development of partnerships in service reform
- quality and effectiveness of service delivery.

These reforms continue to be monitored annually through the *National Mental Health Report*.

Victoria

Victoria's reform goals were contained in *Victoria's Mental Health Service: A Framework for Service Delivery* (March 1994), which stated that 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.

As a result of these reforms, mental health services in Victoria are now organised and delivered on an area basis. There are 21 mental health areas across Victoria. Agencies are contracted to provide child and adolescent, adult and aged services in these areas.

Victoria's Mental Health Service: Improved Access Through Coordinated Client Care (July 1995) built on *Victoria's Mental Health Service: A Framework for Service Delivery*. It requires that all people receiving public mental health services have a case manager who has responsibility 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 articulated as part of the above policies and as part of the service agreements between the department and agencies, as follows:

- Services must 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 must be provided routinely through community mental health services, including a crisis assessment and treatment service, a community mental health service and/or an intensive mobile treatment service.
- Area mental health services must have a single point of management and accountability.

Pursuant to the conditions of service agreements, services are required to develop written policies and practices which ensure that the above policies and standards are implemented.

In support of these reforms, guidelines have been developed in consultation with service providers concerning many aspects of service delivery. The guidelines set out service requirements, relevant policy and legislation and a range of other useful information. Regular program management circulars are also distributed to services, providing guidance to practitioners on specific matters. A list of these publications is contained in appendix 2.

Monitoring and evaluation

Reform of Victorian mental health services has included a continuing commitment to monitoring and evaluation of service delivery. The commitment was stated in *Victoria*'s *Mental Health Service: The Framework for Service Delivery - Better Outcomes Through Area Mental Health Services* (1996 and restated in *New Directions for Victoria's Mental Health Services 2002*), which outlined a range of evaluative programs undertaken to monitor service provision and outcomes. Clinical reviews form a centrally important part of the monitoring and evaluation of service delivery.

National standards and the role of clinical review

National standards for mental health services were developed as part of the National Mental Health Policy and National Mental Health Plan. The standards are intended to apply to all elements of mental health service delivery and address:

- rights
- safety
- consumer and carer participation
- promotion of community acceptance
- privacy and confidentiality
- prevention and mental health promotion
- cultural awareness
- integration (service integration, integration within the health system, integration with other sectors)
- service development
- documentation

- delivery of care (access, entry, assessment and review)
- treatment and support
- community living
- supported accommodation
- medication and other medical technologies
- therapies
- inpatient care
- planning for exit
- exit and re-entry to a service.

Accrediting organisations such as the Australia Council on Health Care Standards and the Quality Improvement Council have incorporated these standards in their quality improvement models. Whilst clinical reviews are not directly linked to general or specialist accreditation of services and are more oriented to individual patient care issues, services may wish to utilise clinical review processes as part of their preparation for accreditation.

The legal context

The *Mental Health Act* contains a series of objects and principles which form the basis for clinical reviews. Services are required to provide treatment and care in a manner which is consistent with these objects and principles.

Objects of the Mental Health Act

The objects require that the Mental Health 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 is to be 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 upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect is to be kept to the minimum necessary in the circumstances.

Principles of treatment and care

The Mental Health Act principles are consistent with the United Nations Principles, the National Mental Health Policy, National Mental Health Plans and the National Standards for Mental Health Services.

The principles state that 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 multi-disciplinary framework
- every effort that is reasonably practicable should be made to involve a person in the development of an ongoing treatment plan. Treatment and care should be based on this plan and the plan should be reviewed regularly and revised as necessary.

How are the objects and principles used in a clinical review?

The objects and principles form part of the terms of reference for clinical reviews, which are contained in appendix 3. The detailed criteria used during a clinical review are contained in part two of this protocol and are drawn from the Mental Health Act and associated policy and program guidelines.

Responsibilities of the Chief Psychiatrist and authorised officers

The Chief Psychiatrist

The responsibilities, duties and powers of the Chief Psychiatrist are set out in Division 4 of the Mental Health Act. The Chief Psychiatrist is appointed under section 105 of the Act and subject to the general direction and control of the Secretary of the Department, is responsible for the medical care and welfare of persons receiving treatment or care for a mental illness.

Authorised officers

Under section 106 of the Mental Health Act, the Chief Psychiatrist can appoint authorised officers to exercise the powers set out in that section. All appointments must be in writing. Authorised officers must carry an identity card when undertaking a review and this card must be produced to any person on request.

Powers of the Chief Psychiatrist and authorised officers under the Act when conducting a review

Subject to the directions of the Chief Psychiatrist, when conducting a clinical review an authorised officer appointed under the Act can:

- make inquiries relating to the admission, detention, care, treatment and control of people with a mental disorder in or from a mental health service
- by written notice, require the production of any document or any record required to be kept under the Mental Health Act by a mental health service relating to any person who is receiving, or has received, treatment or care for a mental disorder in that service
- make copies of, or take extracts from any such document or record.

Powers of the Chief Psychiatrist to give directions

The Mental Health Act empowers the Chief Psychiatrist to give directions in relation to treatment and care following a review or investigation.

A formal direction of this kind would only be given in the event that a service failed to implement recommendations made to the Authorised Psychiatrist or Director of Clinical Services during or following a review.

Under the Act, the Chief Psychiatrist may direct a service to:

- discontinue or alter a practice, procedure or treatment observed or carried out by the service
- observe or carry out a practice, procedure or treatment specified
- provide treatment, or a particular treatment, to a person with a mental disorder.

Any such direction must be in writing. The Chief Psychiatrist can only give such a direction if satisfied, following an investigation or review, that it is necessary for the medical care or welfare of the person or people who is, are, or will be receiving treatment or care for a mental disorder at that service. If giving a direction to a service concerning provision of treatment to a person, the Chief Psychiatrist must be satisfied that the direction is necessary for the medical care or welfare of the person and must also be satisfied that the person consents to treatment by the service.

Powers of the Chief Psychiatrist to direct admission of an involuntary patient

Following a review or investigation, the Chief Psychiatrist may direct that a person be admitted to an approved mental health service as an involuntary patient. A formal direction of this kind would only be given in the event that a service failed to act on a recommendation made to the Authorised Psychiatrist or Director of Clinical Services during or following a review or an investigation.

Prior to giving such a direction, the Chief Psychiatrist is required to take into account the availability of adequate facilities and appropriately qualified staff for treatment of the person in the service, and any adverse effects the admission may have on other patients in the service. The Chief Psychiatrist must also be satisfied that the person meets the criteria in section 8(1) of the Mental Health Act.

Service obligations during a review

Responsibilities of service staff

The statutory responsibilities and duties of service staff and management in relation to clinical reviews or investigations are also contained in Part 6 Division 4 of the Mental Health Act. Staff and management of services are required to provide reasonable assistance to authorised officers to enable effective conduct of reviews or investigations.

Staff and management must not:

- unreasonably refuse or neglect to render assistance when required to do so during a review.
- refuse or fail to give full and true answers to the best of their knowledge to any questions asked during a review.
- assault, obstruct, hinder, threaten, intimidate or attempt to obstruct or intimidate authorised officers visiting a service.

Confidentiality

As members of the Quality Assurance Committee, all authorised officers are prevented by section 24 A (1) of the Health Act from disclosing identifying information obtained in the course of, or in connection with, their membership of the committee.

Consultations with staff, consumer consultants and consumer and carer organisations form an important part of the review process, however, in accordance with the provisions referred to above, reports prepared by review teams do not identify staff or consumers by name, nor do they identify specific sources of information. Consultations with service staff are oriented to general queries concerning service provision, as opposed to specific patient care issues.

As a result of the statutory limitations in the Mental Health Act and Health Act, review reports are subject to strict controls. However, it is intended that during 2004 key review findings and recommendations will be published by the Chief Psychiatrist to ensure that mental health services, consumers and carers are informed of ways in which the service system seeks to continually improve.

Scope of review

During a review, the following key aspects of mental health service delivery are assessed against the criteria contained in Part Two–Review Guidelines:

A: Clinical record

1. Documentation

Clinical records are reviewed by authorised officers to ensure compliance with Departmental and legislative requirements relating to:

2. Entry and assessment

This aspect of the review includes consideration of issues relating to:

- Referral
- Intake and assessment
- Request and recommendation for admission to an approved mental health service
- Sedation for the purpose of transport to an approved mental health service
- Restraint for the purpose of transport to an approved mental health service
- Transport to an approved mental health service
- Admission to an approved mental health service

3. Treatment and support

This aspect of the review includes consideration of issues relating to:

- Consent to treatment
- Individual service plans (ISPs)
- Case management
- Medication and medical review
- Risk management
- Community treatment orders (CTOs)
- Annual examination
- Critical incidents
- Electroconvulsive therapy (ECT)
- Non-psychiatric treatment
- Major non-psychiatric treatment
- Major medical procedures
- Mechanical restraint
- Seclusion
- Reportable deaths

4. Discharge and case closure

This aspect of the review includes consideration of issues relating to:

- Discharge from an approved mental health service
- Case closure

B: Policies and procedures

Service policies and procedures are also reviewed by authorised officers, to ensure their consistency with departmental and legislative requirements relating to:

1. The authorised psychiatrist

2. Rights relating to treatment and care

This includes consideration of issues relating to:

- Provision of information
- Complaints
- Privacy and confidentiality
- Use of interpreters
- Mental Health Review Board

3. Registers and returns

This includes consideration of issues relating to:

- Electroconvulsive therapy
- Major non-psychiatric treatment
- Mechanical restraint
- Seclusion
- Community visitors

Preparing for a review

Notice

Services nominate suitable dates for clinical review. On settlement of the review schedule, confirmation of the review date is given by the Office of the Chief Psychiatrist to the chief executive officer of the service. Approximately six weeks prior to the review, a review orientation is conducted with service managers, (including the review liaison officer and departmental executive officer discussed below) and the review team. Any preliminary service queries are addressed at this time and scheduling issues are discussed.

Planning for a review

Service managers should inform staff and users of the service of the forthcoming review. This protocol should be circulated to ensure that review purposes, process and outcomes are understood prior to commencement of the review.

Review liaison officer and departmental executive officer

The service should nominate an existing staff member as a key liaison point for the duration of the review. The liaison officer assists the review team in orienting to the service and works closely with the departmental executive officer to ensure the review is appropriately coordinated. The liaison officer also typically assists the departmental officer to:

- arrange a venue, date and time for the preliminary meeting
- arrange a space at each of the service elements (inpatient, community mental health service, community care unit) for use by authorised officers during the period of review
- ensure authorised officers have easy access to telephone, facsimile and photocopy facilities and workspace for use during the review
- arrange for requested documentation to be made available to authorised officers (see further below)
- arrange suitable times for authorised officers to meet with key staff
- ensure the protocol is circulated prior to review
- be contactable during the review to deal with any issues which may arise, or resources which may be required.

Documentation provided prior to review

The following documentation for each service element should be forwarded to the departmental officer, two weeks prior to commencement of the review:

- service organisation chart, indicating lines of responsibility
- service system chart
- list of key clinical and management personnel with phone numbers (including the authorised psychiatrist, senior clinical staff, team leaders/coordinators)
- staff profile by classification and allocation
- list of key meetings, their function, participants and scheduled times such as handover meetings for intake/CAT/inpatient/community mental health services; clinical review meetings; clinical standards meetings)
- list of consumer consultants and community visitors

- contacts for the following organisations in the area:
  - general practitioner and police district mental health liaison, psychiatric disability support services, protective services and regional representative and consumer/carer organisations
- standard pro forma clinical documentation where available
- approximate total case load for each component of community service.

The following information should be available at the service for reference during a review:

- numbers of persons currently on newer treatment regimes
- numbers of persons currently in shared care
- arrangements
- contact forms for persons not accepted for service
- minutes of key meetings (where taken) for the preceding 12 months
- policy and procedure manuals

Should the service wish the review team to view any other documentation during the review, this can be provided with the above.

Documentation collated by departmental executive officer for review

The following information is typically collated by the departmental executive officer for the 12 month period preceding the review:

- information concerning frequency of admissions
- information concerning frequency of contacts with the service
- information relating to persons currently subject to community treatment orders
- information concerning persons restricted community subject to treatment orders
- electroconvulsive therapy returns required under section 80 of the Mental Health Act
- seclusion register (including details on length and frequency of seclusion) as required under section 82 of the Mental Health Act
- mechanical restraint register (including details on length and frequency of seclusion) required under section 81 of the Mental Health Act
- reportable death information, required under section 106A of the Mental Health Act
- annual examination reports required under section 87 of the Mental Health Act.

The following is also collated:

- information concerning new contacts in the fortnight prior to review
- information concerning persons transferred from the service within the last six months
- information concerning recent case closures.

Following collation and perusal of the above data, a number of clinical records are selected for review. Arrangements are made by the liaison officer for these records to be made available for perusal at each service element.

Review methodology

During a review, authorised officers typically visit each of the service elements, (inpatient, community mental health service, community care unit) using the methods outlined below.

Review of records

Clinical records from each service element are reviewed against the criteria in Part two. The criteria are in the form of positive statements and are minimum standards or parts of standards adapted from the Mental Health Act and published policy and program management circulars. The information sought should be easily accessible on clinical records, or be part of existing service documentation.

The use of the criteria in Part two ensures that a range of relevant issues are considered when reviewing clinical records, though some criteria will not be relevant in some service elements or will require modification.

In reviewing clinical records against these criteria ,it is acknowledged that there may sometimes be a limited correlation between standards of care and standards of documentation. For this reason, review of records is one of a range of methods used during clinical review.

Consultations with service managers and key personnel

During a review, authorised officers will meet with key service personnel to discuss service delivery issues identified in Part two of the protocol. Authorised officers at an inpatient service may also meet with the Director of Medical Services, the Director of Nursing and Director of Accident and Emergency during a review.

Consultations with clinical staff

Consultations with clinical staff are generally informal. As noted above, authorised officers may seek general information or clarification in relation to the operation of the service.

Authorised officers are available during a review to discuss any queries concerning the review process. However, because of the team structure of clinical reviews and the need to integrate information collected, findings or outcomes cannot be discussed whilst a review is being undertaken.

Consultations with consumer consultants and consumer and carer organisations

Consumer consultants and consumer and carer organisations are consulted concerning treatment and care provided by the service. These consultations are informal, and are only undertaken with consultants or organisations who are willing to discuss these issues during a review.

Consultations with the Mental Health Review Board, Public Advocate, Community Visitors, Victoria Police, general practitioners and other related service providers

Discussions with the Mental Health Review Board, Office of the Public Advocate, Community Visitors, Victoria Police, local division of general practitioners, private psychiatrists, psychiatric disability support, protective services and regional representatives address whether these organisations consider the service to be accessible, responsive and meeting the needs of seriously mentally ill people.

Review of seclusion, restraint, non-psychiatric treatment registers, electroconvulsive therapy returns and reportable deaths

The above registers and returns are reviewed by reference to the relevant criteria in the Mental Health Act.

Policy and procedure manuals

Authorised officers consider whether policy and procedure manuals are consistent with current legislative and departmental requirements in relation to the areas of review. The criteria in Part two are used as a reference during this process.

Other information considered

Authorised officers may also refer to the range of data which is currently collected by services in relation to treatment and care. Such information is considered as contextual, background information only.

Following a review

Meeting with service

On the completion of a review, the team typically meets with service representatives for a general discussion of the review process and outcomes.

Report of review team

On completion of a review, a report is prepared by the review team for the Chief Psychiatrist. Included in the report is the review methodology, examples of best practice and any recommendations for change, improvement, or action.

Following review of the report by the Chief Psychiatrist, it is provided to the Chief Executive Officer of the service. Where necessary, recommendations in relation to improvement or change are identified, together with examples of best practice. The report remains the property of the Department of Human Services.

Report of service

Services are requested to respond in writing to review reports, and meet with the Chief Psychiatrist and senior clinical advisers to discuss the report. If recommendations are made by the review team concerning change, improvement or action, each recommendation should be separately addressed by the service including timelines for implementation.

The response to the review report should be accompanied by an action plan

Follow up visits may be undertaken by review teams where a review identifies matters requiring action. Additional reports may be requested by the Office of the Chief Psychiatrist or Quality Assurance Committee.

Twelve monthly report on action plan

Following a review, services are required to report to the Quality Assurance Committee on the status of review recommendations. This report should be forwarded no later than twelve months after reciept of the review report.

The purpose of providing this report is to ensure appropriate follow up on review recommendations, and as such, it should reflect the action taken to implement review recommendations, and any planned activities to implement recommendations in the future.

Service concerns

If a service has concerns about how a review is being conducted, these should be raised immediately by the Director of Clinical Services or service manager with the review team leader.

Should concerns or problems not be resolved through these discussions, details should be set out in writing and forwarded to the Chief Psychiatrist. A copy should be given to the review team leader. A meeting will then be convened to discuss the service's concerns.

If these discussions fail to resolve the issues, formal notification should be given by the service to the Director Mental Health as delegate of the Secretary, who will then convene a further meeting of the service and Chief Psychiatrist to resolve the problem.
If unresolved, the matter will be referred to the Secretary of the Department for determination.

Part Two: Review guidelines

Introduction

As indicated in Part one, this protocol has been developed to provide information about clinical reviews conducted by members of the Quality Assurance Committee. This part of the document is intended for use in review of clinical records. During a review, evidence is sought to establish if the criteria have been met.

Services should note that some criteria will not be applicable to certain mental health services, or may require modification. These criteria are current as at 2003.

Services are encouraged to use this document in clinical record or policy and procedure reviews, where appropriate.

A. Clinical record

1. Documentation

The clinical record has:

- a unique medical record number
- the consumer's name, current residential address, date of birth and gender recorded in full
- an emergency contact number for the consumer's next of kin/primary carer
- all entries signed, dated, legible, and showing designation of author
- each page identifying the consumer's name and medical record number.

• The clinical record is a comprehensive, factual and sequential record of the consumer's condition and the treatment and support offered.
• Where relevant, statutory documentation under the Mental Health Act 1986 is current, completed and readily identifiable in the clinical record.
• Where the consumer is subject to a Guardianship and Administration Order, or where there is an operative power of attorney, a copy of the order or contact details for the Attorney is contained in the clinical record.

2. Entry and assessment

2.1 Referral

Prior to intake or admission, the consumer has received a comprehensive assessment by either the crisis assessment and treatment (CAT) team, psychogeriatric assessment team (PGAT) or child and adolescent mental health service assessment treatment and liaison (CAMHS ATL) service to determine:

• mental state
• treatment requirements
• level of support available
• additional supports required to maintain the consumer in the community
• level of risk of harm to self or others.

Where necessary, the CAT/PGAT/CAMHS ATL service has documented liaison with the inpatient service in relation to the consumer's admission.

2.2 Intake and assessment

On intake or admission, a clearly documented and comprehensive initial psychiatric assessment has been undertaken by an appropriately qualified and experienced mental health professional.

- A history has been taken with the consumer, addressing:
  - presenting problem
  - history of illness
  - drug, alcohol and forensic history
  - pre-morbid personality
  - family structure and genogram
  - history of family involvement with the consumer.
- Where the consumer is a primary carer, the intake and assessment procedure includes details of any dependants such as children or elderly relatives, identification of current family responsibilities and clarification of alternative care arrangements for dependants.
- An examination of the consumer has been undertaken, including:
  - mental state examination
  - physical examination, including neurological examination
  - risk assessment.
- Following examination relevant investigations have been ordered, reason documented and results of investigations initialled.
- A diagnosis has been made, using internationally accepted standards, by an appropriately qualified and experienced mental health professional.
- Alternative diagnoses are noted and explored.
- When a diagnosis is made, the consumer (and primary carer, unless otherwise indicated) is provided with information on the diagnosis, options for treatment and possible prognosis.
- Where a consumer is not accepted for service, there is documentation of the contact, reasons for non-acceptance and any referral activities.

2.3 Request and recommendation for admission to an approved mental health service

Where involuntary admission is considered necessary:

- a request to admit and detain the consumer as an involuntary patient in an approved mental health service has been completed
- the request is signed, dated and in the required form
- a recommendation to admit and detain the consumer in an approved mental health service has been completed
- the recommendation is signed, dated and in the required form
- if no facts are personally observed by the recommending practitioner, reference is made in the required form to the personal observations of another examining medical practitioner.

2.4 Sedation for purpose of transport to an approved mental health service

If sedation for the purpose of transport to an approved mental health service is considered necessary:

- it has been administered by a registered medical practitioner or registered nurse
- particulars of sedation have been recorded in the required form, which is signed and dated with a recommendation attached
- where intramuscular or intravenous sedation is used, the consumer has been transported by ambulance to the inpatient service.

2.5 Restraint for purpose of transport to an approved mental health service

Where restraint for the purpose of transport to an approved mental health service is considered necessary:

- it has been applied by a registered medical practitioner or registered nurse
- particulars of restraint have been recorded in the required form, which is signed and dated with a recommendation attached.

2.6 Transport to an approved mental health service

Where transport without recommendation is considered necessary:

- an authority to transport without recommendation has been completed by a mental health practitioner engaged in acute psychiatric assessment and treatment (registered nurse, registered psychologist, social worker, occupational therapist)
- the consumer has been transported to the approved mental health service in accordance with the General Adult Community Mental Health Services: Guidelines for Service Provision, Program Management Circular on Ambulance Transport of People with Mental Illness and/or the Protocol Between the Victoria Police and Psychiatric Services, following an assessment of the consumer's:
  - mental state
  - physical state
  - immediate treatment and monitoring needs
  - risk of harm
  - need for support and supervision
  - the availability of transport and distance.

2.7 Admission to an approved mental heath service

Where the consumer has been admitted to an approved mental health service involuntarily:

- they have been oriented to the ward and given the printed statement *Involuntary Patient: About Your Rights* and required oral explanation of rights and entitlements under the Mental Health Act
- the Authorised Psychiatrist has examined the consumer within 24 hours of admission, confirmed their admission as an involuntary patient, consented to treatment for the consumer's mental illness in the required form OR discharged the consumer as an involuntary patient
- unless otherwise indicated, and with the consumer's consent, the consumer's next of kin/primary carer has been notified of the admission.

3. Treatment and support

3.1 Consent to treatment

In relation to the consumer’s consent to treatment:

- An assessment of the consumer's capacity to give informed consent to treatment for the mental illness has been undertaken by the admitting medical practitioner prior to the administration of any treatment.
- Informed consent has been obtained prior to the administration of any treatment for the mental illness (where relevant from parent or guardian in a CAMHS) OR where urgent treatment is required following admission or intake and prior to the authorised psychiatrist's examination, the admitting medical practitioner has assessed whether the consumer is capable of consenting to treatment.
- Where the consumer has a guardian, the authorised psychiatrist has notified the guardian of the consumer's admission to the service, and the grounds for it.

3.2 Individual service plans

In relation to the services to be provided to the consumer:

- The consumer has a completed 'needs for service' assessment.
- There is an individual service plan (ISP) which is:
  - developed with the consumer
  - current
  - relevant
  - readily accessible
  - clearly documented.
- The ISP addresses:
  - the consumer's current situation, goals, strategies and responsibilities
  - medication and psychological treatments
  - collaborative education about the illness and medication

- liaison with carers and significant others (unless otherwise indicated)
- accommodation needs
- the consumer's social skills and wider social network
- work opportunities
- collaborative service arrangements
- review of treatment for its effectiveness.

- Treatment and care reflect the goals and strategies contained in the ISP.
- The ISP is reviewed at least six monthly, revised as necessary and the outcome recorded.

3.3 Case management

In relation to case management:

- The consumer has been assigned a case manager at entry to the service.
- The case manager has participated in the consumer's treatment and discharge planning during any inpatient admission.
- The case manager has facilitated implementation of the consumer's ISP.

3.4 Medication and medical review

In relation to medication and review:

- Psychotropic medication has been prescribed, monitored and reviewed in accordance with the Royal Australian and New Zealand College of Psychiatrists Guidelines for Psychotropic Drugs in Psychiatric Practice.
- The reason for any treatment or intervention is recorded.
- Where there is doubt in relation to diagnosis, or concern in relation to treatment responses, a comprehensive review has been conducted, and/or a second opinion has been obtained, documented and evaluated.
- The date and outcome of any medical review is recorded.

3.5 Risk management

In relation to the assessment and management of risk:

- A risk assessment is completed on admission/intake to the service.
- Where appropriate a risk management plan is developed and risk management strategies are clearly identified.
- Risk is regularly reviewed, revised as necessary and any revision recorded.

3.6 Community treatment orders

Where a consumer has been made subject to a community treatment order, the following have been explained to the consumer:

- purpose of the order
- proposed course of treatment
- duration of the order
- terms and conditions of the order
- consequences of non-compliance with the order
- annual examination requirements.

- The consumer has been given a copy of the patients' rights pamphlet in relation to community treatment orders: *Community Treatment Orders: About Your Rights.*
- There is evidence in the clinical record that the supervision and reporting conditions of the community treatment order have been communicated to the supervising medical practitioner prior to making the order .
- The consumer's community treatment order specifies:
  - the authorised psychiatrist or delegate of the authorised psychiatrist who is to monitor the treatment of the consumer
  - the registered medical practitioner who is to supervise the treatment of the consumer
  - where the consumer is to receive the treatment
  - the intervals at which the supervising medical practitioner must submit a written report concerning the treatment of the consumer to the monitoring psychiatrist
  - the duration of the community treatment order.
- Where the community treatment order has been varied, the clinical reason for variation is recorded, and a variation of community treatment order has been completed.
- Where a community treatment order contains a residency condition pursuant to s14(2A) of the Mental Health Act, the clinical reason for inclusion of this condition is recorded, the need for the residence condition has been regularly reviewed and evaluated and the review outcome recorded.
- Where a community treatment order has been extended, a comprehensive mental state examination has been conducted by the authorised psychiatrist prior to the extension, and the results of the examination recorded and evaluated.
- Where a community treatment order has been extended, this has occurred before the order expires.

3.7 Annual examination

A comprehensive annual examination of the consumer's mental and general health has been conducted by the authorised psychiatrist where the consumer has remained an involuntary patient for a continuous period of one year (including persons subject to community treatment orders) and consideration has been given in the examination to the consumer's:

- current mental state
- current medication
- review of medication and ISP
- general health needs.

- The authorised psychiatrist has submitted a report in the required form to the Chief Psychiatrist in relation to the annual examination.

3.8 Critical incidents

In relation to clinical incidents:

- Any critical incident occurring during treatment has been appropriately managed, reviewed and recorded.
- Critical incident debriefing has been undertaken with consumers, carers, staff and relevant others where required.

3.9 Electroconvulsive therapy

In relation to consumers who are provided with electroconvulsive therapy:

- The reason for the use of electroconvulsive therapy (ECT) is recorded and reported to the Chief Psychiatrist as required under s80 of the Mental Health Act.
- The consumer has consented to the performance of ECT in accordance with the Mental Health Act OR where the consumer is unable to give consent to ECT, the authorised psychiatrist has consented on the consumer's behalf in accordance with the Mental Health Act.
- The consumer has been given the required printed statement and an oral explanation of their rights and entitlements under the *Mental Health Act: Electroconvulsive Therapy: About Your Rights.*
- All reasonable efforts have been made to inform the consumer's guardian or primary carer of the performance of ECT.
- A thorough physical examination has been conducted prior to administration of ECT.
- Details of second opinions and/or case management reviews have been recorded and evaluated.
- ECT has been effectively administered by an appropriately qualified and experienced medical practitioner in accordance with the *Electro Convulsive Therapy Manual: Licensing, Legal Requirements and Clinical Practice Guidelines.*
- The response to ECT is recorded and evaluated.

3.10 Non-psychiatric treatment

In relation to consumers who receive non-psychiatric treatment:

- The reason for the non-psychiatric treatment is recorded.
- The consumer has consented to the non-psychiatric treatment in accordance with the Mental Health Act OR where the consumer is unable to give consent to non-psychiatric treatment, the guardian or authorised psychiatrist has consented to performance of non-psychiatric treatment in accordance with the Mental Health Act.
- The response to the non-psychiatric treatment has been recorded and evaluated.

3.11 Major non-psychiatric treatment

In relation to consumers who receive major non-psychiatric treatment:

- The reason for the major non-psychiatric treatment is recorded and entered in the register of major non-psychiatric treatment required to be kept under s85(2) of the Mental Health Act.
- The consumer has been given the required printed statement and an oral explanation of their rights and entitlements under the *Mental Health Act: Major Non-Psychiatric Treatment: About Your Rights*.
- The consumer has consented to the performance of the major non-psychiatric treatment in accordance with the Mental Health Act OR where the consumer is unable to consent to the major non-psychiatric treatment, the guardian or authorised psychiatrist has consented to its performance in accordance with the Mental Health Act.
- The response to the major non-psychiatric treatment is recorded and evaluated.

3.12 Special procedures

In relation to consumers who receive special procedures (as detained in s3 of the *Guardianship and Administration Act 1986*)

- The reason for the special procedure is recorded.
- The consumer has consented to the performance of the special procedure in accordance with the Mental Health Act OR where the consumer is unable to consent and is a person to whom Part 4A of the Guardianship and Administration Act applies, the consent of the Victorian Civil and Administrative Tribunal has been obtained prior to the special procedure being undertaken.
- The response to the special procedure is recorded and evaluated.

3.13 Mechanical restraint

In relation to consumers who require mechanical restraint while an in-patient:

- The reason for the use of mechanical restraint is recorded, and reported to the Chief Psychiatrist as required under s. 81(3) of the Mental Health Act.
- The restraint has been approved by the authorised psychiatrist, (or, in the case of an emergency, by the senior registered nurse on duty and notified to a registered medical practitioner without delay).
- There is a description of the consumer's condition at the commencement of the restraint.

- Mechanical restraint has been applied in accordance with the Mental Health Act and in accordance with a management plan which relates to:
  - primary diagnosis
  - assessment of clinical needs
  - anticipated outcomes
  - risk assessment
  - strategies to manage identified risks.
- While restrained, the consumer has been reviewed and examined in accordance with the requirements of the Mental Health Act.
- Details of second opinions and/or case management reviews have been recorded and evaluated.
- Where the authorised psychiatrist has varied the requirement for medical review by extension, the reason for this decision is recorded.
- Where the authorised psychiatrist has varied the requirement for medical review by extension, the consumer has:
  - had a medical examination
  - been in the unit at least 24 hours
  - not received intramuscular psychotropic medication.

3.14 Seclusion

In relation to consumers who require seclusion while an in-patient:

- The reason for the decision to seclude the consumer is recorded and reported to the Chief Psychiatrist as required under s82 (5) of the Mental Health Act.
- The seclusion has been approved by the authorised psychiatrist, (or in the case of an emergency, by the senior registered nurse on duty and notified to a registered medical practitioner without delay).
- Seclusion has been undertaken in accordance with the Mental Health Act and in accordance a management plan which relates to the:
  - primary diagnosis
  - assessment of clinical needs
  - anticipated outcomes
  - risk assessment
  - strategies to manage identified risks.
- There is a description in the clinical record of the consumer's condition at the commencement of seclusion.
- While secluded, the consumer has been reviewed and examined in accordance with the requirements of the Mental Health Act.
- Any major medical complications experienced while in seclusion (for example fractures, burns, deliberate self harm) are recorded and evaluated.

- Details of second opinions and/or case management reviews have been recorded and evaluated.
- Where the authorised psychiatrist has varied the requirement for medical review by extension, the reason for this decision is recorded.
- Where the authorised psychiatrist has varied the requirement for medical review by extension, the consumer has:
  - had a medical examination
  - been in the unit at least 24 hours
  - not received intramuscular psychotropic medication.

3.15 Reportable deaths

Where a consumer has died whilst undergoing treatment and care for a mental disorder:

- The service has forwarded notice of the death in the required form to the Chief Psychiatrist, containing a comprehensive report of the circumstances of the death.
- Appropriate support is provided to carers, relatives, staff and persons affected by the death
- The service has a system for review of all deaths to identify any relevant issues.

4. Discharge and case closure

In relation to discharge planning and case closure:

- There is evidence that discharge planning has commenced on admission to the inpatient service and as appropriate in community based programs.
- A comprehensive clinical review and consultation with the consumer (and primary carer unless otherwise indicated) has been undertaken prior to discharge.
- There is evidence that the discharge decision has been reviewed by the clinical team.
- Necessary referrals have been undertaken.
- Necessary follow up has been undertaken within a reasonable time for the consumer's condition.
- Discharge has been formalised in writing.
- The consumer, carers (unless otherwise indicated), and any relevant service providers have been advised how to re-access the service if necessary in the future, and provided with emergency contact numbers.

B. Policies and procedures

The second part of this document is intended for use in review of policy and procedure. During a review evidence is sought to establish if the criteria have been met.

1. The authorised psychiatrist

The service has:

- an appropriately qualified authorised psychiatrist
- a documented clinical management structure ensuring overall responsibility for clinical leadership rests with the Director of Clinical Services
- a clinical director of ECT who is a psychiatrist and a senior nurse with theoretical and practical training in ECT administration and supervision
- documented policies and procedures which ensure that on appointment of the authorised psychiatrist, the service notifies the Mental Health Review Board and (if necessary) the Secretary of the Department of Human Services of the appointment within five days of the appointment being made
- documented policies and procedures which ensure that when the authorised psychiatrist delegates to a qualified psychiatrist any power, duty or function of the authorised psychiatrist, the authorised psychiatrist has completed an instrument of delegation in accordance with section 96(4) of the Mental Health Act
- documented policies and procedures which ensure that when the authorised psychiatrist delegates a power, duty or function under section 12 of the Mental Health Act, he/she reviews the operation of the delegation as soon as practicable after the delegation has expired
- documented policies and procedures which ensure discipline-based formal and informal supervision for all clinical staff.

2. Rights relating to treatment and care

2.1 Provision of information

The service has documented policies and procedures which ensure that:

- Copies of the Mental Health Act (reprinted as at July 2002 or later) and Mental Health Regulations 1998, the Guardianship and Administration Board Act 1986 (reprinted as at 1 January 2000 or later) and any publications prepared by the Department of Human Services for the purpose of explaining the provisions of these Acts, are readily accessible to all consumers receiving treatment or care at the service.
- Copies of the statement of patients' rights are readily accessible to all consumers receiving treatment or care at the service.

- The address and business telephone number of the following organisations are readily accessible to all people receiving treatment or care at the service:
  - the Mental Health Review Board
  - the Public Advocate
  - the Chief Psychiatrist
  - Community Visitors
  - Victoria Legal Aid
  - the Ombudsman
  - the Health Services Commissioner.

2.2 Complaints

The service has documented policies and procedures which ensure that:

- there is a clearly identifiable complaints process
- there is timely response to, and resolution of, complaints.

2.3 Privacy and confidentiality

The service has documented policies and procedures which ensure that the confidentiality and privacy of consumers and carers is respected in accordance with the requirements of the Mental Health Act and the Health Records Act 2001.

2.4 Use of interpreters

The service has documented policies and procedures which ensure that:

- on-site interpreting is available 24 hours per day
- accredited interpreters are used appropriately
- telephone interpreters are used appropriately
- there are monitoring mechanisms supporting the appropriate use of interpreters.

2.5 Mental Health Review Board

The service has documented policies and procedures which ensure that:

- Where a consumer appeals their continued involuntary detention, this is documented in the clinical record and a copy of the appeal is filed in the clinical record.
- Where a consumer is an inpatient, any notice of hearing from the Mental Health Review Board is delivered to the consumer without delay, and explained to them.
- Consumers with hearings before the Mental Health Review Board are entitled to inspect or otherwise have access to any documents to be given to the Mental Health Review Board in connection with a board hearing at least 24 hours before the commencement of the hearing.
- The report on continued detention required by the Mental Health Review Board is prepared by the treating practitioner, and explained to the consumer prior to the hearing.

3. Registers and returns

3.1 Electroconvulsive therapy

The service has documented policies and procedures which ensure that details of ECT are entered in the required returns as soon as practicable after treatment is performed, and forwarded at the end of each month to the Chief Psychiatrist.

3.2 Major non-psychiatric treatment

The service has documented policies and procedures which ensure that details of major non-psychiatric treatment are entered in the register of major non-psychiatric treatment as soon as practicable after treatment is performed.

3.3 Mechanical restraint

The service has documented policies and procedures which ensure that the authorised psychiatrist submits reports in the required form to the Chief Psychiatrist on the use of mechanical restraint during each month and the register is available for inspection as required.

3.4 Seclusion

The service has documented policies and procedures which ensure that the authorised psychiatrist has submitted reports in the required form to the Chief Psychiatrist on the use of seclusion during each month.

3.5 Community visitors

The service has documented policies and procedures which ensure that there is a record of visits by community visitors in the required form kept by the authorised psychiatrist.

4. Policy and procedure manuals

The service has documented policies and procedures which ensure that the criteria addressed in the clinical record section of this document are met. These criteria relate to:

- documentation
- referral
- intake and assessment
- request and recommendation for admission to an approved mental health service
- sedation for the purpose of transport to an approved mental health service
- restraint for the purpose of transport to an approved mental health service
- transport to an approved mental health service
- admission to an approved mental health service
- consent to treatment
- ISP
- case management

- medication and medical review
- risk management
- critical incidents
- ECT
- non-psychiatric treatment
- major non-psychiatric treatment
- major medical procedures
- mechanical restraint
- seclusion
- community treatment orders
- annual examination
- reportable deaths
- discharge and case closure.

Appendix 1: Glossary of terms

Adult mental health services

Public mental health services providing assessment, treatment and support for people aged 16-64 years with serious mental illness or other severely disabling psychiatric disorders. Services include community mental health centres, crisis assessment and treatment services, mobile support and treatment services, psychiatric inpatient services and non-government psychiatric disability support services.

Aged persons' mental health services

Aged persons' mental health services are for people with serious mental illness who are 65 years of age and over. Services include psychogeriatric assessment and treatment services and psychiatric inpatient services.

Approved mental health service

Publicly funded psychiatric service or unit of a general hospital at, or through which, treatment is provided to involuntary, security or forensic patients, and proclaimed as such by the Governor in Council.

Area mental health services

The network of public mental health services managed by general health services which operate within a defined geographical area and provide clinical services.

Authorised officer

An experienced mental health professional appointed by the Chief Psychiatrist under section 106 to exercise powers under that section relating to the monitoring of mental health services.

Authorised psychiatrist

A qualified psychiatrist with specific powers and duties under the Mental Health Act. A consultant psychiatrist may carry out the responsibilities of the authorised psychiatrist under delegation.

Carer

A person who has a caring role with a consumer and whose life is affected by the consumer's welfare.

Case management

A process which aims to ensure the consumer receives the best possible treatment and support through the identification of needs, planning of individual goals and strategies and linking to appropriate services to meet those needs.

Case manager

A mental health professional employed by a mental health service who has the primary responsibility for case management of a particular consumer. This person may be a social worker, psychiatric nurse, consultant psychiatrist, occupational therapist, medical officer or psychologist.

Chief Psychiatrist

The Chief Psychiatrist is appointed pursuant to the Mental Health Act by the Secretary to the Department of Human Services, with overall responsibility for the medical care and welfare of people receiving treatment for a mental illness in Victoria.

Child and adolescent mental health services (CAMHS)

Specialist public mental health assessment and treatment services provided for children and adolescents up to 18 years of age. They are provided by community based, multi-disciplinary services and inpatient services. Child and adolescent mental health assessment treatment and liaison (CAMHS ATL) services may be centre, clinic or hospital based.

Community mental health centre (CMHC)

First point of contact during business hours for access to a mental health service. Mental health professionals employed by the CMHC provide initial screening and consultancy for people requesting public mental health services, to guide the person to appropriate services. They also provide assessment, treatment, continuing care and support for people with severe mental illness.

Community treatment order

An order made pursuant to section 14 of the Mental Health Act requiring treatment for a person's mental illness in the community.

Consumer

A person who is currently using public mental health services.

Crisis assessment and treatment service (CAT)

A component of an area mental health service which is available 24-hours a day to provide community-based assessment and treatment for people experiencing psychiatric crisis. The CAT service is responsible for screening all people who require inpatient treatment.

Critical incident

A serious incident which threatens consumers or staff. This may include death or injury to a consumer, co-worker or visitor, self injury, physical or psychological threat.

Diagnosis

The identification of symptoms which are consistent with a particular illness or disorder. Diagnosis of a mental illness is based on clinical observations and interviewing the person and others who know them.

Director of clinical services

The person with overall responsibility for clinical leadership of an area mental health service.

Guardianship and Administration Board orders

The Guardianship and Administration Board has powers to make a range of orders in relation to the appointment of guardians and administrators. See further the Guardianship and Administration Act 1986.

Individual service plan (ISP)

A plan based on a comprehensive assessment outlining the consumer's goals and strategies for their recovery, including details of mental health services and general community services to meet the consumer's needs. The ISP is developed and regularly reviewed by the case manager, the consumer and with the consumer's permission, their family or carer and other workers involved.

Informed consent

Where a person provides permission for specific treatment to occur, based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission and their knowledge of available alternative treatments.

Intake assessment

The process which occurs when a person first becomes a consumer of a mental health service. The person will have an initial psychiatric assessment in order to determine the nature of their psychiatric problem, their treatment needs and the most appropriate service required.

Involuntary patient

A person who meets the criteria set out in the Mental Health Act for involuntary treatment and care, and who is admitted and treated under the procedures set out in the Act.

Mental Health Act 1986

Legislation concerning the treatment and care of people with a mental disorder in Victoria.

Mental health practitioner (within the meaning of section 9(7A)(b) of the Mental Health Act)

A registered nurse, registered psychologist, social worker or occupational therapist employed by an approved mental health service and engaged in the provision of acute psychiatric assessment and treatment functions in the community.

Mental health professionals

Staff of mental health services with professional training, qualifications and experience in working with people who have a mental illness. Includes social workers, psychiatric nurses, psychiatrists, medical officers, occupational therapists and psychologists.

Mental Health Review Board

An independent board established under the Mental Health Act. Its purpose is to hear appeals and regularly review all persons who are involuntary detained.

Mental state examination

An interview with a person using a standardised set of questions, with the primary purpose of identifying a person's current mental state. (See also psychiatric assessment.)

Mental illness

Defined in the Mental Health Act as a medical condition characterised by a significant disturbance of thought, mood, perception or memory.

Mobile support and treatment service (MST)

A multidisciplinary, community-based mental health service which operates for extended hours seven days per week. The MST service provides treatment and support on an outreach basis for persons who have experienced many psychiatric crises, have associated psychiatric disability and are at risk of readmission to hospital without this support.

Prescribed registered medical practitioner

Can be a registered medical practitioner in general practice, a medical practitioner who has recommended that a person be admitted to and detained in an approved mental health service, head of an emergency department of a hospital, employee of a mental health service, psychiatrist, or forensic physician.

Psychiatric assessment

A thorough assessment of a person by a mental health professional which includes identifying their current mental state, personal and social history, social situation and any relevant past psychiatric history. Psychiatric assessment enables selection of the most appropriate form of treatment for the person.

Psychiatric nurse

Registered nurse who specialises in the nursing care and treatment of people with mental illness. This role includes administration of medication, counselling and long term support and may include psychological therapies.

Psychogeriatric assessment and treatment services (PGAT)

Specialist community mental health services that provide assessment, treatment and support for people with a mental illness aged 65 and over.

Psychologist

Clinical psychologists have specialist training in the assessment of behaviour and mental functioning and a range of interventions aimed at changing how people think, feel and act towards themselves and others.

Quality Assurance Committee

The committee is established under section 106AC of the Mental Health Act. The committee consists of the Chief Psychiatrist and all authorised officers. Its function is to oversee and monitor standards of mental health services. The committee is declared a consultative council under the *Health Act 1958*.

Request and recommendation

Process required for the involuntary admission of a person. The process is closely regulated under the Mental Health Act.

Restraint

The application of devices (including belts, harnesses, manacles, sheets or straps) on a person's body to restrict movement. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restrict the capacity of the person to get off the furniture.

Seclusion

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.

Sedation

The prescribing and administration of medication that has a tranquillising, calming effect.

Transport without recommendation

When a person requires involuntary treatment for their mental illness but a registered medical practitioner is not available to sign a recommendation for admission, the Mental Health Act permits lawful transport to an approved mental health service on the completion of an authority to transport by a prescribed mental health practitioner.

Treatment

The use of professional knowledge and skill to bring about an improvement in a person's mental illness or to lessen its ill effects or the pain and suffering which it causes.

Appendix 2: Current publications relevant to clinical reviews

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Access to Beds (July 1997)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Ambulance Transport of People with Mental Illness (Updated February 2002)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Appointment of an Authorised Psychiatrist (October 1997)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Apprehension of Patients Absent Without Leave (October 1997)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Assessment of Intoxicated Persons (December 1999)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Community Treatment Order Guidelines (Updated November 2001)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Discharge Planning for Adult Community Mental Health Services Guidelines (August 2002)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: High Dependency Unit Guidelines (August 2002)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Illicit Substance Use in Acute Inpatient Mental Health Services (November 2001)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Mechanical Restraint (June 1996)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Physical Examination, the annual examination and attention to client' general medical health needs (August 2002)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Non-psychiatric Treatment and Special Procedures (Updated March 2003)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Patient Access to Files for Mental Health Review Board hearings (Updated November 2001)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Reportable Deaths (Updated December 1999)

Clinical Practice Guidelines, Office of the Chief Psychiatrist: Seclusion (June 1996)

Guidelines for Mental Health Services: Working with People who are Deaf or Hard of Hearing, 2000

Collaborative Service Arrangements: Private Psychiatrists and Public Mental Health Services (June 1996)

ECT Manual: Licensing, Legal Requirements and Clinical Practice Guidelines (January 2000)

General Adult Community Mental Health Services: Guidelines for Service Provision (July 1996)

Guidelines for Service Provision for People with Brain Disorders (September 1996)

A Guide to Mental Health Terminology (June 1996)

In Partnership: Families, Other Carers and Public Mental Health Services (October 1996)

Mobile Support and Treatment Services: Guidelines for Service Provision (September 1995)

Program Management Circular: Responding to Allegations of Physical and Sexual Assault (November 1995)

Protocol Between Victoria Police and Psychiatric Services (September 1995)

Program Management Circular: Accessing Services Across Regions and Areas (July 1995)

Program Management Circular: Accessing Statewide Forensic Services (April 1996)

Program Management Circular: Amendment to the Mental Health Act regarding Confidentiality (1996)(See also PMC 07/02)

Program Management Circular: Amendment to the Mental Health Act Regarding Involuntary Patients (June 1996)

Program Management Circular: Apprehension of Mentally Ill Persons by a Member of the Police Force Under the Mental Health Act 1986 (2003)

Program Management Circular: Authority to Transport without a recommendation (June 1996)

Program Management Circular: Confidentiality: Amendment to s120A of the Mental Health Act 1986 (July 2002)

Program Management Circular: Cross Border Services: Victoria and NSW (2003)

Program Management Circular: Guidelines on catchment areas in relation to the implementation of the Primary Mental Health and Early Intervention Initiative (July 2002)

Program Management Circular: Ministerial Exemption Relating to the Release of Information: Persons Unfit to Possess, Carry or Use a Firearm (July 2000)

Program Management Circular: Out of Area Patients (May 1996)

Program Management Circular: Protecting People Who Want to Discharge Themselves Contrary to Medical Advice (June 1996)

Program Management Circular: Transport, Assessment and Admission of Involuntary Patients

Psychiatric Crisis Assessment and Treatment Services: Guidelines for Service Provision (September 1995)

Resources for Case Managers: Individual Service Planning (July 1996)

Resources for Case Managers: Meeting Consumer Needs for Housing and Accommodation: A Guide for Case Managers (July 1996)

Resources for Case Managers: Needs for Service Assessment and Review: A Collaborative Approach (July 1996)

Sharing the Care: General Practitioners and Public Mental Health Services (June 1996)

Victoria's Mental Health Service: The Framework for Service Delivery (March 1994)

Victoria's Mental Health Service: The Framework for Service Delivery-Aged Persons Services (April 1996)

Victoria's Mental Health Service: The Framework for Service Delivery-Better Outcomes Through Area Mental Health Services (April 1996)

Victoria's Mental Health Service: The Framework for Service Delivery-Child And Adolescent Services (April 1996)

Victoria's Mental Health Service: Improved Access Through Coordinated Client Care (September 1994)

Victoria's Mental Health Service: Improving Services for People From a Non-English Speaking Background (July 1996)

Victoria's Mental Health Service: Tailoring Services to Meet the Needs of Women (April 1997)

Working with Consumers: Guidelines for Consumer Participation in Mental Health Services (March 1996)

Appendix 3: 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 authorised officers in accordance with the Mental Health Act. The review team is led by a consultant psychiatrist and includes a senior clinical adviser 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 with respect to 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 should be designed to assist people with a mental disorder to, wherever possible, live, work and participate in the community.
- The provision of treatment and care for people with a mental disorder should promote and assist self reliance.
- 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 multi-disciplinary 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 4:
Quality Assurance Committee terms of reference

The function of the Quality Assurance Committee (QAC) under section 106AC of the Mental Health Act is to oversee and monitor standards of mental health services. The QAC terms of reference state that subject to the direction of the Chief Psychiatrist, members of the QAC may be required to:

- participate in clinical review of area mental health services
- collect and interpret information concerning 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