Chief Psychiatrist's annual report 2020–21

VICTORIA State Government | Department of Health

Acknowledgement of country

The Victorian Government proudly acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past and present.

We acknowledge Aboriginal peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we live, work and play.

We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches our society more broadly.

We embrace self-determination and reconciliation, working towards equality of outcomes and ensuring an equitable voice.

Acknowledgement of lived experience

We would like to recognise all people with a lived experience of trauma, neurodiversity, mental ill-health and substance use or addiction, and their families, carers and supporters. This recognition extends to the clinical and non-clinical workforces that support people with lived experience.

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Foreword from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist's annual report for 2020–21. This year continues to be a time of unprecedented challenges as the COVID-19 pandemic causes upheaval in people's lives. The report illustrates the many ways that the Office of the Chief Psychiatrist (OCP) has worked with its partners during this difficult period to carry out its role in promoting safety and quality in mental health services, providing clinical leadership and upholding the rights of consumers.

A major development that marked the year was the publication of the final report of the Royal Commission into Victoria's Mental Health System. The long-awaited report – with its 65 recommendations to rebuild Victoria's mental health system from the ground up – was tabled in Victoria's parliament in March 2020. It has been hailed as a once-in-a-lifetime opportunity for transformational change, elevating mental health on the agenda for public investment and paving the way for reforms that enable people living with mental illness and their families and carers to receive the support they need when they need it.

An enormous amount of work lies ahead to implement the recommendations, and my office is ready to play its part in helping bring Victoria towards the better future envisaged by the Royal Commission. In July 2021, the Office of the Chief Mental Health Nurse moved to Safer Care Victoria as part of the new quality and safety architecture proposed by the Royal Commission. My office is also in the process of handing over some of its responsibilities around quality and safety improvement to the Mental Health Improvement Unit, which is due to be set up in Safer Care Victoria at the beginning of 2022.

These changes have had a significant impact on the OCP, altering the composition of its personnel and the way it conducts its core business. However, they are a timely opportunity to consolidate the OCP's role as one of Victoria's main oversight and clinical leadership bodies in the area of mental health. Indeed, under the new governance architecture, the OCP will be better placed to assist services to resolve quality and safety issues and to help consumers receive care, treatment and support that is respectful and attentive to their needs.

When I wrote the foreword for my annual report this time last year, I described the adverse effects that COVID-19 was having on people's psychological wellbeing and the immense pressures it was placing on Victoria's mental health system. Unfortunately, a year on, the pandemic continues to take its toll on people and the system in these profound ways. Remote work, homeschooling, interrupted employment and restrictions on physical contact with loved ones and friends have remained a part of our daily lives, contributing to the prevalence of anxiety, stress, social isolation and depression. Staff administering care and treatment in an already overloaded mental health system are increasingly vulnerable to poor mental health, running the risk of vicarious trauma and burnout.

My office has been responding to people who are struggling during this difficult time and supporting mental health services that are under strain. Through our enquiries line, we respond daily to crises as they emerge and in their various forms. This may take the form of phone calls and emails from consumers, families, carers, mental health services, government- and non-government agencies, Members of Parliament, and the general public. The volume of enquiries to the OCP has increased significantly during the pandemic. Nevertheless, my staff continue to respond empathetically and with a strong sense of duty and care, hearing people's concerns and providing advice to meet their individual needs.

My office has continued to support health services to manage the ever-present risk of COVID-19 outbreaks in mental health inpatient units. We have been active contributors to health service meetings, which enabled resources to be pooled towards minimising the impact of ward closures and staff being placed on furlough during outbreaks. These efforts to stem disruptions have been complemented by the preparedness health services showed to come to each other's assistance as the pressures of the pandemic mounted. They shared vital resources such as staff, beds, expertise and knowledge, keeping at bay the worst consequences of the pandemic and enabling consumers to continue receiving care and treatment.

In this time, we have also continued to participate in case conferences with services. These bring together professionals from different disciplines and sectors to assist patients with complex care needs in a holistic, structured and coordinated manner.

A number of partners and colleagues play a part in the vital work carried out by the OCP, and I wish to acknowledge their contribution. Staff in my office with lived experience as carers and consumers support me to fulfil my statutory duties, helping me with identifying safety, quality and human rights issues in mental health services, as well as finding the best solutions for resolving those issues. I have gained much from their input and advice during audits, reviews and investigations and have had the benefit of tapping into their networks and leadership groups across the state.

The consumer and carer peak groups Tandem and the Victorian Mental Illness Awareness Council worked collaboratively with my office. I am grateful for their role in helping us understand the perspectives of consumers and carers, and the kinds of actions we need to take to realise their rights.

I am fortunate to receive an exceptional level of support from senior staff who are seconded to the OCP from clinical mental health services. These staff include deputy chief psychiatrists and clinical advisors. I offer my thanks to the various services that permit and encourage the assignment of their employees to our office. The value of these exchanges cannot be overstated: they boost the clinical knowledge, expertise and breadth of skills within the OCP while also allowing the work of the OCP to remain grounded in contemporary clinical practice.

I extend my gratitude to the various colleagues and stakeholders who partner with us to improve safety and quality across the system. These include the Mental Health Complaints Commissioner, the Mental Health Tribunal, the Office of the Public Advocate Community Visitors Program, the Victorian Agency for Health Information and the Royal Australian and New Zealand College of Psychiatrists, among other organisations and agencies that share our deeper purpose of creating a mental health system that is high-quality, equitable and responsive.

I would also like to acknowledge the work of the Chief Mental Health Nurse, Anna Love, and her team. Their presence and functions within the OCP have been critical for supporting mental health workforce development through planning, education and training, and promotion of best practice within the mental health system. I am confident we will continue to enjoy a strong collaborative relationship.

Finally, my heartfelt gratitude goes out to my staff, who are the lifeblood of the OCP. They have had to put in extra effort during this time of crisis, making adjustments towards remote work and devising innovative ways of being available for people in distress under the constraints posed by the pandemic. In this regard, the OCP is no different from other parts of the mental health workforce: we manage the same risks of exhaustion and overwhelming stress as we strive to do the best in our jobs and meet increasing demands for our services. I thank my staff for their extraordinary efforts this year and for the support they provided me to promote high standards of care in Victoria's mental health system.

Neil Coventry
Chief Psychiatrist

Foreword from the Chief Mental Health Nurse

I am pleased to outline the year of work of the Office of the Chief Mental Health Nurse (OCMHN) in the context of the close partnership we have working with the Office of the Chief Psychiatrist.

I wish to acknowledge all mental health nurses, lived experience advisors, allied health practitioners, psychiatrists and psychologists across the state and to thank you for the incredible work you do every day to support consumers and carers within our services and to recognise the compassion, professionalism and commitment of all of you.

During 2020, I continued to lead the Department of Health and Human Services COVID-19 mental health response, which has included leading a team working across the Mental Health and Drugs Division. This team has worked hard to translate public health directions for the mental health and community sector, consumers and carers, ensuring people's mental health needs have been at the forefront of conversations across the department. This has included hosting statewide forums to help support sector leads during this unprecedented time in Australia. I thank the mental health COVID response team for their commitment, resilience and professionalism.

In March 2021, the long-awaited Royal Commission into Victoria's Mental Health System's final report was released. The report outlines the sector reform we have been asking for, including planned service and workforce reforms, and more responsive services to support the mental health and wellbeing of our community.

In line with recommendations from the Royal Commission's report, on 1 July 2021 my office moved into Safer Care Victoria from the Department of Health. This move aligns with the quality improvement focus of the Chief Mental Health Nurse role with the other Chiefs in Safer Care Victoria. The Mental Health Improvement program of work will focus on reducing the use of seclusion, restraint and compulsory treatment and on tackling the unacceptable rate of gender-based violence.

A number of staff also moved across to continue to lead this important workplan within Safer Care Victoria. The team who moved across to Safer Care Victoria has a focus on lived experience collaboration and support, education and training initiatives, promoting best practice standards that contribute to improved outcomes for people and their families and communities, workforce planning and development, and professional leadership.

We have continued to work on best practice standards, implementing Victoria's *Clinical supervision for mental health nurses* framework, *Equally well in Victoria: Physical health framework for specialist mental health services* and *Mental health intensive care framework*, and continuing work on Safewards sustainability in mental health and implementation into general hospitals.

We will also continue to lead and support the mental health nursing workforce and develop our program of work to support the reform of our mental health and wellbeing system. We can all be part of this reform work by becoming involved.

Anna Love
Chief Mental Health Nurse

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Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, carers, service providers and members of the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2020–21 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health Act 2014*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The *Mental Health Act 2014* aims to improve the treatment experiences of people with a mental illness by actively involving and supporting them, and their families and carers, in making decisions about their treatment and exercising their rights.

The Act has several core principles and objectives including that:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and participate in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that are responsive to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under s. 119 of the Act, the Secretary of the Department of Health (formerly 'Department of Health and Human Services'; abbreviated as 'the department' hereon) can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s. 120 of the Act, is to:

- provide clinical leadership and expert clinical advice to mental health service providers
- promote continuous improvement in the quality and safety of mental health services
- promote the rights of people receiving mental health services
- provide advice to the designated minister and the departmental Secretary about mental health services.

Under the Act, 'mental health service providers' are designated mental health services (often public or denominational hospitals) and publicly funded mental health community support services. Often referred to jointly as 'public mental health services', these services include a range of hospital and community-based clinical mental health services and the Victorian Institute of Forensic Mental Health (known as 'Forensicare'). More information about the Mental Health Act and how it relates to the role of the Chief Psychiatrist can be found on the department's website <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist>.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health services. Supported by the OCP, the role promotes quality and safety in services that are provided to some of the state's most vulnerable people. The functions of the Chief Psychiatrist, as summarised under s. 121 of the Act, are to:

- develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- develop and provide information or training, and monitor service provision, to promote quality and safety
- assist mental health services to comply with the Act, with regulations made under the Act and with codes of practice
- conduct clinical practice audits and clinical reviews of mental health service providers and investigations in relation to service provision
- analyse data, undertake research and publish information about mental health services
- publish an annual report
- give directions to mental health service providers about service provision
- promote cooperation and coordination between mental health services and providers of health, disability and community support services.

Office of the Chief Psychiatrist and the Department of Health

The Act defines the statutory role of the Chief Psychiatrist, who also holds an executive officer role in the department, where they lead the OCP. As the department's quality and safety 'arm' in the stewardship of clinical mental health services, the OCP supports the Chief Psychiatrist's responsibility to provide clinical leadership to the sector. The OCP undertakes a wide range of activities including:

- monitoring restrictive and invasive interventions, which include seclusion, restraint and electroconvulsive treatment (ECT)
- responding to serious clinical incidents
- working with mental health and other service providers to improve care for individual consumers
- helping to embed new practices and models of care.

The Chief Mental Health Nurse is an executive officer who leads the Office of the Chief Mental Health Nurse (OCMHN) within the OCP. The Chief Mental Health Nurse provides leadership in the mental health nursing sector and promotes collaboration between the department and mental health nurses. The Chief Mental Health Nurse represents the profession at all levels of government and across all health service sectors. The Chief Mental Health Nurse promotes recognition of the mental health nursing profession, provides education and training, and promotes best practice standards, workforce planning/development and professional leadership.

On 1 July 2021 the OCMHN transferred to Safer Care Victoria. This change was part of implementing the new mental health governance architecture recommended by the Royal Commission into Victoria's Mental Health System (see below).

The year in review

In March 2021 the final report of the Royal Commission into Victoria's Mental Health System was tabled in the Victorian Parliament. It set out an ambitious reform agenda, handing down 65 recommendations to fundamentally transform how mental health and wellbeing treatment, care and support are provided in Victoria. These recommendations were developed through an inquiry into Victoria's mental health system that lasted nearly two years and focus on four main areas of reform:

- the expansion of a community-based model of care, where people receive treatment, care and support close to their homes and their communities
- the promotion of inclusion, where stigma and discrimination are reduced and the system is more accessible to people experiencing disadvantage
- strengthened leadership and oversight, where government bodies collaborate with one another more frequently to plan, fund and monitor services, and where people with lived experience of mental illness or psychological distress have more opportunities to participate in decision making on issues that affect their lives
- greater adaptability, where the new system is better equipped to keep pace with new expectations, trends and challenges that affect the promotion of mental health and wellbeing.

The Victorian Government made a commitment to implement all the recommendations, with the Premier describing them as 'our blueprint for delivering the biggest social reform in a generation'.

The Royal Commission's reform agenda entails significant change in the OCP and the broader Mental Health and Wellbeing Division within which the office sits. As part of the Royal Commission's new approach to the governance of mental health and wellbeing services, quality and safety improvement responsibilities will be undertaken by the Mental Health Improvement Unit. This new team will be established in Safer Care Victoria and become operational by January 2022. Quality and safety oversight of clinical services, along with clinical leadership, will continue to be core responsibilities of the Chief Psychiatrist.

This new arrangement will be consolidated through replacing the current Mental Health Act with a new Mental Health and Wellbeing Act – due to be enacted by mid-2022. A memorandum of understanding between the OCP and the Mental Health Improvement Unit will outline the coordinated approach these entities will take to promote quality and safety in clinical services.

A further aspect of this new governance architecture is the transfer of the OCMHN from the OCP to Safer Care Victoria. This was completed on 1 July 2021, increasing the capacity of Safer Care Victoria to carry out improvement activities in the mental health and wellbeing sector. Under this new arrangement, the OCP will continue to collaborate with the OCMHN to promote best practice in delivering treatment, care and support.

The expansion of the OCP, supported by additional fixed-term funding from 2019–20 and into 2020–21, has been crucial in enabling the OCP to continue to meet the significant increase in demand experienced as a result of the COVID-19 pandemic and the final report of the Royal Commission. As foreshadowed in 2019–20, the team has continued to work remotely through most of the 2020–21 year, in line with public health directions. This has led to further innovations and new ways of working, including a series of online ECT forums in late 2020 and remote participation in health service reviews and investigations.

E.F., Senior Clinical Adviser, Office of the Chief Psychiatrist

I am a registered mental health nurse, qualified in the United Kingdom with a Bachelor of Mental Health Nursing with First Class Honours. I have dedicated my adult career, 15 years to date, to working in public mental health services. I moved from the UK to Australia in 2013, looking to continue my career in a warmer climate, and was offered a sponsorship to work for Monash Health. For eight years I worked in the secure extended care unit (SECU) as both nurse and nurse manager, caring for consumers with serious mental illness and providing support to their family and carers.

In my time at the SECU, I had contact with the OCP, informing the Chief Psychiatrist on workplace matters that fall within their statutory role. Late in 2020 an opportunity presented itself to work at the OCP as a clinical advisor. I applied and was offered the position. Since then, I have not looked back, using my experience to support clinicians, consumers and carers across Victoria and to contribute to service improvement initiatives.

As a senior clinical advisor in the OCP, no two days are the same. The pace of work is often set by the volume of calls we receive through the OCP enquiry line and the requests we receive from the minister's office to provide advice and support to carers, consumers and clinicians across Victoria.

I work closely with other members of the OCP's clinical team to respond to enquiries, and I liaise with mental health services to support the coordination of care for Victorians with complex mental health needs. I am also involved in monitoring the use of restrictive interventions by services, a statutory function of the OCP. Carrying out this task requires the frequent review of data and the delivery of feedback to services on how they can improve from a quality and safety standpoint.

I find satisfaction in my job by knowing that I assist people to access services and the support they need. There are so many amazing mental health and social support services in Victoria; I am still learning about them and seem to stumble across a new one every day. It is heartening to know that there are many people out there providing sanctuary and support to those in need.

I also have the privilege of working with an extremely professional and warm team. There is always someone in the team to talk to, hear a new perspective from, and learn from.

Enquiries received and the COVID-19 mental health response

Table 1 and Figure 1 provide an outline of the enquiries received by the OCP over a period of several years. What is clear from the data is that most contacts with the OCP during the 2020–21 year (36.8 per cent) came via clinical services, closely followed by contact from consumers. These contacts were frequently related to treatment access and clinical practice.

Table 1: Type of enquiries to the Office of the Chief Psychiatrist, 2020–21

Enquiry type	Number	Proportion (%)
Clinical	365	36.8%
Consumer	302	30.4%
Carer	192	19.3%
General	95	9.6%
Legal	20	2.0%
Other	13	1.3%
Coroner	6	0.6%
Total	**993**	**100%**

The enquiry types received by the OCP can be explained as follows:

- *clinical* – relate to clinical practice and service delivery
- *consumer* – relate to consumers of mental health services
- *carer* – relate to carers of mental health consumers
- *general* – relate to complaints about care and treatment, operational matters and requests for information
- *legal* – relate to apprehension orders, non-custodial supervision orders, subpoenas, the Mental Health Act, the Forensic Leave Panel and intra-Australian transfers
- *coroner* – relate to information that assists coroner investigations.

Figure 1: Enquiries received by Office of the Chief Psychiatrist, by number per quarter, 2014–15 to 2020–21

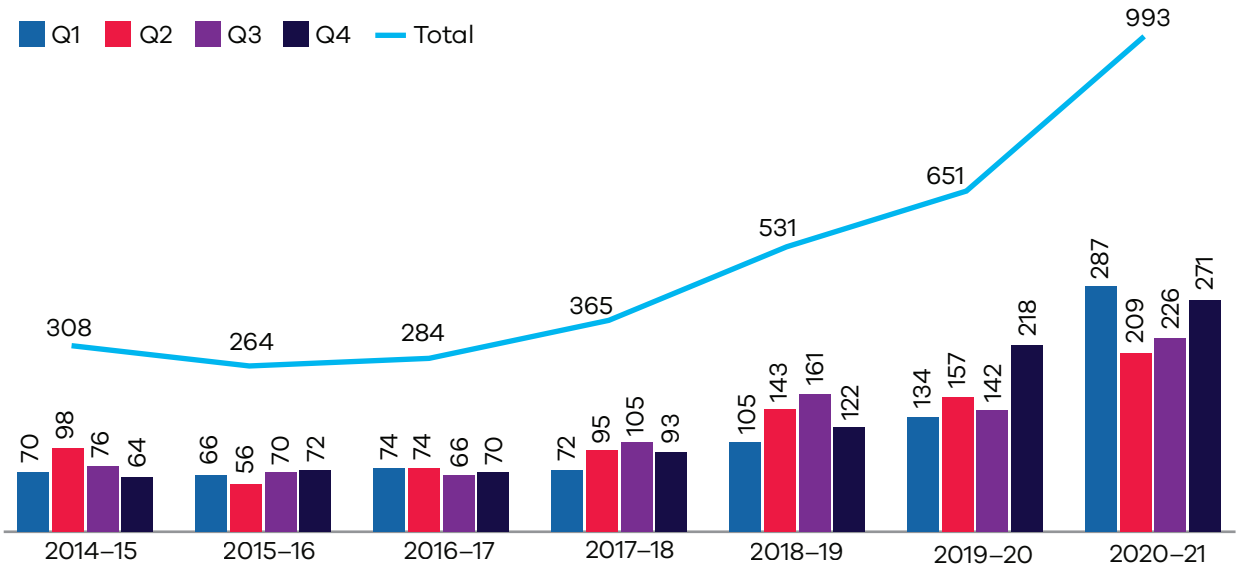


Table 2: Enquiries received by the Office of the Chief Psychiatrist, by number per quarter, 2014–15 to 2020–21

Time	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Q1	70	66	74	72	105	134	287
Q2	98	56	74	95	143	157	209
Q3	76	70	66	105	161	142	226
Q4	64	72	70	93	122	218	271
Total	**308**	**264**	**284**	**365**	**531**	**651**	**993**

Note: This table corresponds with the graph above. It is included for purposes of accessibility.

Table 3: Enquiries to the Office of the Chief Psychiatrist, trend data, 2018–19 to 2020–21

Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2018–19	28	49	28	40	50	53	62	49	50	50	36	36
2019–20	50	42	42	72	42	43	59	42	41	69	63	86
2020–21	97	106	84	67	72	70	70	64	92	96	79	96

Note: This table corresponds with the graph above. It is included for purposes of accessibility.

Figure 1 illustrates the volume of enquiries received by the OCP over the course of seven years. These have been on an upward trend since 2015–16, rising from 264 enquiries in that year to 651 in 2019–20. However, the increase was especially steep between 2019–20 and 2020–21, when enquiries rose to 993, a 53 per cent increase on the previous year. This significant difference coincides with the COVID-19 pandemic. As such, the markedly higher rate of enquiries can in part be explained by mental health services, consumers and carers coming to terms with the impact of the virus by raising treatment and safety issues and seeking to grasp the implications of physical distancing on the continued delivery of and access to clinical care.

The steep increase in enquiries over the period corresponding with the COVID-19 pandemic may also demonstrate the heightened stress and anxiety created by the pandemic. During lockdowns, the volume of requests for support and advice coming to our office in relation to people experiencing distress and managing access to treatment tended to increase.

A further factor that helps to explain the rise in enquiries is the operation of the Royal Commission into Victoria's Mental Health System. The Royal Commission's sittings of witnesses were held from 2018 to 2020. These sittings created increased exposure to mental illness and triggered a public debate on the issue. It also invoked strong emotions from some consumers, who recalled their negative experiences with mental illness and their treatment in the mental health system. The OCP received enquiries from these individuals, who contacted the office to talk about their experiences.

With the outbreak of COVID-19, the OCP was required to shift resources to support the Victorian mental health sector's preparedness and outbreak responses. This included clinical practice change across the acute mental health sector, including in the private mental health sector.

The role of the OCP in the COVID-19 response in the then Mental Health and Drugs Branch (and later the Mental Health and Wellbeing Division) involved several interrelated but distinct pieces of work. Initially the work centred on supporting area mental health services (AMHS) and non-government organisations (NGOs) in their pandemic preparedness and COVID-19 infection prevention and control processes. This work included authoring personal protective equipment guidance, including representationon the department's Personal Protective Equipment Taskforce, to ensure the continued delivery of mental health services and administration of antipsychotic depot medication. The OCP also contributed to developing inpatient and community consumer pathways of care and workforce documents to support mental health service delivery as part of the Mental Health COVID response team.

The OCP worked to continue clinical oversight of COVID-19-related incidents, including clarifying issues relating to the Mental Health Act. This work included maintaining and improving access to mental health treatment while considering appropriate infection prevention and control measures. Our role extended to examining consumer and carer complaints about service delivery and the impact on inpatient hospital visitors and consumer leave. We were tasked with ensuring that service providers understood how to apply the department's information and guidance and directives from the Chief Health Officer.

Our partnership with the department's Public Health team regarding outbreak management assisted supported clinical decision making for consumers with complex needs. Many of these consumers were either unable or unwilling to comply with public health infection control requirements and detention orders. This assistance ensured that consumers were able to continue to live in accommodation that was attentive to their needs, including supported residential services, rooming houses and public housing towers, and that the health response included targeted mental health support.

The timely distribution of department directives/guidance and evidence-based information to AMHS and NGOs through the Mental Health and Drugs Branch and Mental Health Reform Victoria communiques and multiple regular forums for clinical leaders (AMHS clinical directors and operational directors) bolstered the mental health system's capacity to respond in a timely and humane way during this critical period. This advice included Chief Health Officer Hospital Visitor Directions and liaison with safeguarding organisations, with a view to treatment safety and continuation. The target audience included leaders in youth and aged-focused AMHS, NGO community providers and ECT coordinators and directors.

The OCP will continue to monitor data and AMHS service responses in relation to quality and safety with reference to the impacts of this pandemic on the mental health service system, mental health workforce, consumers and carers. This will require an undertaking that considers the direct impacts on people's wellbeing and mental health and the unintended consequences of the pandemic such as increases in eating disorder and drug misuse presentations in mental health services. While at some stage an end may be called to the pandemic, all expectations are that the consequences of this pandemic on people's mental health and wellbeing will persist for many years to come.

M.A., Principal Project Adviser, Office of the Chief Psychiatrist

I have a background as a generalist counsellor and have worked in alcohol and other drug (AOD) services for about 15 years as a clinician and, following this, almost 20 years as a service manager at various levels of leadership. This includes being the CEO of two small not-for-profit organisations, one of which I was the founder of. I also have postgraduate qualifications in public health with a focus on AOD and a Master of Health Administration.

In my role as a Principal Project Adviser at the OCP, I draw on the various skills I have gained over the years that are relevant to the operation of systems, finding ways of improving and streamlining them. I manage projects of different sizes to consider how we can modernise and increase the efficiency of processes we use to collect data and handle queries from the sector. The goal of this work is to ensure the OCP continues to be effective at overseeing services and promoting quality and safety within them as changes take place and the recommendations of the Royal Commission into Victoria's Mental Health System are implemented.

I am also involved in the more strategic aspects of the OCP, providing advice on how our work can be positioned to ensure better clinical governance and leadership for a sector set to evolve significantly over the next decade or so.

Most days at work involve juggling a whole lot of different moving pieces, and I gain satisfaction from knowing that what I do ultimately benefits the people we serve, some of whom are the most vulnerable members of the community. It is also gratifying working in a team where everyone's opinion and experience is valued and where hierarchy and position is truly a secondary consideration. This reality helps me feel valued and ensures that I can contribute in significant and meaningful ways to the work of the office.

1. Statutory reporting

Under the Mental Health Act, mental health services must report to the Chief Psychiatrist about their use of ECT and restrictive interventions. They must also report the deaths of mental health consumers. The Chief Psychiatrist understands that the loss of a loved one or the use of restrictive practices has impacts on people, their families and the workforce and is working with services to improve consumers' physical wellbeing and minimise the use of restrictive practices.

Data collected by the Chief Psychiatrist offer the opportunity to monitor trends, identify issues and support improvements to quality and safety within clinical services. This section of the report provides data and analysis regarding ECT, restrictive interventions and consumers' deaths for the year 2020–21.

The gender categorisation in this section is grouped *female* and *male*. The OCP acknowledges that some people express their gender in ways that do not correspond with these differences. This includes people who are gender non-binary, gender queer, agender or gender fluid/diverse. The OCP data systems are operating under historical and current data-gathering methods, which typically group gender data according to these two gender categories. The OCP acknowledges that this binary approach does not provide a full picture of the experiences of consumers and is currently working towards adopting a more inclusive approach that better captures the diverse ways people express their gender.

Electroconvulsive treatment

ECT is a safe, effective, evidence-based treatment of mood disorders, psychosis and catatonia. It may be recommended when other medical treatments have not worked, or take too long to work, or cannot be undertaken safely. It might also be recommended to people for whom the treatment has worked well previously.

ECT is now individually tailored to maximise its benefits and reduce side effects including cognitive impairment. Adverse effects are minimised by preferentially applying stimulation to one side of the head (unilateral ECT) with the smallest possible dose of electrical stimulation. Bilateral ECT is used when clinically indicated. Treatments are typically administered on two or three occasions per week over a period of two or more weeks. A small proportion of people benefit from ongoing occasional treatments to prevent relapse.

The Chief Psychiatrist and the Mental Health Tribunal oversee the use of ECT. Services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use.

Electroconvulsive treatment in public mental health services

In 2020–21, 910 people received ECT (Table 4). With a total of 11,965 ECT treatments delivered that year, the rate of treatments delivered per person was 13.2.

Table 4: Number of treatments and people treated by ECT in public hospitals, 2015–16 to 2020–21

Measure	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Number of ECT treatments	11,947	12,299	13,292	12,977	12,094	11,965
Number of people receiving ECT	933	1,033	1,031	974	893	910

While the numbers of treatments administered vary from year to year, some of the variation from 2018–19 to 2020–21 may reflect changes in practice due to COVID-19. To reduce the risk of infection, some outpatient treatments (which account for about half of the total) were postponed, and access to theatre was sometimes constrained. One consequence of this regrettable but necessary move to contain viral transmission might be a prolonged recovery for some mental health consumers or a greater vulnerability to relapse in others.

Mood disorders accounted for 61 per cent of treatments in 2020–21, followed by schizophrenia and other psychoses (Table 5).

Table 5: Number of ECT treatments in a public hospital, by diagnosis, 2015–16 to 2020–21

Health condition	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Mood disorders	7,566	8,159	8,249	7,868	7,442	7,240
Schizophrenia and other psychoses	3,927	3,705	4,468	4,424	3,806	4,090
Other conditions	277	236	308	214	206	126
Not reported	177	199	267	485	648	509

Table 6 shows that, overall, more women than men were treated with ECT across the life span.

Table 6: Number of ECT treatments, by age group and gender, 2020–21

Measure	0–18	18–29	30–39	40–49	50–59	60–69	70–79	80+
Male	35	536	991	1,153	868	990	766	222
Female	29	760	737	932	869	1,024	1,364	681

Deaths of people receiving mental health treatment

The death of a person receiving treatment or support for a mental illness is a tragic event. The Chief Psychiatrist collects data from mental health services to learn from each incident, with a view to improving the quality and safety of clinical practices and reducing the number of preventable deaths.

The Chief Psychiatrist must be notified of the deaths of all mental health inpatients where an inpatient is defined as any person, regardless of legal status, who:

- had been admitted to a mental health inpatient unit
- was on approved leave from an inpatient unit
- had absconded from an inpatient unit
- had been transferred to a non-psychiatric ward during a mental health admission
- had been discharged from a mental health inpatient unit within the previous 24 hours
- had been waiting in an emergency department for a mental health bed to become available.

In the case of deaths in the community, the Chief Psychiatrist must be notified of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of people who had been registered as a mental health consumer within the previous three months or who had sought care from a mental health provider within that period and had not received treatment
- all deaths of patients under community treatment orders or non-custodial supervision orders.

People are considered to be mental health consumers until their case is closed and they have been told of this change in status (or the service has made reasonable efforts to do so).

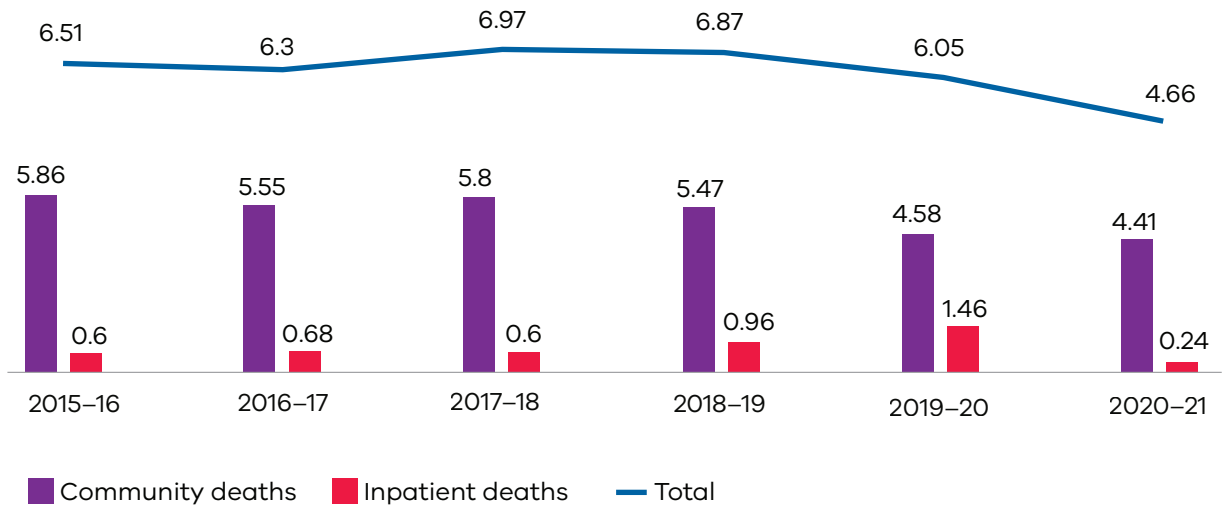
The Chief Psychiatrist is accountable for the following functions with respect to consumers' deaths:

- to maintain a database of reportable deaths
- to contribute to coronial inquiries and recommendations when requested by the coroner
- to review clinical reports provided by services to identify systemic issues that may have contributed to a person's death
- to identify statewide issues and provide guidance to mental health services to help reduce and prevent deaths and to provide safe and effective care.

Reportable deaths in 2020–21

In 2020–21 mental health services reported 320 deaths, of which 17 were defined as 'inpatient deaths' (Table 8). This encompasses the deaths of people while on leave, shortly after their discharge or following their transfer to other types of wards. When adjusted for population, rates of community deaths were close to the norm, while those of inpatient deaths have decreased (Figure 2). None of these deaths were known at the time of writing to have been the result of COVID-19.

Figure 2: Reportable deaths per 100,000 Victorian population, 2015–16 to 2020–21



Note: Reportable deaths data is continuously revised following confirmation of cause of death by coroner. As such, figures may vary slightly between annual reports from previous years.

Table 7: Reportable deaths per 100,000 Victorian population, 2015–16 to 2020–21

Measure	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	Average
Community deaths	5.86	5.55	5.80	5.47	4.58	4.41	5.27
Inpatient deaths	0.60	0.68	0.60	0.96	1.46	0.24	0.75
All deaths	6.51	6.30	6.97	6.87	6.05	4.66	6.02

Note: This table corresponds with the graph in Figure 2. It is included for purposes of accessibility.

Of the 320 notified deaths in 2020–21 (Table 8), the cause of death has yet to be determined in 35 per cent of instances. Of the remainder, suicide and medical causes accounted for nearly equal proportions (31 per cent and 27 per cent respectively). Suicide data is cross-validated with data received from the coroner's court. The OCP maintains an active interest in ongoing coronial investigations relating to reportable deaths. It receives and reviews the outcome of these as they arise, which may be several years after a death.

Table 8: Reportable deaths by category, 2020–21

Category	Inpatient	Community	Total	Proportion
Suicide	4	95	99	31%
Medical condition	7	78	85	27%
Accident/misadventure	1	22	23	7%
Homicide	0	1	1	0%
Not yet known	5	107	112	35%
Total	**17**	**303**	**320**	**100%**

Notes: 'Not yet known' figures relate to deaths that are under investigation by the Coroner and not yet determined. Some of these investigations may result in a finding of undetermined.

Out of 320 notified deaths, 12 are out of scope (not reportable to the OCP). These are reviewed by other relevant authorities.

The 'medical condition' figures include a number of inpatient deaths due to medical events unrelated to acute mental health care and a small number of deaths that took place as part of an end-of-life pathway for terminal illness.

The percentages may not add to exactly 100 per cent because of rounding.

Tables 7 and 8 include 12 notified deaths that were out of scope for the OCP reportable deaths criteria. These include deaths occurring in private hospitals, deaths due to natural causes not receiving mental health treatment or deaths of discharged patients who had little to no contact with mental health services before their death.

The OCP views every suicide in care as potentially preventable. Each number represents a person who has suffered and left behind family and loved ones. All inpatient suicides are classified as sentinel events by Safer Care Victoria and are the subject of detailed reports by health services. These reports are reviewed within the OCP by a panel of senior clinicians and consumer and carer representatives. The panel makes recommendations to services where indicated about actions to reduce the possibility of a recurrence. The panel may also make recommendations to enhance the rigour of review processes. Important learnings are communicated to services through the Chief Psychiatrist's *Quality and safety bulletin*.

J.B., Deputy Chief Psychiatrist, Office of the Chief Psychiatrist (February 2020 – February 2021)

My background is in public mental health. I have worked in this area for the past 20 years, taking up roles in both inpatient and community adult services.

I worked at the OCP on a 12-month secondment from a major public health service in Melbourne. During my time in the OCP, I was involved in clinical leadership and monitored the provision of mental health care through case conferences of consumers with complex needs. I was also involved in reviewing the clinical governance of an area mental health service, analysing quality and safety data, and promoting cooperation and coordination between mental health, justice, disability and community services. An important aim of this work was to assist mental health service providers to comply with the Mental Health Act and to provide advocacy for persons receiving care in public mental health services to ensure their rights were being respected.

I was also a member of the COVID Response Team in the Mental Health and Drugs Branch. My role there was to support public mental health services to improve the safety of staff and consumers through leadership and guidance.

I value the time I spent at the OCP. I had the opportunity to build enduring relationships with colleagues in the office and benefited from their professionalism. I also gained an insight into how the Department of Health functions. I will be able to draw on this knowledge to work effectively with the Department of Health from the outside.

Despite completing my secondment and returning to my substantive role in a public health service, my connection with the OCP remains. I am a member of its Sexual Safety Committee, and through this committee, promote gender safe and sensitive practices in mental health services. I look forward to continuing to collaborate with the OCP and playing a part in implementing the recommendations of the Royal Commission into Victoria's Mental Health System, which will see major improvements in the delivery of services.

Restrictive interventions

The Chief Psychiatrist and Chief Mental Health Nurse share a commitment to reducing and eventually eliminating restrictive interventions in accordance with the recommendations of the Royal Commission into Victoria's Mental Health System and the *Seclusion and restraint declaration* launched by the National Mental Health Commission. Several local initiatives led by the OCP and OCMHN, such as Safewards, have aimed to encourage alternative clinical practices that avoid relying on restrictive interventions (see below).

Restrictive interventions are defined in the Mental Health Act as the use of seclusion or bodily restraint. Seclusion is 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave' (s. 3). Bodily restraint is 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs' (s. 3).

The Act provides that a person may only be placed in seclusion or restraint to prevent imminent and serious harm to the person or another person or, in the case of restraint, to administer treatment. The principles outlined in the Act specify that people receiving mental health services should be treated in the least restrictive way possible, meaning that seclusion and restraints can be applied only after all reasonable and less restrictive options have been tried or considered and found unsuitable.

Data on the use of restrictive interventions are shown separately for inpatient and secure extended care units (SECU). As a result, the numbers of events listed below cannot be compared directly with those listed in reports prior to 2016–17. This change in practice standardises Victorian reporting modalities across a number of national data platforms.

Staff from the OCP and the OCMHN have led the statutory committee and internal governance of the Chief Psychiatrist statutory portfolio on eliminating restrictive interventions. In October 2019 the Statewide Chief Psychiatrist's Restrictive Intervention Committee agreed to a program of work to support the elimination of restrictive interventions. This is aligned with national directions from the Safety and Quality Partnerships Subcommittee and is supported by the Council of Australian Governments.

The impact of COVID-19 on restrictive interventions has been closely monitored and an inpatient pathway developed, supporting sensory responses and engagement within services during this unprecedented time for people, their families and the workforce. The OCP is currently developing a secure web portal to support incoming data from health services and reduce reliance on paper or fax-based information exchange. This will allow the OCP to respond and provide feedback more efficiently in response to significant variances in practice.

Acute inpatient units

Seclusion – acute inpatient units

Table 9 shows the number of episodes of bodily restraint and seclusion in acute inpatient units over the past six years. The use of bodily restraint has increased, while seclusion has fallen.

Table 9: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2015–16 to 2020–21

Intervention	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Bodily restraint	1,233	1,230	1,312	1,475	1,557	1,630
Seclusion	1,265	1,280	1,206	1,169	1,113	1,106

In 2020–21 most episodes of seclusion in admitted settings were among 18 to 49-year-olds (Table 10).

Table 10: Number of seclusion episodes in acute inpatient units, by age and gender, 2020–21

Gender	0–17 years	18–29 years	30–39 years	40–49 years	50–59 years	60–69 years	70–79 years	80+ years
Female	175	292	459	219	83	29	8	2
Male	50	771	705	331	483	35	13	5

Note: Some age groups have been further aggregated to protect the confidentiality of individuals.

For bodily restraint, most episodes were among the 30 to 39-year-old age group (Table 11).

There is a difference in seclusion and bodily restraint episodes between genders. This relates to underlying clinical conditions and skewing in various age brackets.

Table 11: Number of bodily restraints in acute inpatient units, by age and gender, 2020–21

Gender	0–12	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	133	804	697	698	543	249	144	95	55
Male	45	194	1,385	1,671	437	933	115	146	152

Note: Some age groups have been further aggregated to protect the confidentiality of individuals.

Table 12 lists the numbers of episodes of seclusion per 1,000 occupied bed days. Rates have fallen in adult wards over the past six years and remain low in services for older people. Rates have increased in child and adolescent units, in part because of the challenges presented by a very small number of young people with complex combinations of mental illness and intellectual or developmental disability.

Notwithstanding this, seclusion rates lay below the current statewide benchmark of 15 or fewer episodes per 1,000 occupied bed days in all program areas except for the forensic program. The increased rate of seclusion at Forensicare can be explained by a reliance on the practice to deliver treatment and care to a small number of consumers with significant complexity and comorbid conditions. The OCP continues to work closely with Forensicare to monitor and develop strategies to reduce the use of restrictive interventions on patients with complex care needs.

Table 12: Seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2015–16 to 2020–21

Type of unit	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	11.9	11.3	10.5	9.5	10.0	9.4
Aged	1.0	1.8	1.2	0.7	0.6	0.6
Child and adolescent	5.5	5.4	8.8	12.0	14.4	10.1
Forensic	13.1	28.7	34.3	26.8	33.0	41.1
Specialist	0.5	3.1	0.6	0.4	0.5	2.9
Total	**9.2**	**10.0**	**9.7**	**8.6**	**9.7**	**10.0**

Table 13 shows that, when seclusion happened, it typically occurred only once within the whole of an admission to hospital. Multiple episodes of seclusion were relatively uncommon. This pattern has remained consistent in recent years.

Table 13: Frequency of seclusion episodes within a single admission, 2015–16 to 2020–21

Frequency	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
1	902	950	894	868	795	788
2	260	258	243	224	212	205
3	118	96	119	101	103	100
4	61	54	53	53	61	50
5	52	35	30	29	34	31
6	20	28	23	16	20	22
7+	76	77	70	64	85	81

In 2020–21 close to half of all episodes of seclusion lasted for four or fewer hours, consistent with most previous years (Table 14).

Table 14: Duration (hours) of acute inpatient seclusion episodes, 2015–16 to 2020–21

Period	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
≤ 4 hours	1,735	1,624	1,504	1,654	1,852	1,720
4–12 hours	729	862	908	715	726	770
> 12 hours	660	995	1,066	816	996	1,170

Restraint – acute inpatient units

Bodily restraint refers to physical restraint (placing hands on a person to restrict movement) and mechanical restraint (the use of devices, such as belts, for the same purpose). Applying mechanical restraint typically involves using physical restraint for very brief periods. The Act requires that mental health services inform the Chief Psychiatrist of both types of practice.

Table 15 shows that bodily (physical and mechanical) restraint episodes per 1,000 occupied bed days fell from a rate of 26.1 in 2018–19 to 21.1 in 2020–21. Rates rose a little in adult acute inpatient units but fell steeply in the forensic service. As mentioned already, the growing clinical complexity encountered in child and adolescent inpatient units is thought to have contributed to a continuing rise in rates of restraint.

Understanding the factors that are leading to an increase in the use of bodily restraint among children and adolescents remains a work in progress. There appears to be multiple factors contributing to this, including improvements in reporting practices. Furthermore, any explanation of the increase should take into account the smaller population size of units for children and adolescents relative to units for adults. Owing to this difference in population size, variations in the use of bodily restraint can appear more significant among adolescents and children compared with adults.

Table 15: Bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2015–16 to 2020–21

Type of unit	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Adult	9.8	8.4	9.0	10.6	11.8	13.3
Aged	5.0	7.3	6.4	6.0	8.9	8.5
Child and adolescent	13.9	17.8	33.4	45.0	49.9	57.0
Forensic	172.4	115.8	146.6	162.1	90.3	76.5
Specialist	1.8	1.1	1.1	0.5	0.8	1.0
Total	**25.7**	**19.1**	**22.8**	**26.1**	**21.0**	**21.1**

Physical restraint accounted for the vast majority of instances (Table 16). While the number of episodes of mechanical restraint stabilised in 2020–21, its use has fallen steeply since 2015–16.

Table 16: Type of restraint episodes, 2015–16 to 2020–21

Restraint type	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Mechanical and physical	1,062	301	167	116	113	102
Mechanical only	1,049	496	349	384	401	396
Physical only	7,380	6,432	8,319	9,995	7,888	7,999

When restraint was applied, it typically represented a single occurrence within the whole of an admission (Table 17). Multiple episodes of restraint were relatively uncommon. This pattern has remained consistent in recent years.

Table 17: Frequency of restraint episodes within the same hospital admission, 2015–16 to 2020–21

Frequency of episodes	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
1	809	843	862	960	1,009	1,050
2	274	210	279	276	320	364
3	98	98	112	134	143	163
4	59	69	64	70	88	101
5	39	28	34	53	58	60
6	17	26	26	32	33	46
7+	116	124	133	165	184	169

With respect to duration, there were 19 episodes of restraint in excess of 12 hours, representing 0.2 per cent of the total in 2020–21. This is a reduction of 79 per cent relative to 2015–16 (Table 18). The majority of restraints last less than three minutes and may reflect the use of restraint to facilitate the administration of medication or to guide a person towards a different space. There is ongoing work to understand the variation in clinical practice.

Table 18: Duration of physical, mechanical and combined restraint episodes, 2015–16 to 2020–21

Duration	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Less than 3 minutes	4,978	3,479	4,806	6,083	5,379	5,743
≥ 3 to < 15 minutes	3,825	3,010	3,416	3,787	2,441	2,164
≥ 15 to < 30 minutes	238	216	225	213	170	213
≥ 30 to < 45 minutes	61	70	75	76	68	87
≥ 45 mins to < 1 hour	40	39	39	46	49	67
≥ 1 to < 4 hours	186	282	166	218	205	159
≥ 4 to < 12 hours	73	88	66	46	55	45
≥ 12 hours	90	45	42	26	35	19

Secure extended care units

SECUs aim to cater to the needs of consumers facing complex challenges in the context of limitations on current community care provision options. It is anticipated that increased community resources, including other accommodation options and supports, will create a wider range of settings conducive to recovery-oriented care.

Seclusion – secure extended care units

Table 19 shows that seclusion episodes per 1,000 occupied bed days in SECUs rose relative to 2018–19. A number of factors may have contributed to this increase, including COVID-19 lockdown, staffing changes, leave and access to visitors (including support staff). The SECU program is included in all the initiatives designed to bring a recovery focus to mental health treatments and to minimise the use of restrictive interventions.

Table 19: SECU seclusion episodes per 1,000 occupied bed days, 2015–16 to 2020–21

Year	Rate
2015–16	2.0
2016–17	2.5
2017–18	2.9
2018–19	1.8
2019–20	3.7
2020–21	4.0

Restraint – secure extended care units

A similar pattern emerged with respect to restraint episodes over the past two years (Table 20). We note the increase since 2016–17 and are seeking to understand the contributing factors. We are also working individually with services to reduce their rates of restrictive practice in conjunction with the work undertaken by the Chief Psychiatrist's Restrictive Interventions Committee.

Table 20: SECU bodily restraint episodes per 1,000 occupied bed days, 2015–16 to 2020–21

Year	Rate
2015–16	3.1
2016–17	2.2
2017–18	2.9
2018–19	2.6
2019–20	3.7
2020–21	3.3

S.H., Principal Data Officer, Office of the Chief Psychiatrist

I have a business analyst and management background and have worked in the Department of Health for 4.5 years. Prior to this, I held positions in the Department of Justice, Telstra and GE Capital (in India, New Zealand and London). I also have postgraduate qualifications in business administration and a Diploma in Project Management.

Data and analytics are my areas of interest, and so I was naturally drawn to the principal data officer role when it became available at the OCP. My role primarily revolves around parsing through data, analysing it and interpreting it. I normally spend my workdays digging into raw data and making it useable for my OCP colleagues and our stakeholders. This includes tasks like analysing data systems, automating information retrieval, and preparing reports and dashboards that show managers how data could be applied to fulfil the Chief Psychiatrist's statutory functions and advance the OCP's strategic goals.

The data we receive at the OCP helps us understand the context of mental health crises and why they happen in the first place. This data also allows us to see system-wide trends in the performance of mental health services from a quality and safety standpoint. In doing so, the data helps us determine where we should focus our attention and channel our resources to assist services to meet their obligation of providing safe and high-quality care. I gain satisfaction from being a part of this team effort, knowing that it contributes to something so important in people's lives.

2. Leadership and quality and safety improvement

Quality and safety initiatives

Electroconvulsive treatment audits

Over the past three years, all ECT services in Victoria have been audited to ensure adherence to the Chief Psychiatrist's guideline on ECT. Audit teams have included a deputy chief psychiatrist, senior clinical advisor, an ECT director and nurse coordinator from other services, and consumer and carer representatives. During their day-long visits, team members met with senior clinicians, inspected the ECT treatment facilities and reviewed services' clinical policies and practices, educational programs and quality improvement activities. As a result of the audit, treatment practices have become more consistent across the state. Important improvements have included better assessments of people's capacity to give informed consent to ECT, the use of strategies to minimise cognitive impairment, and regular checks of clinical progress.

Sentinel event reviews

Sentinel events are wholly or largely preventable adverse health incidents that result in serious harm or death. Health services must report such incidents to Safer Care Victoria in accordance with the Australian National Sentinel Event Protocol. They must also conduct a detailed analysis of the circumstances leading to the event and make recommendations where applicable to reduce the likelihood of a recurrence. In the case of mental health services, suicides in acute inpatient units and small numbers of unexpected incidents with catastrophic consequences must be reported in this way.

The OCP and members of the Chief Psychiatrist's Morbidity and Mortality Committee (including representatives of consumer and carer peak bodies) work with Safer Care Victoria to give feedback to mental health services about their analyses of events and their recommendations for action. Sentinel events are uncommon, and this extra level of scrutiny and support ensures services' reviews are truly comprehensive and lead to practical action to identify and remediate risk for future consumers and carers.

Inspire report

The Victorian Agency for Health Information collaborates with the Chief Psychiatrist to prepare the *Inspire mental health* benchmarking report for distribution to mental health services every six months. Each report compares services on a varying range of indicators extracted from the data submitted routinely to the department. Indicators are selected by an expert advisory group based on their clinical relevance and strategic importance. The purpose of the report is to highlight variance in practice (including variance between services' various inpatient units and community teams) and to encourage debate within and between services about the clinical, cultural and operational factors that contribute to these differences. The Chief Psychiatrist then engages in discussion with 'outlier' services to promote action to address unexplained variance in clinical practices that might have an adverse effect on consumers' experiences.

Quality and safety bulletin

The Chief Psychiatrist endeavours to publish a quality and safety bulletin twice a year to highlight issues affecting consumer safety. The bulletins, which are published on the Chief Psychiatrist's website <https://www2.health.vic.gov.au/about/publications/researchandreports/chief-psychiatrist-quality-and-safety-bulletin>, describe de-identified cases found through coroners' reports, notifications to Safer Care Victoria and other means. The purpose of the bulletin is to alert service providers to issues of grave clinical risk and to provide advice about strategies to mitigate these risks. This provides a useful opportunity to remind providers of existing guidelines and clinical practice advisory notices and of the need to embed these guidelines and notices within their policy and procedure documents. Matters of importance are also raised in meetings with clinical and operational leaders and in other relevant settings to ensure safety alerts are received and enacted within services.

New Chief Psychiatrist's guidelines

The Chief Psychiatrist's guideline on risk assessment and safety planning in mental health inpatient services was finalised in March 2020. However, it was not released for distribution because of concerns that mental health services would struggle to implement the guideline successfully while responding to the COVID-19 pandemic. Once issued, the guideline's focus on risk assessment as a component of safety planning should further limit the use of restrictive interventions and reduce self-harm.

As Victoria and the mental health system move towards a new 'COVID normal' in 2021–22, the approach to disseminating new guidelines and supporting mental health services to implement them will be revised and adapted to ensure continued focus on quality and safety of service provision in the context of new ways of working.

This work will pick up pace once the Mental Health Improvement Unit is set up in Safer Care Victoria at the beginning of 2022. The Mental Health Improvement Unit will play a major part in promoting quality and safety in Victoria's mental health and wellbeing system in partnership with the OCP. As such, the OCP is making plans to develop guidelines and support mental health services in collaboration with the Mental Health Improvement Unit. This will ensure the development and delivery of advice and standards of best practice to the sector will be coordinated between the two entities.

Safewards

The program of work associated with Safewards transitioned to Safer Care Victoria in July 2021 with the OCMHN. As part of the program, three emergency departments from Peninsula Health and Bendigo Health took part in a trial focused on addressing conflict and containment events involving staff and patients in emergency departments. This work began in 2019 and received support from the Victorian Managed Insurance Authority.

The evaluation was recently completed. One of its key findings was that some Safewards interventions have applicability in emergency department settings. The trial demonstrated a combined reduction rate of 30 per cent in code grey events, improved communication skills and collaboration between staff and patients. Significantly fewer medications were administered to manage aggressive behaviour. The trial did not significantly reduce the rate of mechanical restraint. However, it did produce a significant effect in the reduction of the duration rate of mechanical restraint. A longer trial has the potential of further promising results.

Sexual safety

The Chief Psychiatrist continues to carry out work to improve sexual safety in mental health services. The sexual safety program of work seeks to raise awareness around sexual safety incidents in inpatient settings, to monitor mental health service programs supporting sexual safety interventions and, ultimately, to increase the safety of consumers in inpatient settings.

The work has included:

- reporting back to mental health services on the sexual safety notifications that were received
- conducting high-level analysis of the incidents reported, as well as information for statewide reporting
- supporting the workplan for the Chief Psychiatrist's Statewide Sexual Safety Committee, composed of consumers, carers and clinical leaders
- overseeing the revision of the Chief Psychiatrist's guideline for sexual safety in acute mental health inpatient units and of the department's *Service guideline on gender sensitivity and safety*.

The Victorian Mental Health Interprofessional Leadership Network was engaged to coordinate the consultation and rewrite the Chief Psychiatrist guideline on sexual safety in mental health inpatient units. The new guideline will provide up-to-date information on legislation, policies and procedures to support services to deliver safe, consumer-centred care within all acute inpatient units, including adult, child and youth, aged, forensic, SECUs and community bed-based services, such as prevention and recovery care services and community care units. The guideline will outline the process for reporting sexual safety incidents that occur in inpatient units to the Chief Psychiatrist. It aims to help units and staff protect against sexual safety incidents, minimise harm and provide access to support and justice options if incidents do occur. The guideline reinforces that people receiving care in inpatient units, as well as staff and visitors, have a right to feel and be safe. In this sense, it promotes safety for all.

Deidentified information about sexual safety notifications will continue to be regularly collated and reported back to health services. Services will be encouraged to disseminate this information for quality improvement to inpatient nurse unit managers, assistant nurse unit managers, relevant medical staff, quality managers and consumer and carer consultants.

This project entered its final phase in 2021, with the OCP commencing work to design a standardised method for reporting sexual safety incidents in acute inpatient units. Once implemented, the new approach will serve as a foundation for monitoring and promoting sexual safety across Victoria by providing guidance around the consistent classification of sexual safety incidents, a clear threshold for incident reporting and easing the administrative burden and duplication of data entry. The standardised reporting structure will strengthen the reliability of sexual safety incident data, enable proper comparisons between services and across periods to detect trends and variations, and establish staff confidence in reporting through clarity in what qualifies as a reportable incident.

Promoting human rights by working to eliminate restrictive interventions

The OCP continues to promote human rights by monitoring the use of restrictive interventions. It also receives and monitors sexual safety notifications and conducts service reviews and ECT audits. Lived experience advisors and sector representatives have been present among the staff involved in these activities, contributing to the oversight of how care and treatment are delivered and assisting clinicians and services to meet standards of best practice.

As part of these efforts, the OCP and OCMHN began a webinar series in 2021 called Towards Elimination. The series was hosted in partnership with the Te Pou and the Health Quality and Safety Commission New Zealand. Its aim was to provide the sector practical support, build skills and disseminate information important for planning and implementing reduction and elimination strategies.

The series focused on Kevin Ann Huckshorn's six core strategies for preventing conflict and violence that can lead to the use of seclusion and restraint in inpatient and residential settings.

Those strategies involve:

- improving leadership to drive organisational change
- using data to inform practice
- focusing on workforce development
- using seclusion and restraint prevention interventions
- employing the expertise of people with lived experience of mental illness to work alongside clinical staff
- using debriefing techniques to create understanding and avert the use of restrictive interventions in the future.

These strategies sit alongside recovery-oriented and trauma-informed care as central to Victoria's approach to reducing and eliminating seclusion and restraint. The series ran monthly, beginning in May and scheduled to conclude in November. It serves as an important educational resource for the sector to develop strategies towards eliminating restrictive interventions.

H.L., Program Manager, Office of the Chief Psychiatrist

I qualified as a pharmacist in the United Kingdom and felt drawn to working with some of our most complex vulnerable patients – infants and children in intensive care. Inspired by a curiosity to contribute to this specialty, I completed a Master of Philosophy for research into adverse drug reactions in children and went on to lead women's and children's pharmacy services in one of the largest teaching hospitals in the world in Leeds. Since arriving in Australia in 2000, I pursued certification in project management and change management to deliver statewide quality and safety improvement projects and became a registered counsellor, developing specialist interests in trauma, psychological safety and workplace wellbeing.

I recently transitioned to the OCP as a program manager in medicines, mental health and wellbeing. My role involves program management of the suite of Chief Psychiatrist guidelines in alignment with the recommendations from the Royal Commission into Victoria's Mental Health System. In addition to the Royal Commission's recommendations, guidelines are developed in response to a range of factors, including feedback from consumers via the Mental Health Complaints Commission, data collated from mental health services, changes to legislation and emerging evidence to support quality and safety improvement. Throughout my work with the guidelines, my clinical experience guides me to 'walk with' consumer and carers. We do this through consultation, collaboration and co-design with people who have lived experience of mental illness. In this way we ensure the guidelines follow the principles of being trauma-informed, recovery-focused and support decision making by consumers and their families or family of choice.

I also chair our Mental Health and Wellbeing Division's People and Culture Committee. One of the highlights of my role is to work alongside a dedicated, multidisciplinary team of clinicians, non-clinicians and diverse communities from whom I learn and grow daily. In the context of the coronavirus pandemic, I'm mindful of the need to promote psychological safety within our stakeholder consultations across the department and within mental health services and to recognise that supporting the wellbeing of our care teams is critical for optimising mental health care and achieving the best outcomes for our community.

3. A final word: lived experience and the OCP in the future system

People with lived experience are a central part of the OCP's work, being present in many of the office's core activities. Three lived experience advisors were employed in the OCP through 2020–21 – two represented the consumer perspective and one the carer perspective. Through these dedicated lived experience roles, the OCP has ensured consumer and carer voices have been present at clinical meetings and on investigation panels and audit teams that monitor restrictive interventions and sexual safety.

The OCP also maintains a strong collaborative relationship with Tandem and the Victorian Mental Illness Awareness Council (VMIAC), the peak bodies that advocate for the interests of carers and consumers. VMIAC and Tandem maintain registers of people with lived experience that can be accessed to support the work of the OCP. People from the registers have been involved in the OCP's audits of ECT and clinical reviews of services. They have also attended forums hosted by the OCP as speakers. In addition, staff from VMIAC and Tandem attend the meetings of the Chief Psychiatrist's statutory committees, sharing lived experience perspectives with other leaders and representatives from the mental health and wellbeing sector on those committees.

In July 2021 the OCP's three lived experience advisors were transferred – with the OCMHN – to Safer Care Victoria in the first stage of implementing the new quality and safety architecture recommended by the Royal Commission into Victoria's Mental Health System. The departure of lived experience advisors was a significant loss for the OCP, given the important contribution they made in our planning and oversight activities.

However, the OCP will once again benefit from the input of consumer and carer staff through the creation of a Lived Experience Branch in the Mental Health and Wellbeing Division. The Lived Experience Branch is working across the division to ensure consumers and carers are central to the design and delivery of mental health services. Through this new arrangement, lived experience participation will remain an essential part of the OCP's work, ensuring the OCP continues to be effective at protecting the rights of consumers and promoting quality and safety in mental health services. In the spirit of such inclusion, we give the final word to our senior consumer adviser colleague in the vignette below.

J.A., Senior Consumer Adviser, Office of the Chief Mental Health Nurse

I am an expert by experience in mental health issues. I have completed a Company of Directors course at the Australian Institute of Company Directors and a Graduate Certificate in Community and Consumer Engagement. I have sat on the board of Forensicare and was chair of Neami for 10 years. My other experience includes membership of a writing group that advised the Australian Government on writing the *Fifth national mental health and suicide prevention plan*. I have also presented at conferences in the United Kingdom, Canada, New Zealand and Australia on consumer participation and leadership.

I have worked in the OCMHN for three years. My role as senior consumer adviser involves varying tasks and duties focused on monitoring and promoting quality and safety in mental health services. A guiding purpose of my role is to ensure the perspectives of consumers informs the key work carried out by the OCMHN and the broader OCP. I have been able to do this through membership in various committees and project groups involved in planning, monitoring and improving the delivery of mental health and wellbeing services to ensure they are safe, high-quality and adhere to standards of best practice. This has involved attending clinical meetings, sittings of restrictive intervention and sexual safety committees, and partnership meetings with VMIAC. It has also involved contributing to the development of frameworks and guidelines, membership of teams that conduct ECT audits and clinical reviews, going on hospital visits, reviewing data on restrictive interventions and sexual safety incidents, and giving conference and sector presentations.

My presence in the OCMHN and OCP, along with the presence of other lived experience colleagues there, helps to address historical power imbalances between those with lived experience and the professional workforce that makes decisions about how mental health care, treatment and support should be delivered. Our immersion in the daily life of these offices contributes to its problem-solving and strategic capabilities because we are attuned to safety risks that can be easily overlooked by others. By highlighting those risks, we foster active thinking about them and help to identify where improvements are required in the system and what changes are likely to be most effective. This input complements that of our other colleagues, who bring their own specialised knowledge and skills to their roles, leading to outcomes that are more considered and better meet the needs of consumers.

I find my job highly rewarding. I play a part in protecting the rights of consumers and facilitating change towards a mental health and wellbeing system that is compassionate, accountable and upholds people's dignity. A strong sense of collegiality exists within my team, and my colleagues include me in all the important aspects of the office's work. They respect my lived experience and draw on it to understand issues and find solutions to problems. It is rewarding to know that the work I do contributes to a better experience for people in mental health and wellbeing services.

Feedback on this report

If you have any feedback on this report, either wanting to respond to the content or requiring more detail, please email the OCP <ocp@health.vic.gov.au> and we will respond as soon as we can.

Notes on data

Please note that not all percentages in graphs and tables may add to 100 per cent because of rounding. For some tables, categories were further aggregated to protect the privacy and confidentiality of individuals.

The data in this report is extracted from live databases. This means there may be slight variations in the numbers when compared with previous annual reports.

The OCP kindly thanks the Victorian Agency for Health Information for extracting ECT and restrictive interventions data from the statewide mental health database.