Chief Psychiatrist's annual report 2021–22

VICTORIA State Government | Department of Health

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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 and living experience

We would like to recognise all people with lived and living experience of mental illness and psychological distress, substance use, and their carers, families and supporters. This recognition extends to the clinical and non-clinical workforces that support people with lived and living experience. Thank you for working in partnership to transform the system.

Foreword from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist's annual report for 2021–22. COVID-19 continues to pose significant challenges in running mental health services. Despite this, my staff and I are focused on providing clinical leadership and oversight in Victoria's mental health and wellbeing system and promoting the rights of people who receive treatment and care within it. The Office of the Chief Psychiatrist (OCP) has been working with the sector to ensure mental health and wellbeing services can operate and be available for all Victorians. At the same time, we have been working with sector partners to build a new mental health and wellbeing system through implementing the recommendations from the Royal Commission into Victoria's Mental Health System, carrying out reforms that are strengthening quality and safety, deepening human rights, and increasing the voice of consumers and their carers, families and supporters.

Service delivery in a reform environment and pandemic comes with a unique set of challenges. On the one hand, we are reshaping the fundamentals of the mental health and wellbeing system so that it is contemporary, effective, compassionate and informed by human rights. On the other hand, we are doing this at a moment in time when staff absences and sick leave are at historically high levels due to recurring COVID-19 outbreaks. Staff shortages and high workloads can hamper efforts to keep services operational. The once-in-a-lifetime opportunity to effect change over the course of the next decade must be realised against these constraints. During this challenging period, the role of the OCP is ever more important through its support to the mental health workforce and to consumers and carers dealing with interruptions in their daily lives.

In July last year the Office of the Chief Mental Health Nurse transferred from the OCP to Safer Care Victoria. There, it continues its education and training activities to improve quality and safety and supports the newly established Mental Health Improvement Unit. This change is one of the Royal Commission's recommendations for a new mental health governance architecture. The lived experience staff who were a part of this move continued to provide input into the work of my office, doing so until the Lived Experience Branch was set up in the Mental Health and Wellbeing Division. I am grateful for their availability to support us in this way. The OCP continues to work closely with the Office of the Chief Mental Health Nurse in all the areas of responsibility that we share to ensure high-quality and safe service delivery across Victoria.

The implementation of this Royal Commission recommendation was a timely opportunity to restructure my office and prepare it for the future. There are now two broad teams with specialised functions that make up the OCP. One team carries out clinical service and consumer support tasks. The other team carries out tasks focusing on reform and project management.

The secondment of mental health professionals from other workplaces plays an important part in equipping the OCP to carry out its core functions. I offer my thanks to the various services that permit and encourage their employees to work with my team. Such secondments are a vehicle for knowledge exchange, bringing people with different clinical backgrounds to my office and allowing me and my staff to keep up with new developments across multiple clinical disciplines. This arrangement also strengthens the ties between my office and mental health services, all of which leads to better oversight and more effective improvements in quality and safety by allowing us to better understand what is happening on the ground.

I would like to thank the many people from across the mental health and wellbeing sector who take part in the committees and working parties I convene. This engagement allows us to address issues

with services jointly and at the systemic level, leading to better outcomes. In these settings, I enjoy the support of senior leaders and clinicians, those with lived and living experience (both as consumers and carers), union and workforce representatives, and academics. These people work across four statutory and non-statutory Chief Psychiatrist committees (which include committees monitoring electroconvulsive treatment and neurostimulation therapies, morbidity and mortality, restrictive interventions, and notifications of sexual safety incidents). There are also many other people involved in leadership and sector forums and gatherings that support this work. They are too numerous to mention here. However, I am grateful for their generosity, passion and effort in working with me to ensure the principles of the *Mental Health Act 2014* and Chief Psychiatrist's guidelines are adhered to.

Two significant projects prioritised over the course of this year relate to notifications of sexual safety incidents and eliminating restrictive practices, both arising from Royal Commission recommendations. Through this work, we aim to improve reporting systems with the goal of avoiding duplication and reducing the administrative burden on clinicians. We have also been examining the accuracy and consistency of data. This work will be vital to strengthening how services are monitored and improving the experience of people who receive treatment and care within them.

My office has been working with colleagues across the Mental Health and Wellbeing Division and Safer Care Victoria to develop policies and guidelines to eliminate restrictive practices in the next 10 years. Restrictive practices have a profoundly negative impact on people, making their reduction and eventual elimination a special area of concern for us. As we proceed with this initiative, we are striving to instil practice that is humane, dignified and ensures the safety of consumers and staff.

At the time of writing this report, the Mental Health and Wellbeing Bill was passed in the Victorian Parliament, becoming the *Mental Health and Wellbeing Act 2022*. This marked a significant milestone in the Royal Commission reform process, consolidating into law the foundations of the future system. From the vantage point of my role, the new Act will expand my responsibilities to include mental health care delivered in custodial and community settings. My office is already deeply engaged with colleagues from the Department of Justice and Community Safety on this area of reform, exploring ways to improve service delivery in custodial settings and attain the same standards of quality and safety as in the broader community.

There are many government agencies and organisations that my office partners with to uphold quality and safety across the system. These include the Mental Health Complaints Commission, Safer Care Victoria, 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 others. These organisations all share our purpose of creating a mental health system that is high-quality, equitable and responsive. In particular, I would like to acknowledge the strong collaborative relationship I have with Treasure Jennings, the Mental Health Complaints Commissioner, and Anna Love, the Chief Mental Health Nurse. Through our close connections, we have adopted a coordinated and productive approach to governance and leadership in the various areas that our roles and responsibilities overlap.

I also wish to acknowledge the extraordinary efforts of Victoria's mental health workforce. Staff administering care and treatment have had to do so in challenging environments. They constantly run the risk of vicarious trauma and burnout, and yet continue to help others in need. I thank them for the great job they do and encourage them to persevere. Better times lie ahead with the Victorian Government investing unprecedented resources into expanding and upskilling the state's mental health workforce.

A special thanks goes to the staff in my office for their tireless work. My team is made up of deputy chief psychiatrists, clinical advisers, managers, project officers, a data analyst, a policy adviser and admin officers, all of whom make a huge effort assisting me in my role and being available to help people in distress. Their strong work ethic and compassion ensures my office is well placed to support consumers and promote high standards of care in Victoria's mental health system going into the future.

Finally, I wish to thank those with lived and living experience, along with their carers, families and supporters. With your input, we are building a more humane, modern, effective and accessible mental health system. I am grateful for your insights and generosity in this vitally important work.

Neil Coventry
Chief Psychiatrist

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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 2021–22 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 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 take part 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 respond 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://www.health.vic.gov.au/practice-and-service-quality/mental-health-act-2014>.

The Royal Commission into Victoria's Mental Health System recommended the Victorian Government repeal the Mental Health Act and enact a new Mental Health and Wellbeing Act. In June 2022, the Victorian Government introduced the new Mental Health and Wellbeing Bill to the Victorian Parliament as part of implementing this key recommendation. The new Act is expected to take effect about one year after parliament passes the Bill.

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 Mental Health Act, include a requirement to:

- develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- assist mental health services to comply with the Act, with regulations made under the Act and with codes of practice
- develop and provide information or training, and monitor service provision, to promote quality and safety
- 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 guiding 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 OCP works closely with Safer Care Victoria to ensure mental health services are safe and of a high standard. In the new mental health and wellbeing system recommended by the Royal Commission, quality and safety governance is a responsibility shared between each body. The OCP undertakes its oversight activities alongside Safer Care Victoria's training and education activities to embed contemporary approaches to treatment and care. Regular meetings with Safer Care Victoria help align these activities and ensure mental health governance is integrated and effective.

The year in review

In July 2021 the OCP began operating in a new structure as part of setting up the overarching Mental Health and Wellbeing Division. This resulted in two distinct teams – a clinical team led by the newly created Clinical Manager role, and a non-clinical team comprising project, policy and administrative staff, led by the Strategy, Policy and Operations Manager. Although line management arrangements have been aligned in this way, staff across both teams continue to be involved across the breadth of operational and project activities. The commitment to collaboration and building a supportive team culture has enabled the OCP to grow positively, with a shared sense of purpose.

The transition of the Office of the Chief Mental Health Nurse from the OCP to Safer Care Victoria in July 2021 resulted in our consumer and carer adviser colleagues moving to Safer Care Victoria as part of that team. While we continue to work with them closely across existing and emerging pieces of work, the OCP has also forged new relationships with the Lived Experience Branch of the division. This is in addition to our connections with the peak consumer and carer bodies, Victorian Mental Illness Awareness Council (VMIAC) and Tandem. This ensures our work continues to be grounded in co-design and respects and reflects the views of consumers and carers.

The establishment of the Mental Health Improvement Program in Safer Care Victoria has required all parties to consider how we collaborate across the quality and safety landscape to create value and minimise duplication. We have jointly led several quality and safety forums and workshops, including a recent national Mental Health Summit. The summit included attendees from quality and safety agencies and Offices of Chief Psychiatrists across Australia and New Zealand.

The OCP has also been building new relationships with the Department of Justice and Community Safety to collectively build our understanding, and plan for the future role, of the Chief Psychiatrist in custodial settings once the Mental Health and Wellbeing Act commences in mid-2023.

The Chief Psychiatrist continued to chair the Crimes Mental Impairment Act and Complex Needs Advisory Panel. This is a collaborative forum that discusses service delivery options for people subject to the *Crimes Mental Impairment and Unfitness to Plead Act 1997*. These people may be at risk of poor outcomes because either their needs fall outside standard service responses, there are no appropriate care and treatment options in the service system or existing pathways of treatment and care are ineffective or unsustainable.

The Program Manager – Complex Needs at the OCP supports the panel. The panel includes experts from across the Department of Health and the Department of Family, Fairness and Housing, the service sector, and people with lived experience.

In January 2022 the OCP began regular huddles with staff from adolescent psychiatric inpatient units, bringing together leaders from various services to help each other manage demand for inpatient services. These huddles have been taking place alongside similar ones coordinated by the Mental Health and Wellbeing Division throughout the year to support mental health services experiencing significant impact due to COVID-19.

The past year has seen a growing focus in the OCP on planning to implement the Royal Commission's recommendations and the anticipated changes to the jurisdiction of the Chief Psychiatrist, as specified in the new Mental Health and Wellbeing Act. The OCP has been consistently engaged in supporting the reforms led across the division. We have consulted on the drafting of the Mental Health and Wellbeing Bill, reflecting the deep system knowledge and clinical expertise held within the team.

We have been required to think about the changes that must be made to the OCP's operating model and workplan so the OCP can deliver on critical business as usual as the future role of the Chief Psychiatrist changes through the Royal Commission reform process. This planning has occurred in the context of a significant increase in frontline activity during the year, as highlighted in the data included below.

We have started on a range of project and program activities to plan for the expanded jurisdiction of the Chief Psychiatrist in 2023 and to streamline our existing processes. This will enable the office to focus on its core functions and reduce the reporting burden on the sector at the same time that it maintains quality in mental health system and strengthens oversight in participation with its partners, including those with lived and living experience. Significant projects are also underway to

revise the full suite of Chief Psychiatrist's guidelines, to review and rebuild the OCP webpages and to consider the future role of the OCP enquiry line.

Enquiries received and the COVID-19 mental health response

Tables 1–3 and Figure 1 provide an outline of the enquiries the OCP received over several years. Most contacts with the OCP during 2021–22 (36.1 per cent) came via clinical services, closely followed by contact from consumers. These contacts frequently related to treatment access and clinical practice.

Table 1: Type of enquiries to the Office of the Chief Psychiatrist, 2021–22

Enquiry type	Number	Proportion (%)
Clinical	474	36.1%
Consumer	361	27.5%
Carer	249	18.9%
General	186	14.2%
CCNAP	22	1.7%
Coroner	17	1.3%
Legal	5	0.4%
Total	**1,314**	**100.0%**

The enquiry types the OCP received 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
- *CCNAP* – relate to the Complex Needs Advisory Panel, which offers advice on the circumstances of people who are subject to the Crimes Mental Impairment and Unfitness to Plead Act
- *coroner* – relate to information that assists coroner investigations
- *legal* – relate to apprehension orders, non-custodial supervision orders, subpoenas, the Mental Health Act, the Forensic Leave Panel and intra-Australian transfers.

Figure 1: Enquiries received by Office of the Chief Psychiatrist, by number per quarter, 2017–18 to 2021–22

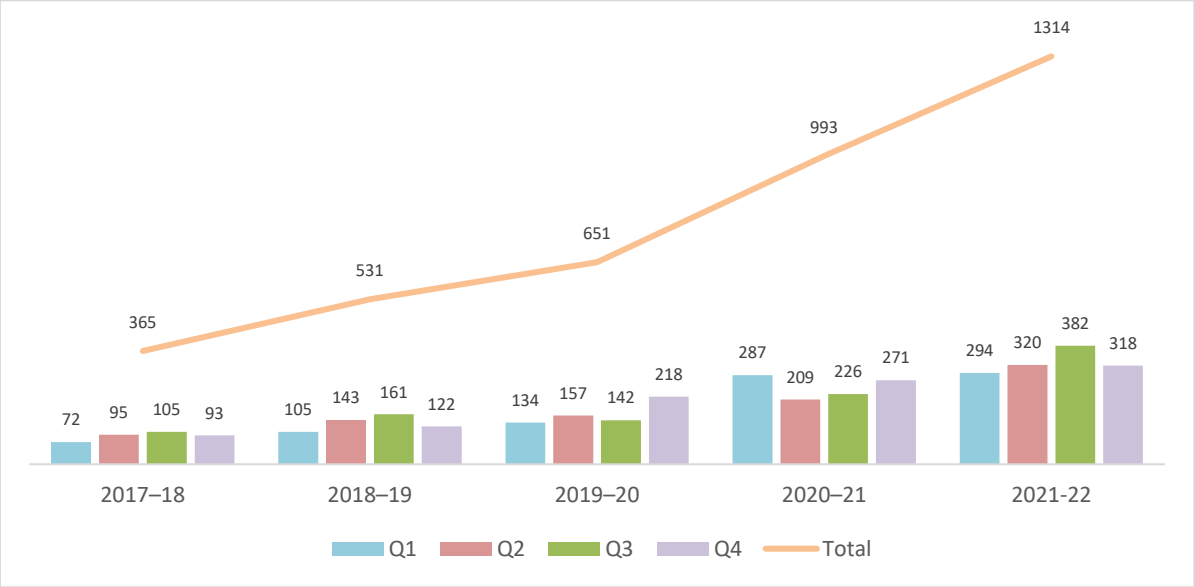


Table 2: Enquiries received by the Office of the Chief Psychiatrist, by number per quarter, 2017–18 to 2021–22

Quarter	2017–18	2018–19	2019–20	2020–21	2021–22
Q1	72	105	134	287	294
Q2	95	143	157	209	320
Q3	105	161	142	226	382
Q4	93	122	218	271	318
Total	**365**	**531**	**651**	**993**	**1,314**

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, 2019–20 to 2021–22

Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
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
2021–22	118	131	133	141	87	90	72	103	119	99	98	123

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

Figure 1 illustrates the volume of enquiries the OCP received over the course of five years. These have been on an upward trend since 2017–18, rising from 365 enquiries in that year to 651 in 2019–20. As was highlighted in last year's report, 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 is attributed to the COVID-19 pandemic. The steep increase in enquiries over that period may have demonstrated the heightened levels of stress and anxiety created by the pandemic in the community.

The number of enquiries to the OCP continued to rise throughout 2021–22, with 32 per cent more enquiries received compared with the previous year. This trend may be explained by the

persistence of stress and anxiety in the community caused by the pandemic and difficulties people have faced gaining access to treatment and care as mental health services have operated at the limit of their capacity.

Approaches to oversight: Investigations, clinical reviews, clinical practice audits and site visits

The Mental Health Act gives the Chief Psychiatrist powers to conduct investigations, clinical reviews clinical practice audits, and site visits of mental health service providers as part of their oversight role.

Investigations

Investigations can originate either on the Chief Psychiatrist's own initiative or at the request of the Secretary of the Department of Health.

They can be conducted if the Chief Psychiatrist or the Secretary believes that the health, safety or wellbeing of a person is or was endangered as a result of receiving treatment and care in a designated mental health service.

Investigations are the most formal intervention that the Chief Psychiatrist can make in response to a quality and safety issue, consisting in various legal procedures of approval and administration. In practice, investigations are rare. They are often a last resort after other less formal interventions do not result in required changes or when the Chief Psychiatrist has serious concerns about hazardous practices in a health service.

The more common approach taken by the Chief Psychiatrist is informal and collaborative. It is based on a process of enquiry with a service to understand the specific circumstances that are compromising quality and safety and to develop the remedial actions most attuned to those circumstances. These non-punitive and inquiry-based interactions are preferred because they are more effective in eliciting a positive and prompt response from a service while avoiding the legally onerous and time-consuming pathway of a formal investigation.

Clinical reviews

The Act also gives the Chief Psychiatrist authority to conduct clinical reviews. The purpose of a clinical review is to identify processes and procedures that must be changed to improve quality and safety in a service. The Chief Psychiatrist has broad discretion to choose the parameters and process for conducting clinical reviews, which can focus any aspect of mental health treatment and care that a service provides. While an investigation is typically conducted reactively – that is, in response to a particular incident – a clinical review is intended to be used proactively to assist a service with identifying processes and practices that improve quality and safety.

Clinical practice audits

The Act also allows the Chief Psychiatrist to conduct a clinical practice audit. Such audits can be initiated either at the Chief Psychiatrist's own initiative or at the request of the Secretary. They are carried out to identify systemic issues or trends that need to be addressed in order to improve quality and safety in mental health services. Clinical practice audits mostly involve analysing data on rates of specific treatments and incidents across Victoria. Like clinical reviews, clinical practice audits also aim to be used proactively to improve quality and safety.

Site visits

Informal site visits are another effective way that the Chief Psychiatrist proactively promotes quality and safety. Through such visits, the Chief Psychiatrist helps services detect and rectify issues at their early stages. Site visits are also a means for positive reinforcement, whereby exemplary practice by a service is acknowledged and further encouraged.

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 for ECT, restrictive interventions and consumers' deaths in 2021–22.

The data 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 binary 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 data according to categories of biological sex. 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

The Chief Psychiatrist and the Mental Health Tribunal oversee 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 2021–22, 881 people received ECT (Table 4). With a total of 11,751 ECT treatments delivered that year, the rate of treatments delivered per person was 13.3.

Table 4: Number of treatments and people treated by ECT in public hospitals, 2017–18 to 2021–22

Measure	2017–18	2018–19	2019–20	2020–21	2021–22
Number of ECT treatments	13,292	12,991	12,107	11,982	11,751
Number of people receiving ECT	1,031	974	893	910	881

While the numbers of treatments administered vary from year to year, some of the variation from 2018–19 to 2021–22 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 during the COVID-19 pandemic might be a prolonged recovery for some mental health consumers or a greater vulnerability to relapse in others.

Mood disorders accounted for 60 per cent of treatments in 2021–22, followed by schizophrenia and other psychoses (Table 5).

Table 5: Number of ECT treatments in a public hospital, by diagnosis, 2017–18 to 2021–22

Health conditions	2017–18	2018–19	2019–20	2020–21	2021–22
Major affective and other mood disorders	8,249	7,868	7,442	7,255	6,991
Schizophrenia, schizoaffective and other psychotic disorders	4,468	4,424	3,811	4,104	4,202
Other mental health disorders	312	226	233	167	209
No mental health diagnosis recorded	263	473	621	456	349

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 sex, 2021–22

Measure	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	6	907	825	857	1,052	1,117	1,106	635
Male	0	457	745	979	1,171	919	718	251
Sex other than male or female	0	0	0	6	0	0	0	0

What is 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, 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 highly advanced and 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.

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:

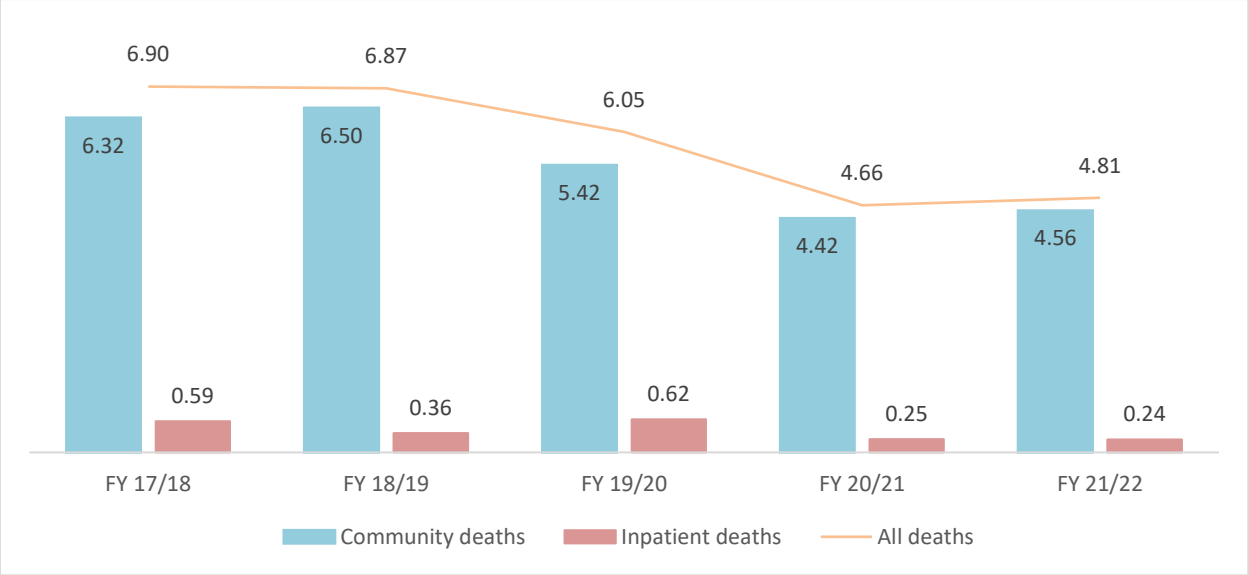
- to maintain a database of reportable deaths
- to contribute to coronial inquiries and recommendations when requested by the coroner
- to review clinical reports provided by services to identify systemic issues that may have contributed to a person's death
- to identify statewide issues and provide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

The Chief Psychiatrist collaborates with the Coroner's Court to match data and identify suicides of people who were recently discharged from mental health services. This cross-checking of data is also used to detect increased episodes of suicide in specific areas, enabling the Department of Health to take early action in support of services responding to suicide clusters.

Reportable deaths in 2021–22

In 2021–22 mental health services reported 336 deaths, of which 17 were defined as 'inpatient deaths' (Table 8). The overall number 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 inpatient deaths have been on a downward trend, while those of community deaths have increased slightly on the previous year but are also decreasing over the long term (Figure 2 and Table 7). 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, 2017–18 to 2021–22



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, 2017–18 to 2021–22

Measure	2017–18	2018–19	2019–20	2020–21	2021–22	Average
Community deaths	6.32	6.50	5.42	4.42	4.56	5.44
Inpatient deaths	0.59	0.36	0.62	0.25	0.24	0.41
All deaths	**6.90**	**6.87**	**6.05**	**4.66**	**4.81**	**5.86**

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

Of the 336 notified deaths in 2021–22 (Table 8), the cause of death has yet to be determined in 34 per cent of instances. Of the remainder, suicide and medical causes accounted for nearly equal proportions (33 per cent and 28 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, 2021–22

Category	Community patient	Inpatient	Total	Proportion
Accident/misadventure	16	0	16	5%
Homicide	2	0	2	1%
Medical condition	88	7	95	28%
Not yet known	111	2	113	34%
Suicide	102	8	110	33%
Total	**319**	**17**	**336**	**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 336 notified deaths, four are out of scope (not reportable to the OCP). These encompass deaths in private hospitals and community support services, and are reviewed by other relevant authorities.

The 'medical condition' figures include several 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 four 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. Safer Care Victoria classifies all inpatient suicides as sentinel events; they trigger detailed reports from 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 lessons are communicated to services through the Chief Psychiatrist's *Quality and safety bulletin.*

Restrictive interventions

The Chief Psychiatrist is committed to reducing and eventually eliminating restrictive interventions in line with the Royal Commission's recommendations and the National Mental Health Commission's *Seclusion and restraint declaration*. Several local initiatives led by the OCP and the Office of the Chief Mental Health Nurse, such as Safewards, have encouraged alternative clinical practices that aim to avoid restrictive interventions.

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 Mental Health 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 Mental Health 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.

The new Mental Health and Wellbeing Act will provide a legal framework to reduce and eliminate restrictive interventions in our mental health services over the next 10 years in line with Royal Commission recommendations. The new Act will also define the use of chemical restraint as a restrictive intervention. How chemical restraint and its regulation will be operationalised in the sector is currently under review. While the principles of the new Act will be laid out in legislation, work will

continue to determine the best pathways of implementation so there is meaningful and enduring change in practice.[1]

Staff from the OCP continue to lead the Statewide Chief Psychiatrist's Restrictive Intervention Committee towards eliminating restrictive interventions.

The OCP has developed a secure SharePoint site to facilitate information sharing of data from health services. This allows 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 and seclusion decreased in 2021–22 compared with the previous year.

Table 9: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2017–18 to 2021–22

Intervention	2017–18	2018–19	2019–20	2020–21	2021–22
Bodily restraint	8,822	10,359	8,269	8,328	7,550
Seclusion	3,478	3,182	3,574	3,660	3,313

Note: The table in last year's annual report with these data contained an error; the data represented bodily restraint and seclusion by *number of people* instead of *number of episodes*. The error has been corrected in this table.

In 2021–22 most episodes of seclusion in admitted settings were among 18- to 49-year-olds (Table 10).

[1] At the time of this report's publication, the new Mental Health and Wellbeing Act was passed in parliament.

Table 10: Number of seclusion episodes in acute inpatient units, by age and sex, 2021–22

Sex	0–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	90	232	347	147	65	13	9	0
Male	39	840	828	439	243	14	n.p.	0

Notes:

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

n.p. refers to data that is not published. This is done 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 sexes, with each being more frequent in males, except in the 0- to 17-year-old age group, where it was more frequent in females.

Table 11: Number of bodily restraints in acute inpatient units, by age and sex, 2021–22

Sex	0–12	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	247	743	810	450	292	281	97	80	73
Male	22	59	1,068	1,842	629	589	99	90	71

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 are beginning to trend down for child and adolescent units and are thought to represent a small number of individuals with complex combinations of mental illness and intellectual or developmental disability.

Rates of seclusion are high in Forensicare. This 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, 2017–18 to 2021–22

Type of unit	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	10.6	9.5	10.0	9.5	8.5
Aged	1.2	0.7	0.6	0.6	0.2
Child and adolescent	8.8	12.2	14.6	10.7	7.7
Forensic	51.4	39.2	47.3	58.7	65.8
Specialist	0.6	0.4	0.5	3.2	10.6
Total	9.9	8.8	10.0	10.3	9.8

Table 13 shows that, when seclusion happened, it typically occurred only once within 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, 2017–18 to 2021–22

Frequency	2017–18	2018–19	2019–20	2020–21	2021–22
1	894	868	795	788	636
2	243	224	212	205	178
3	119	100	103	100	74
4	53	53	61	50	59
5	30	29	34	31	33
6	23	16	20	22	17
7+	70	64	85	81	60

In 2021–22 close to half of all episodes of seclusion lasted for four or fewer hours, consistent with most previous years (Table 14). The occasions of seclusion beyond 12 hours are closely monitored.

Table 14: Duration (hours) of acute inpatient seclusion episodes, 2017–18 to 2021–22

Period	2017–18	2018–19	2019–20	2020–21	2021–22
≤ 4 hours	1,504	1,651	1,852	1,720	1,510
4–12 hours	908	715	726	770	580
> 12 hours	1,066	816	996	1,170	1,223

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). The Mental Health Act requires mental health services to inform the Chief Psychiatrist of both types of practice.

Table 15 shows that bodily restraint episodes per 1,000 occupied bed remains steady. Rates rose somewhat in adult acute inpatient units but reduced substantially in the forensic service. There continues to be a rise in rates of restraint in child and adolescent inpatient units. This is a trend that will be examined more closely.

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 consider 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 in the child and adolescent age group compared with the adult age group.

Table 15: Bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2017–18 to 2021–22

Type of unit	2017–18	2018–19	2019–20	2020–21	2021–22
Adult	9.0	10.7	11.8	13.4	13.7
Aged	6.4	6.0	8.9	8.5	6.4
Child and adolescent	32.7	37.2	42.3	50.4	67.4

Type of unit	2017–18	2018–19	2019–20	2020–21	2021–22
Forensic	146.6	162.1	90.3	76.5	59.8
Specialist	1.1	0.5	0.8	1.1	10.0
Total	22.7	25.8	20.7	20.9	19.8

Physical only restraint accounted for the vast majority of instances of restraint (Table 16). The number of episodes of mechanical restraint increased in 2021–22.

Table 16: Type of restraint episodes, 2017–18 to 2021–22

Restraint type	2017–18	2018–19	2019–20	2020–21	2021–22
Mechanical and physical	167	115	113	102	79
Mechanical only	339	381	399	394	561
Physical only	8,316	9,863	7,757	7,832	6,910

'Mechanical and physical' refers to mechanical and physical restraint being used at the same time.

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, 2017–18 to 2021–22

Frequency of episode	2017–18	2018–19	2019–20	2020–21	2021–22
1	862	960	1,008	1,048	934
2	279	274	321	364	343
3	112	133	142	163	154
4	64	69	86	101	82
5	34	53	58	59	49
6	27	32	33	46	41
7+	132	161	181	166	162

With respect to duration, there were 22 episodes of restraint longer than 12 hours, representing less than 1 per cent of the total in 2021–22 (Table 18). This is a significant reduction compared with 2017–18. Most restraints last less than three minutes and may reflect the use of restraint to administer 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, 2017–18 to 2021–22

Duration	2017–18	2018–19	2019–20	2020–21	2021–22
Less than 3 minutes	4,803	6,082	5,365	5,737	4,964
≥ 3 to < 15 minutes	3,416	3,672	2,330	2,012	1,905

Duration	2017–18	2018–19	2019–20	2020–21	2021–22
≥ 15 to < 30 minutes	224	198	165	207	193
≥ 30 to < 45 minutes	72	73	68	85	82
≥ 45 minutes to < 1 hour	38	45	49	66	84
≥ 1 to < 4 hours	161	217	202	158	243
≥ 4 to < 12 hours	66	46	55	45	57
≥ 12 hours	42	26	35	18	22

Secure extended care units

Secure extended care units, or SECUs, are inpatient bed units that cater to the needs of consumers facing complex challenges in light of limited options for community care. SECUs offer the means for consumers facing complex challenges to benefit from a slower recovery course and longer length of stay. It is anticipated that increased community resources, including other accommodation options and supports, will create a wider range of settings for recovery-oriented care.

Seclusion – secure extended care units

Table 19 shows that seclusion episodes per 1,000 occupied bed days in SECUs decreased in 2021–22 relative to the previous year but were higher relative to 2018–19. A number of factors may be contributing to this higher rate, including changes to staffing, leave and access to visitors (including support staff) brought about by the pandemic. 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, 2017–18 to 2021–22

Year	Rate
2017–18	2.9
2018–19	1.8
2019–20	3.7
2020–21	4.0
2021–22	3.5

Restraint – secure extended care units

There has been a downward trend with respect to restraint episodes over the past three years (Table 20). We continue to work 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, 2017–18 to 2021–22

Year	Rate
2017–18	2.9
2018–19	2.6

Year	Rate
2019–20	3.7
2020–21	3.3
2021–22	2.9

Restrictive practices: Contributing factors and positive change

A cornerstone recommendation of the Royal Commission into Victoria's Mental Health System is to reduce seclusion and restraint in mental health and wellbeing service delivery, with the aim to eliminate these practices within 10 years. This recommendation was handed down with the purpose of upholding the rights of consumers and responding to the service failure relying on restrictive practices embodies.

The rate of restrictive practices and how they are used can vary significantly from one mental health service to the next. Understanding why this variation exists is key to determining which interventions are most effective at reducing and eventually eliminating their use.

The Royal Commission identified several factors that contribute to restrictive practices:

- *Resourcing:* Staffing levels and bed vacancies that do not meet demand for care and treatment leads to an increased threshold for access. This results in more people coming to a service in severe distress or crisis and fewer people receiving treatment at an earlier stage of their illness.
- *Workforce skill levels and experience*: Services lacking experienced and skilled staff with the ability to provide trauma-informed care, to apply conflict resolution techniques and to support junior staff who are responding to people in crisis and distress will have less capacity to avoid restrictive practices.
- *Physical environment*: Shared bedrooms and overcrowding in inpatient units can make it difficult to respond to consumer distress and agitation. Noisy spaces and custodial features that create a sense of disempowerment can contribute to consumer distress and agitation, increasing the potential for restrictive practices to be used.
- *Patient characteristics*: Patients with severe behavioural disturbances that pose a high risk of harm to themselves or others are more likely to be restrained and sedated compared with other patients.

Furthermore, reporting culture influences the extent to which services can be monitored and areas in need of change identified. When a service is transparent about its use of restrictive practices, the data that is collected will more accurately reflect practice. By contrast, where a commitment to transparency is weak, the data will understate the true extent of restrictive practices, limiting opportunities to improve a service's quality of care. Underreporting does not appear to be widespread in Victoria. However, where it does occur, it can skew data on restrictive practices.

The multiple factors that contribute to restrictive practices, and the varying significance of those factors across contexts, points to the importance of taking action at both a system- and individual service level to bring about positive change. This multifaceted approach underpins the Royal Commission reforms currently underway to progressively eliminate restrictive practices in Victoria over a 10-year period.

These reforms encompass:

- revised legislation and policy on rules and expectations around restrictive interventions
- new governance bodies to strengthen enforcement of rules and accountability over the use of restrictive interventions
- increased consumer participation and leadership in decision making at the clinical and governance levels
- a recruitment drive to boost the size of the mental health workforce
- education and training programs to equip mental health workers with the skills and knowledge to provide compassionate care
- infrastructure upgrades that embody therapeutic design principles
- continued engagement with services to encourage consistent reporting on the use of restrictive interventions.

2. Leadership in clinical mental health

Quality and safety initiatives

Electroconvulsive treatment audits

Over the past three years, all ECT services in Victoria have been audited to ensure they adhere to the Chief Psychiatrist's guideline on ECT. Audit teams have included a deputy chief psychiatrist, senior clinical advisor, an ECT director and a nurse coordinator from other services, and consumer and carer representatives. During their visits, which are typically daylong, team members meet with senior clinicians, inspect ECT treatment facilities and review services' clinical policies and practices, educational programs and quality improvement activities. As a result of these audits, 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, strategies to minimise cognitive impairment, and regular checks of clinical progress.

In 2021 the Chief Psychiatrist's ECT Committee was renamed the Neurostimulation Committee. The committee now includes newer neurostimulation therapies within its scope, such as transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS). Overseeing ECT will continue to be the primary function of the committee. However, the committee will also keep pace with new developments in TMS and DBS to ensure these therapies are administered safely.

The OCP also set up the ECT Complex Consultation Expert Panel. This will advise the Chief Psychiatrist on matters involving extreme clinical, ethical and legal complexity with respect to administering ECT. Such matters typically sit outside existing guidelines, standard practices and statuary protections, and need to consider alternative, individualised models of care. As part of this new arrangement, public mental health services must refer complex clinical, ethical and legal matters to the OCP for the panel's review. Upon receiving the panel's advice, the Chief Psychiatrist may seek further expert opinion where necessary before offering direction to mental health services on how to proceed with the ECT.

In April 2022 a Chief Psychiatrist's Neurostimulation Forum was held, attracting mental health service representatives from across Victoria. Participants and presenters included people with lived experience, their family and carers, clinicians, researchers and experts in the field on neurostimulation. Professor Colleen Loo and Doctor Donel Martin from New South Wales provided important insights on neurostimulation therapies. Craig Wallace, CEO of VMIAC, and Andrew Tomlinson, from Tandem, provided lived experience perspectives on ECT. Kate Thwaites and Jodie Ten-Hoeve from Safer Care Victoria highlighted nursing perspectives, and Doctors Ashu Gandhi and Vivek Phutane shared experiences of ECT and TMS.

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 line 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 Subcommittee, Sentinel Event Review 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 the services' reviews are 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 data routinely submitted 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 publishes a quality and safety bulletin that highlights issues affecting consumer safety. The bulletins, which are available on the Chief Psychiatrist's website <https://www.health.vic.gov.au/publications/chief-psychiatrist-quality-and-safety-bulletins>, 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 pace of Chief Psychiatrist guideline development, review and updates slowed from March 2020, acknowledging the pressures on the mental health sector of meeting the needs of consumers and the families, carers and supporters during the coronavirus pandemic.

As Victoria has moved into a new phase of the pandemic, it has been possible to renew the OCP's focus on providing clinical leadership, guidance and advice through Chief Psychiatrist guidelines. This guidance is informed by recommendations from the Royal Commission. Central to the Royal Commission's recommendations is the need to partner with consumers, carers and families, supporting them to make decisions in their treatment, care and support. To this end, the Chief Psychiatrist's guidelines are being co-designed with lived experience consultants and revised to integrate language that promotes cultural reform through an approach that is trauma-informed, least restrictive, culturally and psychologically safe and is delivered seamlessly in collaboration with carers and families.

In addition to partnering with lived experience consultants, the strategic partnerships between the OCP, Safer Care Victoria and the Mental Health Improvement Unit places greater focus on

supporting the sector to implement the guidelines, to optimise improvements in the quality and safety in mental health treatment, care and support.

The OCP aims to publish updated guidelines for gender-based safety (sexual safety), ECT, transfer of care (discharge planning), criteria for searches and supporting smoke-free environments early in 2023.

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
- monitor mental health service programs supporting sexual safety interventions
- increase the overall safety of consumers in inpatient settings.

The work has included:

- reporting to mental health services on 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 give 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 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 to health services. Services will be encouraged to distribute this information for quality improvement to:

- inpatient nurse unit managers
- assistant nurse unit managers
- relevant medical staff
- quality managers
- consumer and carer consultants.

This project entered its final phase in 2021, with a focus on standardising the reporting of sexual safety incidents. Once implemented, the new approach will serve as a foundation for monitoring and promoting sexual safety across Victoria by:

- providing guidance for classifying sexual safety incidents

- specifying a threshold for incident reporting
- 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
- establish staff confidence in reporting through clarifying what qualifies as a reportable incident.

Also, there is ongoing work on realising sexual safety goals through, for example, capital upgrades to units, as well as improving reliability and reporting of clinical incident (including sexual safety incidents) data. This will lead to better local service clinical governance and review processes. It will also inform the improvement work that is concurrently being undertaken by Safer Care Victoria.

Promoting the rights of mental health consumers

The OCP promotes the rights of mental health consumers by:

- enforcing the Mental Health Act
- developing and embedding standards of clinical best practice
- supporting Royal Commission reforms that empower consumers to exercise their rights.

The OCP detects clinical practice that falls short of contemporary safety and quality standards or that constitutes a breach of the Act through system-wide monitoring. This monitoring involves analysing data on restrictive interventions, ECT and inpatient deaths. Also, serious incidents and hazardous practices are reported to the OCP by consumers, carers, family members, mental health staff and advocacy groups. The OCP uses these data and first-hand insights to drive positive change at the system level and to compel individual services to meet their obligations around the rights of consumers. In the Act, these obligations consist in a requirement to:

- provide treatment in the least restrictive way possible
- allow consumers to make decisions about their assessment, treatment and recovery
- respond to the individual, cultural and medical needs of consumers
- include carers in decision making.

Where these consumer rights have been violated, the OCP approaches services to understand the contributing systemic, cultural, environmental and staffing-related factors. Instructions are issued on remedial actions that must be taken to comply with principles set out in the Act and Chief Psychiatrist guidelines.

Alongside these routine oversight activities, the OCP engages proactively with the sector in other ways to promote the rights of consumers. In May 2022 the OCP hosted a forum on the use of personal electronic devices by consumers in inpatient units. The forum brought together mental health services and consumer and carer representatives to raise awareness about the rights of patients to communicate with mobile phones, tablet devices and computers under the Mental Health Act and *Charter of Human Rights and Responsibilities Act 2001*. The forum also highlighted the therapeutic benefits associated with electronic communication devices (such as when they are a means to staying connected with family and friends and accessing music, games and self-help apps). The forum also clarified the specific circumstances when access to electronic communication devices can be legitimately restricted (most significantly, when they pose a risk of harm or breach privacy). The exchange of ideas and lessons shared provided practical knowledge around how services can align rules on patient use of electronic devices with legislation on patient rights. The

OCP also gained an understanding of the kind of support individual services require in their efforts to implement changes and create a safe environment for using electronic communication devices.

The collaborative work that the OCP undertakes with consumers and carers continued to be an important avenue for promoting consumer rights. Consumers and carers were represented on OCP statutory committees and took part in OCP investigation panels and audit teams. Also, the OCP met with peak bodies and advocacy groups to better understand consumer and carer views on Victoria's mental health and wellbeing system. This partnering with consumers and carers helped the OCP to detect quality, safety and human rights issues, and to find the right solutions to address them.

The OCP began a review of the Chief Psychiatrist's guidelines, with a particular emphasis on incorporating human rights as foundational principles of clinical practice. When the review is finished, the guidelines will contain explicit statements about meaningful participation by patients in decisions about their treatment and care. Changes are also being made to the language of the guidelines to better embody the dignity and autonomy of mental health consumers. Insofar as the Chief Psychiatrist's guidelines are an authoritative benchmark for best practice on wide-ranging aspects of clinical treatment and care, these updates will have a significant impact on culture and practice. They will underpin learning and training in the workforce and serve as a normative framework for holding services to account.

The OCP continues to promote human rights through initiatives aimed at reducing and eventually eliminating restrictive practices. It has been contributing to this program of work in the Mental Health and Wellbeing Division through the specialist knowledge of its clinical adviser and psychiatrist staff and its longstanding partnerships with mental health services, consumers, carers and industrial bodies. An important aspect of this work is the Chief Psychiatrist's membership on the Human Rights Project Advisory Group in the Department of Health. This body designs and implements projects that promote the human rights of people living with mental illness or psychological distress through a coordinated and collaborative approach with Safer Care Victoria, with a particular focus on implementing the Royal Commission's recommendations. The OCP's involvement in these Royal Commission reforms is an extension of previous work it has been undertaking over many years with the Office of the Chief Mental Health Nurse to reduce restrictive interventions. This includes the *Creating safety: addressing restraint and seclusion practices* project of 2006, the *Providing a safe environment for all: Framework for reducing restrictive interventions* project of 2013, and the Safewards program trialled from 2019 to 2021 to encourage alternative clinical practices that avoid relying on restrictive interventions.

Supporting consumers to understand and exercise their rights

Sarah* rang the OCP enquiry line requesting to be discharged from a mental health inpatient unit. She explained that it was her first admission and that she was overwhelmed by the experience. She described being on an inpatient treatment order, which she believed was unnecessary because she felt she could be treated in the community. She was distressed and teary and concerned about her safety. Sarah had spoken to her treating team but was left with the impression that they weren't listening to her.

There are several key mental health principles that are relevant to Sarah's situation, articulated in the Mental Health Act and Chief Psychiatrist's guidelines:

- People receiving mental health services should be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.
- People receiving mental health services should be provided by those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- People receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or take part in, those decisions, and their views and preferences should be respected.
- People receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- People receiving mental health services should have their rights, dignity and autonomy respected and promoted.

The OCP took these principles into account when responding to Sarah's enquiry and determining the course of action that best protected her rights.

As a first step, a senior clinical adviser from the OCP listened to Sarah's story and validated her experience. The clinical adviser asked Sarah about the supports available to her. Sarah said that she wished to avoid contact with family but that she sees a private psychologist in the community.

The senior clinical adviser asked Sarah if there were any staff on the unit that she could share her concerns with, such as a peer worker. Sarah said that she could speak to her treating team with the support of a third party.

In order to facilitate this arrangement, the senior clinical adviser gave Sarah the contact details of Independent Mental Health Advocacy, an organisation that helps people who are receiving, or at risk of receiving, compulsory mental health treatment. Through Independent Mental Health Advocacy's involvement, there was a better chance that Sarah's preferences would be taken into consideration during her communication with the treating psychiatrist and in developing an advance statement.

Sarah was also given information about the Mental Health Tribunal. By learning about the tribunal's role in decisions on treatment orders, Sarah would be able to determine whether recourse to the tribunal was a viable option in her situation.

Sarah was also made aware of legal representation that she is entitled to were she to appear at a Mental Health Tribunal hearing about her treatment order. Victoria Legal Aid was recommended as a suitable organisation for such representation, and its contact details were forwarded to Sarah.

Sarah was also given information about the Second Psychiatric Opinion Service. By engaging this service, Sarah would be able to exercise her right to a second opinion about her mental illness and treatment options.

The senior clinical adviser offered to contact Sarah's treating team to inform them about Sarah's experience of feeling distressed and unsafe in their care. Sarah agreed to this, seeing it as a helpful intervention in her circumstances.

When the senior clinical adviser contacted Sarah's treating team, it responded positively. The mental health nurse said she would talk to Sarah about her concerns and take steps to ensure Sarah felt safe and supported on the unit.

In the end, Sarah did not wish to make a complaint about her treatment. She was encouraged to contact the OCP again if she needed more help.

Note: **Sarah is a pseudonym. It has been adopted to protect the consumer's privacy.*

3. A final word: mental health as a shared responsibility

The Royal Commission described mental health as a 'shared responsibility of society'. It envisaged a future where collaboration and communication take place within and beyond the mental health system and at all levels of government.

The Royal Commission's vision recognises that building and sustaining a mental health system that benefits all Victorians can only ever be a collective endeavour. It is our different efforts, strengths and relationships that make it possible to create a system that is integrated, efficient, easy to navigate, and allows people to receive care when it makes the most difference to their recovery. Social and institutional connections are an essential part of this. They link together dispersed initiatives to drive improvements and serve as the very basis for building momentum, learning, shared decision making, and aligning actions towards a common purpose among those who regulate, fund, use and work in the mental health system.

One year on since the Royal Commission released its final report, a reform landscape has emerged that takes this interdependence seriously. There is a mobilisation of collective power to address major mental health problems, with government departments and agencies, legislators, mental health services, consumers, carers, peak bodies and community organisations and leaders coming together with the shared goal of transforming the way mental health care is provided in Victoria. Through various forums, workshops and meetings across the state, system-wide changes are being enacted that are increasing capacity for accountability, service monitoring and service provision. This will equip the system to keep pace with the significant demand that is placed on it and to improve the experiences and outcomes of people who use it.

The OCP is at the centre of this expansion and intensification of cooperation and collaboration. It is deepening already existing partnerships and forging new ones that will prepare it to continue upholding quality and safety in a system being changed from the ground up.

The OCP meets regularly with members of the Mental Health Improvement Program at Safer Care Victoria to coordinate actions and ensure they lead to continuous improvements in clinical practice. As part of assuming oversight responsibilities over mental health services in custodial settings, the OCP has started discussions with the Department of Justice and Community Safety to determine effective ways of working together in this new arrangement of governance. The OCP maintains its longstanding collaborative relationship with Tandem and the Victorian Mental Illness Awareness Council, giving it access to people with consumer and carer lived experience to support its core activities. In the Mental Health and Wellbeing Division, the OCP works with colleagues in the Lived Experience Branch to find ways of embedding consumer and carer perspectives in the OCP's projects. It also works with colleagues in the Clinical Advisory Hub to pool specialist knowledge around clinical mental health in support of Royal Commission reforms. The Chief Psychiatrist chairs the Complex Needs Advisory Panel, which brings together multidisciplinary and multiagency expertise to support people with complex needs who are subject to the Crimes Mental Impairment and Unfitness to Plead Act. A protocol with the Mental Health Complaints Commission outlining information sharing and referring arrangements with the OCP has strengthened coordination around resolving complaints and putting forward recommendations for improving services. Regular meetings with authorised psychiatrists and the Royal Australian and New Zealand College of Psychiatrists allows the OCP to stay attuned to the challenges and opportunities in the mental health system from the standpoint of the psychiatrist workforce.

The OCP will continue to invest in these relationships and foster new ones, considering them vital for fulfilling its shared responsibility to promote mental health and wellbeing in Victoria.

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.