Chief Psychiatrist's annual report 2023–24

VICTORIA State Government | Department of Health

Acknowledgements

Acknowledgement of country

The Office of the Chief Psychiatrist 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.

Recognition of lived and living experience

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

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Foreword from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist's annual report for 2023–24.

The Office of the Chief Psychiatrist provides statutory oversight, clinical governance and leadership functions across Victoria's clinical mental health services.

This year's report marks a period of significant change with the new *Mental Health and Wellbeing Act 2022* taking effect on 1 September 2023 and the ongoing work to realise the vision of the Royal Commission into Victoria's Mental Health System to achieve transformative reform.

The implementation of the new Act has required shifts in approach with the formal introduction of mental health and wellbeing principles, a stronger focus on human rights, broadened requirements for reporting restrictive interventions (most notably with the introduction of new reporting obligations for chemical restraint), the expansion of reporting obligations into physical health and custodial settings, and the adoption of new definitions of mental health service providers.

For the first time in Victoria, chemical restraint is defined as a restrictive intervention under the Mental Health and Wellbeing Act. This puts us at the forefront of work internationally to define, monitor and improve our therapeutic use of medications in acute settings. During this first year of regulating chemical restraint, we have worked with the sector to better understand when medication is administered primarily for therapeutic purposes as distinct from limiting a person's movement for their own safety or the safety of others. For the first time, we are expecting the general health sector, and in particular emergency department staff, to understand mental health approaches and to report alongside their mental health colleagues.

The Office of the Chief Psychiatrist has sought to address these implementation issues forthrightly. During this year, we led a restrictive interventions advisory committee made up of senior health clinicians and people with lived experience of mental illness or psychological distress to work together to develop shared oversight. The committee was responsible for working towards a governance approach that will enable chemical restraint to be consistently identified, reported and monitored with the intent that it is used only as a last resort.

The new Act expands the scope of regulation into all health services that include a designated mental health service. This means that the reporting of restrictive interventions now extends to local emergency departments, hospital wards and intensive care units. It also means there are added expectations for reporting in emergency departments when people are brought in by police under the care and control aspects of the Act. The Office has held information sessions and developed information resources for emergency leaders, hospital executives and the sector more broadly to support this work.

The Office of the Chief Psychiatrist also continued to expand the Chief Psychiatrist's functions and powers into custodial settings as recommended by the Royal Commission and defined in the Mental Health and Wellbeing Act.

The Office has worked closely with partners in the Department of Justice and Community Safety to establish oversight processes specific to custodial settings. These processes are evolving to reflect the clinical, legal and governance complexities of providing quality mental health treatment and care in custodial settings.

In addition to addressing the evolving implications of the new Act, the Office of the Chief Psychiatrist has continued to provide support for the daily work of designated mental health services. We have continued to monitor restrictive interventions, sexual safety, electroconvulsive therapy and the deaths of people in the care of a mental health and wellbeing service. The Office also publishes clinical guidelines, supports the sector through regular meetings, provides clinical leadership and support to services struggling with individual complex cases and responds to serious clinical incidents to improve the quality and safety of care.

This report reflects the significant contribution made to the people of Victoria by Dr Neil Coventry, Chief Psychiatrist of Victoria from 2016 to 2023. We are indebted to him for his consistent championing of both the mental health sector and people with lived and living experience of mental illness or psychological distress. He has been vocal in his belief that the lived experience voice is pivotal to instilling best practice in Victoria's clinical mental health and wellbeing services, a conviction that I also hold and will endeavour to act on through continued collaboration with consumer and carer advocates and colleagues.

I am fortunate to have inherited a multidisciplinary team of skilled and compassionate people who are dedicated to improving Victoria's mental health and wellbeing system. I acknowledge and thank the staff of the Office of the Chief Psychiatrist for their enduring efforts to support the mental health and wellbeing sector. We will be working together in years to come to grow our role in clinical leadership and governance for those needing mental health support in Victoria to ensure compassionate, person-centred and safe care wherever people need it.

Sophie Adams
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 2023–24 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health and Wellbeing Act 2022* (the Act)
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The Act aims to improve the experiences of people using mental health and wellbeing services 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 265 of the Act, the Secretary of the Department of Health can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s 266 of the Act, is to:

- provide clinical leadership and expert clinical advice to clinical mental health service providers
- promote the highest standard of clinical practices and care provided by clinical mental health service providers
- promote the rights of persons receiving services from clinical mental health service providers
- provide advice to the Minister and Health Secretary about the provision of services by clinical mental health service providers.

Under the Act, 'clinical mental health service provider' means:

a) a designated mental health service
b) a mental health and wellbeing service provider that provides mental health and wellbeing services in a custodial setting, or
c) any other prescribed entity or prescribed class of entity.

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 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/mental-health-and-wellbeing-act>.

Mental health and wellbeing principles

The Act has a set of core mental health and wellbeing principles. It requires mental health and wellbeing service providers to make all reasonable efforts to comply with and give proper consideration to the principles when making a decision under the Act.

The 13 principles, set out in ss 16 to 28 of the Act, are summarised below.

Dignity and autonomy principle

The rights, dignity and autonomy of a person living with mental illness or psychological distress are to be promoted and protected and the person is to be supported to exercise those rights.

Diversity of care principle

A person living with mental illness or psychological distress is to be given access to a diverse mix of care and support services. This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.

Least restrictive principle

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy, with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.

Supported decision making principle

Supported decision making practices are to be promoted. People receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be prioritised.

Family and carers principle

Families, carers and supporters (including children) of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery.

Lived experience principle

The lived experience of a person with mental illness or psychological distress and their families, carers and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.

Health needs principle

The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs. In doing so, the ways in which a person's physical and mental health needs may intersect should be considered.

Dignity of risk principle

A person receiving mental health and wellbeing services has the right to take reasonable risks to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk.

Wellbeing of young people principle

The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways. It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system.

Diversity principle

The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered, noting that such diversity may be due to a variety of attributes including any of the following:

- gender identity
- sexual orientation
- sex
- ethnicity
- language
- race
- religion, faith or spirituality
- class
- socioeconomic status
- age
- disability
- neurodiversity
- culture
- residency status
- geographical disadvantage.

Mental health and wellbeing services are to be provided in a way that:

- is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma
- considers how those needs and experiences intersect with each other and with the person's mental health.

Gender safety principle

People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that:

- are safe
- are responsive to any current experience of family violence and trauma or any history of family violence and trauma
- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery
- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Cultural safety principle

Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given, having regard to the views of Elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

Wellbeing of dependants principle

The needs, wellbeing and safety of children, young people and other dependants of people receiving mental health and wellbeing services are to be protected.

Promotion of the mental health and wellbeing principles

The Chief Psychiatrist promotes the mental health and wellbeing principles in their various clinical oversight and leadership activities. This includes ensuring the principles are embedded in the key publications of the Chief Psychiatrist, such as revised and newly developed guidelines, and alerting clinical mental health services of the obligation to make the principles a central part of their treatment and care.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health and wellbeing 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 267 of the Act, are to:

- develop, publish and promote standards, guidelines and practice directions for mental health and wellbeing services
- assist clinical mental health service providers to comply with the standards, guidelines and practice directions issued by the Chief Psychiatrist
- assist clinical mental health service providers to develop and maintain clinical governance frameworks to improve the quality and safety of those services
- provide clinical leadership to clinical mental health service providers in relation to their obligations under the Act, the regulations and any Codes of Practice
- conduct clinical reviews of clinical mental health service providers
- analyse data, undertake research and publish information about mental health and wellbeing services
- prepare an annual report for publication
- conduct investigations into how clinical mental health service providers deliver mental health and wellbeing services
- give directions to clinical mental health service providers for providing mental health and wellbeing services
- promote cooperation and coordination between clinical mental health service providers and providers of health, disability and community support services.

Office of the Chief Psychiatrist and the Department of Health

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 clinical leadership and 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.

Clinical leadership activities in 2023–24

In the 2023–24 financial year, the OCP carried out the following clinical leadership activities:

- implemented components of the Act relevant to the Chief Psychiatrist role, most notably, expanding the role's jurisdiction to encompass mental health services in custodial settings and the use of chemical restraint
- supported the mental health and wellbeing sector transition to the Act by:
  - convening an expert advisory group of health professionals and people with lived experience of mental illness or psychological distress to prepare emergency departments and urgent care centres to comply with new legislative requirements on using restrictive interventions
  - briefing Act Implementation Leads working directly with services to establish operational readiness
  - developing fact sheets and an e-learning module explaining rights and obligations relevant to providing mental clinical services
- consolidated and improved oversight arrangements for sexual safety in clinical mental health services, including protocols for reporting sexual safety incidents and a clinical guideline on sexual safety
- provided clinical advice into Department of Health activities to guide the transformation of the mental health service sector in response to the recommendations of the Royal Commission
- revised existing Chief Psychiatrist guidelines and developed new ones to embody contemporary understandings of clinical best practice – this included publishing a new guideline on restrictive interventions that outlines compliance obligations and best practice advice on using chemical restraint and a revised sexual safety guideline that establishes minimum standards for prevention strategies and responses to sexual safety incidents
- convened the Statewide Complex Needs Advisory Panel, providing pathways into mental health and wellbeing services for people who fall outside standard service responses and pose a serious risk to themselves or others
- convened an expert advisory group of health professionals and people with lived experience of mental illness or psychological distress to help implement an oversight regime for chemical restraint by the Chief Psychiatrist
- participated as a standing member of the Forensic Leave Panel, assessing the leave applications of forensic patients at Thomas Embling Hospital
- convened a weekly statewide adolescent inpatient psychiatric unit huddle to support urgent inpatient care for adolescents through managing demand across services
- began overseeing mental health services in custodial settings in collaboration with Forensicare, the Department of Justice and Community Safety, Corrections Victoria and the Commission for Children and Young People
- convened regular infant, child and youth clinical leaders' meetings with area mental health services to support coordination and care across the infant, child and youth sector
- convened regular older adults' mental health service clinical leaders' meetings, fostering collaboration between services to improve treatment and care for older adults

- worked with Authorised Psychiatrists to identify issues in the clinical mental health and wellbeing system via a series of ongoing forums (topics included briefings on emerging reforms and compliance requirements relating to Royal Commission recommendations and the Act)
- provided a submission and oral evidence to assist the Coroners Court of Victoria to make findings in its Trans and Gender Diverse Suicide Cluster Inquest
- continued to modernise systems to ease the administrative burden on services reporting clinical incidents and practices to the OCP
- chaired a statewide Emergency Services Liaison Committee made up of Victoria Police, Ambulance Victoria, Act Implementation Leads and divisional colleagues, addressing systemic issues related to the health-led response of people experiencing a mental health crisis.

Statutory and oversight reporting

Under the Act, mental health services must report to the Chief Psychiatrist on their use of restrictive interventions, ECT and neurosurgery. 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.

The Chief Psychiatrist collects data to help monitor trends, identify issues and improve quality and safety in clinical services. This section of the report provides data and analysis for ECT, restrictive interventions and consumers' deaths in 2023–24.

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 and neurosurgery

ECT is an established, safe, effective, evidence-based treatment for 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 only when clinically indicated. Acute treatments are typically administered on 2 or 3 occasions per week over 2 or more weeks. A small proportion of people benefit from ongoing or maintenance treatments to prevent relapse.

Both the Chief Psychiatrist and the Mental Health Tribunal have a role in overseeing ECT. Public mental health and wellbeing services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use. Data is reported as amalgamated and deidentified, some of which is provided below. Clinical decision making for people receiving ECT may also be reviewed by the Chief Psychiatrist on request – for example, if there are adverse outcomes or complex clinical, legal or ethical considerations.

In 2023 the Chief Psychiatrist set up the ECT Complex Consultation Expert Panel to discuss clinically, legally and ethically complex matters related to ECT. The panel's intent is to help consolidate learnings and provide advice to the sector. To date it has considered 3 such cases, and lessons have been fed back to the sector via various means. The panel was not set up to give urgent clinical opinions, and clinical governance still sits with the treating service.

Also, ongoing individual monitoring of ECT for young people under 18 is maintained to enhance oversight for this vulnerable cohort. The Mental Health Tribunal is responsible for authorising ECT for people who lack the capacity to provide consent. Consent is provided through the Act or through the medical decision-maker, for all people under 18 years of age.

The Chief Psychiatrist also receives notifications from the Mental Health Tribunal about approval for neurosurgery for mental health consumers. The OCP engages with relevant services to ensure quality care and improved oversight.

The Chief Psychiatrist plans to re-commence the ECT Education Forum in 2025 to bring knowledge and build capacity for the sector.

Electroconvulsive treatment in public mental health services

In 2023–24, 942 people received ECT (Table 1), with 11,860 individual ECT treatments delivered. The average rate of treatments delivered per person was 12.6.

Table 1: Number of treatments and people treated by ECT in public hospitals, 2019–20 to 2023–24

Measure	2019–20	2020–21	2021–22	2022–23	2023–24
Number of ECT treatments	12,107	11,982	11,947	11,787	11,860
Number of people receiving ECT	893	910	894	887	942

Variation from 2019–20 to 2023–24 is not significant despite the impact on practice due to COVID-19 during this time.

Major affective and other mood disorders accounted for 60% of treatments in 2023–24, followed by schizophrenia and other psychoses, which accounted for 36% of treatments (Table 2). The 'no mental health diagnosis recorded' component of Table 2 is predominantly a data collection limitation because there are very few indications for ECT without a mental health diagnosis. These include in rare circumstances some acute neurological conditions.

Figure 1: Number of ECT treatments in a public hospital, by diagnosis, 2019–20 to 2023–24

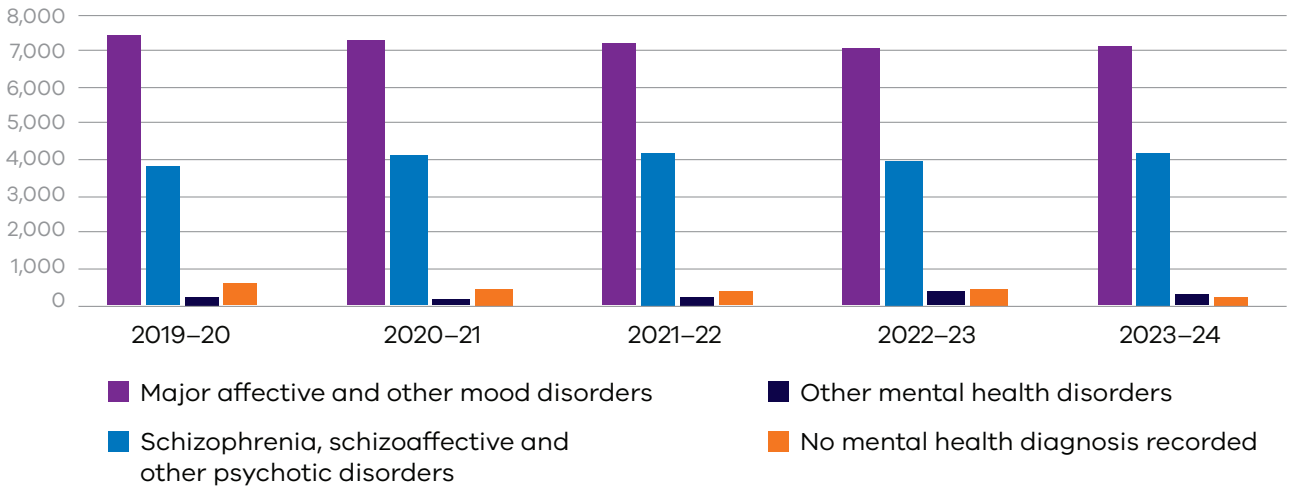


Table 2: Number of ECT treatments in a public hospital, by diagnosis, 2019–20 to 2023–24

Health conditions	2019–20	2020–21	2021–22	2022–23	2023–24
Major affective and other mood disorders	7,442	7,255	7,168	7,074	7,129
Schizophrenia, schizoaffective and other psychotic disorders	3,811	4,104	4,215	3,941	4,214
Other mental health disorders	233	167	214	357	304
No mental health diagnosis recorded	621	456	350	415	213

Notes: This table corresponds with the graph in Figure 1. It is included for purposes of accessibility.
ECT data is continuously revised as new treatments are recorded in the data system used by mental health services. As such, figures may vary slightly between annual reports from previous years.

Figure 2 and Table 3 show the age range of those receiving ECT and that, overall, more women than men were treated with ECT across the life span.

Figure 2: Number of ECT treatments, by age group and sex, 2023–24

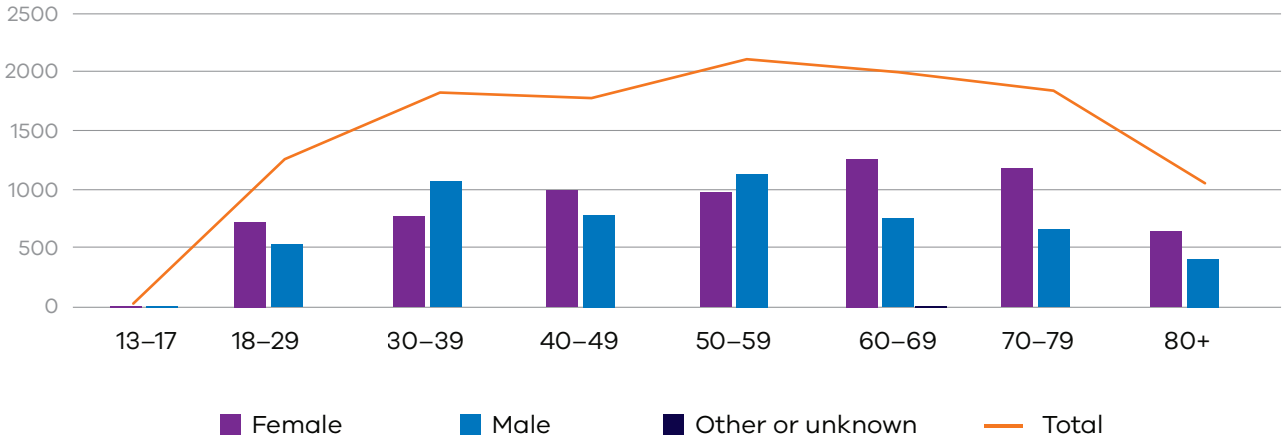


Table 3: Number of ECT treatments, by age group and sex, 2023–24

	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+	Total
Female	13	727	769	992	971	1,249	1,182	647	6,550
Male	12	526	1,059	776	1,122	751	657	401	5,304
Other or unknown	0	0	0	0	6	0	0	0	6
Total	**25**	**1,253**	**1,828**	**1,768**	**2,099**	**2,000**	**1,839**	**1,048**	**11,860**

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

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 are, or had been in the previous 3 months, a registered mental health consumer or who had sought care from a mental health provider even though it had not led them to being a registered mental health consumer
- 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, including through the Chief Psychiatrists Sentinel Event Review Subcommittee
- to identify statewide issues and provide guidance to mental health services to reduce and prevent deaths and to provide safe and effective care.

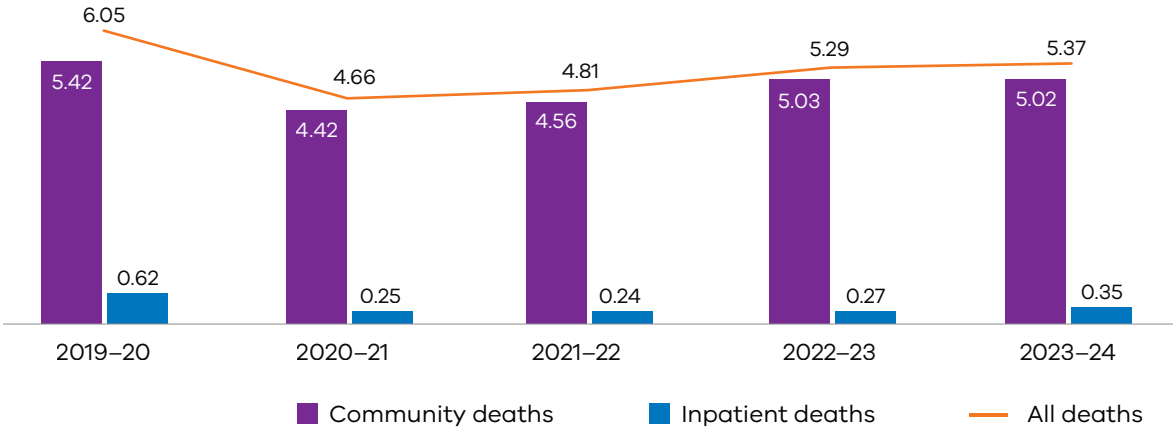
The Chief Psychiatrist works with the Coroners Court to match data and identify suicides of people who were recently discharged from a mental health service. The Chief Psychiatrist also collaborates with the Suicide Prevention and Response Office in the Victorian Department of Health by cross-checking data to better identify deaths and improve safety and the quality of care for those receiving mental health care. This data is used to detect suicide in specific areas or demographics, enabling the Department of Health to take early action in support of services responding to suicide clusters.

Reportable deaths in 2023–24

In 2023–24 mental health services reported 389 deaths, of which 25 were defined as 'inpatient deaths' (Figure 3 and Table 4). Nine of these 25 deaths were recorded as suicide. The overall number of inpatient deaths encompasses the deaths of people while on leave, shortly after their discharge or following their transfer to another type of ward.

When adjusted for population, inpatient deaths show some variability across the years, which we believe to relate mostly to the small number of inpatient deaths each year. Community deaths remain consistent. The figures in this report also include reported deaths in custodial settings as part of the new reporting requirements under the Act.

Figure 3: Reportable deaths per 100,000 Victorian population, 2019–20 to 2023–24



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

Table 4: Reportable deaths per 100,000 Victorian population, 2019–20 to 2023–24

Measure	2019–20	2020–21	2021–22	2022–23	2023–24	Average
Community deaths	5.42	4.42	4.56	5.03	5.02	4.89
Inpatient deaths	0.62	0.25	0.24	0.27	0.35	0.35
All deaths	6.05	4.66	4.81	5.29	5.37	5.24

Note: This table corresponds with the graph in Figure 3. It is included for purposes of accessibility.

Of the 389 notified deaths in 2023–24 (Table 5), the cause of death has yet to be determined in 33% of instances. Medical causes accounted for 25%. Suicides accounted for 34%. Suicide data is cross-validated with reports received from the Coroners 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 and updates the dataset. This may be several years after a 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 activate detailed reports from health services. These reports are reviewed by the Chief Psychiatrist's Sentinel Event Review Subcommittee supported by a panel of senior clinicians of various disciplines and consumer and carer representatives. The panel makes recommendations to services to reduce the possibility of a recurrence. The panel may also make recommendations to enhance the rigor of service review processes. Important lessons are communicated to services through the Chief Psychiatrist's *Quality and Safety Bulletin*.

Table 5: Reportable deaths by category, 2023–24

Category	Community Patient	Inpatient	Total	Proportion
Accident/misadventure	31	1	32	8%
Homicide	1	0	1	0.26%
Medical condition	86	10	96	25%
Not yet known	122	5	127	33%
Suicide	124	9	133	34%
Total	**364**	**25**	**389**	**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 389 notified deaths, 23 were deemed out of scope. These encompass deaths in private hospitals and community support services or where the death was not judged as not unexpected, unnatural or violent.

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% because of rounding.

Restrictive interventions

Restrictive interventions are defined in the Act as 'seclusion, bodily restraint or chemical restraint' (s 3(1)):

- Seclusion means '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'.
- Bodily restraint means 'physical restraint, or mechanical restraint, of a person'.
  - Physical restraint means 'the use by a person of their body to prevent or restrict another person's movement but does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to—
    (a) enable the person to be supported or assisted to carry out daily activities; or
    (b) redirect the person because they are disoriented'.
  - Mechanical restraint means 'the use of a device to prevent or restrict a person's movement'.
- Chemical restraint means 'the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment'.

The Chief Psychiatrist is committed to supporting services to reduce and eventually eliminate restrictive interventions as identified in the Royal Commission's recommendations and the National Mental Health Commission's *Seclusion and Restraint Declaration*.

The Act has brought a greater emphasis on reporting restrictive practices that occur in all parts of designated mental health services, including in emergency departments and medical wards. It also introduced the reporting of chemical restraint for the first time in Victoria. This provides greater governance of restrictive practices, and the Office of the Chief Psychiatrist is involved in the oversight of more instances of restrictive practice.

Owing to extra reporting outside mental health environments, the data reflects the expanded reporting and oversight of restrictive practices under the Act. Increased reporting and oversight ensures the Chief Psychiatrist can more effectively monitor and assist health services to reduce their restrictive practices.

The increased reporting and oversight provide opportunities for health services to better appreciate the impacts of restrictive practices and to monitor and address restrictive practices strategically. The broader capture of restrictive interventions enables the OCP and services to better target areas of greater risk across the health sector.

The OCP continues to convene the Chief Psychiatrist's Restrictive Intervention Committee and has expanded the membership to include a greater variety of voices. There is also increased membership from medical leadership, which will assist the sector in further reducing restrictive interventions, particularly in emergency departments and medical wards. The committee regularly receives updates on work being done for reducing and eventually eliminating restrictive practices. Members also provide feedback to the OCP on matters of concern to the community.

Acute inpatient units – episodes of restrictive interventions

Table 6 shows the number of episodes of bodily restraint and seclusion in acute inpatient units over the past 5 years. The use of bodily restraint and seclusion decreased in 2023–24 compared with previous years. We believe this reflects the increased quality improvement focus and acceptance of the key principle of the Royal Commission that restrictive interventions are not therapeutic.

Table 6: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2019–20 to 2023–24

Intervention	2019–20	2020–21	2021–22	2022–23	2023–24
Bodily restraint episodes	8,269	8,329	7,557	6,560	6,257
Seclusion episodes	3,575	3,653	3,316	2,812	2,290

In 2023–24 seclusion in acute inpatient units showed an age/sex difference, highlighting the predominance of middle-aged men experiencing seclusion (Figure 4 and Table 7).

Figure 4: Number of seclusion episodes in acute inpatient units, by age and sex, 2023–24

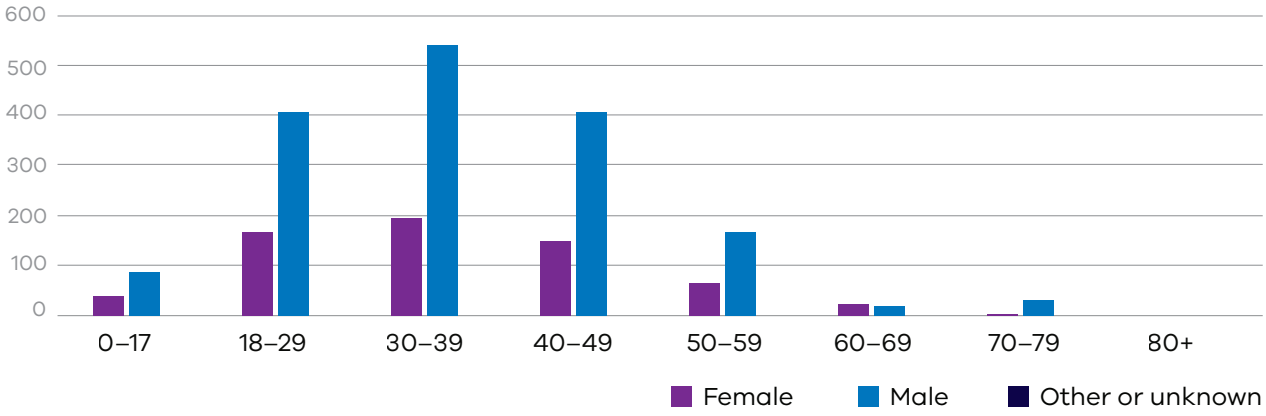


Table 7: Number of seclusion episodes in acute inpatient units, by age and sex, 2023–24

Sex	0–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	37	166	193	148	65	21	5	n.p.
Male	87	405	538	407	166	18	31	n.p.
Other or unknown	n.p.	0	0	0	0	0	0	0

Notes: This table corresponds with the graph in Figure 4. It is included for purposes of accessibility.
Some age groups have been further aggregated to protect the confidentiality of individuals.
n.p. refers to data that is not published due to low numbers. This is done to protect the confidentiality of individuals.

For bodily restraint, most episodes were among the 30 to 39-year-old age group in both sexes (Figure 5 and Table 8).

There is a difference in bodily restraint episodes between sexes, with episodes being more frequent in males, except in the 13 to 17 and the 60 to 80+-year-old age groups, where it was more frequent in females than males.

Figure 5: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2023–24

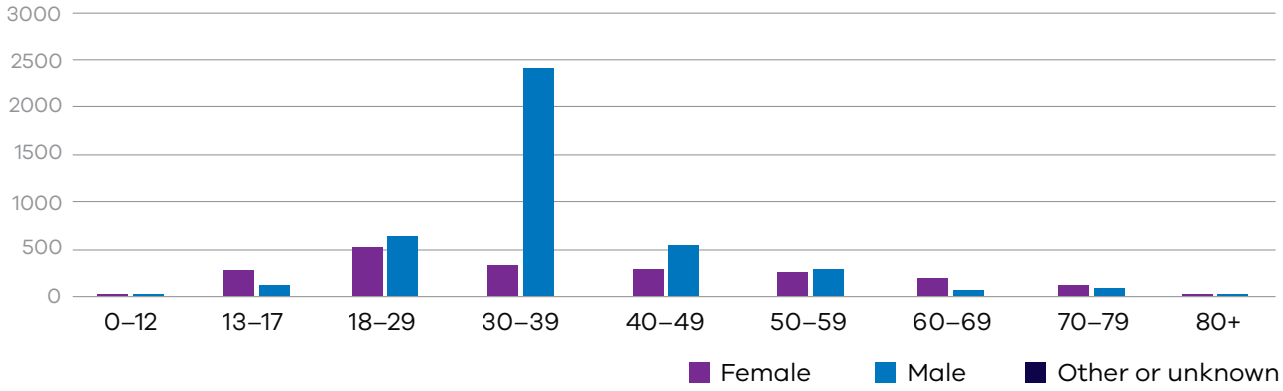


Table 8: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2023–24

Sex	0–12	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	5	272	528	335	290	255	191	130	27
Male	15	123	642	2,418	541	293	72	88	20
Other or unknown	0	n.p.	n.p.	0	0	0	0	0	0

Notes: This table corresponds with the graph in Figure 5. It is included for purposes of accessibility.
Some age groups have been further aggregated to protect the confidentiality of individuals.

Acute inpatient units – rates of seclusion

Figure 6 and Table 9 present the numbers of episodes of seclusion per 1,000 occupied bed days. Rates have fallen in adult wards over the past 5 years and remain low in services for older people. The rate in child and adolescent units has decreased, with a small number of young people with complex combinations of mental illness and intellectual or developmental disability being represented in these figures. The OCP assists services to escalate coordination of care of these young people through multiagency collaboration, including with the Department of Fairness, Families and Housing and the National Disability Insurance Agency.

Forensicare has undertaken extensive quality improvement activities around restrictive practices, and it is pleasing to see the improvement in their figures over recent years (Table 9).

Figure 6: Rate of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2019–20 to 2023–24

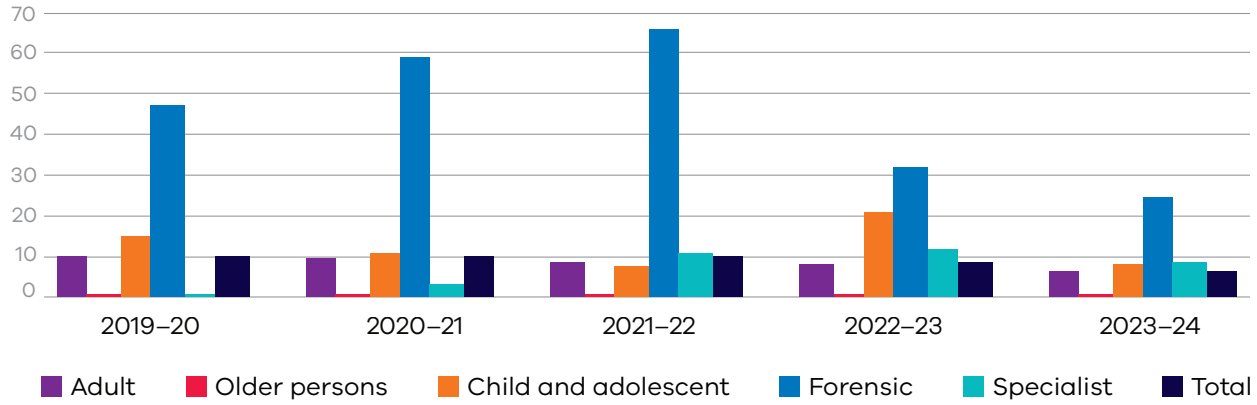


Table 9: Rate of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2019–20 to 2023–24

Type of unit	2019–20	2020–21	2021–22	2022–23	2023–24
Adult	10.0	9.5	8.5	8.0	6.5
Older persons	0.6	0.6	0.2	0.4	0.7
Child and adolescent	14.6	10.7	7.6	20.4	8.1
Forensic	47.3	58.7	65.8	31.8	24.4
Specialist	0.5	3.2	10.6	11.6	8.7
Total	**10.0**	**10.3**	**9.8**	**8.3**	**6.3**

Note: This table corresponds with the graph in Figure 6. It is included for purposes of accessibility.

Table 10 shows that, when seclusion happened, it typically occurred once within an admission to hospital. For those receiving multiple episodes of seclusion, these typically occur as services work to trial transitioning the person out of seclusion. There are a small number of consumers experiencing multiple episodes of seclusion. This generally reflects severe and complex mental illness and risks to others in the inpatient environment.

Table 10: Frequency of ended seclusion episodes within a single inpatient admission, 2019–20 to 2023–24

Frequency	2019–20	2020–21	2021–22	2022–23	2023–24
1	796	789	637	599	655
2	212	205	178	174	178
3	103	100	73	70	91
4	61	50	60	49	46
5	34	31	33	30	14
6	20	22	17	19	9
7+	85	80	60	63	55

Table 11 shows that in 2023–24 close to half of all episodes of seclusion lasted for 4 or fewer hours, consistent with most previous years. There was a significant reduction in the numbers of seclusions that went beyond 12 hours, which is a positive development. The occasions of seclusion beyond 12 hours are closely monitored by the OCP, as are seclusions that are beyond 4 hours for those aged 65 or older and those aged 18 or younger.

Table 11: Duration of ended seclusion episodes in acute inpatient units, 2019–20 to 2023–24

Duration	2019–20	2020–21	2021–22	2022–23	2023–24
≤ 4 hours	1,852	1,716	1,512	1,453	1,110
4–12 hours	726	767	580	612	566
> 12 hours	997	1,170	1,224	747	614

Acute inpatient units – rates of restraint

Bodily restraint refers to physical restraint (placing hands on a person to restrict movement) and mechanical restraint (using a device to prevent or restrict a person's movement). The Act requires mental health services to inform the Chief Psychiatrist of both types of practice.

Chemical restraint is now defined as a restrictive intervention in the Act. As with bodily and physical restraint, the use of chemical restraint must also be reported to the Chief Psychiatrist. The OCP is working with services to standardise reporting processes across Victoria, and will be including chemical restraint data in future annual reports once this work is completed and there is greater reliability in the data (see below).

Figure 7 and Table 12 show that bodily restraint episodes per 1,000 occupied bed days have again decreased overall, with most types of units trending in this direction. Child and adolescent units have decreased over 3 financial years. Forensic units have a slight increase this year while trending down significantly since 2019–20.

Figure 7: Rate of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2019–20 to 2023–24

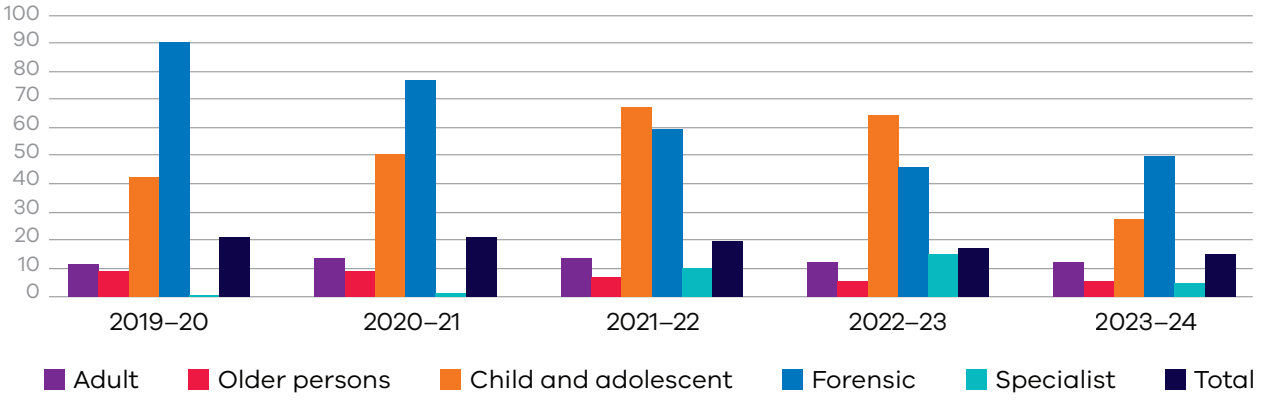


Table 12: Rate of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2019–20 to 2023–24

Type of unit	2019–20	2020–21	2021–22	2022–23	2023–24
Adult	11.8	13.4	13.7	12.5	12.0
Older persons	8.9	8.5	6.4	5.3	5.4
Child and adolescent	42.3	50.4	66.8	64.6	27.3
Forensic	90.3	76.5	59.7	45.8	50.2
Specialist	0.8	1.1	10.2	15.2	4.7
Total	**20.8**	**21.0**	**19.8**	**17.0**	**15.2**

Note: This table corresponds with the graph in Figure 7. It is included for purposes of accessibility.

'Physical only' restraint accounted for most instances of restraint (Table 13). The number of episodes of mechanical restraint has increased slightly in 2023–24, as has the physical-only type of restraint. This may be due to the increased reporting required under the Act. The number of episodes where mechanical and physical restraint were used simultaneously has increased slightly. However, this likely reflects more accurate reporting of instances where a person was physically restrained before applying mechanical restraints. The OCP will continue to monitor this.

Table 13: Number of bodily restraint episodes in acute inpatient units, by type of bodily restraint, 2019–20 to 2023–24

Restraint type	2019–20	2020–21	2021–22	2022–23	2023–24
Mechanical and physical	113	102	79	149	154
Mechanical only	399	394	561	341	364
Physical only	7,757	7,833	6,917	6,070	5,739

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

When restraint was applied, it was still most commonly a single occurrence within one admission (Table 14). However, multiple episodes of restraint are not uncommon, and this pattern has not significantly changed in recent years. As with seclusion, increased awareness of trialling people out of restraints may lead to more separate episodes of restraint.

Table 14: Frequency of ended bodily restraint episodes within a single inpatient admission, 2019–20 to 2023–24

Frequency of episode	2019–20	2020–21	2021–22	2022–23	2023–24
1	1,008	1,048	934	855	843
2	321	364	343	307	355
3	142	163	154	119	177
4	86	101	81	88	78
5	58	59	49	47	39
6	33	45	41	44	37
7+	181	167	163	139	122

With respect to duration, there continues to be a decrease in the number of episodes of restraints lasting less than 15 minutes (Table 15). Many restraints are less than 3 minutes and may indicate the use of restraint to administer medication or to guide a person towards a different space. While acknowledging the goal of zero restrictive interventions, there is a positive reduction from 35 restraints exceeding 12 hours in 2019–20 to 3 instances in 2023–24.

Table 15: Duration of physical, mechanical and combined bodily restraint episodes, 2019–20 to 2023–24

Duration	2019–20	2020–21	2021–22	2022–23	2023–24
Less than 3 minutes	5,365	5,738	4,966	4,387	4,909
≥ 3 to < 15 minutes	2,330	2,012	1,910	1,669	931
≥ 15 to < 30 minutes	165	207	193	189	119
≥ 30 to < 45 minutes	68	85	82	73	52
≥ 45 minutes to < 1 hour	49	66	84	46	37
≥ 1 to < 4 hours	202	158	243	167	181
≥ 4 to < 12 hours	55	45	57	14	25
≥ 12 hours	35	18	22	15	3

Secure extended care units

Secure extended care units, or SECUs, are inpatient bed units that provide for the needs of consumers facing complex challenges. SECUs offer the opportunity for consumers facing complex challenges to benefit from a longer length of stay with a rehabilitation focus.

Seclusion – secure extended care units

Table 16 shows that seclusion episodes per 1,000 occupied bed days in SECUs decreased in 2023–24 relative to the previous year. It is likely that the years 2019 to 2022 reflect the effects of the pandemic including limitations on leave and access to visitors (including support staff) and staffing shortages. 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 practices. The OCP will continue to monitor SECU programs to ensure work continues to reduce restrictive practices in these areas.

Table 16: Rate of seclusion episodes per 1,000 occupied bed days, secure extended care units, 2019–20 to 2023–24

Type of unit	2019–20	2020–21	2021–22	2022–23	2023–24
SECU	3.7	4.0	3.5	2.2	2.1

Restraint – secure extended care units

There has been a continued downward trend with a plateau of restraint episodes per 1,000 occupied bed days over 2022-23 and 2023-24 of 2.1, since a peak of 4.0 in 2019–20 (Table 17).

Table 17: Rate of ended bodily restraint episodes per 1,000 occupied bed days, secure extended care units, 2019–20 to 2023–24

Type of unit	2019–20	2020–21	2021–22	2022–23	2023–24
SECU	4.0	3.6	3.2	2.1	2.1

Restrictive interventions in emergency departments and urgent care centres

Urgent care centres are GP-led care centres for people needing urgent care but not requiring emergency care. Urgent care centres are being delivered in partnership with the Victorian Primary Health Networks.

Restrictive interventions on people receiving a mental health and wellbeing service in an emergency department or the urgent care centre of a designated mental health service are subject to the same regulations and oversight under the Act as other parts of a designated mental health service. Also, any restrictive practise of a mental health consumer in a general hospital bed is also subject to reporting requirements.

These reporting requirements are new and therefore rates are not yet consistent across services. This data will be presented in future years. It is anticipated that rates will rise over the next few years as reporting compliance improves with awareness.

The practice of using physical and mechanical restraint is potentially more common in emergency departments and medical wards where the environment is less able to be modified for individual needs.

Seclusion is not a permitted restrictive intervention in emergency departments and urgent care centres. The confinement of any person alone in an enclosed space without a means of exit is not permitted.

Chemical restraint

Administering medication (or a 'drug' in the Act) should be understood as chemical restraint when the primary purpose of administering the medication is to exert control over a person's behaviour. There may be ambiguity when the medication has the effect of both controlling behaviour and treating the underlying cause. In situations of ambiguity, the primary purpose for providing the medication must be considered.

The OCP expected that because this is new reporting criteria for Victoria that the data will not be accurate in the first year.

The Chief Psychiatrist is aware of variation in reporting as services continue to navigate the ambiguity and tension between treatment and/or control. The OCP has plans for working with service providers to calibrate the reporting across the services and Victoria. This data will be provided in future years.

Sexual safety

Sexual safety in mental health and wellbeing services is a priority for the Chief Psychiatrist, who has a statutory obligation to provide clinical leadership and guidance to strengthen quality and safety and promote consumer rights. Everyone in mental health services has a right to feel safe. Services have a responsibility to prevent sexual safety incidents from occurring and a duty of care to create environments that are safe.

The Royal Commission noted the need for immediate action to address gender-based violence in mental health and wellbeing services. Recommendation 13 outlined significant reform including ensuring each facility meets the minimum standards for sexual safety set out in the Chief Psychiatrist's guideline. The Chief Psychiatrist guideline and reporting directive can be found on the OCP website <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>.

The Chief Psychiatrist's guideline *Improving sexual safety in mental health and wellbeing* services was developed in consultation with the sector, including with people with lived and living experience, incorporating the mental health and wellbeing principles of the Act. The guideline sets out the relevant legislation and policy and establishes minimum standards for:

- promoting sexual safety
- supporting human rights
- assessing and managing risks
- identifying and responding to incidents
- reporting sexual safety incidents.

The Chief Psychiatrist is supported by a sexual safety committee that has multidisciplinary representation from the mental health sector. This includes from metropolitan and regional/rural areas, across age ranges, lived and living experience, Safer Care Victoria and unions.

Mental health services must appropriately respond to, and report, any alleged, witnessed or suspected occurrence of sexual harassment or sexual assault, and in most cases sexual activity. Mental health services must develop local policies, procedures and governance structures in consultation with consumers, families, carers and supporters that support sexual safety and are consistent with the Chief Psychiatrist guideline.

Sexual safety incident data

Until now, sexual safety data was not made publicly available through the annual report because of being inconsistently collected and open to misinterpretation. Significant work has gone into improving and validating the data to the point where it now has a high degree of reliability and can be published and drawn on to enable improvements in care.

The OCP has worked with mental health services to improve sexual safety reporting systems in the past 12 months. This has led to strengthened reporting compliance across the state, with consistent and timely reporting and a focus on improving the quality and safety of services for consumers, staff and visitors.

All bed-based clinical mental health service providers (including those in hospital, custodial and community settings) must report sexual safety incidents via the Victorian Health Incident Management System (VHIMS). Data includes incidents involving consumers, staff and visitors.

This process has gradually been introduced to bed-based mental health service providers. Starting from November 2023 all bed-based mental health service providers have reported sexual safety incidents via this method. The data presented here for 2023–24 does not include all service providers reporting before November 2023.

The Chief Psychiatrist's reporting directive requires services to report incidents with an incident severity rating (ISR) of 1 or 2 directly to the OCP for clinical review. Incidents with an ISR of 3 or 4 must be reported to the OCP as an extract of this data from service providers on a monthly basis.

ISRs refer to the following circumstances:

- ISR 1 – sexual safety incident that has caused substantial harm
- ISR 2 – sexual safety incident that has caused moderate harm, requiring an increased level of care
- ISR 3 – sexual safety incident that has caused minimum harm, requiring no additional care
- ISR 4 – sexual safety incident that was avoided or no harm was caused.

ISR calculations are based on a World Health Organization algorithm, adapted and refined by subject matter experts from Victorian public health services to support VHIMS incident classification and reporting. The ISR is derived from the response to 3 questions. The questions relate to level of harm, required level of care and level of treatment required. ISR 1 represents the highest level of harm, required level of care and level of treatment required, while ISR 4 is the lowest level.

The total number of sexual safety incidents recorded is less than the total number of individuals involved in a sexual safety incident (Table 18). Several individuals may be involved in a single incident. For example, if a person makes sexually explicit comments, this may be reported by the individuals affected by or involved in a sexual safety incident. The estimated number of incidents that have occurred has been derived by counting reports with a matching date, time and location.

Table 18: Estimated number of sexual safety incidents and number of individuals involved in a sexual safety incident, 2023–24

Total number	2023–24
Estimated number of sexual safety incidents	1,295
Number of individuals involved in a sexual safety incident	1,764

The reporting of sexual safety incidents enables improvements to safety in mental health services.

In 2023–24, 1,764 individuals experienced sexual safety incidents in bed-based mental health services (Table 19). While the majority of these were in severity rating ISR 3 and 4, the Chief Psychiatrist is concerned about all sexual safety incidents and continues to work with services to improve their clinical governance and quality and safety systems.

Table 19: Number of individuals involved in a sexual safety incident by ISR, 2023–24

ISR	2023–24
1	1
2	22
3	254
4	1,487
Total	**1,764**

Figure 8 and Tables 20 and 21 provide more information on the numbers of people involved in sexual safety incidents in 2023–24.

Figure 8: Number of individuals involved in a sexual safety incident by age group and gender, 2023–24

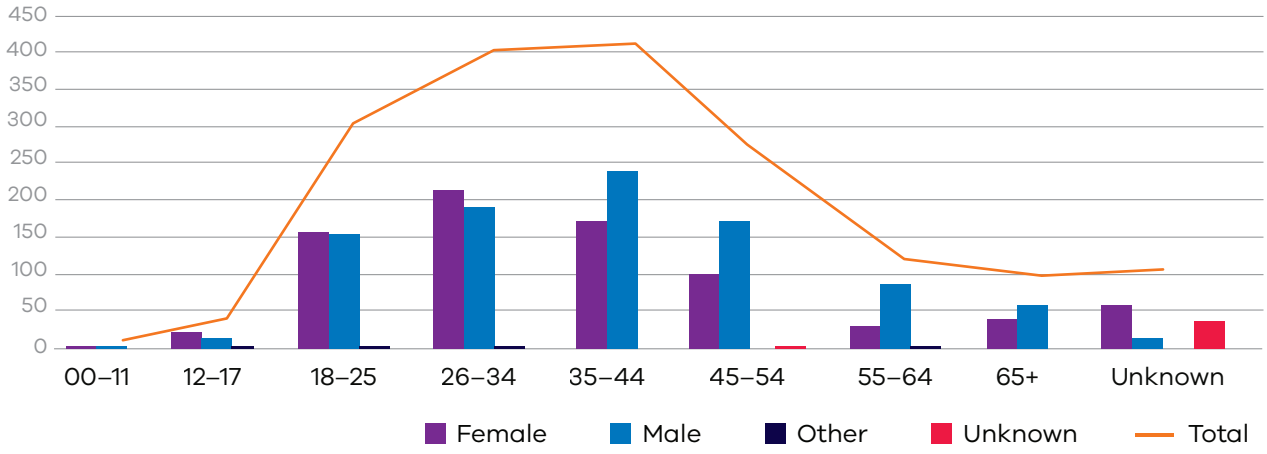


Table 20: Number of individuals involved in a sexual safety incident by age group and gender, 2023–24

Gender	0–11	12–17	18–25	26–34	35–44	45–54	55–64	65+	Unknown	Total
Female	2	23	156	213	170	101	31	39	57	792
Male	1	12	154	192	239	171	86	58	14	927
Other	0	1	2	1	0	0	3	0	0	7
Unknown	0	0	0	0	0	2	0	0	36	38
Total	**3**	**36**	**312**	**406**	**409**	**274**	**120**	**97**	**107**	**1,764**

Note: This table corresponds with the graph in Figure 8. It is included for purposes of accessibility.

Table 21: Number of individuals involved in a sexual safety incident by Mental Health and Wellbeing Act status, 2023–24

Act status	Number
Compulsory	1,219
Voluntary	317
Staff	182
Unknown	46
Total	**1,764**

Through the incident reports received, it was determined that females under 35 and males over 35 were more likely to be involved in sexual safety incidents. Sexual safety incidents predominantly involved people with a compulsory status under the Act. This warrants further understanding of the role of multiple factors that can contribute to involvement in a serious sexual incident including but not limited to the person's mental health status, the care they receive and where they receive it.

Statewide Complex Needs Advisory Panel

Formerly, the OCP convened the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* Complex Needs Advisory Panel (CCNAP). This arose from the initiatives of the Complex Needs Project, which was a joint Department of Health and Department of Families, Fairness and Housing project aimed at improving the service responses for people with complex needs. CCNAP was originally established following a recommendation from the Victorian Ombudsman, with the panel's purpose being to advise decision-makers on coordinated service responses for people subject to Crimes (Mental Impairment and Unfitness to be Tried) Act proceedings or orders.

In 2023, after an extensive review of the CCNAP, which included stakeholder engagement and an expanded panel eligibility with the aim of adding to the panel membership, the OCP established the Statewide Complex Needs Advisory Panel (SCNAP).

The panel brings experts together from across departments and services to provide multidisciplinary, clinical and lived experience advice for people with highly complex needs who pose a serious risk to themselves or others.

The individuals presented are at risk of poor outcomes due to their needs falling outside standard service responses. They also face such challenges as service system barriers, the service system not having appropriate options, or existing pathways being ineffective, exhausted or unsustainable. The panel discussions seek to enable and enhance the development of coordinated, flexible and evidence-based service responses.

The panel's core purpose is to:

- discuss, consider and provide multidisciplinary expert advice and recommendations in response to identified questions relating to people with complex needs
- advocate and support pathways into services for people with complex needs
- review bespoke service responses (models of care) and provide multidisciplinary expert advice and recommendations to senior departmental decision-makers and service providers
- monitor the outcomes of interventions and provide further advice if appropriate.

The panel's systemic focus and functions include to:

- consider identified policy, practice and improvement opportunities and provide multidisciplinary expert advice and recommendations to senior departmental decision-makers
- address ongoing opportunities for systemic improvement by identifying, collating and escalating service gaps and barriers for people with complex needs
- report regularly to Deputy Secretaries on the advice and outcomes of the panel via the panel's annual report

Consultation, advice and panel activities

In 2023–24 the OCP provided complex needs advice and consultation to departments, services and care teams relating to 41 people. This advice was delivered by attending 134 case conferences, consults or care team meetings. A Deputy Chief Psychiatrist was present for 44% (59) of these meetings to provide expert mental health advice.

There were 7 panels held to discuss people who met the eligibility criteria. There were 2 other panels convened: one in December 2023 to discuss the panel's impact and effectiveness and identifying opportunities for improvement, and one in February to review and endorse the 2023 SCNAP annual report.

Custodial settings

Under the Mental Health and Wellbeing Act, the Chief Psychiatrist's jurisdiction was expanded to include mental health and wellbeing services in custodial settings. As of 1 September 2023 specialist mental health services in prison and youth justice settings came under the oversight of the Chief Psychiatrist.

The OCP has worked with Forensicare and Orygen to help expand their reporting to cover mental health services in prison and youth justice settings. The data available from these settings is included with the rest of the mental health sector data in this report.

The successful implementation of the Chief Psychiatrist's expanded role into prison and youth justice settings relies on a collaborative and coordinated relationship with the Department of Justice and Community Safety.

The OCP has been working with the Department of Justice and Community Safety to support the reviews of reportable deaths that have occurred in custodial settings since 1 September 2023 with a view to improving the safety and quality of mental health care in those settings. The OCP has taken part in reviews relating to 6 deaths in custodial settings since the Act came into effect last year.

The OCP has been a member of the working group for the Recommissioning of Forensic Mental Health services in prison. The OCP is working with Department of Justice and Community Safety to develop new quality standards for mental health care in prisons.

River Unit

River Unit is an 8-bed mental health unit at Cherry Creek Youth Justice Centre that is staffed by Orygen and Youth Justice. It opened in July 2024 and is the first bed-based mental health unit in a Victorian youth justice facility. The OCP's work in 2023–24 included collaborating with the Department of Health and Justice Health to prepare for the opening by:

- reviewing operating procedures and guidelines
- undertaking reporting exercises with Orygen, Justice Health and Youth Justice
- meeting with stakeholders.

The majority of reporting that will occur in youth justice settings will relate to care provided in the River Unit.

Forensic Advisory Groups

The Forensic Advisory Groups have been formed to support the Chief Psychiatrist in their role. The OCP has initiated 2 such groups – one with an adult focus and one with a focus on young people involved with the justice system. These Forensic Advisory Groups bring together experts within the sector to connect and discuss the issues affecting the quality and safety of mental health care for people involved with the justice system. The groups play a key role in advising the Chief Psychiatrist on the systemic issues impacting mental health consumers in contact with the justice system, and on what more integrated and effective health care might look like. They provide a forum to connect services and professionals around shared issues, with meetings occurring quarterly.

Transfer of Care Project

Issues in the transfer of care process for justice-involved consumers have been at the centre of a number of coronial findings. In 2023–24 the OCP worked with a range of stakeholders to understand the challenges and barriers to ensuring effective transfers of care for this group. The project will lead to the development of a guideline for transfers of care involving justice-involved consumers.