Chief Psychiatrist's annual report 2024–25

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 Victorian mental health system.

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Foreword from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist's annual report for 2024–25.

The Office of the Chief Psychiatrist (OCP) provides statutory oversight, clinical governance and leadership functions across Victoria's designated mental health services (DMHSs) and works closely across the mental health sector, with key system service stewards, Safer Care Victoria, the Mental Health Tribunal, the Mental Health and Wellbeing Commission, Independent Mental Health Advocacy and key lived and living experience peak bodies Victorian Mental Illness Awareness Council and Tandem to deliver a connected mental health system.

The OCP supports quality and safety of care through monitoring restrictive interventions, sexual safety, electroconvulsive therapy and the deaths of people in the care of a DMHS. It also publishes clinical guidelines, supports the broader mental health and wellbeing sector through regular meetings, provides clinical leadership, assists services with complex individual presentations and care planning and responds to serious clinical incidents to improve the quality and safety of care.

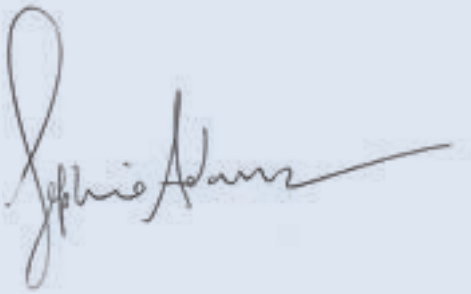
This year's annual report covers the period a year on from implementing the new *Mental Health and Wellbeing Act 2022* in September 2023. It is presented in the context of ongoing work to realise the vision of the Royal Commission into Victoria's Mental Health System to achieve transformative reform.

The mental health sector has continued to work towards transformational change, with further work on embedding the mental health and wellbeing principles and a focus on human rights. We have been aligning requirements for reporting restrictive interventions and publishing the restrictive interventions report, working on expanding reporting obligations into physical health and custodial settings and extending our role in clinical governance with a focus on enhancing strengths alongside regulatory approaches.

A key priority over the past year has been on building visibility and engagement across the sector, with site visits to all DMHSs, creating the quarterly OCP quality and safety forums, responding to system-wide safety and quality concerns via bulletins and newsletters, working with the

department's Mental Health and Wellbeing Division on performance meetings with health services and developing the white paper on risk formulation and mitigation.

I am fortunate to have a committed multidisciplinary team of skilled and compassionate people who are dedicated to improving Victoria's mental health and wellbeing system supporting this work. I acknowledge and thank the OCP staff for their substantial efforts to support the mental health and wellbeing sector. Our vision is to enhance clinical standards using modern clinical governance approaches. We provide connection vertically and horizontally across the sector and through visibility of clinical expertise, seeking to create a safe base for the mental health sector to flourish.



Associate Professor Sophie Adams
Chief Psychiatrist
MBBS, MBioethics, MHLM, PhD, GAICD, FRACMA, FRANZCP

A year at a glance

1,903
mental health-related enquiries received

18 of 22
designated mental health services visited

2
quality and safety clinical forums held

greater clarity
on how to report chemical restraint

28%
reduction in bodily restraint over 5 years

stable
rates of ECT remain

stable
rates of deaths remain

better reporting
of sexual safety incidents

stable
use of Mental Health and Wellbeing Act

68
individuals supported by the Complex Needs Team

6
prison site visits conducted

3
reviews of deaths in custodial settings undertaken

publication
of white paper on principles of mental health risk assessment

Definitions and acronyms

Authorised Psychiatrist: A psychiatrist appointed by a designated mental health service under s 328 of the Mental Health and Wellbeing Act to carry out functions and exercise powers conferred under that Act and to support the Chief Psychiatrist to perform their functions. An Authorised Psychiatrist can delegate a function or power to certain individuals under s 329 of the Act.

Bodily restraint: Physical or mechanical restraint of a person.

Carer: The same meaning as in s 3 of the *Carers Recognition Act 2012* and is defined by the care relationship between 2 individuals. It does not include a parent if the person to whom care is provided is under the age of 16 years.

Chemical restraint: 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.

Clinical mental health service provider: Either a designated mental health service, a mental health and wellbeing service provider in a custodial setting, or any other prescribed entity or prescribed class of entity.

Consumer: A person who either:

- has received mental health and wellbeing services from a mental health and wellbeing service provider
- is receiving mental health and wellbeing services from a mental health and wellbeing service provider
- was assessed by an Authorised Psychiatrist and was not provided with treatment, or
- has sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.

DMHS: Designated mental health service.

ECT: Electroconvulsive treatment.

Emergency department: Part of a hospital that provides 24-hour emergency care to patients who need urgent medical attention for severe injuries or illness. Most public hospitals in Victoria have an emergency department.

Family: Refers to family of origin or family of choice.

Families, carers and supporters: The network of people that support consumers with their mental health and wellbeing.

Legal requirement: Obligations that are mandatory and stipulated in the Act, and therefore must be adhered to.

HITH: Hospital in the home.

ISR: Incident severity rating.

LLE: Lived and living experience.

MARAM: Multi-Agency Risk Assessment and Management Framework.

MHWD: Mental Health and Wellbeing Division (Department of Health).

PARC: Prevention recovery centre.

Patient: an assessment patient, a court assessment patient, a temporary treatment patient, a treatment patient, a security patient or a forensic patient, as specified in s 3(1) of the Mental Health and Wellbeing Act.

Physical restraint: 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.

Restrictive intervention: Practices that limit a person's movement or freedom. Under s 3(1) of the Mental Health and Wellbeing Act, this includes seclusion, bodily restraint (physical and mechanical) or chemical restraint.

SCNAP: Statewide Complex Needs Advisory Panel.

Seclusion: 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.

SECU: Secure extended care unit.

VHIMS: Victorian Health Incident Management System

Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, families, carers and supporters, service providers and the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2024–25 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*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health and wellbeing services.

Statutory framework and role of the Chief Psychiatrist

The Mental Health and Wellbeing Act aims to improve the experiences of people using mental health and wellbeing services by actively involving and supporting them, and their families, carers and supporters, 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, families and supporters are recognised and supported in decisions about treatment and care.

Under s 265 of the Act, the Secretary of the Department of Health appoints 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 those receiving services from clinical mental health service providers
- advise the Minister for Mental Health and the departmental Secretary about services provided by clinical mental health service providers.
- Under the Act, 'clinical mental health service provider' means:
- a designated mental health service (DMHS)
- a mental health and wellbeing service provider that provides mental health and wellbeing services in a custodial setting, or
- 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 and wellbeing 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 as follows.

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 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 DMHSs of the obligation to make the principles a central part of their treatment and care.

This year the OCP partnered with Independent Mental Health Advocacy to deliver professional development sessions on the 'Principles in Practice' to psychiatrists across the state.

The Chief Psychiatrist and the OCP also promoted the mental health and wellbeing principles through presentations, panels and forums with external agencies, interest groups and stakeholders.

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 Chief Psychiatrist 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

The OCP provides a clinical advisory role to the Department of Health's Mental Health and Wellbeing Division (MHWD) and advises the Minister for Mental Health as required. This enables clinical input into future service planning, performance oversight and transformation activities.

The OCP provides clinical leadership to the sector to support the work of the MHWD and to drive the cultural change required for transformation.

The OCP undertakes a wide range of safety and quality activities including:

- monitoring compulsory treatment under the Mental Health and Wellbeing Act
- monitoring reportable deaths
- monitoring restrictive and invasive interventions, which include seclusion, restraint
- monitoring sexual safety in inpatients settings
- monitoring 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, models of care and the principles of the Mental Health and Wellbeing Act
- undertaking activities to enhance clinical standards such as site visits, clinical forums, quality and safety bulletins and other forms of communication.

The OCP works closely with Safer Care Victoria to ensure mental health and wellbeing services are safe and of a high standard. In the new mental health and wellbeing system recommended by the Royal Commission into Victoria's Mental Health System, quality and safety governance is a responsibility shared between Safer Care Victoria, the OCP and DMHSs. 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 2024–25

As part of the Chief Psychiatrist's legislated clinical leadership responsibilities, the OCP provides direct clinical leadership and governance to Authorised Psychiatrists through both formal and informal mechanisms.

In 2024–25 the OCP delivered a broad range of initiatives to support DMHSs to enhance clinical standards and foster a culture of transformation.

Key activities included:

- **Visibility and engagement:** Quality and safety clinical forums, site visits to DMHSs, ongoing engagement with clinical teams and presentations, panels and forums for external stakeholders.
- **Standard setting:** Chief Psychiatrist guidelines, Chief Psychiatrist bulletins and newsletters to promote best practice.
- **Performance governance:** Active contribution to the MHWD Performance and Commissioning quarterly program meetings with health services to support discussions about clinical governance and quality and safety. Ongoing review of service data through OCP portfolios and the monthly Chief Psychiatrist Statutory Governance Committee meetings.

Throughout the year, the OCP convened regular portfolio advisory committee meetings to seek sector input on core legislated activities including morbidity and mortality, sexual safety, restrictive practices and neurostimulation.

There were also regular structured Authorised Psychiatrist meetings and senior leader meetings for older adults and the infant, child and youth mental health and wellbeing services.

The OCP provides ongoing clinical leadership by offering regular support and guidance to mental health and wellbeing services regarding ethically, legally and clinically complex dilemmas and system demand. This ensures the best outcomes for consumers and their families, carers and supporters.

Quality and safety clinical forums

In early 2025 the OCP began a program of quarterly quality and safety clinical forums to engage the sector in quality improvement, to stimulate sector benchmarking and motivate standard improvements.

The first 2 forums, focused on emergency mental health and on neurostimulation and ECT, were held in March and June respectively.

These large, in-person events brought together senior staff from across the sector to share ideas, take part in lively facilitated discussions and provide feedback to inform policy and contemporary practice. Each forum featured consumer and carer presentations to maintain a strong focus on purpose. Ideas generated in these discussions were promoted to the sector and to the MHWD for consideration.

Feedback was positive, with robust discussions strengthening professional relationships and informing ongoing improvement and future topics and enhancing connections between services and the OCP.

Emergency Mental Health Forum

The first forum in the new series was dedicated to emergency mental health, reflecting changes to the Act that, from September 2023, extended the Chief Psychiatrist's oversight of restrictive interventions to include people receiving mental health and wellbeing services in the emergency departments or urgent care centres of a DMHS.

Senior leaders from mental health and emergency departments, as well as Victoria Police, Ambulance Victoria and sector partners, attended the full-day forum. This cross-sector senior leadership involvement promoted a shared approach to the challenges of managing mental health in acute settings.

Forum sessions focused on mental health care in emergency departments, including:

- the impacts of Mental Health and Alcohol and Other Drugs Hubs in emergency departments
- the use of chemical restraint
- consumer experiences of receiving mental health care in emergency departments
- empowering conversations and reflections from consumers and carers
- a debate on the topic 'Are emergency departments suitable places for mental health care?'.

Forum outcomes included:

- our commitment to collaborate with sector representatives to refine, update and release resources to support emergency department staff to report on chemical restraint, which led to publishing a factsheet on chemical restraint
- Department of Health's Mental Health and Alcohol and Other Drugs Hubs team gaining new insights to inform service design and thinking about crisis care
- Safer Care Victoria continuing to promote Mental Health Improvement Program initiatives.

Emergency mental health forum

Neurostimulation and Electroconvulsive Treatment Forum

Due to strong sector interest, the second forum focused on neurostimulation including ECT. Attendees included Authorised Psychiatrists, ECT directors, coordinators, senior registrars, mental health nurses and lived and living experience (LLE) representatives. The forum explored human rights considerations and emerging neurostimulation approaches relevant to public mental health settings.

Sessions covered included:

- research and clinical best practice
- human rights and the Mental Health and Wellbeing Act in ECT
- innovations in ECT and other neurostimulation treatments
- LLE consumer shared perspectives about their experience of ECT, both as a recipient and how they supported consumers, carers, families and supporters in their service.

The outcomes of the forum included:

- upskilling staff on best practice approaches
- increased awareness of human rights
- encouraging services to consider exploring opportunities to develop transcranial magnetic stimulation (TMS) and other neurostimulation treatments for public mental health consumers.

Neurostimulation and electroconvulsive treatment forum

Site visits

In 2024–25 the OCP launched a program of DMHS site visits across Victoria. The visits aimed to strengthen relationships and engagement with the workforce and to provide a platform to discuss strengths, barriers and areas for continuous improvement in clinical practice.

Visits included:

- meetings with Authorised Psychiatrists, senior clinical and operational leaders
- meetings with the LLE mental health workforce
- discussions with health service executives and emergency department leaders
- reviewing work environments to understand how they impact clinical care
- discussing insights into how services are operationalising clinical guidance and reporting requirements and what approaches are being taken to implement best practice guidance
- promoting the rights of people accessing mental health and wellbeing services
- promoting the vision of the Royal Commission into Victoria's Mental Health System for system transformation and its associated recommendations.

In 2024–25 the Chief Psychiatrist and team members visited 18 of 22 sites. The remaining visits are scheduled for 2025–26.

Designated mental health service site visits

Clinical guidelines

Under the Act, the Chief Psychiatrist is responsible for developing, publishing and promoting standards, guidelines and practice directions for providing mental health and wellbeing services. These guidelines support strong clinical governance and promote safe, high-quality, person-centred care for consumers and their families, carers and supporters.

Chief Psychiatrist guidelines are principles-based and support services by:

- providing a framework to guide local policies and procedures
- promoting consistent, therapeutic and evidence-informed care.

Key achievements in 2024–25:

- Release of 2 new Chief Psychiatrist guidelines:
  - the White paper: On the principles of mental health risk assessment
  - *Implementing the Multi-Agency Risk Assessment and Management (MARAM) Framework in mental health and wellbeing services*.
- Establishing a framework to ensure guidelines continue to be aligned with contemporary best practice. This included:
  - a comprehensive assessment of all existing guidelines
  - archiving outdated guidelines
  - identifying guidelines for review and new guidelines for development.
  - establishing an expert advisory group of diverse stakeholders from across the MHWD, DMHSs and Mental Health and Wellbeing Local Services.

Communications to the sector

In 2024–25 the OCP issued 3 Quality and Safety Bulletins to provide specialist advice on clinical practice issues raised by clinical mental health and wellbeing services. The bulletins provided a means to feedback and promote clinical governance and continuous improvement. The bulletins can be accessed on the OCP website <https://www.health.vic.gov.au/chief-psychiatrist/resources-reports-bulletins>.

The OCP also issued 3 Chief Psychiatrist newsletters, sharing updates, insights and sector-wide developments.

Enquiries to the OCP

In 2024–25 the OCP received 1,903 enquiries via our centralised email inbox and phone line. Of these, 680 enquiries (36%) related to clinical matters, including:

- 228 from consumers
- 117 from carers, families and supporters
- 335 from DMHSs and other mental health and wellbeing services about clinical matters related to individual consumers.

As the OCP does not have a complaints function, enquiries from consumers and carers are better met by contacting the local DMHS, the IMHA or the Mental Health and Wellbeing Commission. The OCP provides a warm referral onwards where possible. Support provided ranges from information and clinical advice to more sustained involvement in multidisciplinary and multiservice conferences and care planning.

The OCP has updated its phone line options to connect callers directly with the most appropriate service. This work is ongoing and will continue to evolve.

Oversight and reporting via Performance and Commissioning Branch meetings

The OCP worked closely with the MHWD's Performance and Commissioning Branch to provide clinical advice and input into performance monitoring, evaluation, quality and safety and service improvement. This helped to integrate service operational components with clinical priorities, barriers and challenges.

The specific OCP role included:

- representing clinical perspectives at Performance and Commissioning Branch-managed program meetings with DMHSs, focusing on the interface between operational matters and clinical governance, risk management and the acuity and complexity of people presenting for care that may impact on demand and performance targets
- providing clinical data and interpretation to ensure performance metrics are understood in context
- advising on operational issues intersecting with clinical governance and risk management in both bed-based and community settings
- supporting risk management where clinical and operational risks overlap. The OCP and Performance and Commissioning Branch provide immediate escalation points for high-risk scenarios.

OCP collaboration

The OCP has an advisory function to the MHWD, supporting service system development and stewardship.

In 2024–25 the OCP contributed to key areas including crisis reform, health-led responses, community service design, infrastructure planning and clinical problem-solving to address the impacts of infrastructure on consumers and their families, carers and supporters.

The OCP also has a strong partnership with Safer Care Victoria and its Mental Health Improvement Unit, which leads 4 priority initiatives:

- Towards elimination of restrictive interventions
- Improving sexual safety in mental health inpatient units
- Implementation of the Zero Suicide Framework in all Victorian health services
- Reducing compulsory treatment.

The Mental Health Improvement Unit is under the executive and clinical leadership of the Chief Mental Health Nurse, the Deputy Chief Mental Health Nurse and the Director of the Mental Health Improvement Unit. Participation in at least one of the initiatives qualifies as a deliverable in the Health Services Statements of Priorities. All Victorian DMHSs are currently taking part.

The Office of the Chief Mental Health Nurse also leads the:

- continued rollout of Safewards
- implementation of the *Equally well framework*
- development of the *Ligature safety tool*
- Health response to restrictive practises governance advisory committee.

The OCP engages closely with key sector stakeholders, including the Mental Health Tribunal, the Mental Health and Wellbeing Commission, the Collaborative Centre, Independent Mental Health Advocacy and peak bodies such as VMIAC, Tandem and Mental Health Victoria.

Clinical governance and Local Mental Health and Wellbeing Services

Local Services are not prescribed entities under the Mental Health and Wellbeing Act and are therefore not under the jurisdiction of the Chief Psychiatrist unless their clinical governance is provided by a DMHS.

The OCP is supporting a collaborative and integrated mental health and wellbeing system that prioritises access to mental health treatment, care and support at the right time in the right place, as envisioned by the Royal Commission. In 2024–25 the OCP supported the MHWD to strengthen clinical governance across the mental health and wellbeing system. This included improving escalation pathways and enhancing relationships between DMHSs and Local Services across Victoria.

National engagement

The Chief Psychiatrist is a member of the federal Mental Health and Suicide Prevention Senior Officials – Safety and Quality group, chaired by the Federal Chief Psychiatrist and attended by Chief Psychiatrists across Australia. A key contribution this year is a project on aligning sexual safety approaches federally.

The Victorian OCP was invited to lead the development of a nationally consistent approach to sexual safety in mental health and wellbeing services. This request acknowledges the leadership and progress Victoria has made in strengthening sexual safety across mental health and wellbeing services. The OCP has begun engaging with representatives from all Australian states and territories to map the current oversight responsibilities of the Chief Psychiatrists in relation to sexual safety. This collaborative effort will inform development of nationally consistent standards to guide practice and improve safety outcomes across jurisdictions.

Seclusion and restraint report 2020–24

The OCP will be publishing the *Seclusion and restraint report 2020–24* to enhance data transparency and clinical accountability for restrictive interventions in Victoria.

The report will be a comprehensive account of the use of restrictive interventions in Victoria over a 4-year period (2020–21 to 2023–24). It will contain data on rates of seclusion and restraint at the health service, state and national levels. It breaks down the data by demographics including by age group, sex and cultural background. This quantitative data will be accompanied by an explanatory narrative to contextualise trends and variations documented at different locations and time periods.

The report was developed by drawing on the OCP's clinical expertise and its system-wide oversight of clinical services. The close interface of the OCP with DMHSs made it possible to gather rich context-specific information to outline the circumstances influencing the rates of restrictive interventions being documented.

Key objectives of the report include:

- supporting public understanding of restrictive interventions through evidence-based, impartial analysis underpinned by clinical and sector knowledge
- reducing risk of misinterpretation and misinformation about restrictive interventions through comprehensive research and analysis
- the department and mental health services demonstrating their commitment to transparency
- mental health services demonstrating their commitment to clinical accountability
- increased public confidence in mental health services through transparency on rates and trends of restrictive interventions
- providing a resource for services to understand patterns of use, benchmark performance against comparable services and monitor the impact of initiatives to reduce restrictive interventions.

Statutory and oversight reporting

As part of clinical governance under the Mental Health and Wellbeing Act, the Chief Psychiatrist has statutory and oversight reporting activities. DMHSs must report to the Chief Psychiatrist on their use of restrictive interventions, ECT and neurosurgery and the deaths of mental health consumers. The OCP also collects data on Mental Health and Wellbeing Act use and on sexual safety in mental health environments.

The Chief Psychiatrist acknowledges the profound impact these events have on consumers, families, carers and supporters and the workforce and works closely with services to improve physical health outcomes and minimise the use of restrictive practices.

The OCP collects and analyses data to monitor trends, identify issues and support continuous improvement in clinical quality and safety. This section of the report provides data and analysis on ECT, restrictive interventions and consumers' deaths in 2024–25.

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.

This section contains information about suicide, self-harm and other potentially distressing topics. Reader discretion is advised. If you or someone you know is affected by these issues, support is available through local mental health services and crisis helplines.

Mental Health and Wellbeing Act use in Victoria

Figure 1: Number of active consumers, 2021–22 to 2024–25

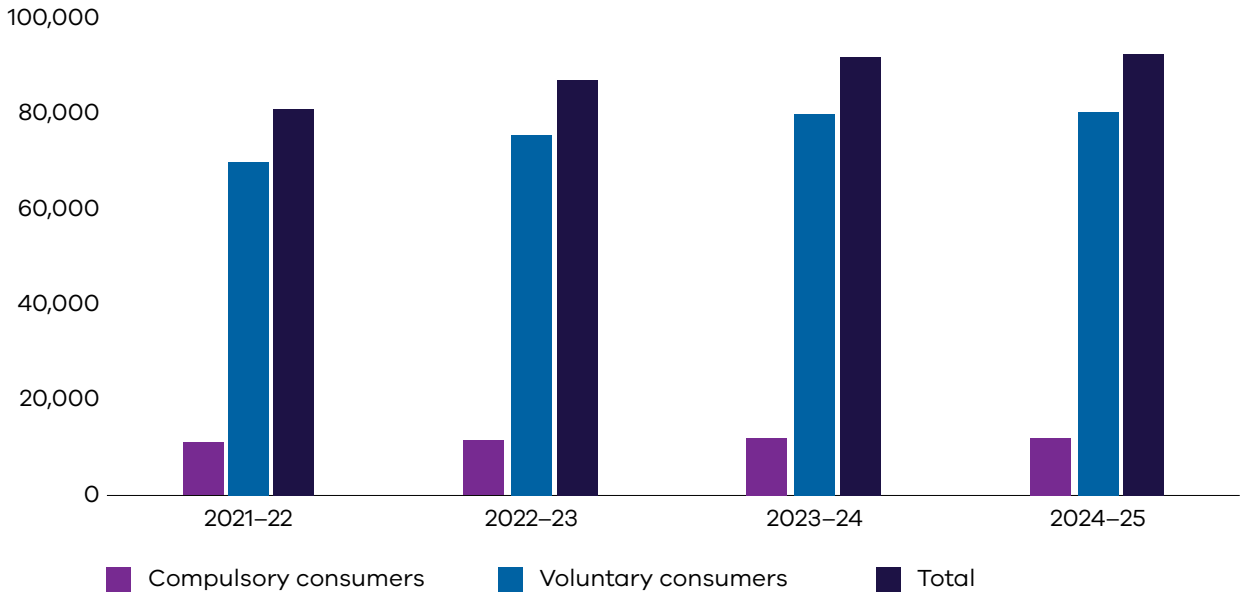


Table 1: Number of active consumers, 2021–22 to 2024–25

Type of consumer	2021–22	2022–23	2023–24	2024–25
Compulsory consumers	11,119	11,537	12,026	12,156
Voluntary consumers	69,913	75,601	80,088	80,509
Total	**81,032**	**87,138**	**92,114**	**92,665**

Figure 2: Number of compulsory orders made, 2020–21 to 2024–25

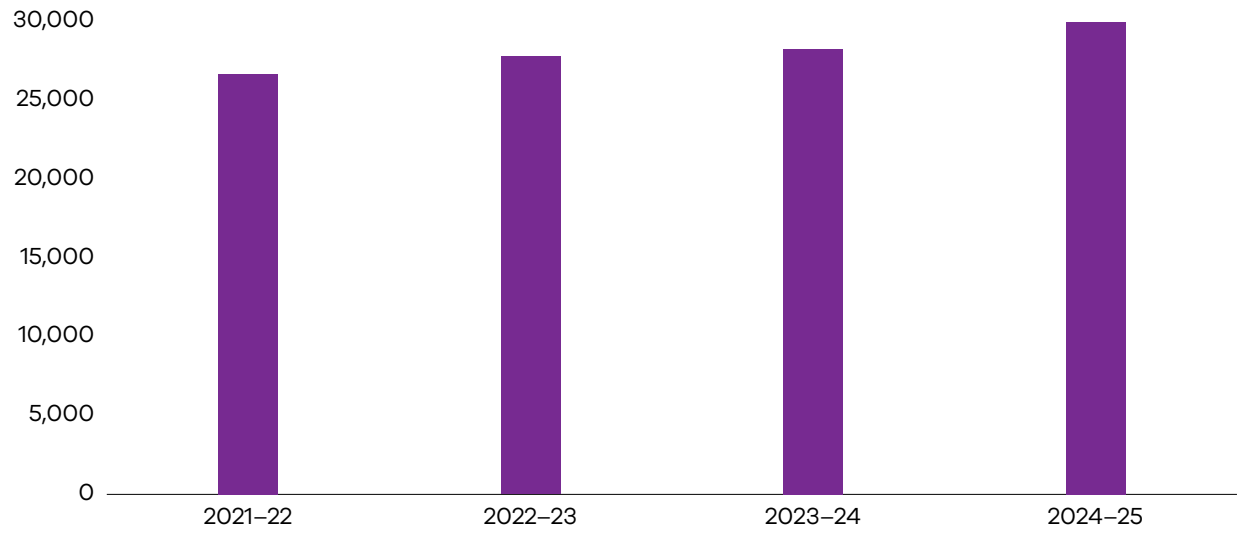


Table 2: Number of compulsory orders made, 2021–22 to 2024–25

2021–22	2022–23	2023–24	2024–25
26,629	27,728	28,185	29,937

Figure 3: Compulsory orders made by type, 2024–25

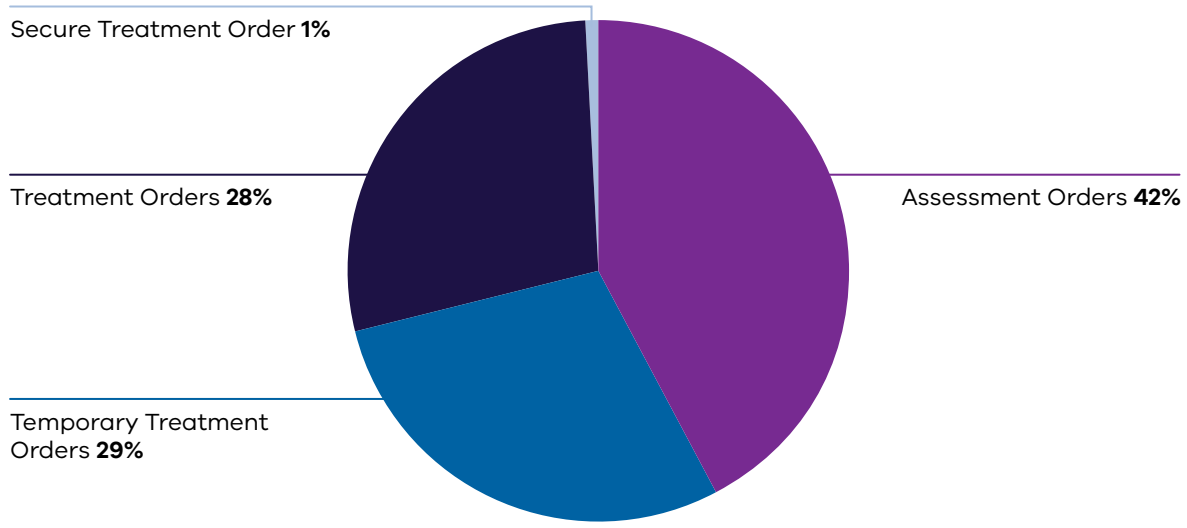


Table 3: Compulsory orders made by type, 2024–25

Type	Number	Proportion (%)
Assessment Orders	12,678	42
Temporary Treatment Orders	8,664	29
Treatment Orders	8,358	28
Secure Treatment Orders	237	1

The mild increases in the use of the Mental Health and Wellbeing Act likely reflect population growth and increased funding to services allowing greater access to care (Figure 1 and Table 1). The increase in voluntary consumers reflects this. Nevertheless, there is an expectation that use of the Mental Health and Wellbeing Act will reduce, with a greater emphasis being placed on the mental health and wellbeing principles, especially the principle of autonomy. This has yet to be reflected in the data.

Electroconvulsive treatment and neurosurgery

ECT remains a well-established, safe and effective practice, supported by evidence, for treating mood disorders, psychosis and catatonia. It is typically considered when other medical approaches have proven ineffective, are too slow to take effect, or pose safety concerns. ECT may also be recommended for people who have previously responded positively to the treatment.

Modern ECT practices are highly refined and personalised to optimise therapeutic outcomes while minimising side effects, particularly cognitive impacts. 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 proportion of people benefit from ongoing or maintenance treatments to prevent relapse.

Oversight of ECT continues to involve both the Chief Psychiatrist and the Mental Health Tribunal. DMHSs must notify the Chief Psychiatrist of each administered treatment, specifying the modality and rationale. All data is collected in a deidentified and aggregated format, some of which is provided below. The Chief Psychiatrist may also review clinical decisions on request, particularly in instances involving adverse outcomes or complex clinical, legal or ethical considerations.

The Mental Health Tribunal is responsible for authorising ECT in cases where the consumer lacks decision-making capacity.

Enhanced monitoring of ECT for people under the age of 18 continues to be a priority, ensuring appropriate oversight for this vulnerable group. For all patients under 18, consent is obtained either through the relevant provisions of the Act or via a medical treatment decision-maker and requires Mental Health Tribunal authorisation.

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 the care of 3 consumers, and lessons have been fed back to the sector. The panel was not set up to give urgent clinical opinions and ensures clinical governance still sits with the treating service.

The Chief Psychiatrist also receives notifications from the Mental Health Tribunal about approval for neurosurgery for mental health consumers. Under the Act, the treating psychiatrist or psychiatrist who made the application to the Mental Health Tribunal must provide a written report to the Chief Psychiatrist within 3 months after the surgery is performed and again within 9 to 12 months of the surgery being performed. The OCP continues to engage with relevant services to ensure quality care and improved oversight.

As previously mentioned, the Chief Psychiatrist hosted a quality and safety forum on 24 June 2025, focused on ECT and neurosurgery, bringing together speakers from clinical and LLE workforce to deliver contemporary education and professional development across the sector.

Electroconvulsive treatment in designated mental health services

The number of ECT treatments remained relatively stable at around 12,000 between 2020 and 2023, followed by a slight increase in 2023–24 and a further rise in 2024–25 (Table 4). The number of people receiving ECT also shows a gradual upward trend, increasing from 910 in 2020–21 to 1,107 in 2024–25. The average rate of treatments delivered per person was 12.85. This likely reflects population growth and relative acuity.

Table 4: Number of treatments and people treated by ECT in public hospitals, 2020–21 to 2024–25

Measure	2020–21	2021–22	2022–23	2023–24	2024–25
Number of ECT treatments	11,982	11,947	11,815	12,316	14,229
Number of people receiving ECT	910	894	888	971	1,107

Major affective and other mood disorders accounted for 57% of treatments in 2024–25, followed by schizophrenia and other psychoses, which accounted for 38% of treatments (Figure 4 and Table 5). The 'no mental health diagnosis recorded' component 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 4: Number of ECT treatments in a public hospital, by diagnosis, 2020–21 to 2024–25

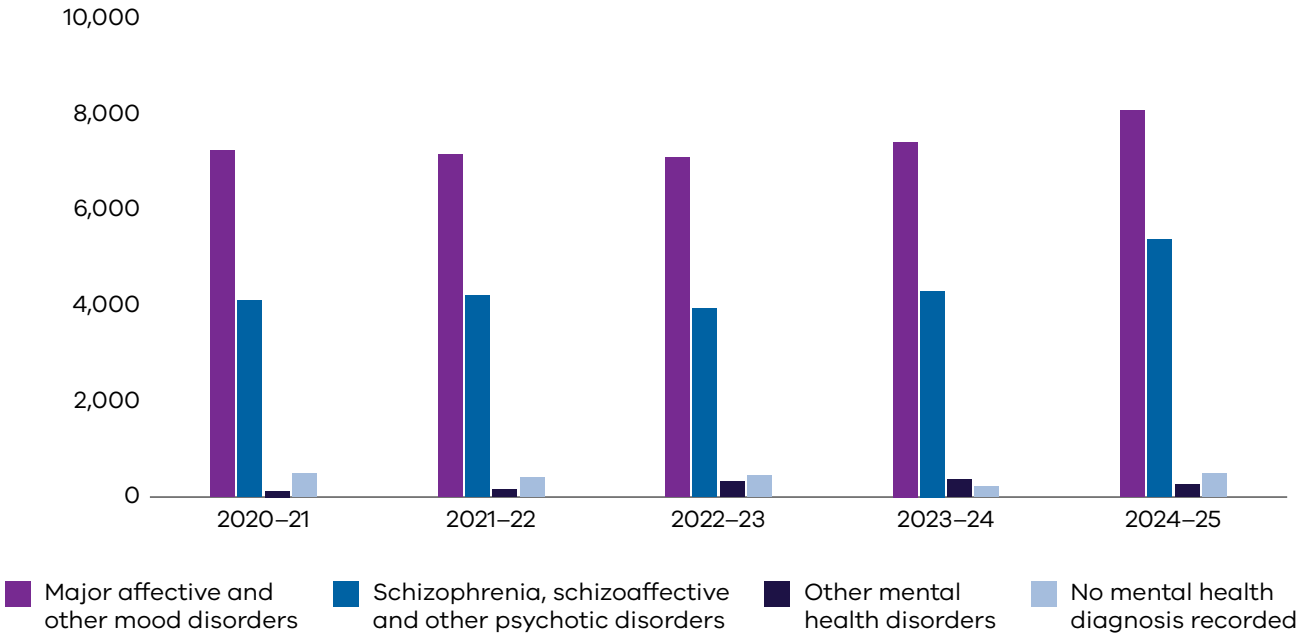


Table 5: Number of ECT treatments in a public hospital, by diagnosis, 2020–21 to 2024–25

Diagnosis	2020–21	2021–22	2022–23	2023–24	2024–25
Major affective and other mood disorders	7,255	7,168	7,098	7,430	8,093
Schizophrenia, schizoaffective and other psychotic disorders	4,104	4,215	3,941	4,311	5,397
Other mental health disorders	126	153	319	362	253
No mental health diagnosis recorded	497	411	457	213	486

Notes: This table corresponds with the graph in Figure 4. It is included for purposes of accessibility. ECT data is continuously revised as new treatments are recorded in the data system used by DMHSs. As such, figures may vary slightly between annual reports from previous years.

Figure 5 and Table 6 present the age distribution and gender of people receiving ECT.

Figure 5: Number of ECT treatments, by age group and sex, 2024–25

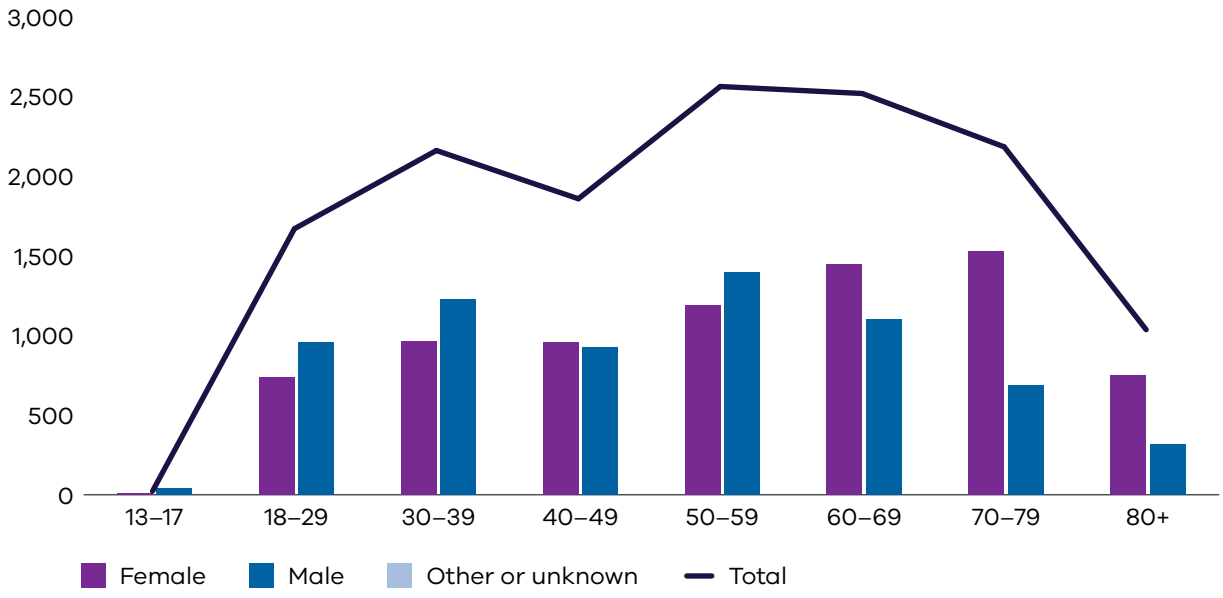


Table 6: Number of ECT treatments, by age group and sex, 2024–25

Sex	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	9	737	961	959	1,192	1,447	1,526	749
Male	40	960	1,227	926	1,398	1,099	685	314
Other or unknown	0	0	0	0	0	0	0	0
Total	**49**	**1,697**	**2,188**	**1,885**	**2,590**	**2,546**	**2,211**	**1,063**

Note: This table corresponds with the graph in Figure 5. It is included for purposes of accessibility.

A personal story from a consumer

This story comes from Maria (a pseudonym), who spent 6 years in a relentless battle with mental health challenges. Despite trying countless medications and therapies, nothing seemed to help. Sleep was rare and suicidal thoughts were constant. She reported there were many occasions when she did not want to live anymore. Eventually, she turned to ECT, and she finally saw significant shifts in her mental state. She told the OCP that for the first time in years, she felt hope. She explained that ECT gave her life back, her strengths and her will to fight.

Today, Maria works in an inpatient unit as a consumer LLE worker, using her journey to support others navigating similar paths. She wants to share her story to challenge misconceptions and reduce the stigma surrounding ECT.

Maria wants to help others understand that ECT is a legitimate, evidence-based treatment – not the frightening image often portrayed in the media. For Maria, ECT wasn't a last resort, it was a turning point. Her message is clear: recovery is possible, and sometimes it comes from places we least expect.

Deaths of people receiving mental health treatment

Deaths of people receiving mental health care are serious and require formal monitoring, oversight and review. They are deeply distressing to families, carers and supporters, and to staff. To enhance clinical safety and quality, the Chief Psychiatrist systematically gathers information from DMHSs following each such incident, aiming to understand contributing factors and prevent future fatalities.

Reporting requirements

Notification to the Chief Psychiatrist is required for all deaths involving mental health inpatients. An inpatient, irrespective of their legal status, is defined as anyone who:

- has been admitted to a mental health inpatient facility
- is on authorised leave from such a unit
- has absconded from inpatient care
- has been transferred to a non-psychiatric ward while still under mental health admission
- has been discharged from an inpatient unit within the past 24 hours
- is awaiting placement in a mental health bed in an emergency department.

For deaths occurring in community settings, reporting obligations extend to:

- any unexpected, unnatural or violent death (including suspected suicide) of people who are, or have been within the last 3 months, registered mental health consumers, as well as those who have sought mental health support without formal registration
- all deaths involving people subject to community treatment orders or non-custodial supervision orders.

People are considered mental health consumers until their episode of care has been formally closed and they have been notified, or reasonable efforts have been made to inform them, of this change.

OCP responsibilities

The Chief Psychiatrist is responsible for several key activities related to the deaths of mental health consumers, including:

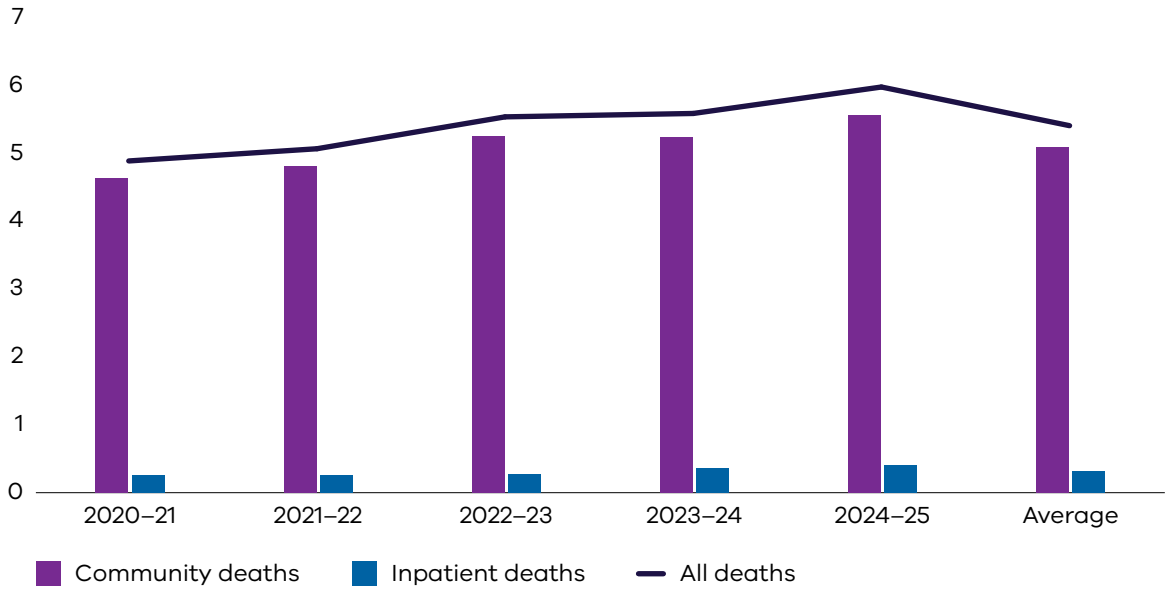
- maintaining a comprehensive database of reportable deaths
- assisting coronial investigations and responding to recommendations as requested
- reviewing clinical documentation from services to identify systemic factors, including through the Sentinel Event Review Subcommittee
- identifying statewide issues and providing strategic guidance to DMHSs, with the goal of minimising risk and promoting safe, effective care.

Collaboration with the Coroners Court enables the Chief Psychiatrist to match records and identify suicides among people recently discharged from DMHSs. Also, partnerships with the Department of Health's Suicide Prevention and Response Office facilitate data verification and analysis, supporting improvements in safety and care quality for mental health consumers. These efforts help pinpoint suicide patterns within regions or population groups, empowering the department to respond proactively to emerging suicide clusters.

Reportable deaths in 2024–25

A total of 445 deaths were reported in 2024–25, of which 422 were in scope as reportable deaths (Figure 8 and Table 9). This represents a rate of 5.98 per 100,000 population (Figure 6 and Table 7). There is a modest increase in reportable deaths for 2024–25, consistent with an upward trend over the past 5 years. This may reflect both population growth and an expanded treatment system due to greater investments in the mental health system in response to Royal Commission reforms.

Figure 6: Reportable deaths per 100,000 Victorian population, 2020–21 to 2024–25



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. Population estimates have been updated. The population estimate is based on Victoria in Future 2023 <https://www.planning.vic.gov.au/guides-and-resources/Data-spatial-and-insights/discover-and-access-planning-open-data/victoria-in-future> estimated on 30 June.

Table 7: Reportable deaths per 100,000 Victorian population, 2020–21 to 2024–25

Category	2020–21	2021–22	2022–23	2023–24	2024–25	Average
Community deaths	4.63	4.81	5.26	5.24	5.57	5.10
Inpatient deaths	0.26	0.26	0.28	0.36	0.41	0.31
All deaths	**4.89**	**5.07**	**5.54**	**5.59**	**5.98**	**5.41**

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

There were 422 reportable deaths to the OCP in 2024–25, with suicide being the largest category with 186 deaths (Figures 8 and 9, and Table 9). Medical causes make up a significant minority at 137, death by accident or misadventure being 64 deaths and a small number by homicide. Thirty-one deaths are listed as not yet known and for many the cause of death will be determined by the coroner in time.

Figure 7: Reportable deaths by sex, 2024–25

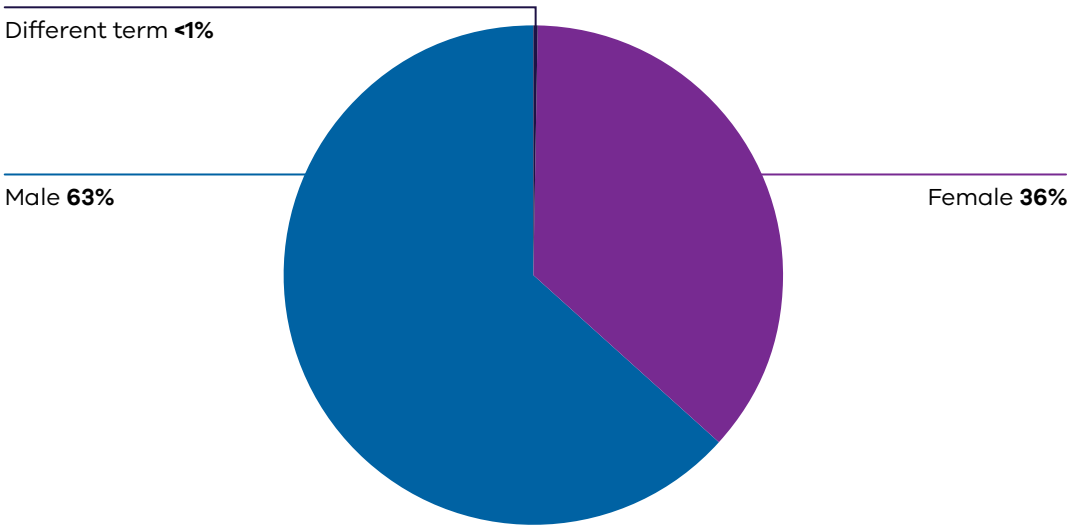


Table 8: Reportable deaths by sex, 2024–25

Category	Total	Proportion (%)
Different term	**< 5**	< 1%
Female	**162**	36%
Male	**281**	63%

Deaths attributed to 'medical conditions' comprise several instances where inpatients experienced fatal medical events not directly linked to acute mental health care, as well as a small subset of cases involving people receiving end-of-life care for terminal illnesses.

Figure 8: Reportable deaths by category, 2024–25

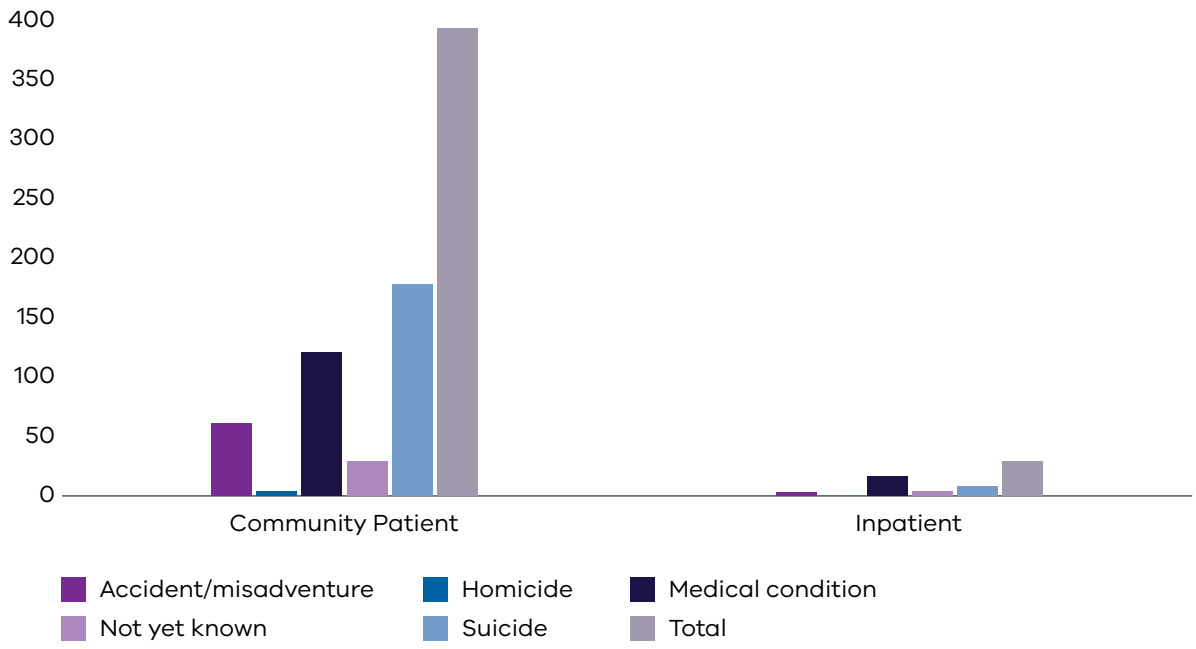


Table 9: Reportable deaths by category, 2024–25

Category	Community patient	Inpatient	Total	Proportion (%)
Accident/misadventure	61	< 5	64	15.2
Homicide	< 5	0	< 5	0.95
Medical condition	121	16	137	32.5
Not yet known	29	< 5	31	7.3
Suicide	178	8	186	44.1
Total	**393**	**29**	**422**	**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'. Note that percentage totals may not equal exactly 100% due to rounding adjustments.

Suicide is a prominent cause of death in reportable deaths across all age ranges (Figure 9 and Table 10). Suicide is the largest proportion of deaths between the ages of 16 and 25 and 26 to 64.

Figure 9: Reportable deaths type of death by age group, 2024–25

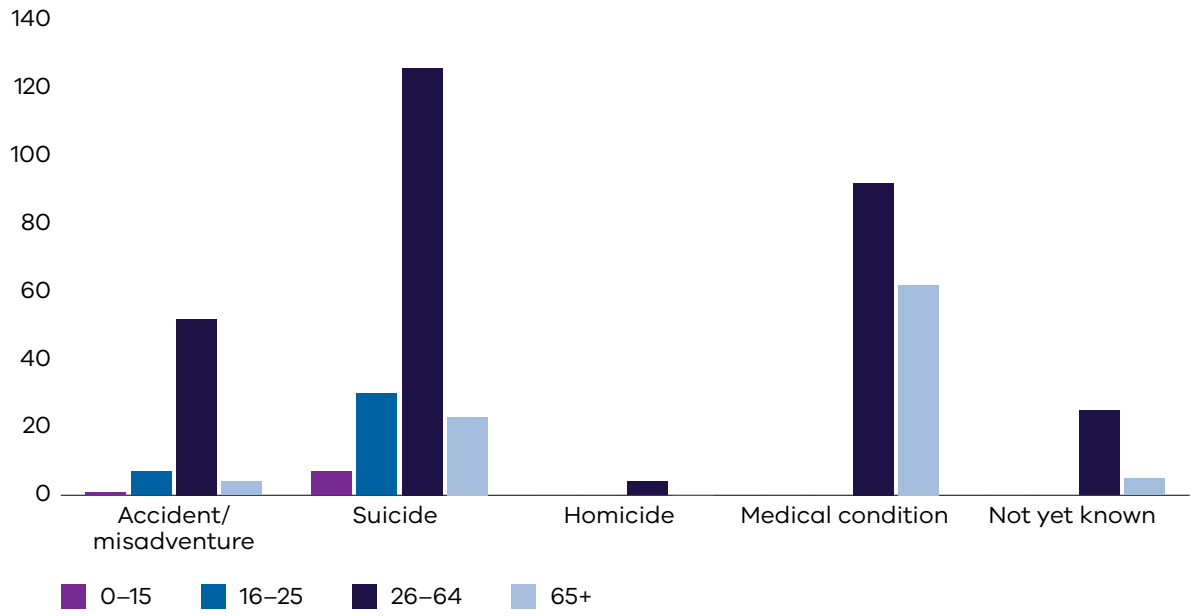


Table 10: Reportable deaths type of death by age group, 2024–25

Age group	Accident/misadventure	Suicide	Homicide	Medical Condition	Not Yet Known
0-15	< 5	7	0	0	0
16-25	7	30	0	0	0
26-64	52	126	< 5	92	25
65+	< 5	23	0	62	5

This year, we have undertaken extensive work within the reportable death's portfolio. We reviewed our data collection process via the MHWA125 form to improve accuracy and strengthen our partnership with the State Coroner's Office to support this effort – work that will continue. We also remain actively involved in the Sentinel Event Program, chairing the Mental Health Sentinel event committee and collaborating with Safer Care Victoria to ensure thorough reviews of inpatient deaths and provide services with support for continuous improvement.

Restrictive interventions

Under the Mental Health and Wellbeing Act, all DMHSs must report the use of restrictive interventions to the Chief Psychiatrist. From 1 September 2023 these reporting obligations were expanded to include chemical restraint and restrictive interventions in emergency departments and urgent care centres.

Restrictive interventions are defined in the Act to include:

- **Seclusion:** '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:**
  - **Physical restraint:** '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:** 'the use of a device to prevent or restrict a person's movement'.
- **Chemical restraint:** '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 health services in reducing and ultimately eliminating restrictive interventions, in line with the recommendations of the Royal Commission and the National Mental Health Commission's Seclusion and restraint declaration.

Legislative reforms have strengthened the focus on reporting restrictive practices across all areas of DMHSs, including emergency departments and general medical wards. Notably, the Act introduced mandatory reporting of chemical restraint for the first time in Victoria, enhancing transparency and governance. As a result, the OCP now oversees a broader range of restrictive interventions across DMHSs.

The increased oversight allows for enhanced visibility and transparency and presents valuable opportunities for services to better understand the impact of restrictive interventions and to implement strategic approaches to reduce their use. By capturing a wider scope of data, the OCP and health services are better positioned to identify high-risk areas and to

tailor interventions accordingly. The OCP has also met with metropolitan and regional services around restrictive practice, and these meetings have provided an important forum for sector engagement and feedback. The key themes emerging from this engagement highlight both the challenges services face in fulfilling reporting requirements and opportunities for OCP to provide more effective support.

The OCP is currently developing the Restrictive interventions clinical practice direction, aimed at offering better guidance and support to mental health and wellbeing service providers and focus on areas of practice change since the Act came into force.

The Chief Psychiatrist's Restrictive Interventions Committee continues to play a central role in this work, with its membership broadened to include a more diverse range of perspectives. The committee regularly receives updates on work to reduce and eventually eliminate restrictive practices. Members also provide feedback to the OCP on matters of concern to the community.

Portfolio focus and outcomes

The OCP's restrictive interventions portfolio is currently focused on:

- monitoring compliance and reporting obligations across all DMHSs
- standardising chemical restraint reporting and addressing wide variation in data
- strengthening collaboration with services to promote best clinical practice
- supporting improved compliance with benchmark reporting while reducing administrative burden
- leveraging eHealth data collection to replace manual register submissions to improve efficiency and further reduction of workloads
- clarifying how breaches of the Act are mostly reported as a tool for human rights breaches.

Improving reporting of chemical restraint

Reporting of chemical restraint was introduced as a new requirement of the Mental Health and Wellbeing Act. It is defined in the Act as:

> … 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.

Chemical restraint is not considered therapeutic but may at times be used to support safety for all. Chemical restraint, along with other forms of physical restraint, is not currently reportable when used outside the scope of the Act, in people who are not presenting with mental health distress as their primary health issue.

There are challenges in distinguishing chemical restraint from prescribing medicine for treatment that may have sedation as a side effect.

Implementing chemical restraint in emergency departments and urgent care centres was postponed until April 2024 to allow the OCP and health services to collaborate with non-mental health clinical staff working in those settings. This delay provided time for engagement and to deliver education and guidance to support compliance with reporting obligations and, most importantly, to reduce the use of chemical restraint.

In 2025, following the first year of chemical restraint reporting, the OCP did further work to improve consistency and understanding across the health system. A key session at the Emergency Mental Health Forum focused on definitional challenges, informing the development of a clear and concise factsheet and flow chart to guide clinicians in meeting reporting requirements.

The restrictive interventions portfolio and advisory groups focused on strengthening the understanding and reporting of chemical restraint through the following key initiatives:

- setting up an expert advisory committee for chemical restraint to review data and existing reporting guidance
- developing monitoring systems to identify trends and inform future quality improvement activities
- publishing clinical resources including:
  - Understanding and reporting chemical restraint: a factsheet for prescribing clinicians <https://www.health.vic.gov.au/chief-psychiatrist/understanding-reporting-chemical-restraint>
  - Determining chemical restraint: a flowchart <https://www.health.vic.gov.au/chief-psychiatrist/understanding-reporting-chemical-restraint>.

These resources highlighted the importance of supporting consumers after a restrictive intervention and the experience of carers, families and supporters.

Recent restrictive interventions quality and safety activities

Over the past 6 months, the OCP has undertaken a series of quality and safety initiatives in the restrictive intervention portfolio including:

- recalibrating chemical restraint reporting across the sector
- meeting with services to address reporting challenges, strengthen clinical governance and explore ways to better support services
- issuing clearer guidance on what constitutes seclusion
- developing a streamlined process and a new template for reporting exceeded benchmarks that allows for low-level breaches of the Act to be reported on the template
- supporting the Legislation and Entities Oversight team to update the following forms after extensive collaboration and feedback:
  - MHWA – Authority for the use of restrictive interventions form
  - MHWA 145A Continuous observation form.

Acute inpatient units – episodes of restrictive interventions

Figure 10 and Table 11 show data on the number of episodes of restrictive interventions (bodily restraint, seclusion and chemical restraint) in acute inpatient units over the past 5 years. There is a clear downward trend with the use of bodily restraint from 8,329 episodes in 2020–21, declining steadily to 6,014 episodes in 2024–25. This entails a significant 28% decrease across 5 years. We believe this reflects the increased quality improvement focus with sector-wide effort to reduce physical restraint use and acceptance of the key principle of the Royal Commission that restrictive interventions are not therapeutic.

Reporting of chemical restraint began in 2023–24, with 159 episodes documented in that year and rising to 229 episodes in 2024–25 (Table 11). This increase may reflect improved familiarity with reporting requirements and cultures among services and a greater willingness to document such interventions.

Figure 10: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2020–21 to 2024–25

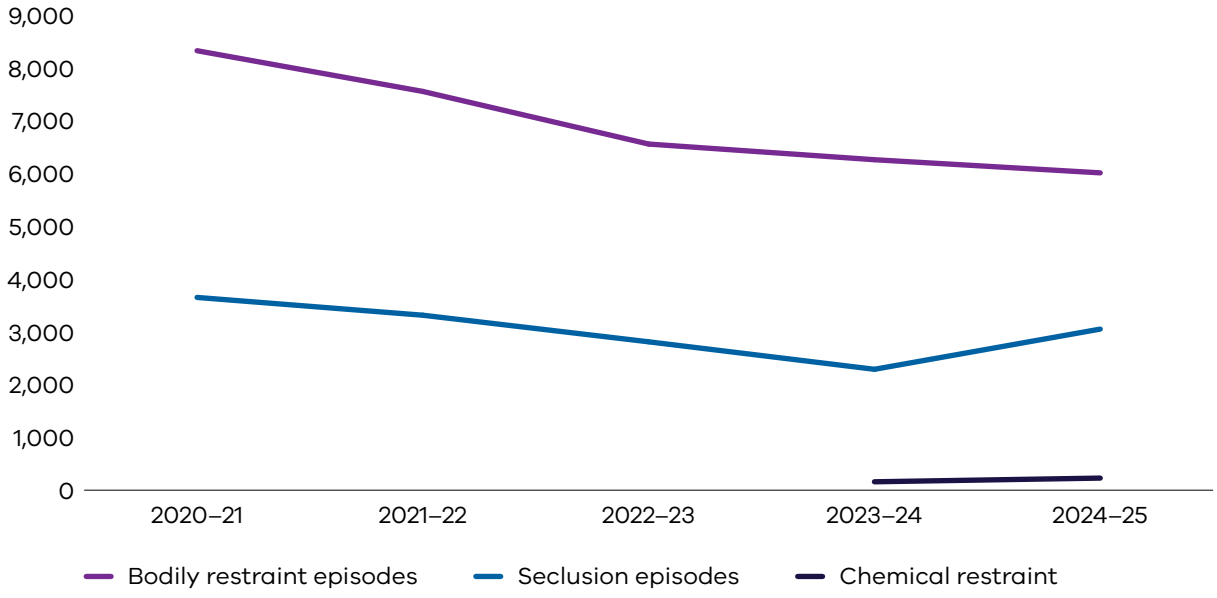


Table 11: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2020–21 to 2024–25

Restraint type	2020–21	2021–22	2022–23	2023–24	2024–25
Bodily restraint episodes	8,329	7,557	6,560	6,263	6,014
Seclusion episodes	3,653	3,316	2,812	2,291	3,053
Chemical restraint	n/a	n/a	n/a	159	229

In 2024–25 seclusion rates increased slightly on the previous year (Figure 10 and Table 11). The reasons for this are likely multifactorial. Services have reported subjective increased bed demand, increased acuity and ongoing staff availability challenges. In addition, increases may be in part a result of significant capital upgrades undertaken at some locations to create safer and more therapeutic spaces. These temporarily limited bed availability and added to the challenges of providing care in an environment suited to the specific needs of consumers.

Seclusion rates in acute inpatient units showed an age/sex difference (Figure 11 and Table 12). The largest group comprises males aged 18 to 29, followed closely by both sexes in the 30 to 39 group. After 40, both men and women experience far fewer seclusion episodes, with males still slightly ahead. The pattern suggests seclusion in acute inpatient units is primarily an issue among younger and middle-aged adults, with men being more frequently secluded than women.

Figure 11: Number of seclusion episodes in acute inpatient units, by age and sex, 2024–25

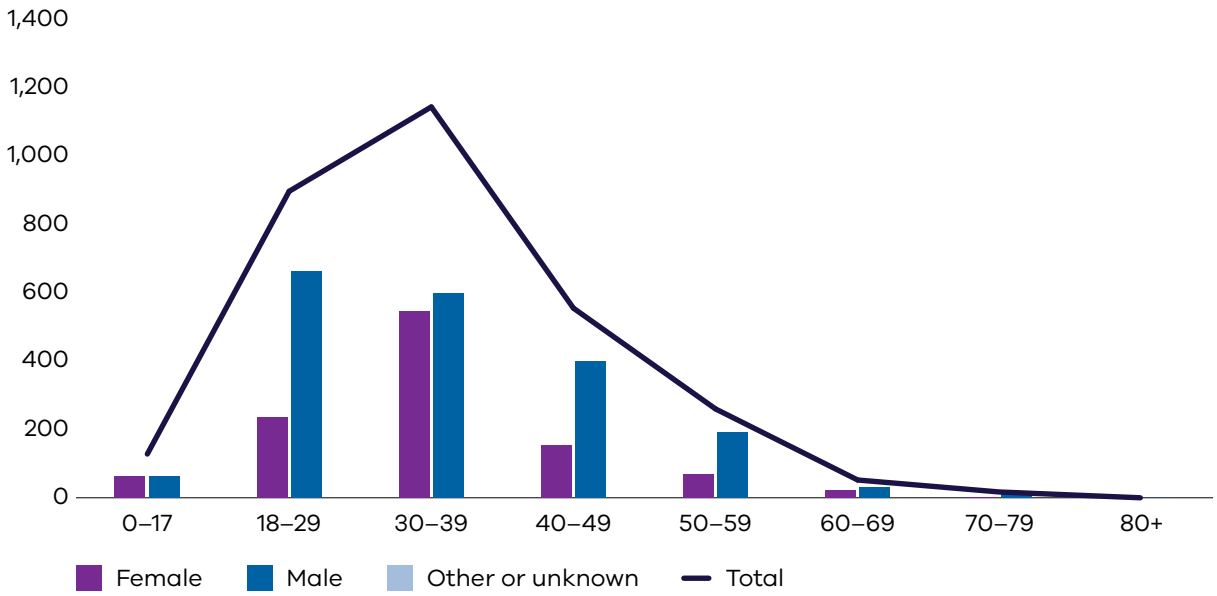


Table 12: Number of seclusion episodes in acute inpatient units, by age and sex, 2024–25

Sex	0–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	64	235	546	155	69	21	< 5	0
Male	64	662	598	400	191	31	16	0
Other or unknown	0	0	0	0	0	0	0	0
Total	**128**	**897**	**1,144**	**555**	**260**	**52**	**17**	**0**

Notes: This table corresponds with the graph in Figure 11. It is included for purposes of accessibility. Some age groups have been further aggregated to protect confidentiality.

For bodily restraint, most episodes were among the 30 to 39-year-old age group in both sexes (Figure 12 and Table 13). Across most age groups, males experienced higher numbers of bodily restraint episodes than females, except in the 13 to 17 and the 60 to 80+-year-old age groups, where it was more frequent in females than males.

This pattern suggests a predominance of bodily restraint use among younger to middle-aged adults, particularly males. Statistically, females live longer than men, so there are simply more women in the 60 to 79 and the 80+ age brackets in inpatient populations. This higher baseline population increases the number of restraint episodes in females.

Figure 12: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2024–25

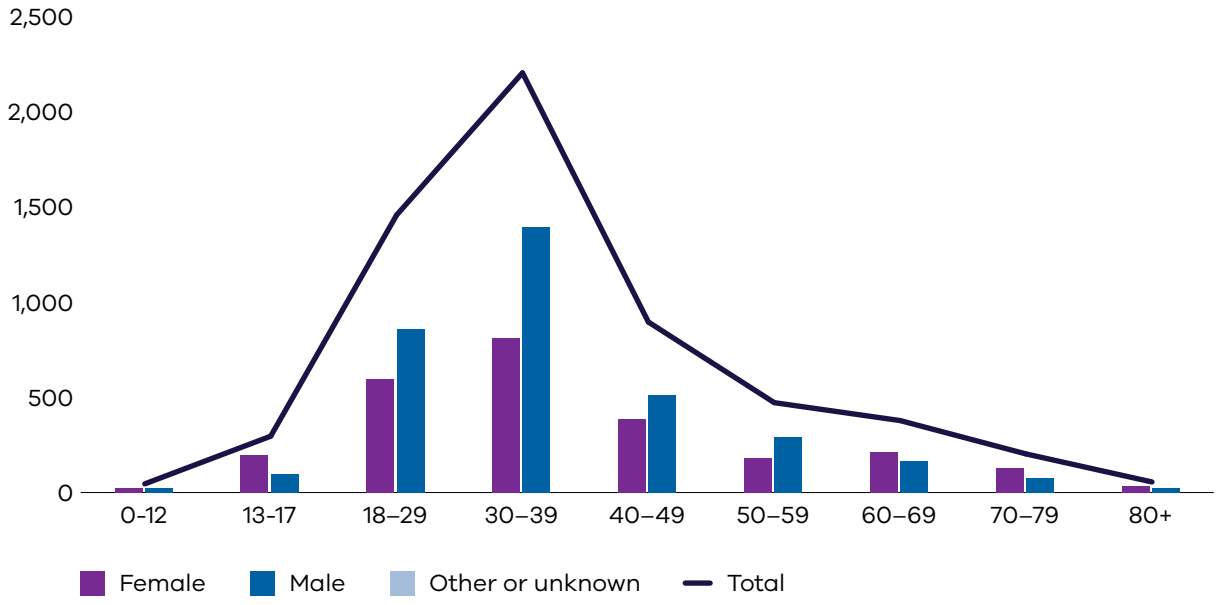


Table 13: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2024–25

Sex	0–12	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	21	198	597	811	385	183	212	128	33
Male	26	99	860	1,392	511	290	167	76	24
Other or unknown	0	0	0	0	n.p.	0	0	0	0
Total	**47**	**297**	**1,457**	**2,203**	**896**	**473**	**379**	**204**	**57**

Notes: This table corresponds with the graph in Figure 12. It is included for purposes of accessibility. n.p. refers to data that is not published due to low numbers. This is done to protect the confidentiality of individuals. Some age groups have been further aggregated to protect confidentiality.

Acute inpatient units – rates of seclusion

Figure 13 and Table 14 present the numbers of episodes of seclusion per 1,000 occupied bed days. Rates have fallen in adult wards over the past 4 years and went up slightly from 6.8 in 2023–24 to 8.8 in 2024–25. But total rates have generally declined over time, from 10.9 in 2020–21 to a low of 6.8 in 2023–24, before increasing slightly to 8.9 in 2024–25. This shows an initial downward trend over 3 years followed by rebound in the most recent year.

Older persons units consistently have the lowest rates, indicating seclusion is used sparingly in this group. Child and adolescent units show marked fluctuations, peaking at 20.4 in 2022–23 before falling again to 9.3 in 2024–25. A small number of young people with complex combinations of mental illness and intellectual or developmental disability are represented in these figures.

A further factor in these figures is the capital upgrades noted above, which involved intensive care area redevelopment in several child and adolescent units. The OCP continues to assist 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 consistently has the highest rates of seclusion, which reflects the higher acuity and behavioural risks in forensic settings. Forensic seclusion peaked in 2021–22 then reduced markedly, but it is still 4 to 5 times higher than adult/child units. Forensicare has implemented extensive quality improvement activities targeting restrictive practices, resulting in a notable reduction in reported figures – from a peak of 65.8 in 2021–22 to 40 in 2024–25 (Figure 13 and Table 14).

Figure 13: Rate of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2024–25

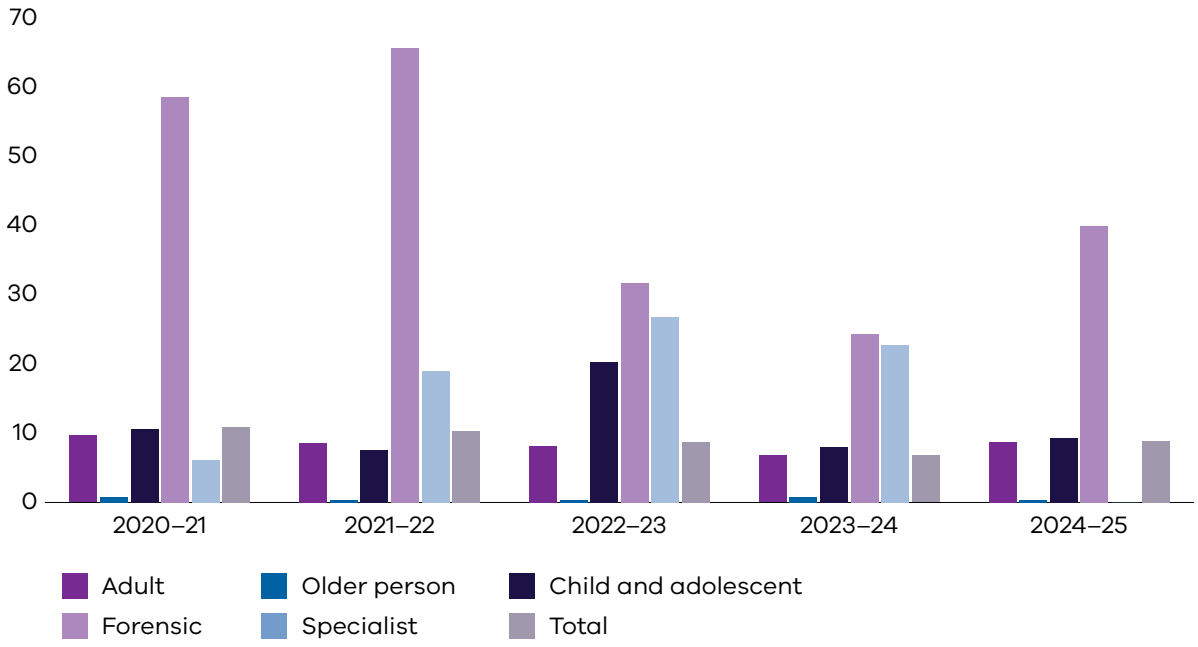


Table 14: Rate of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2024–25

Category	2020–21	2021–22	2022–23	2023–24	2024–25
Adult	9.7	8.6	8.2	6.8	8.8
Older persons	0.8	0.3	0.4	0.8	0.4
Child and adolescent	10.7	7.6	20.4	8.1	9.3
Forensic	58.7	65.8	31.8	24.4	40.0
Specialist	6.1	19.0	26.8	22.8	0.0
Total	**10.9**	**10.4**	**8.8**	**6.8**	**8.9**

Note: This table corresponds with the graph in Figure 13. It is included for purposes of accessibility.

Table 15 indicates that seclusion mostly occurred as a single episode during a hospital admission. In cases involving multiple episodes, these were typically associated with efforts by services to trial transitioning people out of seclusion.

A small number of consumers experienced multiple episodes, generally reflecting the presence of severe and complex mental illness and risk to self and others within the inpatient setting.

Table 15: Frequency of ended seclusion episodes within a single inpatient admission, 2020–21 to 2024–25

Number	2020–21	2021–22	2022–23	2023–24	2024–25
1	789	637	599	655	694
2	205	178	174	178	215
3	100	73	70	91	107
4	50	60	49	46	59
5	31	33	30	13	26
6	22	17	19	10	25
7+	80	60	63	55	66

Table 16 indicates that in 2024–25 nearly half of all seclusion episodes lasted 4 hours or less, aligning with trends observed in previous years. Across the 5 years the shorter episodes (less than 4 hours) make up the largest proportion, but there are persistent episodes lasting more than 12 hours, which remain a critical concern for the OCP. Seclusion events extending beyond 12 hours are subject to close OCP oversight, along with any episodes over 4 hours involving people aged 65 or older or those under 18. The OCP is currently engaged with services experiencing an extended duration of seclusion to collaboratively identify barriers and challenges.

Table 16: Duration of ended seclusion episodes in acute inpatient units, 2020–21 to 2024–25

Duration	2020–21	2021–22	2022–23	2023–24	2024–25
≤ 4 hours	1,716	1,512	1,453	1,110	1,497
4–12 hours	767	580	612	567	683
> 12 hours	1,170	1,224	747	614	873

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 Mental Health and Wellbeing Act requires DMHSs 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 and will continue to include chemical restraint data in future annual reports as this work is carried out and there is greater reliability in the data (refer above).

Figure 14 and Table 17 show a continued overall decline in bodily restraint episodes per 1,000 occupied bed days, with most unit types reflecting this downward trend. Child and adolescent units have shown consistent reductions across the past 3 financial years. Forensic units recorded a notable decrease in the current year with only 31.4 while trending down significantly since 2020–21. Restraint rates in older persons units remained consistently low throughout the reporting period.

Figure 14: Rate of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2024–25

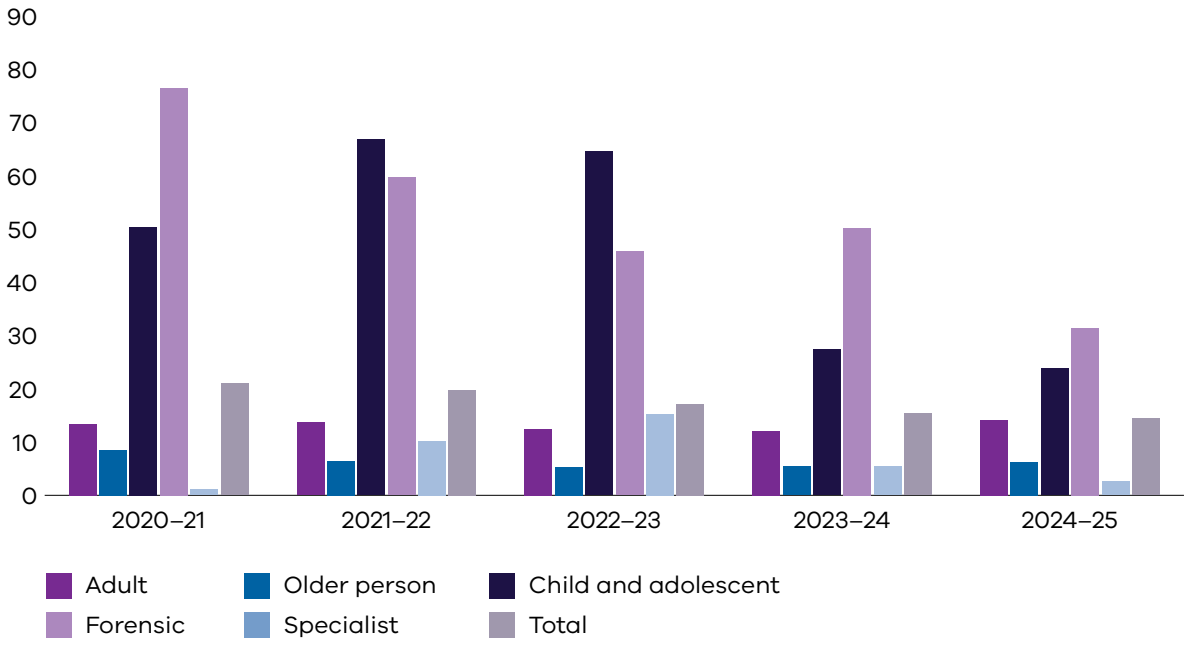


Table 17: Rate of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24

Category	2020–21	2021–22	2022–23	2023–24	2024–25
Adult	13.4	13.7	12.5	12.1	14.2
Older persons	8.5	6.4	5.3	5.4	6.2
Child and adolescent	50.4	66.8	64.6	27.4	23.8
Forensic	76.5	59.7	45.8	50.2	31.4
Specialist	1.1	10.2	15.3	5.4	2.6
Total	**21.0**	**19.8**	**17.1**	**15.4**	**14.4**

Note: This table corresponds with the graph in Figure 14. It is included for purposes of accessibility.

Table 18 shows that 'physical-only' restraint continued to represent most restraint episodes in 2024–25. Both mechanical restraint and physical-only restraint episodes have seen a slight increase during this period, which may be attributed to enhanced reporting requirements under the Act.

Also, there has been a rise in episodes involving the simultaneous use of mechanical and physical restraint. This likely reflects improved accuracy in documenting episodes where physical restraint was applied before using mechanical measures. The OCP will continue to monitor these practices.

Table 18: Number of bodily restraint episodes in acute inpatient units, by type of bodily restraint, 2020–21 to 2024–25

Restraint type	2020–21	2021–22	2022–23	2023–24	2024–25
Mechanical and physical	102	79	149	154	318
Mechanical only	394	561	341	364	389
Physical only	7,833	6,917	6,070	5,745	5,307

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

Table 19 shows that restraint continues to be most frequently applied as a single episode within an admission. Nonetheless, multiple episodes remain relatively common, and this pattern has remained stable over recent years. Like seclusion practices, growing awareness around trialling people out of restraint may contribute to an increase in the number of distinct restraint episodes recorded.

Table 19: Frequency of ended bodily restraint episodes within a single inpatient admission, 2020–21 to 2024–25

Number	2020–21	2021–22	2022–23	2023–24	2024–25
1	1,048	934	855	845	989
2	364	343	307	355	396
3	163	154	119	176	161
4	101	81	88	79	94
5	59	49	47	39	63
6	45	41	44	37	44
7+	167	163	139	122	146

Table 20 highlights a continued decline in the number of restraint episodes lasting less than 15 minutes. A substantial proportion of these episodes – often under 3 minutes – likely reflect brief interventions such as administering medication or guiding a person to a different space. In 2024–25 episodes lasting less than 3 minutes decreased from 4,913 in the previous year to 4,438. In contrast, there was an increase in prolonged restraint episodes exceeding 12 hours, rising from less than 5 in 2023–24 to 14 in 2024–25. The OCP will maintain close oversight of these extended durations.

Table 20: Duration of physical, mechanical and combined bodily restraint episodes, 2020–21 to 2024–25

Duration	2020–21	2021–22	2022–23	2023–24	2024–25
Less than 3 minutes	5,738	4,966	4,387	4,913	4,438
≥ 3 to < 15 minutes	2,012	1,910	1,669	933	990
≥ 15 to < 30 minutes	207	193	189	119	110
≥ 30 to < 45 minutes	85	82	73	52	74
≥ 45 minutes to < 1 hour	66	84	46	37	73
≥ 1 to < 4 hours	158	243	167	181	295
≥ 4 to < 12 hours	45	57	14	25	20
≥ 12 hours	18	22	15	< 5	14

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 who cannot live independently due to complex needs, offering structured care, rehabilitation and safety in a secure environment under the Act.

Seclusion – secure extended care units

Table 21 shows a reduction in seclusion episodes per 1,000 occupied bed days within SECUs in 2024–25 compared with the previous year. The period from 2020–21 to 2021–22 likely reflects the impact of the COVID-19 pandemic, including limitations on leave, limited visitor access and workforce shortages. The SECU program is actively involved in statewide initiatives aimed at embedding a recovery-oriented approach to mental health treatment and minimising the use of restrictive practices. The OCP will continue to closely monitor SECU programs and work with partnered services to support ongoing efforts to reduce restrictive interventions.

Table 21: Rate of seclusion episodes per 1,000 occupied bed days, secure extended care units, 2020–21 to 2024–25

Unit	2020–21	2021–22	2022–23	2023–24	2024–25
SECU	4	3.5	2.2	2.1	1.4

Restraint – secure extended care units

Restraint episodes per 1,000 occupied bed days have shown a sustained downward trend since peaking at 3.6 in 2020–21 (Table 22). This was followed by a plateau at 2.1 across 2021–22 to 2023–24. In 2024–25 a slight increase to 2.3 was observed. The OCP will continue to monitor this trend for concerning patterns.

Table 22: Rate of ended bodily restraint episodes per 1,000 occupied bed days, secure extended care units, 2020–21 to 2024–25

Unit	2020–21	2021–22	2022–23	2023–24	2024–25
SECU	3.6	3.2	2.1	2.1	2.3

Restrictive interventions in emergency departments and urgent care centres

Urgent care centres are GP-led facilities designed to provide timely care for people with urgent but non-emergency health needs. These centres are delivered in partnership with Victorian Primary Health Networks and aim to reduce pressure on emergency departments.

Under the Mental Health and Wellbeing Act, all restrictive interventions applied to people receiving a mental health and wellbeing service in an emergency department or urgent care centre must be reported to the OCP. This includes bodily restraint (physical and mechanical), chemical restraint and seclusion. Also, any restrictive practice involving a mental health consumer in a general hospital bed is subject to the same reporting requirements.

Given these reporting obligations are new, data consistency across services is still evolving. It is expected that reported rates will increase over the coming years as awareness and compliance improve.

The use of physical and mechanical restraint may be more prevalent in emergency departments and general medical wards due to environmental limitations that make individualised care more challenging. Seclusion is not a permitted restrictive intervention in emergency departments or urgent care centres. Confining a person alone in an enclosed space without a means of exit is not permitted.

Sexual safety

Sexual safety in DMHSs is a priority for the Chief Psychiatrist, who holds a statutory obligation to provide clinical leadership and guidance that strengthens quality, safeguards consumer rights and promotes safe care environments. Every consumer accessing mental health and wellbeing services has the right to feel safe and respected. Mental health and wellbeing services must ensure an environment that is free from sexual harm and have a duty of care to ensure sexual safety for consumers, visitors and staff.

The Chief Psychiatrist's guideline, Improving sexual safety in mental health and wellbeing services <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>, was developed in close consultation with the sector, including with people with LLE, and reflects 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, including providing support and ensuring open disclosure
- reporting sexual safety incidents, including to the police and child protection services
- managing patient transfers, discharge and referrals
- engaging families, carers and supporters.

The Chief Psychiatrist is supported by a sexual safety committee that has multidisciplinary representation from across the mental health sector. This includes representation from metropolitan and regional/rural services, infant, child and youth and adult and older adult services, LLE peak bodies and workforce, Safer Care Victoria and relevant unions.

DMHSs must appropriately respond to and report any alleged, witnessed or suspected occurrence of sexual harassment or sexual assault and, in most cases, sexual activity. They must also develop local policies, procedures and governance structures that uphold sexual safety. These must be developed in partnership with consumers, families, carers and supporters and be consistent with the Chief Psychiatrist guideline.

Sexual safety incident data

Over the past 12 months, the OCP has worked with DMHSs to strengthen sexual safety reporting systems. This work has led to better compliance, with more consistent and timely reporting and a renewed focus on enhancing the quality and safety of care 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). This reporting captures incidents involving consumers, staff and visitors. The OCP continues to refine VHIMS reporting to ensure sexual safety data can be effectively used to drive quality improvement across the sector.

Under the Chief Psychiatrist's reporting directive, all DMHSs must report sexual safety incidents according to the Incident Severity Rating (ISR) for the incident. Incidents rated ISR 1 or 2 – indicating a higher severity – must be reported directly to the OCP for clinical review. Incidents rated with an ISR of 3 or 4 are submitted to the OCP as part of a monthly data extract provided by service providers. This reporting process was introduced gradually, with full implementation achieved in November 2023. This marks the first full year in which all bed-based mental health service providers have reported sexual safety incidents exclusively via VHIMS.

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.

ISRs are calculated using an algorithm developed by the World Health Organization that has been adapted and refined by subject matter experts from Victorian public health services to support the classification and reporting within the VHIMS. The ISR is derived by responses to 3 key questions that assess:

- the level of harm experienced
- the level of care required
- the level of treatment needed.

VHIMS reports, including the ISR, are typically submitted soon after a sexual safety incident. But it is not uncommon for a service's understanding of the incident's severity to evolve over time. This may occur as extra support is provided to those affected, or after the service conducts further review through its quality and safety processes. Given the dynamic nature of disclosures, it is reasonable and expected that ISRs may be revised as new information emerges.

The reporting of sexual safety incidents plays a vital role in enhancing safety across mental health and wellbeing services. This year marks the first full year in which all services have submitted sexual safety incidents exclusively through VHIMS. This streamlined process has made reporting easier for services and has contributed to increased reporting of ISR 3 and 4, which are now submitted monthly rather than as each incident happens. The increased reporting of ISR 3 and 4 represent a stronger culture of sexual safety incident reporting. This is demonstrated, for example, in the increase in the reporting of sexual incidents of sexually explicit comments. Table 23 reflects this trend.

Table 23: Estimated number of sexual safety incidents and number of individuals involved in a sexual safety incident, 2023–24 to 2024–25

Total number	2023–24	2024–25
Estimated number of sexual safety incidents	1,304	1,671
Number of individuals involved in a sexual safety incident	1,776	2,285

Figure 15 and Table 24 highlight an overall increase in reported sexual safety incidents between 2023–24 to 2024–25. This rise is primarily attributed to a growth in ISR 3 incidents, which increased from 261 to 359, and ISR 4 incidents, which rose from 1,492 to 1,904. The number of ISR 2 incidents remained steady at 22 across both years, while no ISR 1 incidents were reported in 2024–25, following a single report in 2023–24.

Figure 15: Number of individuals involved in a sexual safety incident by ISR, 2023–24 to 2024–25

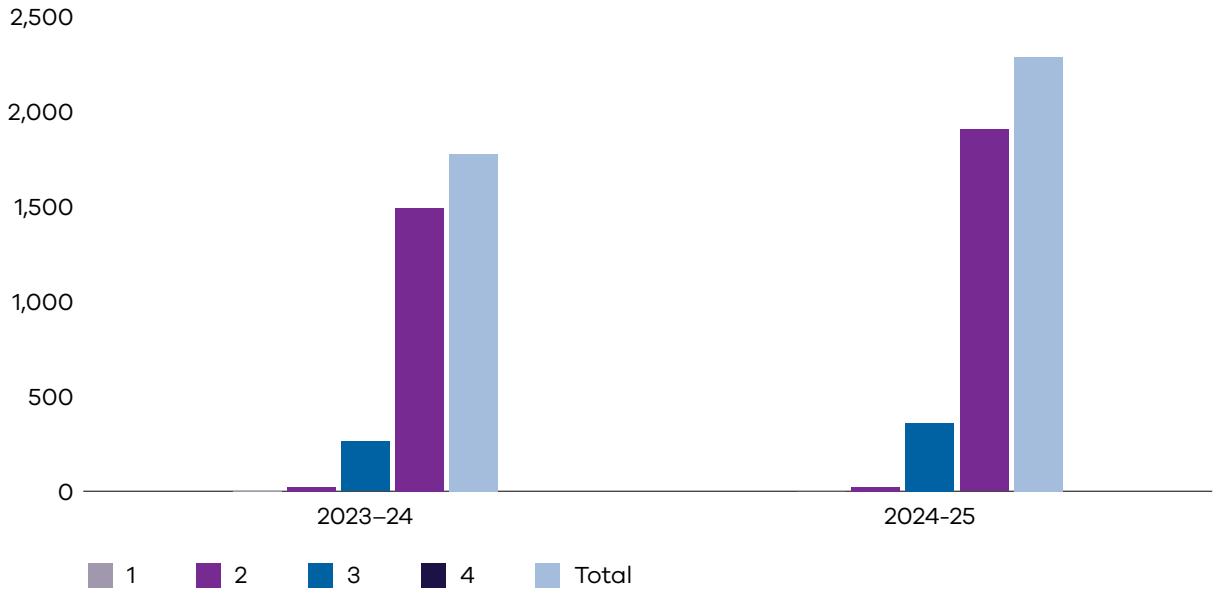


Table 24: Number of individuals involved in a sexual safety incident by ISR, 2023–24 to 2024–25

ISR	2023–24	2024–25
1	< 5	0
2	22	22
3	261	359
4	1,492	1,904
Total	**1,776**	**2,285**

Note: This table corresponds with the graph in Figure 15. It is included for the purpose of accessibility.

In 2024–25, 2,285 people were involved in sexual safety incidents across Victoria's bed-based DMHSs (Figure 16 and Table 25; Figure 17 and Table 26). Males accounted for the largest proportion, with 1,217 (53%), followed by females at 1,003 (44%). One person identified as 'other' and 64 had no gender, which may reflect limitations in data collection. The OCP is working with VHIMS to provide more gender options.

The 35 to 44 age group had the highest number of people involved (526), followed by the 26 to 34 (465) and 18 to 25 (360) age groups (Figure 18 and Table 27). The 0 to 11 and 12 to 17 age groups had the lowest number (6 and 42 respectively), though even small numbers in these cohorts are significant given their vulnerability. In all, 136 older adults (65+) were reported to be involved in sexual safety incidents in 2024–25.

When we combine gender and age data, there is a pattern of females being involved in sexual safety incidents at a younger age than males (Figure 16 and Table 25). In the 18 to 25 age group, 195 females were involved and 164 males. Despite males having a higher overall total, females outnumber males in the 12 to 17 and 18 to 25 age brackets.

The current dataset does not disaggregate gender and age by instigator or victim, which would be particularly useful when considering gender-separated areas and the age mix of patients on a unit.

Figure 16: Number of individuals involved in a sexual safety incident by age group and gender, 2024–25

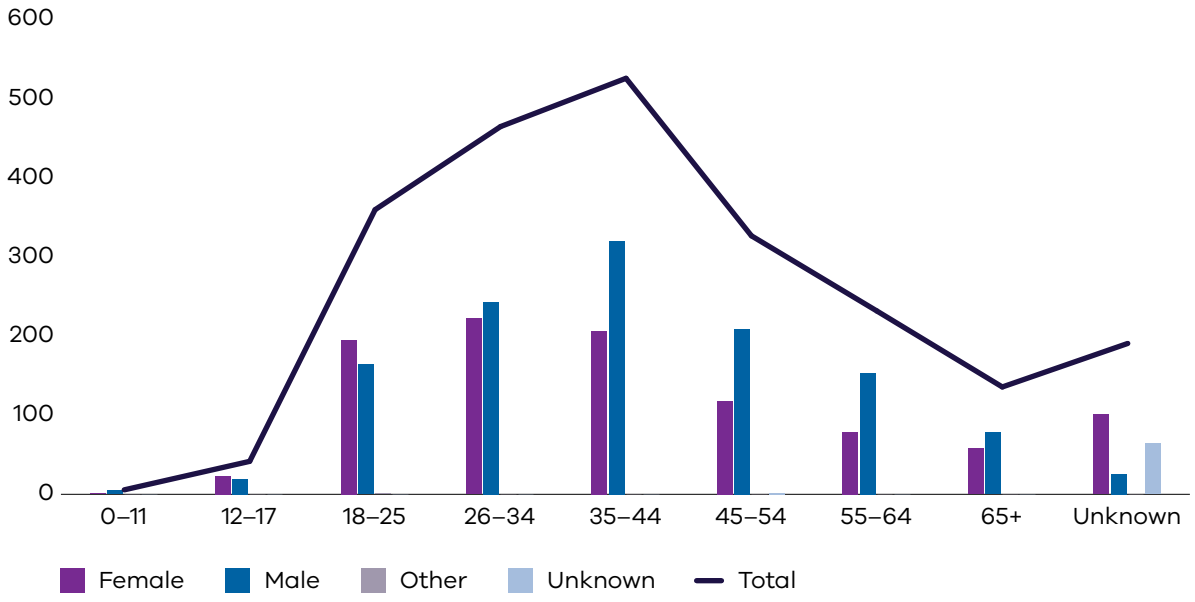


Table 25: Number of individuals involved in a sexual safety incident by age group and gender, 2024–25

Gender	0–11	12–17	18–25	26–34	35–44	45–54	55–64	65+	Unknown	Total
Female	< 5	23	195	222	206	118	79	58	101	**1,003**
Male	5	19	164	243	320	209	153	78	26	**1,217**
Other	0	0	< 5	0	0	0	0	0	0	**< 5**
Unknown	0	0	0	0	0	0	0	0	64	**64**
Total	**6**	**42**	**360**	**465**	**526**	**327**	**232**	**136**	**191**	**2,285**

Note: This table corresponds with the graph in Figure 16. It is included for purposes of accessibility.

Figure 17: Number of individuals involved in a sexual safety incident by gender, 2023–24 to 2024–25

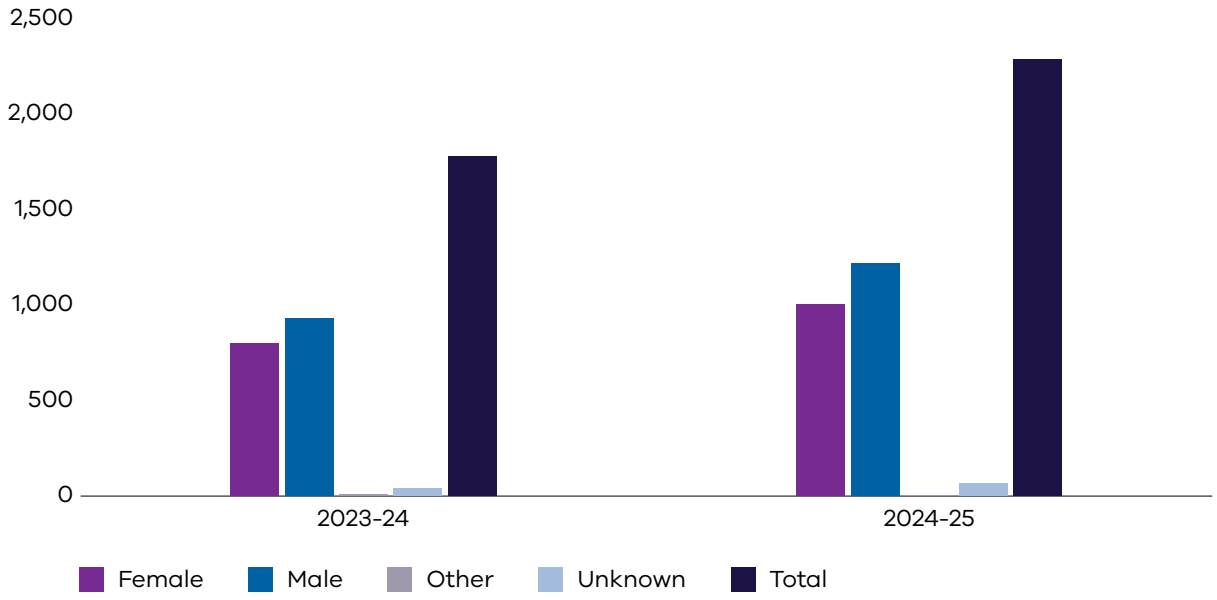


Table 26: Number of individuals involved in a sexual safety incident by gender, 2023–24 to 2024–25

Gender	2023–24	2024–25
Female	800	1,003
Male	931	1,217
Other	7	< 5
Unknown	38	64
Total	**1,776**	**2,285**

Figure 18: Number of individuals involved in a sexual safety incident by age group, 2023–24 to 2024–25

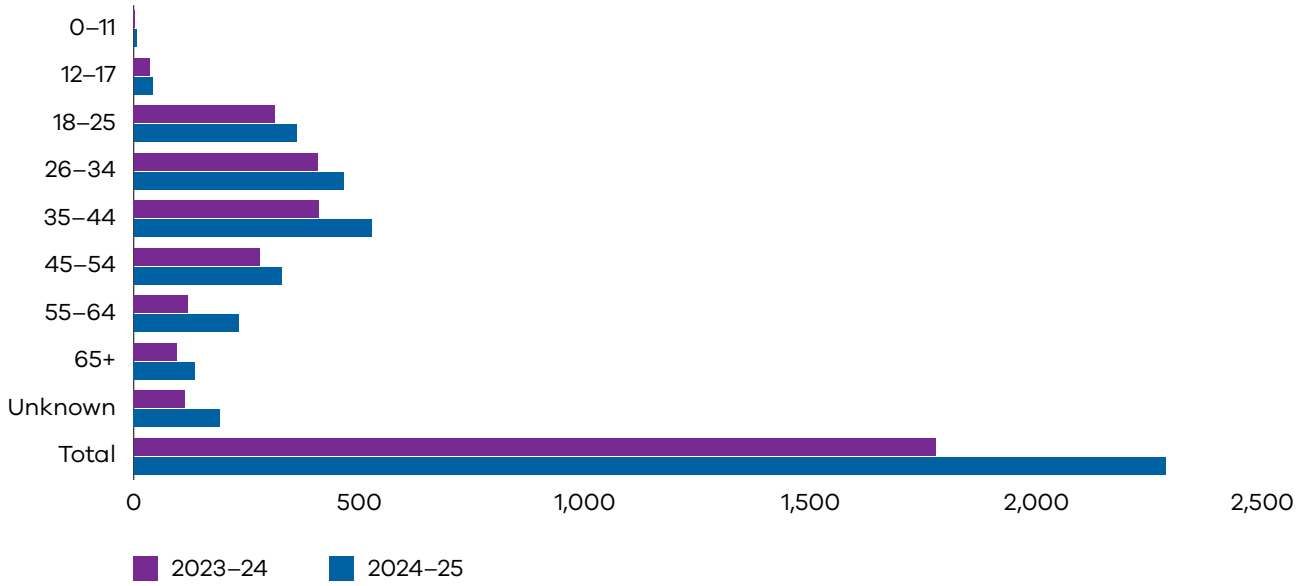


Table 27: Number of individuals involved in a sexual safety incident by age group, 2023–24 to 2024–25

Age group	2023–24	2024–25
0–11	< 5	6
12–17	36	42
18–25	313	360
26–34	407	465
35–44	410	526
45–54	278	327
55–64	120	232
65+	96	136
Unknown	113	191
Total	**1,776**	**2,285**

Figure 19 and Table 28 show that patients on compulsory treatment orders are the largest cohort, making up 63% of all people involved in sexual safety incidents in 2024–25. While voluntary consumers accounted for 19% of all people involved. The high proportion of incidents involving compulsory patients may reflect the vulnerability, complexity and acuity of care particularly in acute settings and highlights the need for robust safeguards and trauma-informed approaches in mental health and wellbeing services.

Staff involvement in sexual safety incidents nearly doubled from 194 in 2023–24 to 360 in 2024–25, which was an 85% increase (Figure 19 and Table 28). Most of these reports involved staff experiencing sexual harassment or assault, including sexually explicit comments and inappropriate touching. This rise reflects an increased focus on the safety of everyone in DMHSs, including staff. While the number of incidents is concerning, it likely represents a positive shift in workplace culture, where staff feel increasingly supported to report incidents and where such behaviours are clearly recognised as unacceptable.

There are a small group of incidents where the person's status under the Act is not known, reflecting a gap in data collection.

Figure 19: Number of individuals involved in a sexual safety incident by Mental Health and Wellbeing Act status, 2023–24 to 2024–25

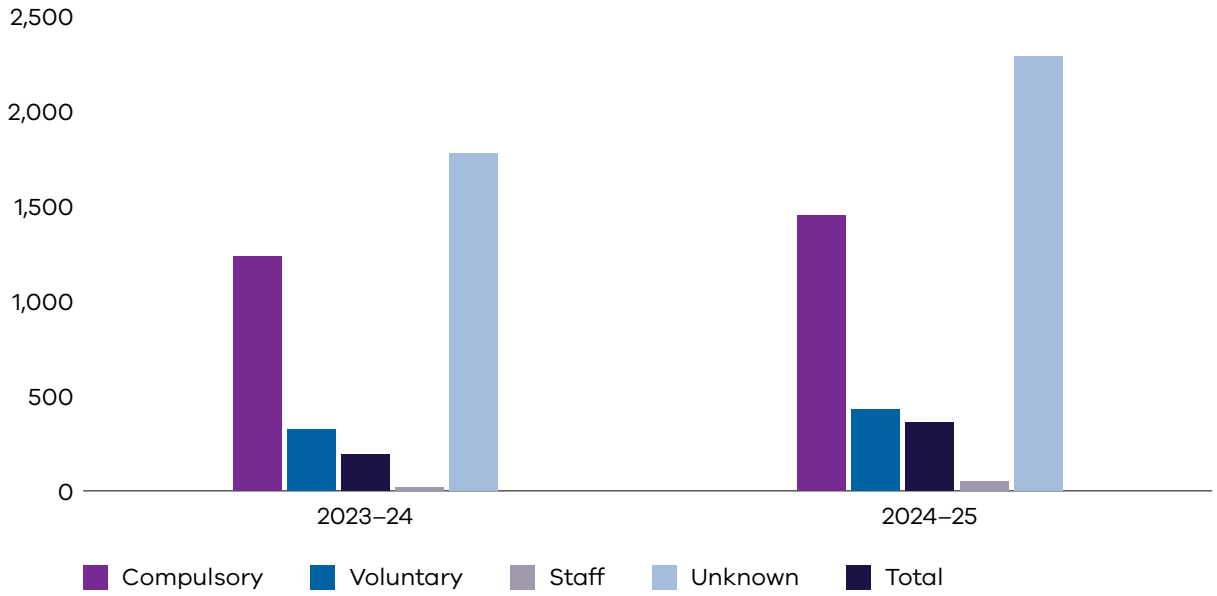


Table 28: Number of individuals involved in a sexual safety incident by Mental Health and Wellbeing Act status, 2023–24 to 2024–25

Act status	2023–24	2024–25
Compulsory	1,237	1,449
Voluntary	325	427
Staff	194	360
Unknown	20	49
Total	**1,776**	**2,285**

Story about sexual safety from the sector

The Chief Psychiatrist and staff from the OCP have been visiting mental health and wellbeing services across Victoria. These visits have highlighted a growing and encouraging commitment to sexual safety in bed-based services. Teams spoke with pride about the proactive steps they've taken to protect the wellbeing of consumers, visitors and staff.

Initiatives ranged from displaying clear, accessible sexual safety resources for consumers, to embedding sexual safety conversations into unit orientation, risk assessment, care planning and discharge processes. These efforts reflect a shift towards making sexual safety a visible and integrated part of everyday practice.

Some services have gone further by establishing dedicated roles focused on improving sexual safety. At every site visit, we met with LLE teams and witnessed the increasingly vital role of peer workers in bed-based environments. Their presence has been instrumental in fostering trust, promoting safety and amplifying the consumer voice.

We also saw significant infrastructure improvements, including refurbished intensive care areas to enable gender separate areas as recommended by the Royal Commission. In several services, these upgrades have not only created the gender separation of bedrooms and bathrooms but more welcoming and safe communal areas with enhanced privacy and dignity for consumers. Many services also have 'pods' to better support patients who may be more vulnerable and have specific care needs.

Also, the emergence of women's inpatient units, including the Women's Recovery Network (Alfred Health, Ramsey Health and Goulburn Valley Health), Western Health and Northern Health, and Prevention and Recovery Centres (PARCs) at Western Health and Monash Health reflects a strong commitment to gender safety and trauma-informed care, tailored to the specific needs of women (including anyone who identifies as a woman) accessing mental health support.

Finally, we heard about the benefits of the Hospital in the Home (HITH) program, which enables consumers who are acutely unwell to get treatment and care at home.

Statewide Complex Needs Advisory Panel

In 2023 the OCP established the Statewide Complex Needs Advisory Panel (SCNAP). This panel is supported by and reports to both the Department of Health and the Department of Families, Fairness and Housing.

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 people presented are at risk of poor outcomes due to their needs falling outside standard service responses. They face service system barriers including the lack of appropriate options for their specific combination of needs, 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:

- provide multidisciplinary expert advice and recommendations relating to people with complex needs
- reduce barriers between services caused by system gaps, inadequate knowledge or lack of coordination
- advocate for and support access to appropriate care pathways
- 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 on the advice and outcomes of the panel via its annual report.

Consultation, advice and panel activities

The OCP Complex Needs Team expanded during the year and now includes a Deputy Chief Psychiatrist, program manager, senior advisor and project officer.

With the extra staffing resources, the Complex Needs Team established additional smaller and more frequent panels called Multidisciplinary Clinical Panels. These panels are chaired by the Deputy Chief Psychiatrist and at least 2 other expert panel members based on the consumer's needs, service system issues and identified questions.

In 2024–25 the OCP Complex Needs Team provided advice and consultation to departments, services and care teams relating to 68 people. This advice was provided by convening 46 clinical consults with a Deputy Chief Psychiatrist and program manager or senior advisor to provide expert mental health and complex needs advice. There were 9 panels held to discuss people who met the eligibility criteria. There were 2 planning panels convened: one in December 2024 to discuss the panel's impact and effectiveness and identifying opportunities for improvement, and another in February 2025 to review and endorse changes to the operating model.

The Complex Needs Team delivered presentations to key stakeholders to increase the awareness and to provide non-clinical services with information about changes to the Mental Health and Wellbeing Act. Presentations were delivered to teams within the Department of Families, Fairness and Housing such as Disability Justice Coordinators and Complex Needs Coordinators, the Infant Child Youth Mental Health Service Autism Spectrum Disorder statewide coordinators forum and Supported Residential Services.

SCNAP annual report

The SCNAP annual report for 2024 (calendar year) was completed and endorsed by the Chief Psychiatrist. The annual report includes information including the number of people supported by the Complex Needs Team, demographics (age, gender, cultural background, legal order), number of consults and panels convened and a thematic analysis of the systemic issues and service gaps and opportunities for system improvement. The annual report is provided to the Deputy Secretary of the Mental Health and Wellbeing Division, Department of Health, and will be presented to the newly established Complex Needs and Forensic Disability Interdepartmental Committee (led by the Department of Families, Fairness and Housing) to support system improvement and sharing of learnings across departments.

External evaluation

Urbis (an external organisation) recently evaluated the panel. The final report, released in October 2024, found the panel has provided the following impact and benefit:

- Oversight and risk sharing mechanism – providing an opportunity to formally document the risk, efforts undertaken by services and to seek advice from a wide group of experts.
- Improving collaboration, communication and connectivity between services – particularly access to services.
- The OCP's expertise and influence is highly influential in addressing barriers such as services refusing to provide support to the complex need cohort.
- Ability to be responsive – quick to provide advice/support and bring services together.
- Escalating and documenting the most complex and intractable systemic issues for this cohort.
- Capacity building – bridging the gap between clinical and non-clinical.

Story from sector about SCNAP

Will (a pseudonym) is a young man diagnosed with schizophrenia, autism spectrum disorder and a moderate intellectual disability who has an extensive history of violence against disability support staff. He is subject to long-term seclusion via a Supervised Treatment Order under the Disability Act 2006. Although the disability service provider is committed to ending long-term seclusion, and despite significant oversight of government departments and the National Disability Insurance Scheme (NDIS), there has been limited success in reducing restrictive practices.

The treating psychiatrist and lead clinician from the DMHS visited Will at home to administer his anti-psychotic medication, but other services were fearful. Will reported he felt safe with 'clinicians', and there had been no incidents.

Will's situation was presented to the panel, which recommended developing a therapeutic model of care and involving a mental health nurse. A panel member collaborated with the care team to gather supporting evidence and spell out the rationale and goals. This was followed by targeted advocacy with senior executives in the NDIS. As a result of the panel recommendation and sustained advocacy, the NDIS approved funding for a mental health nurse for 20 hours per week to provide Will with specialist mental health support and to build the capacity of the disability support staff.

The Program Manager, Complex Needs facilitated a training session for the newly recruited mental health nurse, all rostered disability support staff and the behaviour support practitioner. The treating psychiatrist and lead clinician delivered easy-to-understand information on Will's mental health condition, medications, side effects, psychiatric background, triggers, early warning signs and interplay with his disability. This session resulted in the lead clinician agreeing to provide weekly sessions with the new mental health nurse to facilitate sharing clinical observations, analysing the data collected and to inform the de-seclusion plan.

The mental health nurse has started working with Will. While there have been several challenging moments, the team are integrating the learnings to inform and progress the de-seclusion plan.

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, including specialist 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.

Successfully implementing 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 continued to work 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 3 reviews relating to deaths in custodial settings this financial year.

The OCP team has conducted 6 site visits to prison locations in the past 12 months, in addition to visiting Thomas Embling Hospital during this period.

The OCP has initiated a clinical review under the Act into the care of a consumer who is currently on remand for the alleged homicide of a community member. The first stage of the clinical review involving an in-depth file review is currently in progress. An expert panel will be formed to help develop recommendations in relation to the service system gaps and barriers.

Story about custodial settings from the sector

The OCP facilitates quarterly advisory group meetings with youth and adult forensic stakeholders including lived experience experts, forensic mental health specialists, representatives from the Department of Justice and Community Safety, the Department of Families, Fairness and Housing, the police custodial health service and community support services. Advisory group members play an important role in identifying issues impacting on the mental health care of people involved in the justice system and advising on potential solutions.

The advisory group identified transfers of care as a high-risk period for people leaving custody that need mental health care and recommended a policy be developed to address this transition.

To develop this policy, the OCP's Forensic team reviewed relevant local and international literature and coroners' findings, met with the Magistrates Court, Parole Board and emergency department staff.

A briefing paper was developed outlining the barriers and challenges to safe transfers of care from custodial settings. Significant barriers identified included unpredictable release from court, loss of accommodation in the community, disconnection from both professional and personal supports, gaps in service coordination and communication and effective transport to facilitate the care plan after release.

Through consultation with the advisory group members and Authorised Psychiatrists, a Transfer of care – custodial settings addendum has been developed. It should be considered alongside the existing Chief Psychiatrist's Transfer of care and shared care guideline <https://www.health.vic.gov.au/sites/default/files/2023-09/transfer-of-care-and-shared-care-guideline-2023-09-08.pdf>. The document will provide guidance on these issues and will be available to the sector on the Chief Psychiatrist's website.

Statewide Emergency Services Liaison Committee

The OCP chaired 8 Statewide Emergency Services Liaison Committee meetings with representatives from Victoria Police, Ambulance Victoria, mental health and wellbeing services and the MHWD's Legislation and Entities Oversight team.

This meeting provides a collaborative statewide perspective that aims to replicate and offer a point of escalation to local Emergency Services Liaison Committees across the state. This includes timely feedback to local services that have escalated issues to the committee.

It aims to strengthen communication between Victoria Police, Ambulance Victoria and DMHSs at the local level and to establish clear escalation pathways across agencies when issues cannot be resolved locally. This will ensure mental health crises are resolved in the best interests of the person, their families and carers, and the community.

It strives to bring consistency across Victoria and identify and problem-solve systemic issues and statewide policy implementation.

Conclusion

The 2024–25 reporting period reflects an ongoing commitment to transparency, accountability and continuous improvement. The expansion of statutory oversight into emergency departments, urgent care centres and custodial settings has enabled the OCP to monitor and guide clinical practice across a variety of environments in Victoria's mental health and wellbeing system. Quality and safety forums, site visits, and collaborative partnerships have strengthened relationships with DMHSs, LLE representatives and system stewards. These engagements have brought to light local innovations, identified systemic challenges and generated solutions based on the voices of consumers, carers and clinicians. The OCP will continue to lead with compassion, clinical rigour and a commitment to human rights. It will remain focussed on nurturing clinical governance, reducing harm, and supporting services to deliver safe and person-centred care.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