Quality and Safety Bulletin

Office of the Chief Psychiatrist

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OFFICIAL

In this issue

Spotlight on Sexual Safety in Mental Health Services

Everyone in mental health and wellbeing services, including consumers, staff and visitors, have the right to sexual safety. Services have a responsibility to prevent sexual safety incidents from occurring and a duty to provide bed-based care settings that are safe.

A sexual safety incident is **any alleged, witnessed or suspected occurrence of sexual harassment or sexual assault, and in most cases, of sexual activity.**

The Chief Psychiatrist's guideline on improving sexual safety in mental health and wellbeing services <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety> was updated in 2023. It establishes minimum standards for mental health and wellbeing services to respond to sexual safety incidents and comply with relevant legislation and policy for:

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

To support high quality clinical governance of this area, services must have clear processes to promote sexual safety and to respond appropriately to any sexual safety incidents.

In 2023-2024, 1764 individuals (encompassing consumers, staff and visitors) experienced sexual safety incidents in Victorian bed-based mental health services. Given multiple people may be involved in one incident, these reports represented an estimated 1295 sexual safety incidents. The majority of these were in the lower severity ratings of ISR 3 or 4, resulting in no additional care and minimal or no harm.

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

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

The Office of the Chief Psychiatrist (OCP) recognises the challenges services can face in meeting their reporting obligations. It regards regular reporting as evidence of the importance services place on providing reliable data and therefore the means for proper oversight and internal governance of quality and safety.

Sexual safety incidents and definitions

Bed-based services

Any witnessed, suspected or alleged occurrence of **sexual harassment** or **sexual assault** constitutes a sexual safety incident in all **bed-based clinical mental health services**.

Any witnessed, suspected or alleged occurrence of **sexual activity** also constitutes a sexual safety incident in bed-based services in hospital settings (for example, acute inpatient services and secure extended care units (SECUs) and mother baby units), in all bed-based services for people aged under 18 years, and in all prevention and recovery care (PARC) services and custodial settings.

Non-acute bed-based services that provide a longer term, home-like environment (for example, community care units (CCUs)) can develop local protocols around whether sexual activity is considered a sexual safety incident. Local protocols support consumers who wish to engage in sexual activity to do so safely. Services have a responsibility to ensure support around sex and sexuality is accessible as a part of recovery-oriented practice.

Types of sexual safety incidents

All sexual safety incidents should be reported within designated mental health services (DMHSs) and to the OCP Sexual safety incidents include the following:

- **Sexual assault**: Intentional sexual touching or a sexualised act that is nonconsenting.
- **Sexual harassment**: Unwelcome sexual behaviour that offends, humiliates or intimidates.
- **Sexual activity**: any involvement of these s sexual areas of the body or arousal/gratification. Sexual activity can be consensual. Whilst not a crime, all sexual activity in mental health units is reportable to the OCP.
- **Sexual other**: Not fitting into above categories. For example, non-targeted, sexually disinhibited behaviour such as public disrobing.

Incident Severity Rating (ISR) for sexual safety incidents

The ISR is a method of rating incidents. It is calculated on a World Health Organisation algorithm and adapted and refined by subject matter experts from Victorian public health services to support Victorian Health Incident Management System (VHIMS) incident classification and reporting.

The Incident Severity is determined based on three criteria:

1. Level of harm sustained.
2. Level of care required.
3. Level of treatment provided.

Staff should consider the level of psychological and/or physical harm and the impact that events may have on an affected person's current and future mental health and wellbeing. When considering the care and treatment that was required, it is important to consider all the interventions that were used to respond to an incident, including psychological and interpersonal responses and any referrals (for example, to the Centre Against Sexual Assault) that were made.

ISR	Type of incident
ISR 1 – Severe ***A serious sexual safety incident that has caused substantial harm***	Major harm (psychological and/or physical) has occurred. For example, • a serious sexual assault, such as suspected or alleged rape (as defined by the *Crimes Act 1958*) or statutory rape (illegal sexual activity between an adult and a minor). • Sexual safety incidents that result in pregnancy.
ISR 2 – Moderate ***A sexual safety incident resulting in the consumer, visitor or staff requiring increased levels of care***	Significant harm has occurred (psychological and/or physical). Some instances of sexual assault – for example, • non-consensual touching while clothed. • Sexual activity that may result in pregnancy or transmission of a sexually transmitted infection and testing is necessary. • Incidents where there is a suspicion that a sexual assault may have occurred although parties are not reporting this. • Incidents where an affected party responds in a way that may indicate a sexual assault has occurred and had a substantial impact. This may present in a range of ways – for example, if an affected party is acutely distressed, appears numb, flat or dissociated, or is very controlled in their response. • Incidents where there is suspected coercion, transactional sexual activity, predatory behaviour or a power imbalance between parties. • Sexual activity involving one or more minors (under 18 years old) must be rated as at least ISR 2.

ISR	Type of incident
ISR 3 – Mild ***A sexual safety incident that results in minimal injury with no additional care required***	Temporary minor harm has occurred. • Minor incidents of sexual harassment or sexual activity where there may be mild distress or psychological consequences. • There is no need for medical treatment or testing following the incident. • There is no indication of a significant power imbalance due to trauma history, mental state or sedation, for example.
ISR 4 – Near miss ***A sexual safety incident was avoided***	• None of the involved parties are distressed. • No harm or injury has occurred. • No change in treatment required. • A sexual safety incident has been avoided.

Scope of a sexual safety incident

The Chief Psychiatrist's guideline on improving sexual safety <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety> is relevant to all mental health and wellbeing services in Victoria. All bed-based services delivered by clinical mental health service providers must report sexual safety incidents including services that deliver under public private partnerships. It applies across the life span.

Incidents that involve consumers, visitors and staff are in scope for reporting. Staff to staff incidents are not in scope and are reported through service OH&S procedures and/ or police.

When reporting sexual safety incidents, consider the following:

- In many cases more than one VIMHS report is needed for a single incident due to the relational aspect of the incidents.
- Follow the Chief Psychiatrist's reporting directive < https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety> to make a sexual safety notification.
- Sexual safety incidents are likely to be reportable to police. In some instances, reporting to the police is mandatory.

Responding to sexual safety incidents

Please see the link below for a one-page printable flowchart summary of some of the guidance.

Sexual safety incident 1 pager.pptx

Future updates to the Chief Psychiatrist's Improving sexual safety in mental health and wellbeing services guideline

The Chief Psychiatrist's guideline on sexual safety is being updated to reflect recent developments on quality and safety. There will be three main parts to this update outlined below:

1. **Discharge planning needs to minimise the risk of harm to people being discharged by consideration of sexual safety of the discharge destination**

   This follows a Coronial recommendation to strengthen the Chief Psychiatrist sexual safety guideline to incorporate managing clinical situations involving vulnerable patients being discharged into environments where their sexual safety may be at risk.

2. **Sexual safety in the context of social media and technology is within scope of sexual safety incidents.**

   Inpatient settings can be unique settings for people to disclose to staff sexual safety incidents. Services have reported people being coerced to provide sexualised images during admissions. This situation has occurred several times involving vulnerable young people and may be a

reason to restrict access to communication for a period of time to support recovery.

Such incidents would generally be rated according to impact on the person. However, in a young person, they would be rated ISR 2 with the potential to downgrade the rating on review.

Consideration of police reporting in such instances is important.

3. **Sexual Safety Incident Severity Rating changes may occur but need documentation and escalation**

   It is not uncommon for staff's understanding of the severity of a sexual safety incident to change over time. Disclosures are often dynamic. The following needs to be considered when changing sexual safety incident severity ratings:

- **For under 18-year-olds all incidents are recorded as ISR2.**
- **Changing an ISR rating in a young person should be done in collaboration with the OCP.**
- **Changing an ISR rating for an adult may be undertaken at a local level.**
- **In both cases, documentation of rationale for downgrading should occur.**

Restrictive Interventions

Chemical restraint update

Regulation and monitoring of chemical restraint used across all designated mental health services commenced upon implementation of the *Mental Health and Wellbeing Act 2022*.

This is the first time that chemical restraint has been regulated in emergency settings in Victoria.

At the time of publication, we are almost at the first-year anniversary of chemical restraint regulation for mental health and wellbeing consumers. **Data to date has revealed variable rates of reporting across services.**

Aggregated statewide data indicates that most episodes of chemical restraint occur in emergency departments and mostly involve the use of injectable medication.

This variability was discussed at the OCP Clinical Forum for Emergency Departments in March 2025.

A wide range of views were expressed at the forum on what constitutes chemical restraint, demonstrating a lack of agreement on a consistent definition.

The OCP has formed a chemical restraint working group to address these issues. It will undertake work to better define chemical restraint in clinical situations and therefore when it must be reported.

Practice points

According to the Mental Health and Wellbeing Act, determining whether the administration of a medication is for the purpose of treatment or restraint relies on the prescriber's intent.

If the intent is to restrict bodily movement, this constitutes chemical restraint.

If the intent is to treat a symptom of a mental or physical condition, with a clinically indicated medication this likely constitutes treatment and is not chemical restraint.

Interpretation of this definition may be broad and reflects individual prescribers' comfort with the language of treatment and restraint, leading to differing reporting.

It is therefore recommended that a formulative approach is taken on a case-by-case basis depending on the individual consumer's presentation at the time but also recognising that we need to be reporting the same thing across the sector and aligning with the moderate interpretation so that we can:

- be comfortable that reporting is consistent and
- is balanced to enable targets for continuous improvement.

Some questions to shape thinking could include:

- Is the consumer consenting and willing to take the medication?
- Are there alternative forms that may be offered – e.g. oral, injectable?
- Is the dose prescribed within standard parameters for symptom management, or is the dose likely to restrict bodily movement?
- If there is concurrent use of bodily restraint, is the administration of the medication intended to augment or replace the physical or mechanical restraint?

Please watch this space for the updated guideline and work towards consistency of reporting for the sector.

The importance of documentation regarding experience of care reviews for restrictive interventions

Consumers who are subject to a restrictive intervention must be offered an opportunity to take part in reviewing the intervention (s 138(1)(b), Mental Health and Wellbeing Act).

The aim of the experience of care review is to:

- address trauma and provide supports
- support the potential for making an advance care plan for future similar situations.

Any systemic issues identified from the review should be forwarded to the relevant safety and quality improvement committee for action.

It may be more appropriate to hold an experience of care review one on one with a key nurse in a quiet location with an informal discussion or in a separate room with the care team and support persons present. The care team should collaborate on the most appropriate way for the review to occur and document their decision. Questions should focus on the consumer's experience and whether they are able to offer suggestions for improved care and safety for all.

The OCP recognises that there are times when an experience of care review may be difficult to undertake or even clinically inappropriate. Clear documentation by clinicians about the experience of care review should be undertaken regardless of whether the review was completed.

Documentation

For documentation relevant to experience of care reviews, there should be a clear indication:

- that the documentation is referring to the experience of care review
- whether a review was offered, and if not, why not and how many times it was offered
- whether the consumer declined the review and whether they provided a reason for declining
- what options for follow up care were provided
- if there was no experience of care review, what prevented it and why (e.g. clinically too unwell to participate, risk of occupational violence, discharged home early, absconded, etc.)
- whether systems issues were identified and their nature.

Clear processes should be in place to ensure consumers transferring from an emergency department to an inpatient unit, an alternative inpatient unit, a community mental health service or another service under the designated mental health service are afforded an opportunity to participate in an experience of care review.

Electroconvulsive and Neurostimulation Therapies

Electroconvulsive treatment (ECT) between two designated mental and wellbeing services

This may apply where services do not have ECT capability and ECT is provided by a second service.

Circumstances:

The provision of ECT for compulsory patients is authorised by the Mental Health Tribunal (MHT). It is the treatment itself that is authorised. The location of the treatment is not specified or required to occur at the responsible mental health service.

ECT authorised by the MHT can be delivered at a second service if appropriate and variation of orders is not required for ECT to be delivered at another service.

The prescribing can be by the home team but may be better supported if done in collaboration with the ECT delivery team where possible.

The Psychiatrist administering ECT can adjust the prescription as clinically indicated. Ultimately dose and delivery while recommended by prescription needs to be supported by the ECT delivery team who will provide the treatment.

For compulsory patients, two mechanisms under the Mental Health and Wellbeing Act are identified to facilitate transport for ECT administration at a location other than the responsible designated mental health and wellbeing service.

- **Section 223 – Variation of Orders**. The Authorised Psychiatrist (AP) may vary an Order to allow assessment or treatment at another designated mental health service. To vary the order the AP must be satisfied that the variation is necessary for care. In practice this may be cumbersome, and it requires variation of the order twice (to and from the other service).
- **Part 5.3 – Transport Provisions**. This allows for the transport of a person to or from a designated mental health service. Section 240 permits taking a person into care and control for transport.

For Voluntary patients, it is legally permissible for one service to prescribe ECT and for the treatment to be administered at an appropriate different location, even if the person is not formally a patient there. The Psychiatrist administering ECT can adjust the prescription as clinically indicated.

Feedback from the delivery service to the prescribing service is an important part of ensuring future prescriptions are in line with the evidence base.

Any differences in prescribing should be escalated to the ECT Directors to liaise and determine shared clinically indicated way forwards.

Key Takeaways

For compulsory patients, both options are legally permissible and have their own advantages and disadvantages. The first option also needs to meet the requirement of necessity and may be cumbersome. The second option is simpler. However, other legal and practical implications might complicate the situation, such as a decision making around restrictive practices, or clinical governance of serious adverse events

Therefore, agreement between both services is extremely important. ECT clinical governance and reporting requirements are the responsibility of the service providing ECT. Services are welcome to discuss any difficulties with the OCP (email: ocp@health.vic.gov.au).

OCP in custodial settings

Homicides by consumers of mental health services

Research has shown that consumers of mental health services are much more likely to be victims of violence than perpetrators. However, unfortunately homicides by consumers do occasionally occur. Such tragedies have enduring consequences for all involved, including professionals involved in providing care and treatment.

The UK Royal College of Psychiatrists (RCPsych) has recently produced a useful, free 'guidance booklet' entitled 'If a patient commits a homicide: A resource for psychiatrists'.

It was developed following surveys of psychiatrists who had experience of what RCPsych term 'patient-perpetrated homicide' (PPH), a review of the literature, and from accounts of personal experiences. It aims to provide psychiatrists who may be affected by a PPH with information about an exceptional event which may be hard to discuss, and where there may be few obvious sources of support.

It has relevance for all staff who have been involved in PPH, not only psychiatrists. Although some parts of the booklet are only relevant to UK services, much of it is also relevant to the Australian context. It is available for download here <https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/guidance-booklet---staff-support-following-patient-homicide.pdf?sfvrsn=540ba062_9>.

Authorised Psychiatrist Role Guideline

The OCP has published a new guideline on the Role of Authorised Psychiatrists <https://www.health.vic.gov.au/chief-psychiatrist/authorised-psychiatrist-role-guideline>. The guideline describes the powers and functions of Authorised Psychiatrists under the Mental Health and Wellbeing Act. It also provides information about appointing an Authorised Psychiatrist.

The guideline will be of benefit to executives and clinical staff in designated health services seeking to better understand the statutory responsibilities associated with the Authorised Psychiatrist role.

It is a resource for ensuring people who are experiencing mental illness or psychological distress receive appropriate assessment, treatment and care in keeping with the principles and objectives of the Mental Health and Wellbeing Act.

Complex Needs Team – SCNAP

The OCP has established a Complex Needs Team to provide expert mental health and whole of system complex needs advice via consultations with treating teams and the broader service system. The OCP also convenes the State-wide Complex Needs Advisory Panel (SCNAP).

SCNAP is a statewide escalation point, where departments and services can seek advice from a panel of experts for individuals with complex needs. The panel brings experts together from across departments and services to provide multidisciplinary, clinical, and lived experience advice for individuals with highly complex needs who pose a serious risk to others and/or themselves.

The individuals presented are at risk of poor outcomes because their needs fall outside standard service responses, they face service system barriers, the service system does not have appropriate options, or existing pathways have been ineffective, exhausted or are unsustainable. SCNAP is a forum to discuss and review service responses, service delivery issues and systemic barriers. The discussions seek to improve quality and safety, consider risk management strategies, and enhance the development of coordinated, flexible, and evidence-based service responses.

To discuss eligibility criteria and how to refer, contact Renee Sinclair, Program Manager, Complex Needs renee.x.sinclair@health.vic.gov.au

Release of MARAM Guideline

A new Chief Psychiatrist's guideline is available titled 'Implementing the family violence MARAM Framework in mental health and wellbeing services'

<https://www.health.vic.gov.au/chief-psychiatrist/maram-framework-mental-health-wellbeing-services>.

The Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework was developed in response to Recommendation 1 of the Victorian Royal Commission into Family Violence. Responding to family violence, increasing safety for victim survivors (including children), and holding those who use violence to account are priorities for Victoria's Chief Psychiatrist and for mental health and wellbeing services.

This guideline is for organisational leaders. It outlines their responsibilities for implementing and applying the MARAM Framework and tools.

Service requirements to consider the impacts on children and families when treating people with mental health conditions

Following a recent investigation, the Commission for Children and Young People (CCYP) has made two key recommendations:

1. That the Department of Health, in consultation with the OCP, provide guidance to hospitals regarding comprehensive planning that considers the impact of mental illness on parenting capacity as part of its safety and risk guidelines.
2. That the Department of Health, in consultation with the OCP, urgently update its guidelines in relation to discharge planning to ensure that safety and risk guidelines address the impact of mental illness on parenting capacity.

Background

These recommendations follow from an inquiry report into the death of an infant. The infant's mother was receiving treatment for postpartum psychosis and was subsequently convicted of infanticide.

The focus of the investigation was on comprehensive, multidisciplinary discharge planning. The review highlighted the importance of discharge planning that includes the family and consideration of child safety, prior to post-partum discharge.

In cases where a mother is the subject of current Child Protection involvement, the recommended discharge plan should include a case conference between the hospital, family members, Child Protection, mental health and/or other relevant community-based services that will be providing support to the mother and her baby after discharge.

Key principles

There are key principles to follow as part of considering the impacts on children and families when treating people with mental health conditions:

- Ensure care arrangements are in place for any dependents.
- Recognise that children may be acting as young carers, and carer support should be offered.
- Support the consumer and family to make links with community-based child and family services, including a maternal and child health nurse.
- Consult with Families where a Parent has a Mental Illness (FAPMI), a program that can provide primary or secondary consultation in designated mental health services.
- Include clinical and non-clinical support networks, such as family services, family, carers, and supporters in planning for transfers of care throughout the admission or episode of care. Family meetings, or care team meetings should be held to ensure transfer of care plans are safe and comprehensive. Transfer of care plans should identify other supports the consumer may need to support them to safely fulfill their caring responsibilities when they exit a bed-based service.
- A mental health and wellbeing service's staff member, whose profession makes them a mandatory reporter, has an obligation to notify child protection services when they form a belief on reasonable grounds that a child needs protection from physical injury or sexual abuse. Child protection services should be notified with the knowledge of the consumer, rather than anonymously whenever possible.
- If child protection services are involved, designated mental health services can share information with these services under the Child

Information Sharing Scheme. Services should also support the consumer in their interactions with them.
- Support should be provided to consumers who have pets to arrange for their care during admissions.

Additional considerations

Discharge planning to support young children's needs for safety, stability, and protection should include:

- documentation of parental or caregiver roles at admission and in risk assessments
- parenting assessments where possible
- consideration of home environment and safety for children – this may need Child Protection or family support
- Documenting clear steps to protect the infant or young child if the parent's mental health deteriorates post-discharge (e.g., emergency contacts, urgent notifications to child protection for temporary care arrangements, and crisis admission).

Clinicians should advocate for the infant or the young child as a vulnerable party, even when the parent is the primary patient. Collateral history and liaison with all child health services is crucial. The consideration of mental health and alcohol and substance use impacts should be routine. A good understanding of seeking additional assessments, supports and reporting to Child Protection should be part of clinical review processes.

Families are often the first line of support for parents, infants, and young children. Services should consider the following in relation to families:

- Involving family members in discharge planning, provided they are reliable, supportive, and willing to assist. This includes clarifying their role in supervising the consumer (the parent) or recognising warning signs of relapse.
- Evaluate whether family members have the physical, emotional, and practical resources to support the parent and infant. For example, a grandmother may need guidance on managing postnatal psychosis symptoms, or the mother may need someone to supervise medications to ensure compliance, or assistance to attend review appointments.
- Develop plans to align with the family's cultural backgrounds while prioritising infant safety. Also, develop safety plans for family members so when they recognise early warning signs, they know what they can do. However, services must also remain vigilant to risks within family dynamics (e.g., intergenerational trauma, substance misuse and controlling relationships) that could compromise the welfare of the infant or young child.

In cases where Child Protection is engaged, or where risks meet the threshold for mandatory reporting, services should consider the following:

- Facilitating meetings between Child Protection, mental health clinicians, GP, and community services (e.g., family violence support) before discharge. These meetings should:
  - define roles (e.g., Child Protection monitors protective concerns; MHWS manages medication compliance and mental state)
  - establish communication protocols (e.g., shared risk indicators, timelines for follow-up).
- Utilising *Child Information Sharing Scheme (CISS)* and *Family Violence Information Sharing Scheme (FVISS)* to exchange relevant information with agencies if it reduces risks to the infant.
- Ensuring all agencies agree on steps to take if risks escalate (e.g., hospital readmission, temporary removal of the infant).

Services should be familiar with the following legislative requirements:

- ***Mental Health and Wellbeing Act 2022***: Under section 28, 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.
- ***Children, Youth and Families Act 2005***: There is a legal requirement of certain groups of people to report a reasonable belief of child physical or sexual abuse to child protection authorities. Under this act, mandatory reporters must make a report to child protection if they form a belief on reasonable grounds that a child is in need of protection from physical injury or sexual abuse.

- ***Child Wellbeing and Safety Act 2005****:* This act permits sharing of confidential information between services to promote child safety, overriding privacy laws where necessary.

Recommendations to services

1. All mental health and wellbeing services should include some review their local policy and procedures around discharge planning to ensure the safety and wellbeing of infant and young children are prioritised.
2. All services should consider if their policies address significant gaps in identifying the impact of severe mental illness on parenting capacity and ensuring child safety during transitions from hospital to community care.
3. All services should review their policies in light of the 2022 Transfer of Care and Shared Care Guideline <https://www.health.vic.gov.au/chief-psychiatrist/transfer-of-care-and-shared-care>. This guideline has replaced the old Discharge Planning Guideline and includes the principles of the Mental Health and Wellbeing Act, as well as special considerations for different circumstances, including a section to identify and assess the needs of dependent children that the consumer cares for.

Reflections on young children's needs for safety stability and protection

Finally, this matter highlights the needs for adequate and robust discharge planning, and services should actively engage with all relevant stakeholders to ensure safety and risk mitigation. Working in mental health is challenging and working with a parent with significant mental health issue and recently gave birth add an extra layer of challenge and complexity, services should adopt a proactive, family-centred approach to prioritise infant safety without stigmatising the parent with mental illness.

Key steps involve consideration of capacity to undertake parenting capacity assessments, strengthening multidisciplinary collaboration, and ensuring accountability through follow-up.

Further information

Read about the statutory role of the Chief Psychiatrist to uphold quality and safety in Victoria's mental health and wellbeing system under the Mental Health and Wellbeing Act.

Important information is available for clinical mental health and wellbeing services to understand their core obligations around delivering safe and high-quality treatment and care, and information on reporting a failure to comply with the Mental Health and Wellbeing Act.

Further resources

Helpful resources have been developed by the department, and additional resources are available to assist clinical mental health and wellbeing service providers, consumers, carers and families with information about the Mental Health and Wellbeing Act.

Refer to the links below.

Chief Psychiatrist | health.vic.gov.au

Mental Health and Wellbeing Act 2022 Handbook | health.vic.gov.au

Statement of Rights | health.vic.gov.au

Mental Health and Wellbeing Act 2022 | legislation.vic.gov.au

To receive this document in another format, phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email Office of the Chief Psychiatrist, <ocp@health.vic.gov.au>.

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