Seclusion and restraint report 2020–24

Office of the Chief Psychiatrist

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Acknowledgements

Acknowledgement of country

The Office of the Chief Psychiatrist (OCP) 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 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 Victoria's mental health system.

The OCP thanks all stakeholders who generously gave their time to review this report and provide feedback, including the Victorian Mental Illness Awareness Council (VMIAC), Tandem, Safer Care Victoria, the Lived and Living Experience and the First Peoples Branch in the Department of Health's Mental Health and Wellbeing Division, and Authorised Psychiatrists and operational directors involved in the OCP Restrictive Interventions Advisory Committee.

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

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Contents

Introduction

The *Seclusion and restraint report 2020–24* is a comprehensive account of restrictive intervention use in Victoria. It contains data on rates of seclusion and restraint at the health service, state and national levels, documenting the age groups of impacted people and other relevant demographic characteristics such as sex and cultural background. This quantitative information is accompanied by an explanatory narrative that contextualises trends and variations documented at different locations and during different periods.

In its final report, the Royal Commission into Victoria's Mental Health System highlighted the ways that restrictive interventions are not therapeutic and in fact harm people. It handed down recommendations for reducing and eventually eliminating the practice in Victoria's mental health and wellbeing system.

The *Mental Health and Wellbeing Act 2022* regulates restrictive interventions, setting strict conditions on their use. Under the Act, restrictive interventions may be used only as a last resort to prevent imminent and serious harm (and in the case of bodily restraint – to administer treatment or medical treatment to a person) after less restrictive options were tried. This can involve situations where a consumer is behaving aggressively and endangering their own safety or the safety of other consumers or staff, refusing treatment while severely unwell (for example, while they are suicidal or at risk of death with an eating disorder) or are attempting to leave hospital while severely unwell.

The *Seclusion and restraint report 2020–24* is an important step towards clinical transparency on restrictive intervention use and responds to a Royal Commission recommendation. This transparency increases public confidence in mental health services by informing the public about restrictive interventions through evidence and analysis based on clinical and sector knowledge. It is also the basis for clinical accountability, with health services and the Department of Health highlighting variations in rates of restrictive interventions across Victoria, describing the reasons for the variations, and outlining what is being done to reduce reliance on restrictive interventions and drive systemic improvement.

The report has been developed by drawing on the clinical expertise of staff in the Office of the Chief Psychiatrist (OCP) and their system-wide view of clinical services while undertaking statutory oversight functions in Victoria's mental health and wellbeing system. The OCP's close interface with clinical mental health services made it possible to gather rich, context-specific information for this report to outline the circumstances influencing the rates of restrictive interventions being documented. In this report, the OCP takes a focussed approach to examining restrictive interventions from the standpoint of clinical practice and accountability. The OCP is committed to producing annual seclusion and restraint data.

The analysis in this report is limited by the current obligations of reporting that generate the data on restrictive interventions. In addition, there are differences in service sizes leading to larger fluctuations in rates in smaller services. Changes to reporting practices and links with other data sources may provide future opportunities for more detailed analysis of restrictive interventions.

The data in the report should not automatically be regarded as an indicator of good or bad performance by individual health services. The factors that lead to variations in rates of restrictive interventions are multiple and complex, involving differences in reporting rates, patient acuity, substance use rates, staffing levels, staff turnover, workforce training and the physical environment where treatment and care is provided, among other things. Given this, readers should view this report as a resource for understanding where and how improvements can be made to reduce the reliance on restrictive interventions, rather than an evaluation of the quality of care provided at a specific service.

Chemical restraint is a new area of regulation in Victoria, introduced under the Mental Health and Wellbeing Act. This report does not cover chemical restraint because work continues to consolidate chemical restraint reporting so it is consistent across services and generates meaningful data for analysis. Once this work is complete, the Department of Health will be in a position to report on the use of chemical restraint.

Readers may notice that the data does not at times perfectly match between sections or with previous Department of Health publications. This is due to the data being derived from different sources using different methodologies to prepare it for publication; for example, the data on national jurisdictions is sourced from the Australian Institute of Health and Welfare, while the rest of the report uses data from the eHealth division in the Department of Health. It is also due to the data being derived during different periods. Insofar as the data is live and updated as new or late reporting takes place, it is subject to minor changes over time. These differences are statistically insignificant and do not alter trends or conclusions that can be drawn about seclusion and restraint.

The report is organised in 6 sections. Section 1 looks at seclusion and restraint across Victoria in terms of number of episodes, rates per 1,000 occupied bed days, frequency and duration. This data covers different types of inpatient units, including adult, older persons, child and adolescent, forensic and specialist units. Sections 2 and 3 look at this information in closer detail, focusing on seclusion and restraint in individual mental health services. Section 4 looks at seclusion and restraint across Australia, comparing its use in different states and territories and highlighting Victoria's figures against the national average. Section 5 examines social factors including age, sex and cultural identity that may contribute to the risk that certain people may be more or less likely to be secluded and restrained. Section 6 outlines the reform activities underway to reduce and eventually eliminate restrictive interventions, a key recommendation of the Royal Commission into Victoria's Mental Health System. It should be noted that Mercy Health no longer runs an inpatient site at Footscray.

Mental Health and Wellbeing Principles

The Mental Health and Wellbeing 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 properly consider the principles when making a decision under the Mental Health and Wellbeing Act. These principles, and the Mental Health and Wellbeing Act more broadly, embody human rights that aim to protect people who receive a mental health and wellbeing service.

The following 13 principles are set out in ss 16 to 28 of the Mental Health and Wellbeing Act:

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.

Definitions

In the Mental Health and Wellbeing Act, **restrictive intervention** means 'seclusion, bodily restraint or chemical restraint' (s 3(1)):

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

The provisions relating specifically to restrictive interventions are set out in Part 3.7 of the Act.

1. Statewide – restraint and seclusion

1.1 Number of episodes

The number of episodes is a raw count of events and does not reflect the number of people admitted into mental health beds during the period.

Table 1 and Figure 1 show the number of episodes of bodily restraint and seclusion in acute inpatient units over the past 4 years. The use of bodily restraint and seclusion decreased in 2023–24 compared with previous years.

This has occurred in a time of increased inpatient unit beds, increased episodes of care in inpatient units, reduced length of stay, higher acuity and improved reporting of restrictive interventions since the Mental Health and Wellbeing Act took effect. Against this backdrop, the reduction in the number of restrictive intervention episodes is especially significant. This positive trend reflects an increased focus on quality improvement and acceptance of a key finding of the Royal Commission into Victoria's Mental Health system that restrictive interventions are not therapeutic. Overall, it reflects the cumulative work done across the sector in collaboration with Safer Care Victoria and other consumer-focused bodies and the broadened legislative oversight of the OCP since the start of the Mental Health and Wellbeing Act.

Table 1: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2020–21 to 2023–24

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

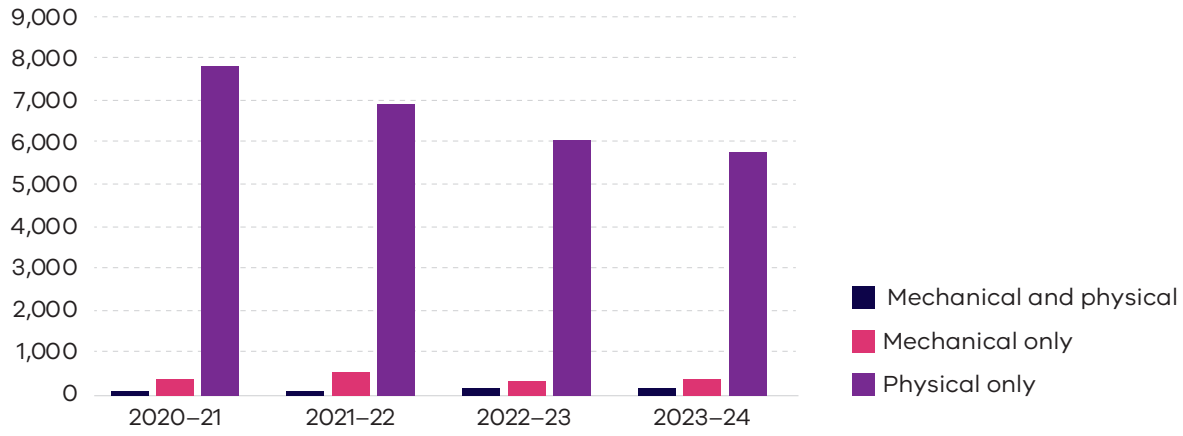
Figure 1: Number of episodes of bodily restraint and seclusion in acute inpatient units, 2020–21 to 2023–24

'Physical only' restraint accounted for most instances of restraint (Table 2 and Figure 2) and has been slowly decreasing. The number of episodes of mechanical restraint has increased slightly in 2023–24, as has the combined mechanical-physical type of restraint. This may be due to the increased reporting required under the Act in new environments. The increase in the number of episodes where mechanical and physical restraint were used together likely reflects more accurate reporting of instances where a person was physically restrained before applying a mechanical restraint due to more communication about the need to record both.

Table 2: Number of bodily restraint episodes in acute inpatient units, by type of bodily restraint, 2020–21 to 2023–24

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

Figure 2: Number of bodily restraint episodes in acute inpatient units, by type of bodily restraint, 2020–21 to 2023–24



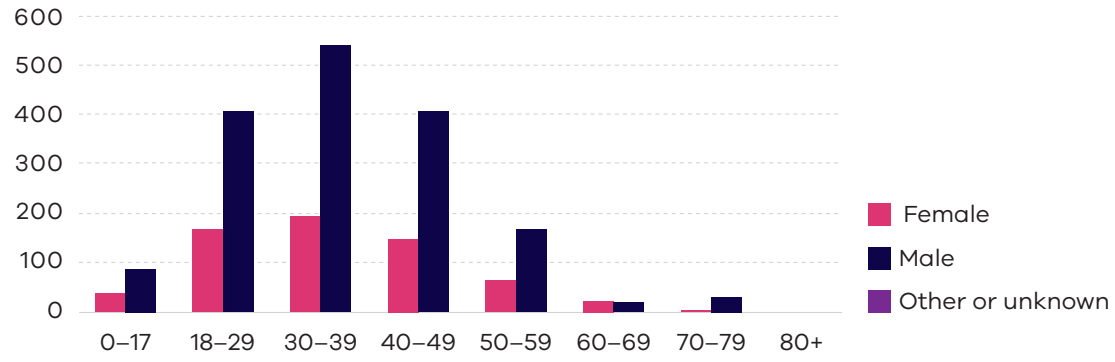
In 2023–24 seclusion in acute inpatient units showed an age/sex difference, highlighting the higher prevalence of middle-aged men experiencing seclusion (Table 3 and Figure 3).

Table 3: Number of seclusion episodes in acute inpatient units, by age and sex, 2023–24

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

Notes: Some age groups have been further aggregated to protect the confidentiality of individuals. n.p. refers to data that is not published due to low numbers. This is done to protect confidentiality.

Figure 3: Number of seclusion episodes in acute inpatient units, by age and sex, 2023–24



For bodily restraint, most episodes were among 30 to 39-year-old men, followed by men and women in the 18- to 29-year-old age group (Table 4 and Figure 4).

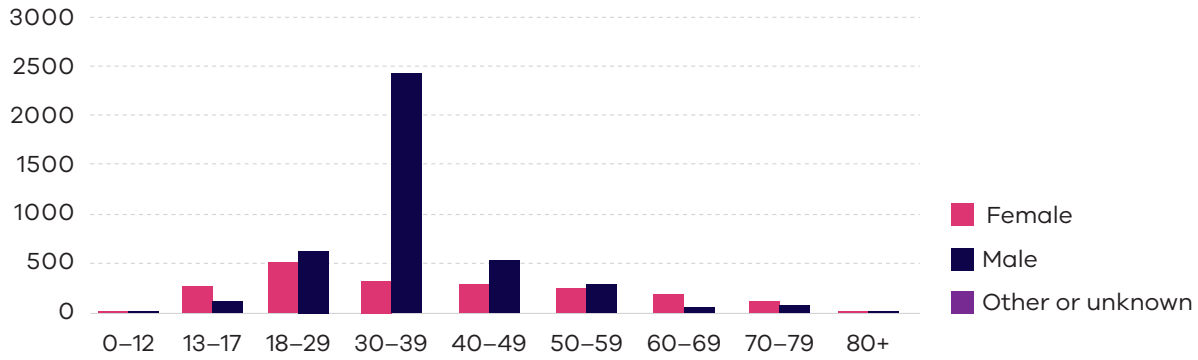
There is a difference in bodily restraint episodes between sexes, with episodes being more frequent in males, except in the 13 to 17 and the 60 to 80+-year-old age groups, where it was slightly more frequent in females than males. The younger age group likely reflects the use of bodily restraint for last resort life-saving refeeding for eating disorders. The older group reflects the greater number of women in this age group.

Table 4: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2023–24

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

n.p. refers to data that is not published due to low numbers. This is done to protect confidentiality.

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



1.2 Rates of episodes

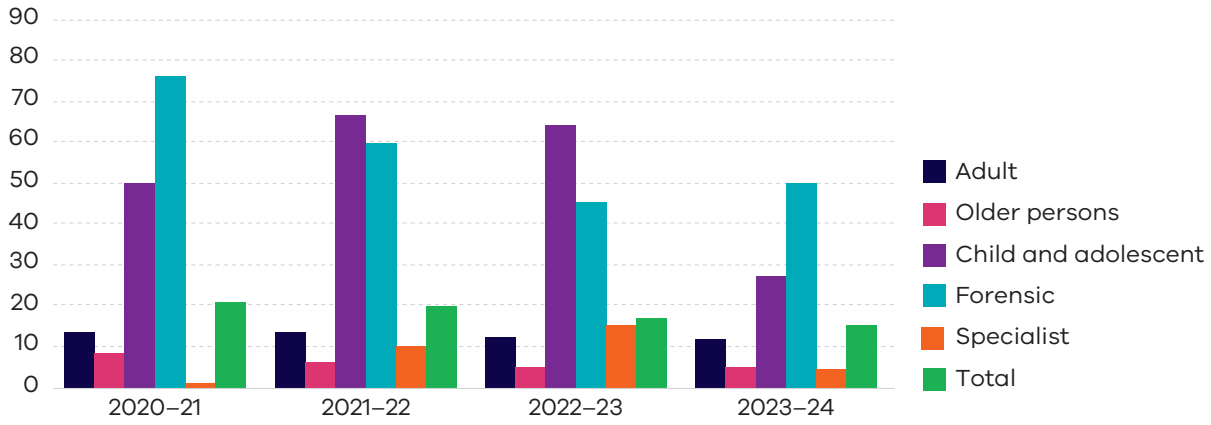
Rates are derived using raw episode counts per 1,000 admitted bed days, allowing an appreciation of relative frequency per periods of time admitted. This method better reflects likelihood than raw counts.

Table 5 and Figure 5 show that bodily restraint episodes per 1,000 occupied bed days have decreased overall, with most types of units trending in this direction.

Table 5: Rates of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24

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

Figure 5: Rates of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24



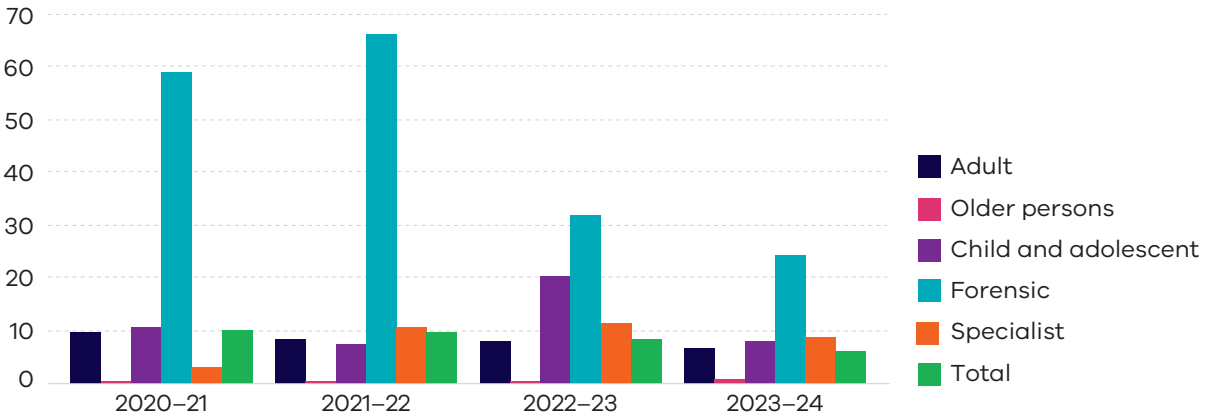
The number of bodily restraint episodes in child and adolescent units has decreased over the past 3 financial years. In child and adolescent units, rates are generally higher than in other units, reflecting small numbers of consumers with high acuity or specific needs. Restraint is used in these situations to prevent immediate self-harm and to administer nasogastric feeding multiple times for young people with eating disorders. Forensic units had a slight increase in 2023–24 while trending down significantly since 2020–21.

Table 6 and Figure 6 present the numbers of episodes of seclusion per 1,000 occupied bed days. The rate is used for comparison because it allows a standardised approach to compare different sized health services. Rates have fallen in adult wards over the past 4 years and remain low in services for older people. The rate in child and adolescent units has decreased, with a small number of young people with complex combinations of mental illness and intellectual or developmental disability being represented in these figures. Where needed, the OCP supports 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.

Table 6: Rates of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24

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

Figure 6: Rates of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24



Because child and adolescent wards are generally smaller in bed numbers and have longer lengths of stay than adult wards, the targets for restrictive practices are deliberately lower. With such low targets, one young person restricted several times may put services over target for a ward in a month. Services generally report that higher rates are due to small numbers of young people having multiple instances of restrictive practices. Higher seclusion rates may reflect greater challenges in managing emotional regulation and higher rates of admission of young people with neurodivergence impacting on difficulties de-escalating conflict.

Forensicare has undertaken extensive quality improvement activities around restrictive practices, helping to explain the significant reduction of their seclusion episodes over recent years.

1.3 Frequency of episodes

When restraint was applied, it was still most commonly a single occurrence within one admission (Table 7). However, multiple episodes of restraint are not uncommon, and this pattern has not significantly changed in recent years. As with seclusion, increased awareness of trialling people out of restraints may lead to more separate episodes of restraint that are shorter in duration.

Table 7: Frequency of bodily restraint episodes within a single inpatient admission, 2020–21 to 2023–24

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

Table 8 shows that, when seclusion happened, most episodes occurred once within an admission to hospital. For those receiving multiple episodes of seclusion, these typically occur as services work to trial transitioning the person out of seclusion. A small number of consumers experience multiple episodes of seclusion. This generally reflects severe and complex mental illness and risks to others, including other consumers in the inpatient environment.

Table 8: Frequency of seclusion episodes within a single inpatient admission, 2020–21 to 2023–24

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

1.4 Duration of episodes

There continues to be a decrease in the number of episodes of restraints lasting less than 15 minutes (Table 9). Many restraint episodes last less than 3 minutes and may indicate using restraint to administer medication or to move a person towards a different space. While acknowledging the goal of zero restrictive interventions, there is a positive reduction from 35 restraints exceeding 12 hours in 2020–21 to 3 instances in 2023–24.

Table 9: Duration of physical, mechanical and combined bodily restraint episodes, 2020–21 to 2023–24

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

Table 10 shows that in 2023–24 close to half of all episodes of seclusion lasted for 4 or fewer hours, consistent with most previous years. There was a significant reduction in the number of seclusions that went beyond 12 hours, which is a positive development. The occasions of seclusion beyond 12 hours are closely monitored by the OCP, as are seclusions that are beyond 4 hours for those aged 65 or older and those aged 18 or younger. Staff in some services report that attempting to reduce time in seclusion has resulted in shorter duration seclusions. Reducing time in seclusion may risk being placed in a ward environment that causes distress, increasing the risk of a further seclusion episode.

Table 10: Duration of seclusion episodes in acute inpatient units, 2020–21 to 2023–24

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

Across the state, designated mental health services report common challenges impacting on the rates of restrictive interventions. These include older infrastructure, workforce safety and occupational violence, limitations in the availability of de-escalation training, workforce shortages and a lack of senior staff. There have been reports of higher acuity and more first presentations in some services, potentially reflecting changes in access related to shifts in police practice in light of Royal Commission recommendations for a health-led response.

Other challenges impacting on restrictive interventions that services reported included:

- the high prevalence of methamphetamine use
- extended waits in emergency departments for inpatient unit beds
- high stimulus environments in emergency departments that can heighten agitation and aggression in consumers
- increased homelessness and consequent delays in treatment for people who end up arriving in emergency departments acutely unwell and less responsive to de-escalation strategies
- people being brought to emergency departments directly from prison or court acutely unwell.

New purpose-built infrastructure, with new models of care and updates to intensive care areas, have been welcomed in services that have received them. This has contributed to reductions in restrictive practices. Innovations such as Hospital in the Home and intensive outreach show promise in reducing lengths of stay and acuity in people admitted for treatment and care.

Efforts to embed the Mental Health and Wellbeing Principles is another contributing factor to reductions in restrictive practices. Person-centred and trauma-informed care, an understanding of people's diverse needs, and recognising the importance of including family and carers in care decisions (including kin for Aboriginal people) all help reduce the reliance on restrictive practices. Mental health staff have stressed the importance of staying true to these principles while also balancing them with the need to minimise the risk of harm when consumers are severely unwell.

Services report keen interest, at their executive and board levels, in work to reduce restrictive interventions. Reporting on this work to health service executives takes place through various channels, including:

- Reducing Restrictive Interventions Committees
- Safety for All Local Committees
- Mental Health Quality and Safety Committees
- monthly variance reporting via service-wide safety and quality meetings
- biannual performance meetings with the Mental Health and Wellbeing Division, Department of Health, and the OCP
- quarterly reporting to the Department of Health against Statements of Priorities.

Overall, services highlighted the following in terms of recent outcomes:

- The Mental Health and Wellbeing Act has resulted in a greater focus on reporting.
- There was an increase in restraint and seclusion numbers during the COVID-19 pandemic, possibly due to consumers with higher acuity being unable to access services as easily and being more unwell at presentation.
- Importantly, there was a significant decrease in the duration of episodes of restrictive interventions and a decrease in the number of consumers having more than one episode, reflecting staff focus on being least restrictive.
- There were prolonged intensive care area bed closures across the sector as part of infrastructure improvement works. This resulted in significant pressure on inpatient units, with increased acuity and less space for complex consumers presenting with high risks.

2. By service – restraint

The type of restraint covered in this section is bodily restraint. As defined in the Mental Health and Wellbeing Act, bodily restraint encompasses both mechanical and physical restraint (refer to 'Definitions' earlier). The following data and accompanying analysis examine each of these restrictive interventions at the service level.

Services are compared with reference to rates of restrictive interventions per 1,000 admitted bed days, rather than *number* of episodes of restrictive interventions, because this provides a common denominator where there are differences in size and capacity between services. There is unevenness in capacity and service provision across the state, with some services having higher bed numbers and greater occupancy than others. Looking at rates removes some of the impact of these factors to allow better comparison. However, it cannot remove all impacts on the data because lower occupancy may result in more staff per consumer. This is a recognised factor in managing complexity of risk and addressing emerging issues early before restrictive practices are used.

2.1 Bodily restraint – adult inpatient units

Table 11 and Figure 7 show rates of bodily restraint in adult units have mostly reduced from 2022–21 to 2023–24. However, in some places, changes in reporting practice have resulted in mild increases of bodily restraint being recorded in this period.

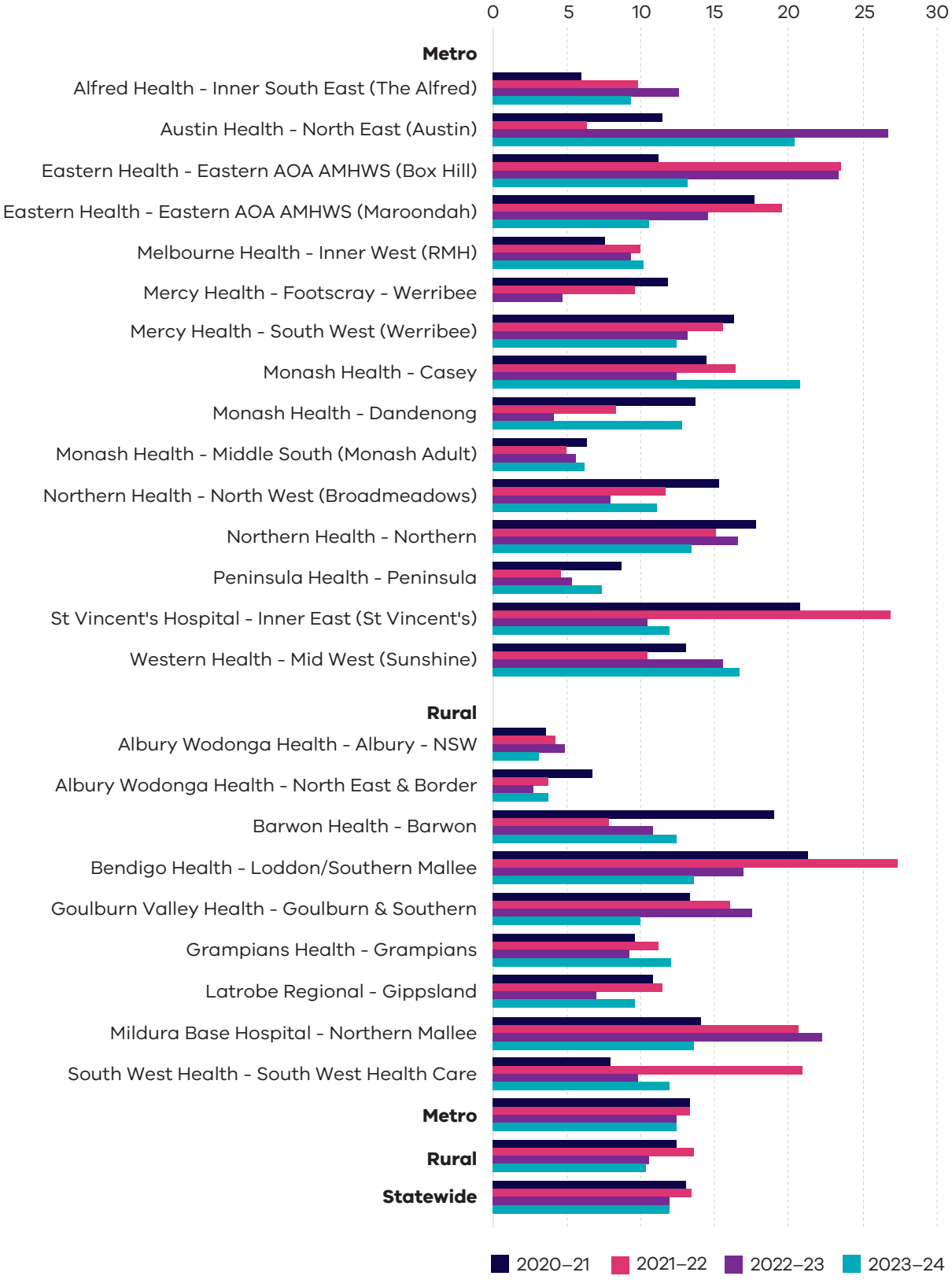
Table 11: Rates of ended bodily restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (The Alfred)	6.0	9.8	12.6	9.3
Austin Health – North East (Austin)	11.5	6.3	26.7	20.4
Eastern Health – Eastern AOA AMHWS (Box Hill)	11.2	23.5	23.4	13.2
Eastern Health – Eastern AOA AMHWS (Maroondah)	17.7	19.5	14.6	10.6
Melbourne Health – Inner West (Royal Melbourne)	7.6	10.0	9.3	10.2
Mercy Health – Footscray	11.8	9.6	4.7	n.a.
Mercy Health – South West (Werribee)	16.3	15.5	13.2	12.4
Monash Health – Casey	14.4	16.4	12.5	20.7
Monash Health – Dandenong	13.7	8.4	4.1	12.8

Health service and campus	2020–21	2021–22	2022–23	2023–24
Monash Health – Middle South (Monash Adult)	6.4	5.0	5.6	6.2
Northern Health – North West (Broadmeadows)	15.3	11.7	8.0	11.1
Northern Health – Northern	17.8	15.0	16.5	13.4
Peninsula Health – Peninsula	8.7	4.6	5.4	7.3
St Vincent's Hospital – Inner East (St Vincent's)	20.7	26.8	10.4	11.9
Western Health – Mid West (Sunshine)	13.1	10.4	15.5	16.6
Albury Wodonga Health – Albury – New South Wales	3.6	4.2	4.9	3.1
Albury Wodonga Health – North East and Border	6.7	3.8	2.7	3.7
Barwon Health – Barwon	19.0	7.8	10.8	12.5
Bendigo Health – Loddon / Southern Mallee	21.2	27.4	16.9	13.5
Goulburn Valley Health – Goulburn and Southern	13.3	16.0	17.5	9.9
Grampians Health – Grampians	9.6	11.2	9.2	12.1
Latrobe Regional – Gippsland	10.8	11.4	7.0	9.6
Mildura Base Hospital – Northern Mallee	14.1	20.6	22.2	13.5
South West Health – South West Health Care	8.0	20.9	9.8	12.0
Metro	**13.3**	**13.3**	**12.4**	**12.5**
Rural	**12.5**	**13.6**	**10.6**	**10.3**
Statewide	**13.1**	**13.4**	**11.9**	**11.9**

Metro sites are shaded.
n.a. = not available

Figure 7: Rates of ended bodily restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



All health services were contacted about their rate fluctuations. Services cited significant difficulties during the COVID-19 pandemic involving higher acuity presentations due to access issues and the readjustment to staffing practices in response. Addressing issues with staff recruitment and retention and ensuring senior experienced staff are present on wards, especially after hours, were highlighted as crucial to reducing rates. Services also reported significant increases in substance-affected consumers who were less amenable to non-restrictive approaches. These consumers tended to be more agitated and found it difficult to remain calm in ward environments that were not always designed with therapeutic principles in mind. Services also talked about the risk of assault and aggression to staff and other consumers and how this both increases staff reactivity and makes it harder to retain and recruit staff willing to work in these environments. In 2023-24, some services had intensive care closures due to upgrades. This added to the challenges of providing care for consumers in a physical environment suited to their specific needs.

2.1.1 Mechanical restraint – adult inpatient units

The OCP expects services will use mechanical restraint only as an absolute last resort. It is most commonly used in emergency departments. Rates may rise in future years with new reporting requirements for emergency departments under the Mental Health and Wellbeing Act. Services with higher rates of mechanical restraint usually have emergency departments located away from wards, leaving them to rely on mechanical restraint to transport consumers to medical wards in certain situations. Mechanical restraint may at times also be used to transport consumers to sites where they can have electroconvulsive therapy or other sites where they can get appropriate treatment and care. Transport services, including Ambulance Victoria, have safety requirements for times when consumers are agitated, which may include mechanical restraint.

Table 12 and Figure 8 show rates of ended mechanical restraint episodes in adult inpatient units.

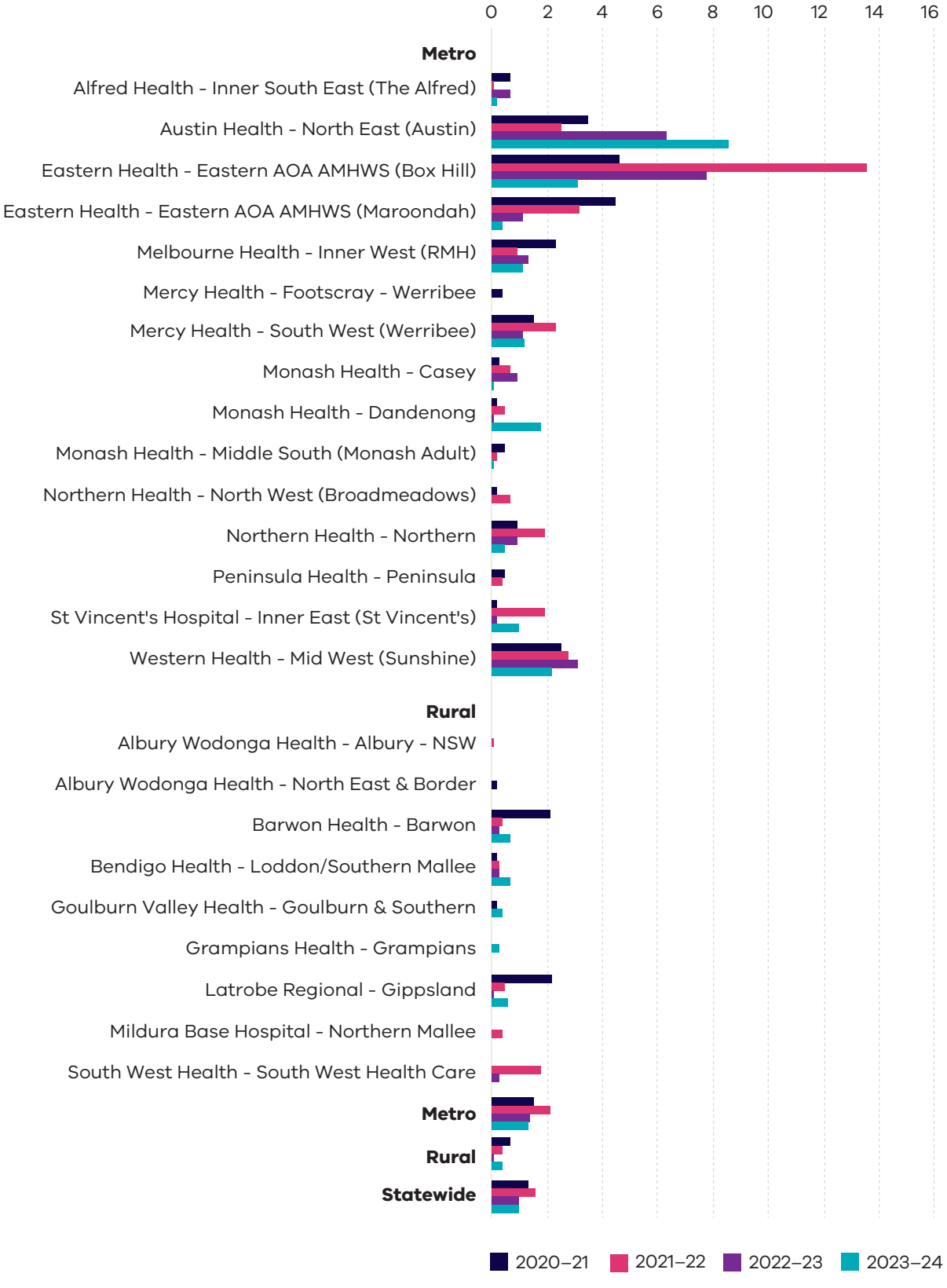
Table 12: Rates of ended mechanical (only) restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (The Alfred)	0.7	0.1	0.7	0.2
Austin Health – North East (Austin)	3.5	2.5	6.3	8.6
Eastern Health – Eastern AOA AMHWS (Box Hill)	4.6	13.6	7.8	3.1
Eastern Health – Eastern AOA AMHWS (Maroondah)	4.5	3.2	1.1	0.4
Melbourne Health – Inner West (Royal Melbourne)	2.3	0.9	1.3	1.1
Mercy Health – Footscray	0.4	0.0	0.0	n.a.
Mercy Health – South West (Werribee)	1.5	2.3	1.1	1.2
Monash Health – Casey	0.3	0.7	0.9	0.1
Monash Health – Dandenong	0.2	0.5	0.1	1.8

Health service and campus	2020–21	2021–22	2022–23	2023–24
Monash Health – Middle South (Monash Adult)	0.5	0.2	0.0	0.1
Northern Health – North West (Broadmeadows)	0.2	0.7	0.0	0.0
Northern Health – Northern	0.9	1.9	0.9	0.5
Peninsula Health – Peninsula	0.5	0.4	0.0	0.0
St Vincent's Hospital – Inner East (St Vincent's)	0.2	1.9	0.2	1.0
Western Health – Mid West (Sunshine)	2.5	2.8	3.1	2.2
Albury Wodonga Health – Albury – New South Wales	0.0	0.1	0.0	0.0
Albury Wodonga Health – North East and Border	0.2	0.0	0.0	0.0
Barwon Health – Barwon	2.1	0.4	0.3	0.7
Bendigo Health – Loddon / Southern Mallee	0.2	0.3	0.3	0.7
Goulburn Valley Health – Goulburn and Southern	0.2	0.0	0.0	0.4
Grampians Health – Grampians	0.0	0.0	0.0	0.3
Latrobe Regional – Gippsland	2.2	0.5	0.1	0.6
Mildura Base Hospital – Northern Mallee	0.0	0.4	0.0	0.0
South West Health – South West Health Care	0.0	1.8	0.3	0.0
Metro	**1.5**	**2.1**	**1.4**	**1.3**
Rural	**0.7**	**0.4**	**0.1**	**0.4**
Statewide	**1.3**	**1.6**	**1.0**	**1.0**

Metro sites are shaded.
n.a. = not available

Figure 8: Rates of ended mechanical (only) restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



Where mechanical restraint rates have declined, services have undertaken measures to achieve this, including removing access to restraints, creating sign-out protocols and implementing extra oversight and monitoring systems. Services have also reported that increasing access on wards to clinical nurse consultants with trauma-informed approaches to care can help reduce mechanical restraint and restrictive interventions more generally. Other factors include person-centred and trauma-informed care, therapeutic environments, a lived experience-led and multidisciplinary workforce (which includes peer support workers in emergency departments) and embedded family-inclusive practices that value the knowledge of family members and their role in de-escalation strategies.

2.1.2 Physical restraint – adult inpatient units

The use of physical restraint has generally decreased over the 4-year period (Table 13 and Figure 9). Services noted that physical restraint rates are higher than seclusion, with physical restraint being employed for briefer periods, often to ensure someone is moved to a safe place, to administer medication or other treatment or to prevent a person from harming themselves or other consumers and staff. During the 4-year period, there were changes in bed numbers at several sites and closures of intensive care areas, leading to higher acuity consumers being moved to lower acuity areas where the environment is less suitable for recovery. Physical restraint may go up as seclusion goes down because all lesser restrictive practices are employed to avoid using seclusion.

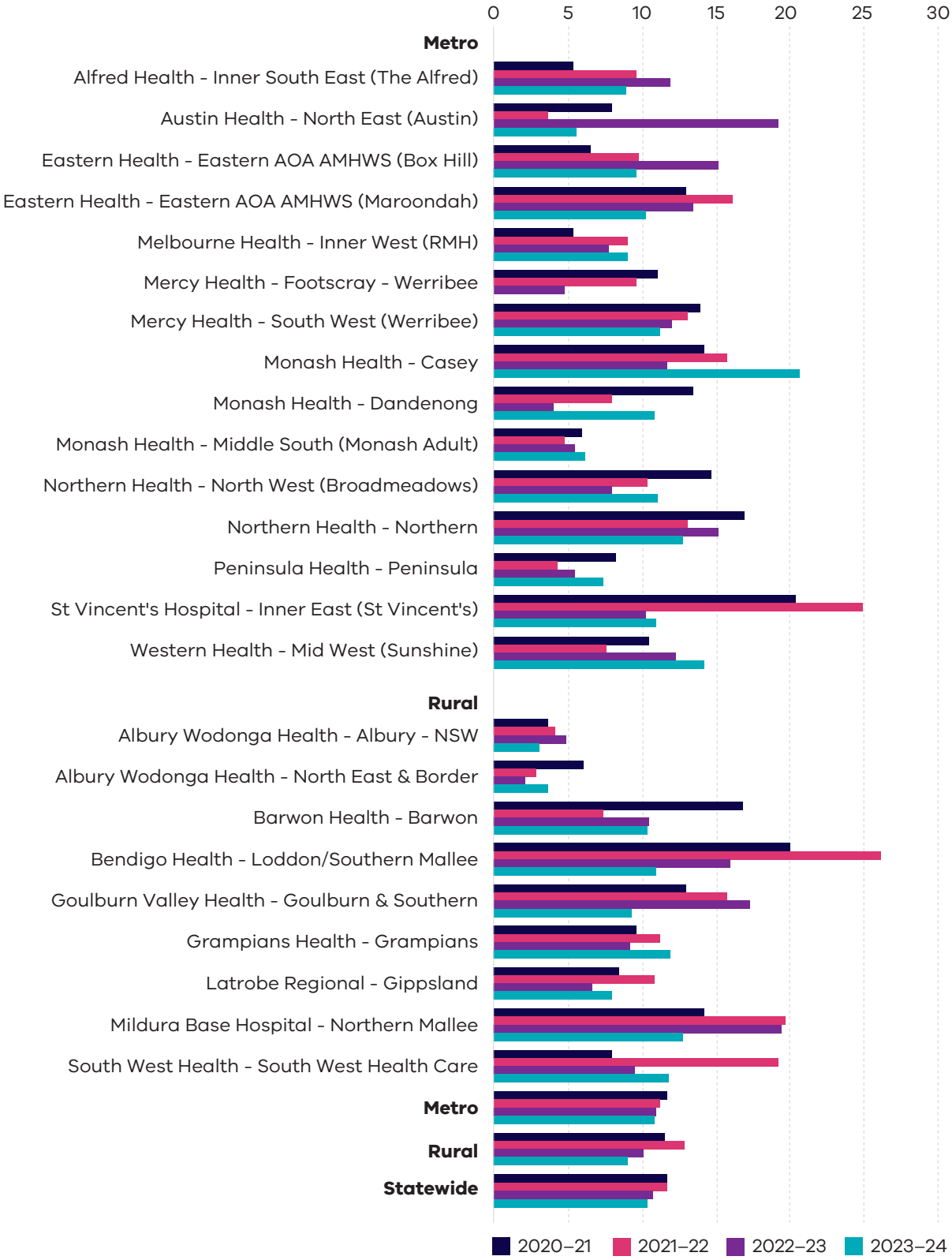
Table 13: Rates of ended physical (only) restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (The Alfred)	5.3	9.6	11.9	8.9
Austin Health – North East (Austin)	7.9	3.6	19.2	5.6
Eastern Health – Eastern AOA AMHWS (Box Hill)	6.5	9.8	15.1	9.6
Eastern Health – Eastern AOA AMHWS (Maroondah)	13.0	16.1	13.5	10.2
Melbourne Health – Inner West (Royal Melbourne)	5.3	9.0	7.7	9.0
Mercy Health – Footscray	11.0	9.6	4.7	n.a.
Mercy Health – South West (Werribee)	13.9	13.1	12.0	11.2
Monash Health – Casey	14.1	15.7	11.6	20.6
Monash Health – Dandenong	13.4	7.9	4.0	10.8
Monash Health – Middle South (Monash Adult)	5.9	4.7	5.5	6.1
Northern Health – North West (Broadmeadows)	14.6	10.3	7.9	11.0
Northern Health – Northern	16.9	13.1	15.1	12.7
Peninsula Health – Peninsula	8.2	4.2	5.4	7.3
St Vincent's Hospital – Inner East (St Vincent's)	20.4	24.9	10.2	10.9

Health service and campus	2020–21	2021–22	2022–23	2023–24
Western Health – Mid West (Sunshine)	10.5	7.6	12.3	14.2
Albury Wodonga Health – Albury – New South Wales	3.6	4.1	4.9	3.0
Albury Wodonga Health – North East and Border	6.0	2.8	2.1	3.7
Barwon Health – Barwon	16.8	7.3	10.5	10.3
Bendigo Health – Loddon / Southern Mallee	20.0	26.1	15.9	10.9
Goulburn Valley Health – Goulburn and Southern	13.0	15.7	17.3	9.3
Grampians Health – Grampians	9.6	11.2	9.2	11.9
Latrobe Regional – Gippsland	8.4	10.8	6.6	7.9
Mildura Base Hospital – Northern Mallee	14.1	19.7	19.4	12.7
South West Health – South West Health Care	8.0	19.2	9.5	11.8
Metro	**11.6**	**11.2**	**10.9**	**10.8**
Rural	**11.5**	**12.9**	**10.1**	**9.0**
Statewide	**11.6**	**11.6**	**10.7**	**10.3**

Metro sites are shaded.
n.a. = not available

Figure 9: Rates of ended physical (only) restraint episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



During 2023–24, 16 inpatient unit teams from 12 health services were taking part in phase 1 of the Towards Elimination of Restrictive Practices (TERP) Collaborative. As of 2025, 27 inpatient unit teams from 17 health services are engaged in phase 2 of the TERP Collaborative.

2.2 Bodily restraint – older persons inpatient units

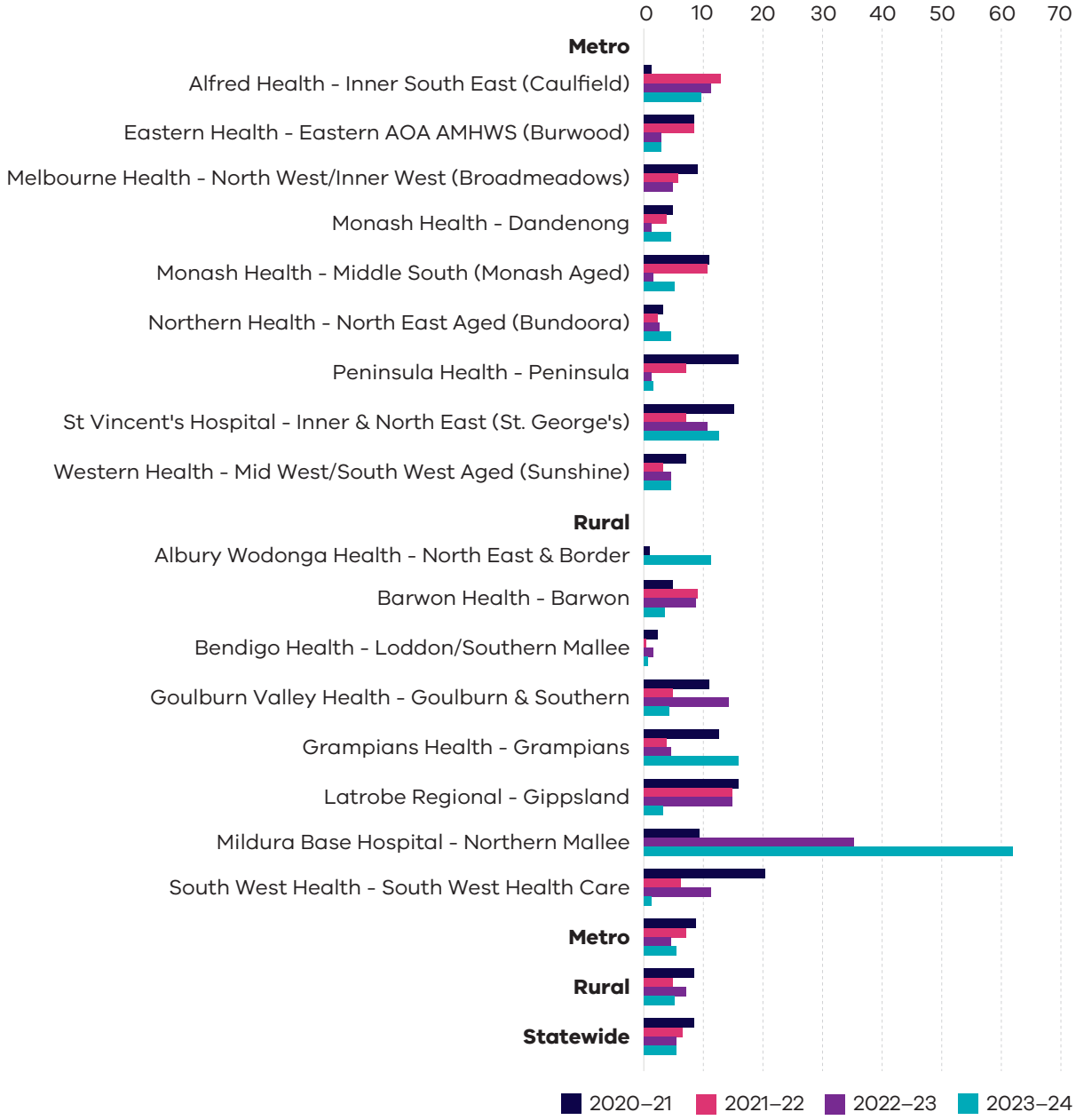
There has been a significant decline in the use of bodily restraint in older persons units at several services (Table 14 and Figure 10). Staff in older age services highlighted the better awareness about physical restraint and improvements in reporting culture. Ongoing education, Safewards, other quality improvement initiatives (such as reducing falls and medication safety) and training about restrictive practices have been leading to a gradual reduction of restraint episodes in older adult services.

Table 14: Rates of ended bodily restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (Caulfield)	1.1	12.8	11.4	9.5
Eastern Health – Eastern AOA AMHWS (Burwood)	8.3	8.3	2.8	3.0
Melbourne Health – North West / Inner West (Broadmeadows)	8.9	5.7	4.7	0.0
Monash Health – Dandenong	4.8	3.8	1.1	4.5
Monash Health – Middle South (Monash Aged)	10.8	10.5	1.6	5.0
Northern Health – North East Aged (Bundoora)	3.2	2.3	2.5	4.5
Peninsula Health – Peninsula	15.7	7.2	1.3	1.5
St Vincent's Hospital – Inner and North East (St George's)	15.0	6.9	10.7	12.5
Western Health – Mid West / South West Aged (Sunshine)	7.2	3.3	4.5	4.5
Albury Wodonga Health – North East and Border	1.0	0.0	0.0	11.3
Barwon Health – Barwon	4.8	9.1	8.7	3.5
Bendigo Health – Loddon / Southern Mallee	2.1	0.3	1.6	0.7
Goulburn Valley Health – Goulburn and Southern	11.0	4.7	14.1	4.3
Grampians Health – Grampians	12.5	3.7	4.5	15.6
Latrobe Regional – Gippsland	15.7	14.7	14.7	3.1
Mildura Base Hospital – Northern Mallee	9.3	0.0	35.0	61.9
South West Health – South West Health Care	20.4	6.1	11.3	1.2
Metro	**8.6**	**7.1**	**4.5**	**5.5**
Rural	**8.2**	**4.7**	**7.1**	**5.0**
Statewide	**8.5**	**6.4**	**5.3**	**5.4**

Metro sites are shaded.

Figure 10: Rates of ended bodily restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



Responding to recommendations from the Royal Commission into Victoria's Mental Health System, some services have lowered the age threshold for admissions to accept referrals based on clinical need. This has led to more episodes of earlier onset behaviours, psychotic illness, substance use and symptoms of dementia with increased risk for behavioural disturbance. Older persons units have not all been designed for this younger cohort, and there are differences in sight lines that need to be factored into staff observations and capacity to identify escalation early. Higher rates of restrictive practices in this cohort generally represents 1 or 2 consumers with complex treatment and care needs that staff have found challenging to support. It does not represent the widespread use of bodily restraint.

2.2.1 Mechanical restraint – older persons inpatient units

Mechanical restraint is uncommon in older persons units. Table 15 and Figure 11 show that it was typically used at very low rates or not used at all in most services between 2020–21 and 2023–24. A single consumer restrained on multiple occasions can influence the data significantly for a given service. However, when these outliers are excluded from the data, episodes of mechanical restraint in older adults have been consistently low.

At Barwon Health the new McKellar inpatient unit opened in 2022 for consumers aged 50 or older has contributed significantly to reducing restrictive interventions for older adults because it provides a person-centred setting more suitable to this age cohort. This illustrates how the right environment and infrastructure can help reduce restrictive interventions.

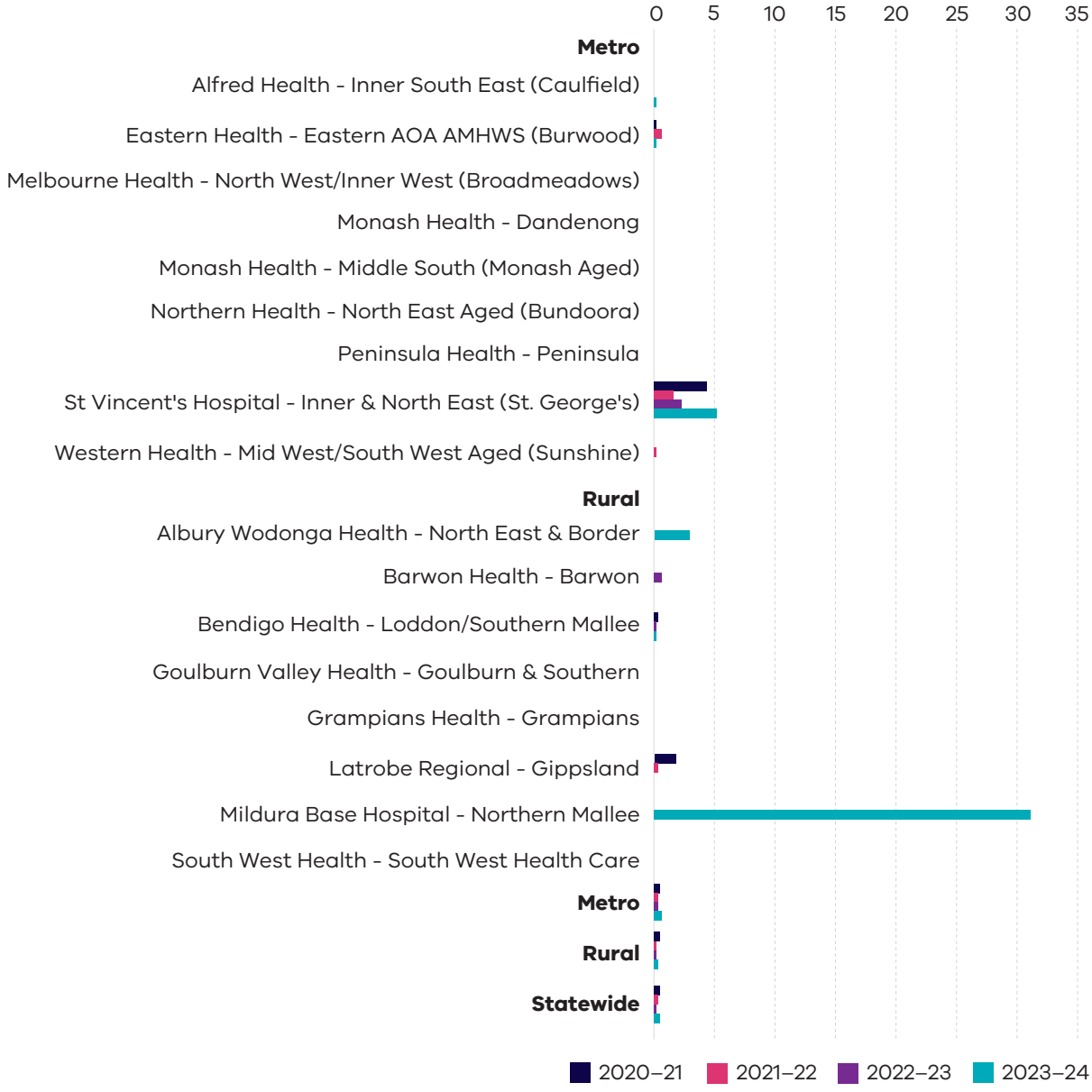
Table 15: Rates of ended mechanical (only) restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (Caulfield)	0.0	0.0	0.0	0.2
Eastern Health – Eastern AOA AMHWS (Burwood)	0.1	0.6	0.0	0.1
Melbourne Health – North West / Inner West (Broadmeadows)	0.0	0.0	0.0	0.0
Monash Health – Dandenong	0.0	0.0	0.0	0.0
Monash Health – Middle South (Monash Aged)	0.0	0.0	0.0	0.0
Northern Health – North East Aged (Bundoora)	0.0	0.0	0.0	0.0
Peninsula Health – Peninsula	0.0	0.0	0.0	0.0
St Vincent's Hospital – Inner and North East (St George's)	4.3	1.6	2.3	5.1
Western Health – Mid West / South West Aged (Sunshine)	0.0	0.2	0.0	0.0
Albury Wodonga Health – North East and Border	0.0	0.0	0.0	2.8
Barwon Health – Barwon	0.0	0.0	0.7	0.0
Bendigo Health – Loddon / Southern Mallee	0.3	0.0	0.1	0.1
Goulburn Valley Health – Goulburn and Southern	0.0	0.0	0.0	0.0
Grampians Health – Grampians	0.0	0.0	0.0	0.0
Latrobe Regional – Gippsland	1.7	0.3	0.0	0.0
Mildura Base Hospital – Northern Mallee	0.0	0.0	0.0	31.0

Health service and campus	2020–21	2021–22	2022–23	2023–24
South West Health – South West Health Care	0.0	0.0	0.0	0.0
Metro	**0.5**	**0.3**	**0.3**	**0.6**
Rural	**0.4**	**0.1**	**0.2**	**0.3**
Statewide	**0.5**	**0.3**	**0.2**	**0.5**

Metro sites are shaded.

Figure 11: Rates of ended mechanical (only) restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



2.2.2 Physical restraint – older persons inpatient units

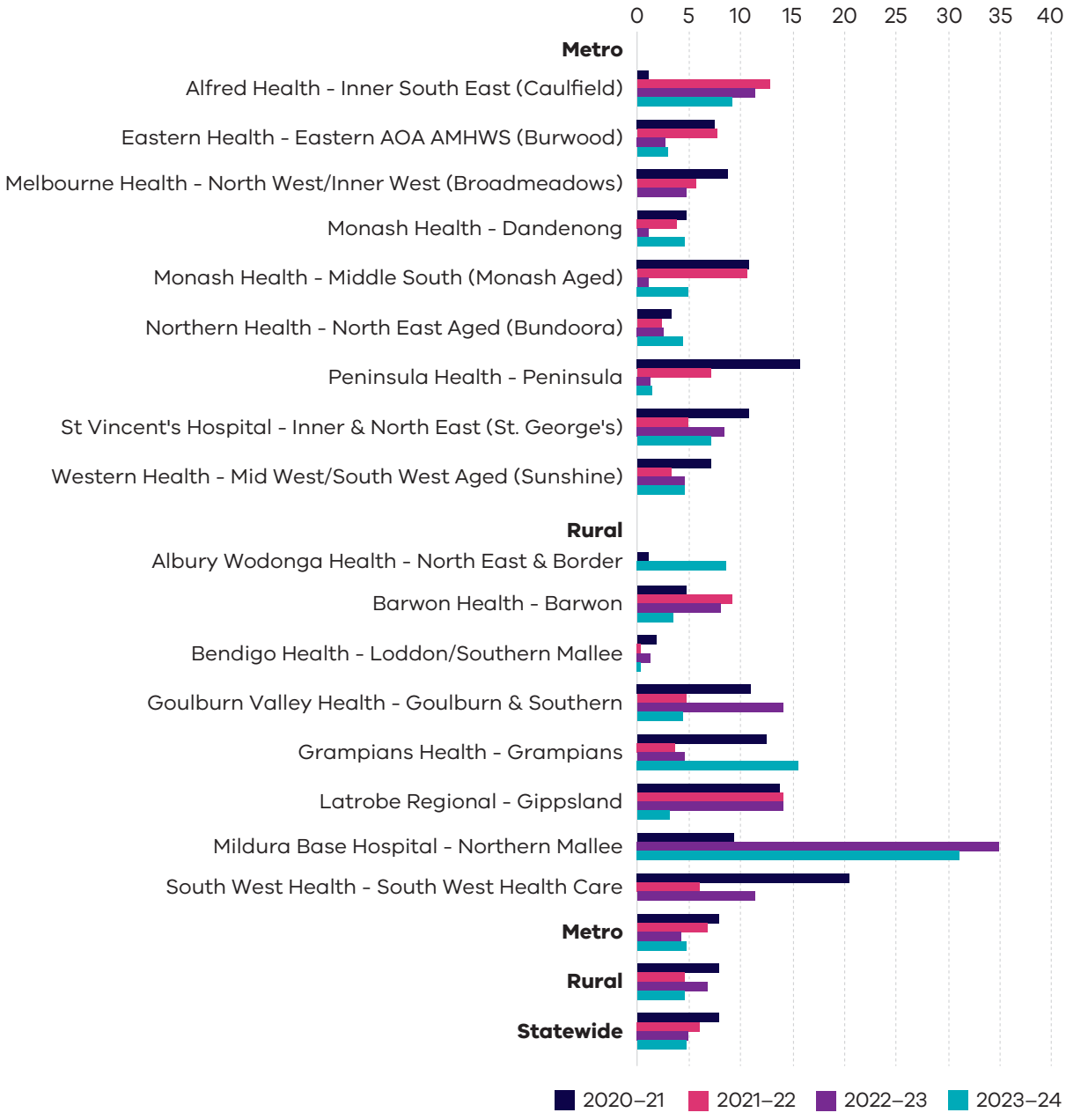
Trends in physical restraint use in older persons units (Table 16 and Figure 12) virtually mirror those of bodily restraint documented above, given the infrequent use of mechanical restraint in older persons units. For example, 75% of physical restraints at St Vincent's Hospital during 2023–24 related to one consumer.

Table 16: Rates of ended physical (only) restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (Caulfield)	1.1	12.8	11.4	9.2
Eastern Health – Eastern AOA AMHWS (Burwood)	7.5	7.7	2.8	2.9
Melbourne Health – North West / Inner West (Broadmeadows)	8.7	5.7	4.7	0.0
Monash Health – Dandenong	4.8	3.8	1.1	4.5
Monash Health – Middle South (Monash Aged)	10.8	10.5	1.0	5.0
Northern Health – North East Aged (Bundoora)	3.2	2.3	2.5	4.4
Peninsula Health – Peninsula	15.7	7.2	1.3	1.5
St Vincent's Hospital – Inner and North East (St George's)	10.7	4.9	8.4	7.2
Western Health – Mid West / South West Aged (Sunshine)	7.2	3.2	4.5	4.5
Albury Wodonga Health – North East and Border	1.0	0.0	0.0	8.5
Barwon Health – Barwon	4.8	9.1	8.0	3.5
Bendigo Health – Loddon / Southern Mallee	1.8	0.3	1.3	0.4
Goulburn Valley Health – Goulburn and Southern	11.0	4.7	14.1	4.3
Grampians Health – Grampians	12.5	3.7	4.5	15.6
Latrobe Regional – Gippsland	13.7	14.1	14.1	3.1
Mildura Base Hospital – Northern Mallee	9.3	0.0	35.0	31.0
South West Health – South West Health Care	20.4	6.1	11.3	0.0
Metro	**7.9**	**6.7**	**4.1**	**4.8**
Rural	**7.8**	**4.6**	**6.8**	**4.6**
Statewide	**7.9**	**6.1**	**4.9**	**4.8**

Metro sites are shaded.

Figure 12: Rates of ended physical (only) restraint episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



2.3 Bodily restraint – child and adolescent inpatient units

There has been an overall reduction in bodily restraint in child and adolescent units from 2020–21 to 2023–24, as shown in Table 17 and Figure 13. Many services have described introducing changes in processes to reduce restrictive interventions, with this action helping to explain the downward trend seen in the data. Many services highlighted the benefits of working with families as crucial to engaging young people and providing quality treatment and care.

Episodes of increased bodily restraint typically involve consumers with a high risk of harm to self and others, with least restrictive interventions unsuccessful in mitigating this risk. Medication use in young people is generally provided at lower doses, and at times this is not enough to address agitation and distress. Also, some services describe system structural issues as contributing factors. This includes issues around transport or managing consumers in medical units when intensive care area beds are all occupied or when a consumer has concurrent medical conditions.

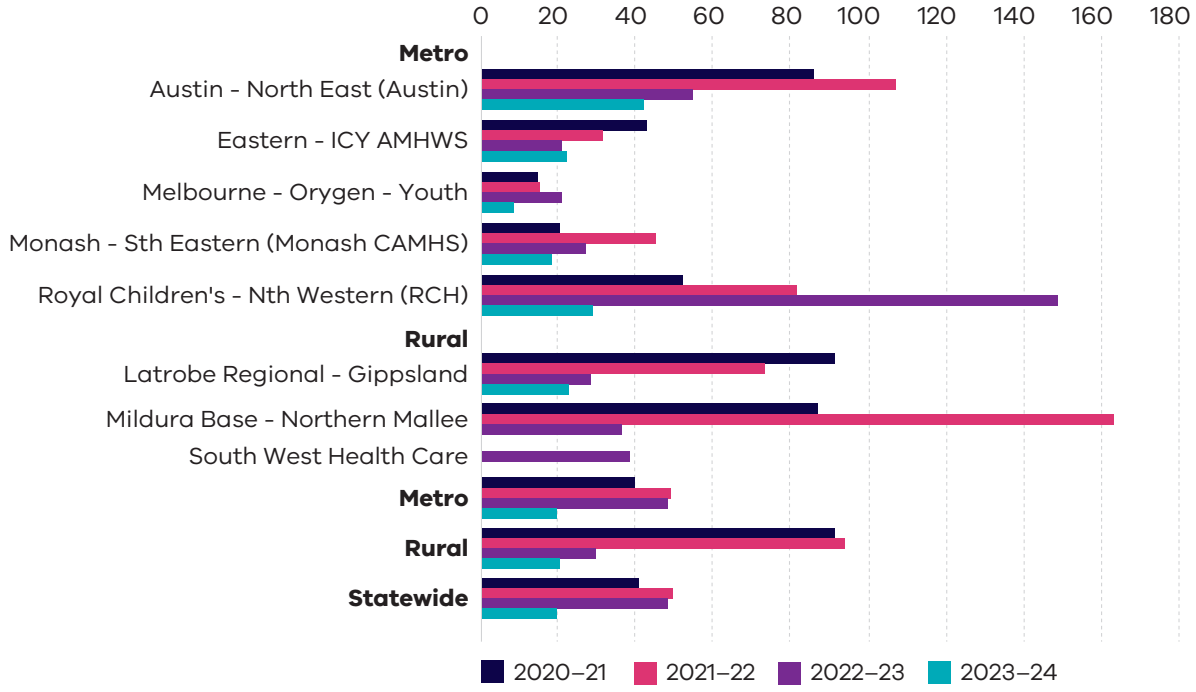
It should be noted that rural services do not have specialist child and adolescent inpatient units and admissions. As such, children and adolescents admitted to rural services need either transport to metro services or management in alternate health service beds. In these circumstances, restrictive intervention use can increase due to wait times and safety concerns.

Table 17: Rates of ended bodily restraint episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Austin – North East (Austin)	84.7	106.0	54.0	41.2
Eastern – ICY AMHWS	41.8	31.0	20.2	21.8
Melbourne – Orygen – Youth	14.3	15.0	20.4	7.8
Monash – Sth Eastern (Monash CAMHS)	20.0	44.5	26.7	17.7
Royal Children's – Nth Western	51.3	80.8	148.0	28.5
Latrobe Regional – Gippsland	90.8	72.5	27.5	22.0
Mildura Base – Northern Mallee	86.0	162.0	35.8	0.0
South West Health Care	n.a.	0.0	37.6	0.0
Metro	**38.9**	**48.1**	**47.6**	**19.4**
Rural	**90.5**	**93.2**	**29.1**	**19.6**
Statewide	**40.2**	**48.8**	**47.4**	**19.4**

Metro sites are shaded.
n.a. = not available.

Figure 13: Rates of ended bodily restraint episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24



2.3.1 Mechanical restraint – child and adolescent inpatient units

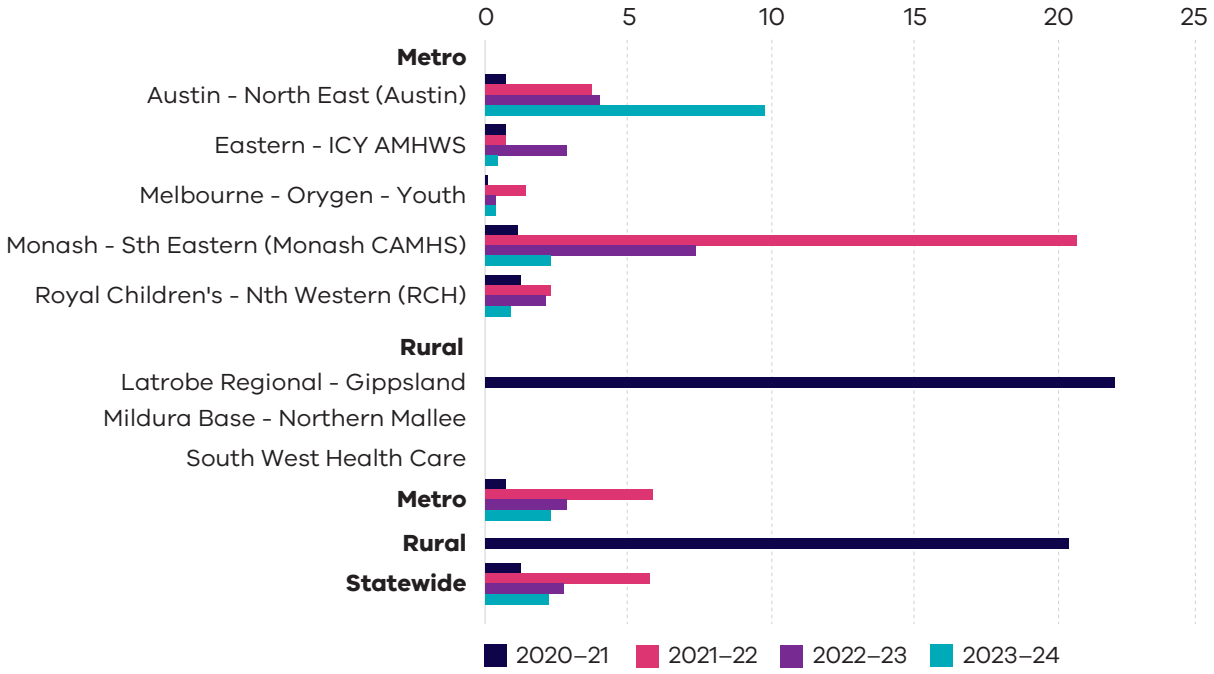
Mechanical restraint has trended down in metro and statewide in the past 3 financial years in child and adolescent units (Table 18 and Figure 14). The most common use of mechanical restraint is to protect physical safety when transporting very unwell young people for care.

Table 18: Rates of ended mechanical (only) episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Austin – North East (Austin)	0.7	3.7	4.0	9.7
Eastern – ICY AMHWS	0.7	0.7	2.8	0.4
Melbourne – Orygen – Youth	0.1	1.4	0.3	0.3
Monash – Sth Eastern (Monash CAMHS)	1.1	20.6	7.3	2.3
Royal Children's – Nth Western	1.2	2.3	2.1	0.9
Latrobe Regional – Gippsland	21.9	0.0	0.0	0.0
Mildura Base – Northern Mallee	0.0	0.0	0.0	0.0
South West Health Care	n.a.	0.0	0.0	0.0
Metro	**0.7**	**5.8**	**2.8**	**2.3**
Rural	**20.3**	**0.0**	**0.0**	**0.0**
Statewide	**1.2**	**5.7**	**2.7**	**2.2**

Metro sites are shaded.
n.a. = not available.

Figure 14: Rates of ended mechanical (only) episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24



2.3.2 Physical restraint – child and adolescent inpatient units

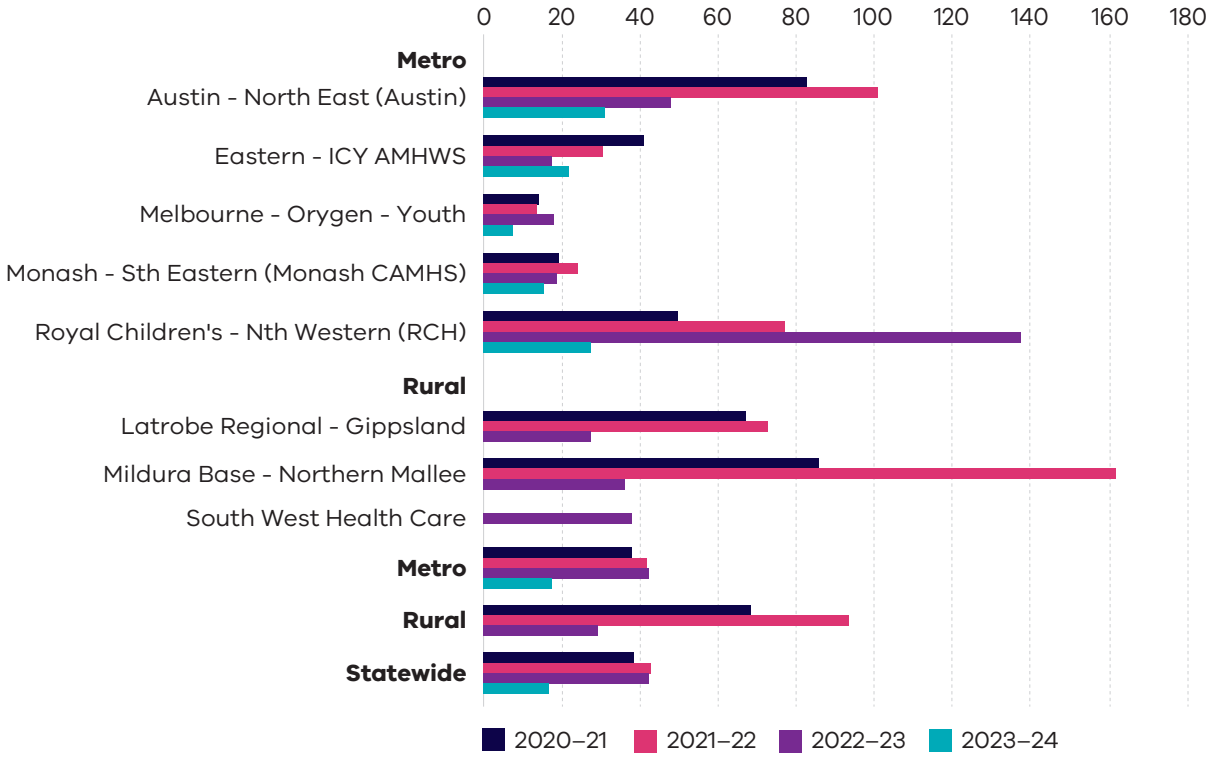
Rates of physical restraint were lower in 2023–24 compared with previous years, with large drops at the Austin Hospital, the Royal Children's Hospital, Latrobe Regional Health and Mildura Health (Table 19 and Figure 15).

Table 19: Rates of ended physical (only) episodes per 1,000 occupied bed days in child and adolescent inpatient units, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Austin – North East (Austin)	82.9	100.9	48.0	31.3
Eastern – ICY AMHWS	40.7	30.2	17.4	21.4
Melbourne – Orygen – Youth	14.2	13.3	17.8	7.4
Monash – Sth Eastern (Monash CAMHS)	18.9	24.0	18.7	15.4
Royal Children's – Nth Western	49.7	77.2	137.5	27.3
Latrobe Regional – Gippsland	67.3	72.5	27.5	0.0
Mildura Base – Northern Mallee	86.0	162.0	35.8	0.0
South West Health Care	n.a.	0.0	37.6	0.0
Metro	**37.8**	**41.8**	**42.1**	**17.0**
Rural	**68.6**	**93.2**	**29.1**	**0.0**
Statewide	**38.6**	**42.6**	**41.9**	**16.9**

Metro sites are shaded.
n.a. = not available.

Figure 15: Rates of ended physical (only) episodes per 1,000 occupied bed days in child and adolescent inpatient units, 2020–21 to 2023–24



3. By service – seclusion

3.1 Seclusion – adult inpatient units

Rates of seclusion episodes per 1,000 occupied bed days in adult units have either remained steady or been on a downward trend in most services from 2020–21 to 2023–24, as shown in Table 20 and Figure 16. We saw significant reductions at Western Health (20.7 to 9.0), Northern Health – North West (17.1 to 9.4) and Mercy Health – South West (16.7 to 4.0). These services have undertaken extensive work since 2020–21 to reduce restrictive interventions. This includes rolling out Safewards with Safer Care Victoria (Mercy Health won an award in 2025 for their work on reducing restrictive interventions).

Mercy Health made reducing restrictive interventions a key priority in 2021. The service began collaborating with Safer Care Victoria in 2022 on a comprehensive project to reduce restrictive interventions. This involved iterative monitoring, education, cultural change, mentorship and, most significantly, employing 2 clinical nurse consultants. Other key aspects of the project included staff training, and strengthening oversight of cultural and structural interventions and environmental enhancements. As noted above, these efforts appear to be producing the desired impact at Mercy Health.

Services have undertaken significant targeted education, training and reflective practices to reduce seclusion rates. Some have employed weekly seclusion review panel meetings with multidisciplinary teams and audits and data monitoring at safety and quality meetings to keep focus in interventions. Some services have rapid response teams for psychiatric emergencies that can mobilise to de-escalate situations as they emerge.

Lived and living experience expertise, peer support workers and consumer consultants have played an important part in effectively implementing Safewards and the positive impact of clinical nurse consultants.

Table 20: Rates of ended seclusion episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (The Alfred)	8.3	8.1	5.7	6.0
Austin Health – North East (Austin)	5.1	2.5	8.1	3.8
Eastern Health – Eastern AOA AMHWS (Box Hill)	9.5	8.5	12.7	6.0
Eastern Health – Eastern AOA AMHWS (Maroondah)	12.9	11.5	9.2	8.1
Melbourne Health – Inner West (Royal Melbourne)	6.1	6.2	6.4	5.8
Mercy Health – Footscray	6.7	7.3	0.0	n.a.

Health service and campus	2020–21	2021–22	2022–23	2023–24
Mercy Health – South West (Werribee)	16.7	9.5	7.4	4.0
Monash Health – Casey	2.4	6.7	8.2	7.2
Monash Health – Dandenong	10.2	9.5	6.1	6.8
Monash Health – Middle South (Monash Adult)	4.6	2.9	4.1	3.7
Northern Health – North West (Broadmeadows)	17.1	12.8	8.2	9.4
Northern Health – Northern	15.2	6.9	15.9	8.3
Peninsula Health – Peninsula	1.4	0.4	0.0	0.0
St Vincent's Hospital – Inner East (St Vincent's)	2.5	4.1	2.9	4.0
Western Health – Mid West (Sunshine)	20.7	16.5	11.0	9.0
Albury Wodonga Health – Albury – New South Wales	4.6	6.2	8.1	3.7
Albury Wodonga Health – North East and Border	6.9	4.0	6.2	5.4
Barwon Health – Barwon	11.8	11.5	9.5	8.9
Bendigo Health – Loddon / Southern Mallee	6.5	16.2	8.4	9.0
Goulburn Valley Health – Goulburn and Southern	6.0	6.2	7.9	3.5
Grampians Health – Grampians	17.0	17.8	11.8	10.4
Latrobe Regional – Gippsland	2.6	3.4	9.4	7.2
Mildura Base Hospital – Northern Mallee	13.2	8.8	7.4	7.9
South West Health – South West Health Care	6.9	11.9	6.3	7.4
Metro	**10.0**	**8.0**	**7.9**	**6.2**
Rural	**7.8**	**10.1**	**8.7**	**7.4**
Statewide	**9.4**	**8.5**	**8.1**	**6.5**

Metro sites are shaded.
n.a. = not available

Figure 16: Rates of ended seclusion episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Significant capital upgrades to intensive care areas across the state has improved sexual safety and created calmer, more therapeutic spaces. While this has meant fewer beds across the state, it is hoped that the upgrades will result in environments that are safer and better aid recovery from mental illness.

Many services report a greater willingness to trial ending seclusions early as a culture change towards least restrictive practice, noting that at times this resulted in more frequent, but briefer, seclusion episodes in people who were very unwell.

Some services have introduced group programs in intensive care areas to help occupy and engage consumers, aiming to make these programs available to all consumers receiving intensive care.

3.2 Seclusion – older persons inpatient units

Older adult services generally admit consumers over 65 with primary mental illness. Seclusion was rarely used in older persons inpatient units between 2020–21 and 2023–24 (Table 21 and Figure 17). Instances of multiple seclusion generally involved the same consumer. The higher rate at Grampians represents a shift to admitting a younger cohort.

In some of the older persons units, seclusion rooms have not been used for many years and are being decommissioned. For example, Alfred Health's Baringa older persons inpatient unit, which in 2025 moved to a new premises and was renamed Greenhouse, does not have a seclusion room. A similar development is underway at Eastern Health, where a seclusion room in its older person unit has also been decommissioned. These services are using innovative processes if they need a contained environment or are admitting older people with higher risk of aggression to adult wards, where specialist behavioural management can be provided.

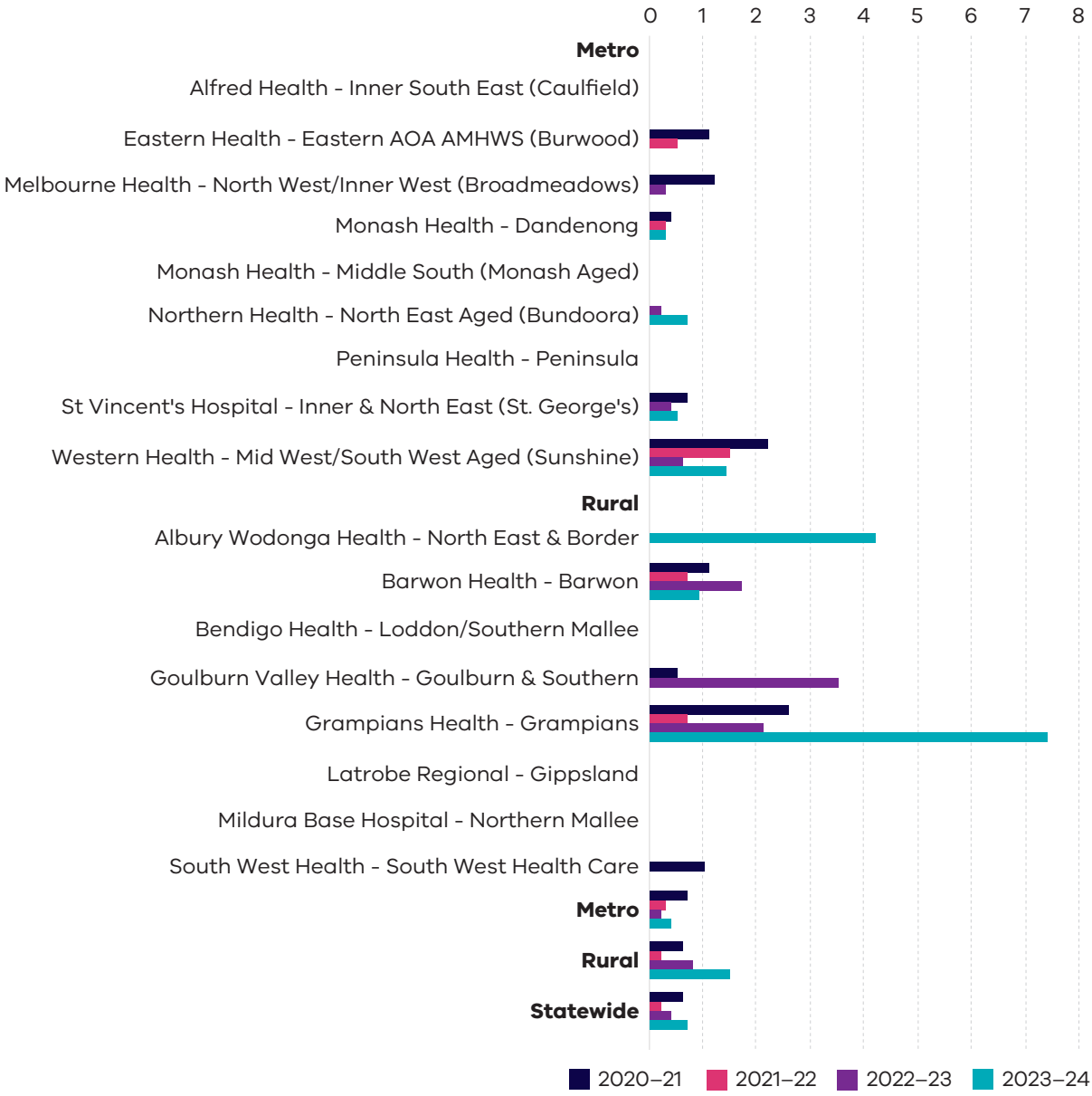
Table 21: Rates of ended seclusion episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Alfred Health – Inner South East (Caulfield)	0.0	0.0	0.0	0.0
Eastern Health – Eastern AOA AMHWS (Burwood)	1.1	0.5	0.0	0.0
Melbourne Health – North West / Inner West (Broadmeadows)	1.2	0.0	0.3	0.0
Monash Health – Dandenong	0.4	0.3	0.0	0.3
Monash Health – Middle South (Monash Aged)	0.0	0.0	0.0	0.0
Northern Health – North East Aged (Bundoora)	0.0	0.0	0.2	0.7
Peninsula Health – Peninsula	0.0	0.0	0.0	0.0
St Vincent's Hospital – Inner and North East (St George's)	0.7	0.0	0.4	0.5
Western Health – Mid West / South West Aged (Sunshine)	2.2	1.5	0.6	1.4

Health service and campus	2020–21	2021–22	2022–23	2023–24
Albury Wodonga Health – North East and Border	0.0	0.0	0.0	4.2
Barwon Health – Barwon	1.1	0.7	1.7	0.9
Bendigo Health – Loddon / Southern Mallee	0.0	0.0	0.0	0.0
Goulburn Valley Health – Goulburn and Southern	0.5	0.0	3.5	0.0
Grampians Health – Grampians	2.6	0.7	2.1	7.4
Latrobe Regional – Gippsland	0.0	0.0	0.0	0.0
Mildura Base Hospital – Northern Mallee	0.0	0.0	0.0	0.0
South West Health – South West Health Care	1.0	0.0	0.0	0.0
Metro	**0.7**	**0.3**	**0.2**	**0.4**
Rural	**0.6**	**0.2**	**0.8**	**1.5**
Statewide	**0.6**	**0.2**	**0.4**	**0.7**

Metro sites are shaded.

Figure 17: Rates of ended seclusion episodes per 1,000 occupied bed days in older persons inpatient units, by financial year, health service and campus, 2020–21 to 2023–24



3.3 Seclusion – child and adolescent inpatient units

Seclusion rates in child and adolescent inpatient units decreased over the 4-year period (except for 2022–23). In 2020–21 there were 9.3 seclusion episodes per 1,000 occupied bed days compared with 6.7 in 2023–24 (Table 22 and Figure 18).

Rates are lower in metro services compared with rural services. It should be noted that specialist inpatient child and adolescent units are located in metro services. Admissions, to these services for young people under 18 in rural settings may face delays awaiting transfer. While waiting, young people may be cared for in wards not specific to age cohorts. Care is provided by staff with specialisations in developmentally informed child and adolescent mental health who work alongside paediatric or adult mental health staff. There can be difficulties accessing suitable child and youth beds, with wait times in less suitable environments.

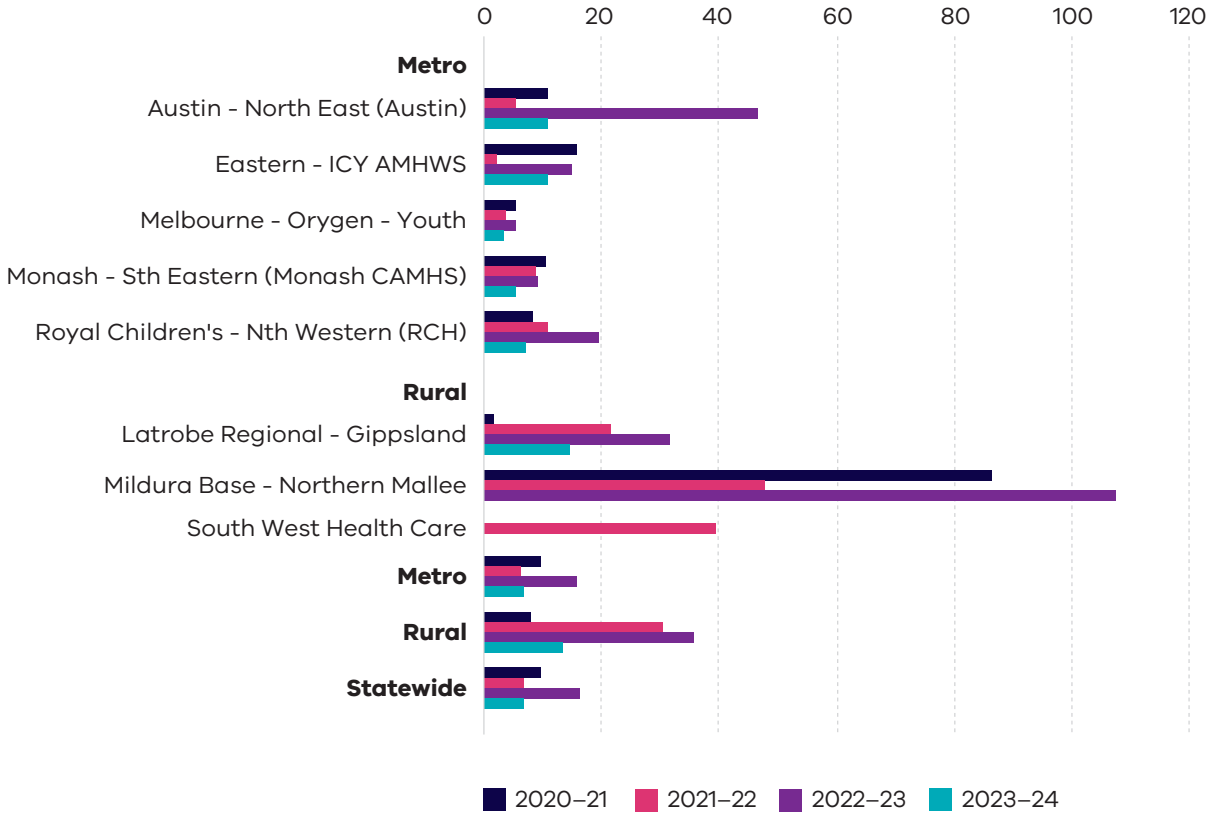
Acutely unwell young people, with comorbid neurodevelopmental issues and limited access to intensive care area beds for 12- to 18-year-olds are common themes in services describing challenges in reducing restrictive interventions.

Table 22: Rates of ended seclusion episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24

Health service and campus	2020–21	2021–22	2022–23	2023–24
Austin – North East (Austin)	10.7	5.1	46.4	10.5
Eastern – ICY AMHWS	15.6	1.8	15.0	10.7
Melbourne – Orygen – Youth	5.2	3.8	5.4	3.1
Monash – Sth Eastern (Monash CAMHS)	10.4	8.5	8.9	5.1
Royal Children's – Nth Western	8.3	10.8	19.5	7.0
Latrobe Regional – Gippsland	1.7	21.3	31.5	14.6
Mildura Base – Northern Mallee	86.0	47.6	107.3	0.0
South West Health Care	n.a.	39.4	0.0	0.0
Metro	**9.3**	**6.2**	**15.6**	**6.6**
Rural	**7.8**	**30.1**	**35.6**	**13.1**
Statewide	**9.3**	**6.6**	**15.9**	**6.7**

Metro sites are shaded.
n.a. = not available.

Figure 18: Rates of ended seclusion episodes per 1,000 occupied bed days in child and adolescent units, 2020–21 to 2023–24



4. Comparison with other Australian jurisdictions

This section examines rates of seclusion and restraint across state and territory jurisdictions in Australia. It uses data from the Australian Institute of Health and Welfare.[1]

Exercise caution when comparing jurisdictions. Differences in legislative definitions and requirements influence recording, reporting and data collection processes. This in turn produces differences in rates of seclusion and restraint across jurisdictions that are unrelated to clinical practice.

Also, differences in business practice across jurisdictions can influence the data. In the case of Victoria, the service delivery model is based on a higher threshold for acute admission. As the Australian Institute of Health and Welfare highlights, this contributes to the higher seclusion and restraint metrics in Victoria compared with other jurisdictions.[2]

Table 23 and Figure 19 show that rates of physical restraint in Victoria from 2015–16 to 2022–23 have been mostly higher than other states and territories. In 2022–23 there were 14 episodes of physical restraint per 1,000 bed days, which was lower only than the Northern Territory, where a rate of 16 was recorded. Western Australia had the lowest rate of physical restraint recorded in that year, with 4 episodes per 1,000 bed days.

Table 23: Rates of physical restraint per 1,000 bed days in public hospital acute mental health services, states and territories, 2015–16 to 2022–23

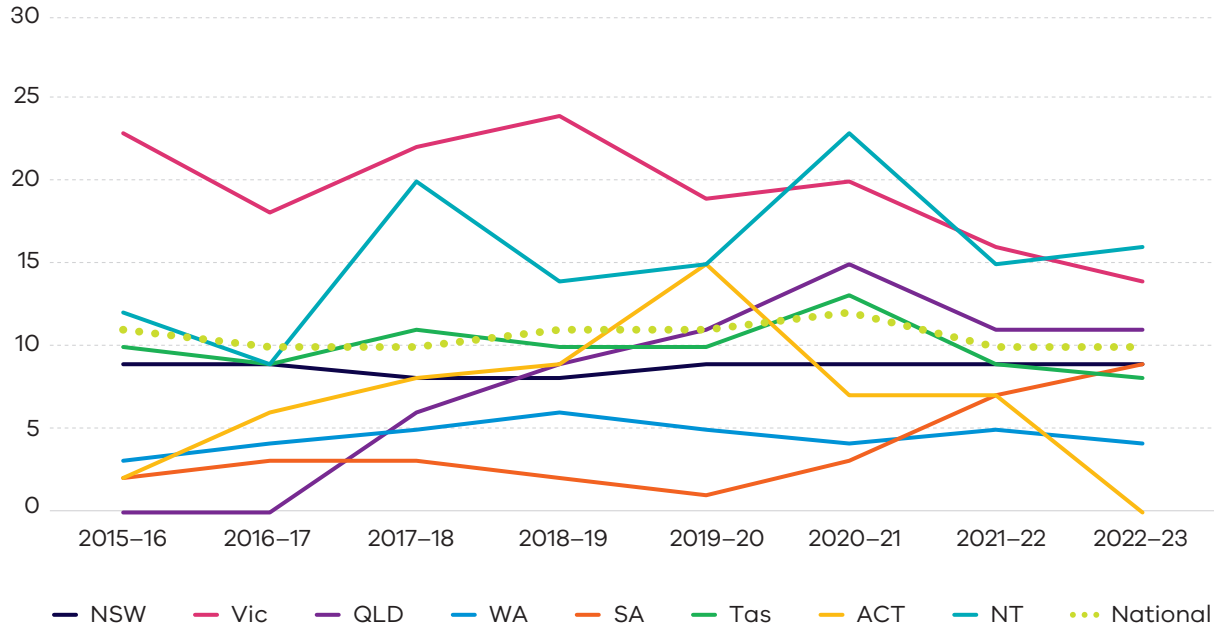
State/ territory	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23
NSW	9	9	8	8	9	9	9	9
VIC	23	18	22	24	19	20	16	14
QLD	n.a.	n.a.	6	9	11	15	11	11
WA	3	4	5	6	5	4	5	4
SA	2	3	3	2	1	3	7	9
TAS	10	9	11	10	10	13	9	8
ACT	2	6	8	9	15	7	7	n.a.
NT	12	9	20	14	15	23	15	16
National	**11**	**10**	**10**	**11**	**11**	**12**	**10**	**10**

n.a. refers to not available.

1 Australian Institute of Health and Welfare, Data tables: Seclusion and restraint in mental health care 2022–23, Seclusion and Restraint, 2025, accessed 29 October 2025.

2 Australian Institute of Health and Welfare, *Data tables: Seclusion and restraint in mental health care 2022–23.*

Figure 19: Rates of physical restraint per 1,000 bed days in public hospital acute mental health services, states and territories, 2015–16 to 2022–23



Since peaking in 2018–19, rates of physical restraint have been on a prominent downward trend in Victoria. This reflects the various initiatives to reduce restrictive interventions in Victorian services documented above. This includes input from lived and living experience staff aiming to reduce restrictive interventions through better communication, collaboration and self-determination. Other jurisdictions where rates of physical restraint have been trending downwards include Queensland, Tasmania, the Australian Capital Territory and the Northern Territory. Rates have held stable in New South Wales and been on an upward trend in South Australia.

Mechanical restraint use has been uniformly low across jurisdictions (Table 24 and Figure 20). Rates in most jurisdictions have been below one, except specific years earlier in the timeframe covered, when rates where temporarily higher (for example, 6 in Victoria in 2015–16 and 4 in South Australia in 2016–17).

In 2022–23 the rate of mechanical restraint was close to zero in most jurisdictions, with Victoria and New South Wales recording rates identical to the national average of one. The relatively low rates of mechanical restraint reflect the sustained effort to avoid the practice across Australia.

Table 24: Rates of mechanical restraint per 1,000 bed days in public hospital acute mental health services, states and territories, 2015–16 to 2022–23

State/ territory	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23
NSW	1	0	0	1	1	1	2	1
VIC	6	2	1	1	1	1	1	1
QLD	0	≈0	≈0	≈0	≈0	≈0	≈0	≈0
WA	≈0	≈0	≈0	≈0	≈0	≈0	≈0	≈0
SA	1	4	1	≈0	≈0	≈0	≈0	≈0
TAS	1	n.p.	1	≈0	≈0	≈0	≈0	≈0
ACT	0	≈0	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
NT	0	0	0	0	1	n.p.	1	≈0
National	**2**	**1**	**≈0**	**1**	**1**	**1**	**1**	**1**

n.a. refers to not available. n.p. refers to not published. ≈0 refers to rounded to zero.

Figure 20: Rates of mechanical restraint per 1,000 bed days in public hospital acute mental health services, states and territories, 2015–16 to 2022–23

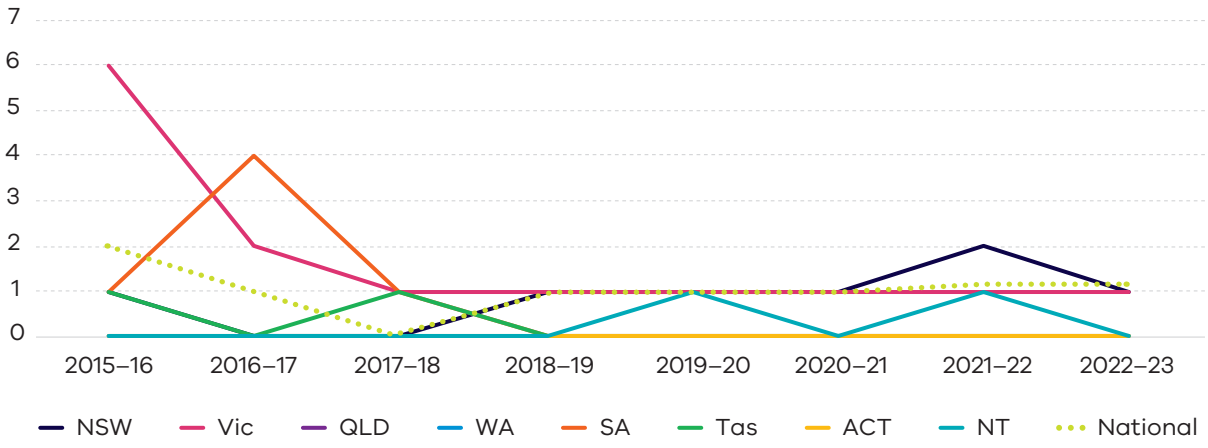


Table 25 and Figure 21 show that seclusion rates in Victoria have been slightly higher than the national average. In 2022–23 there were 7 seclusion episodes per 1,000 bed days compared with the national average of 6 for that period. Jurisdictions with relatively low rates of seclusion in the same year included Western Australia (4), the Northern Territory (4) and New South Wales (5).

The range of variance between jurisdictions in seclusion rates has gradually narrowed over time. In 2013–14 the difference between the highest and lowest rate of seclusion was 21 episodes per 1,000 occupied bed days. By 2022–23 the difference had reduced to 3, indicating a concerted effort across jurisdictions to avoid seclusion wherever possible. This seems especially so in the Northern Territory, where the rates of seclusion have decreased considerably over time, from a peak of 31 in 2014–15 to 4 in 2022–23.

Table 25: Rates of seclusion per 1,000 bed days in public hospital acute mental health services, states and territories, 2013–14 to 2022–23

State/ territory	2013 –14	2014 –15	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20	2020 –21	2021 –22	2022 –23
NSW	8	8	9	7	6	6	8	6	6	5
VIC	9	7	9	9	9	8	9	9	8	7
QLD	11	11	9	8	6	7	10	9	7	7
WA	5	4	5	5	4	7	5	4	6	4
SA	5	5	5	7	9	9	6	6	6	6
TAS	15	10	11	9	6	7	7	8	7	6
ACT	1	3	2	3	6	11	12	10	1	n.a.
NT	22	31	24	17	22	14	10	11	10	4
National	**8**	**8**	**8**	**7**	**7**	**7**	**8**	**7**	**7**	**6**

n.a. refers to not available.

Figure 21: Rates of seclusion per 1,000 bed days in public hospital acute mental health services, states and territories, 2013–14 to 2022–23

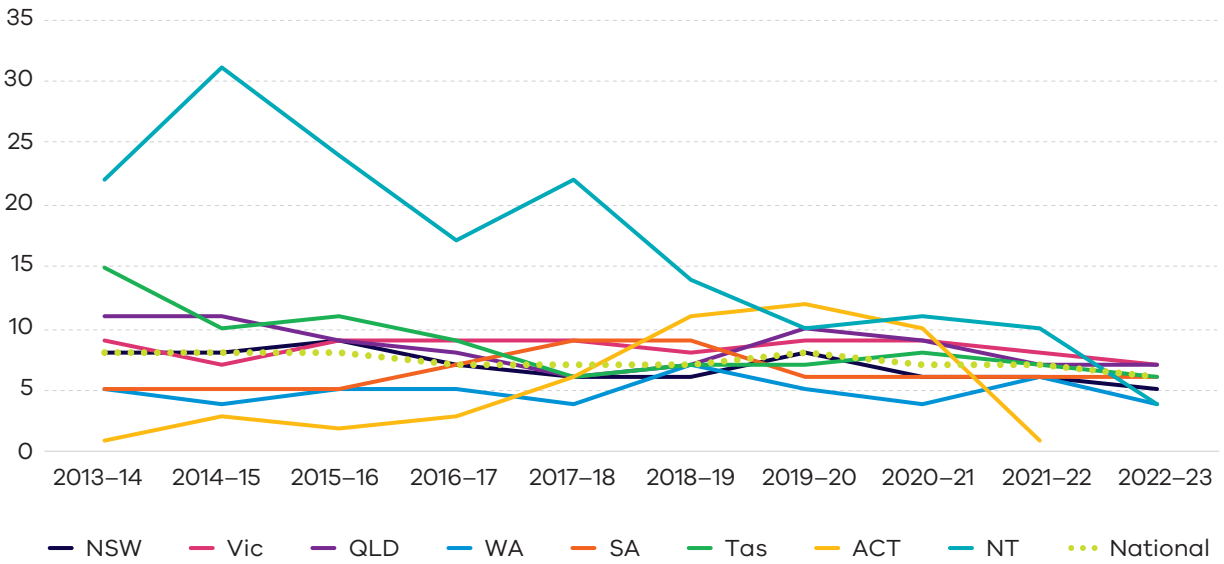


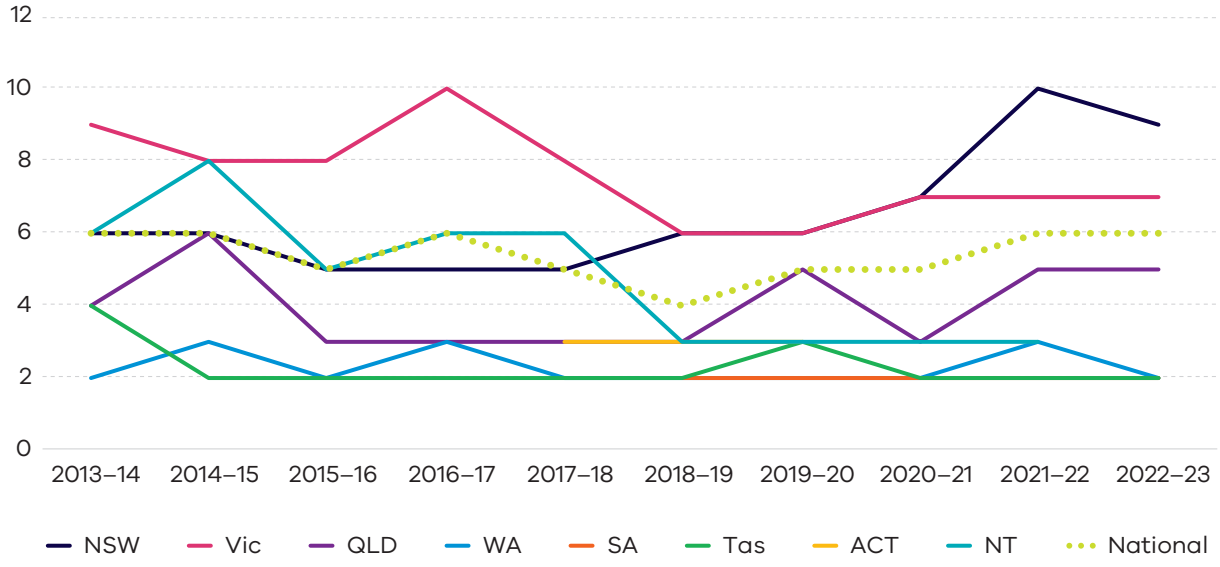
Table 26 and Figure 22 show the average seclusion duration in Victoria of 7 hours in 2022–23 to be higher than other jurisdictions, except New South Wales, where it was 9 hours. Victoria's average, however, is close to the national average of 6 hours. Jurisdictions with the lowest average seclusion durations were Western Australia, South Australia and Tasmania, with 2 hours. The national average duration of seclusion has fluctuated somewhat since 2013–14. However, it has trended upwards since 2018–19, when it reached its lowest level of 4 hours, influenced mainly by the increasing averages recorded in New South Wales, Victoria and Queensland.

Table 26: Average seclusion duration (hours) in public hospital acute mental health services, states and territories, 2013–14 to 2022–23

State/ territory	2013 –14	2014 –15	2015 –16	2016 –17	2017 –18	2018 –19	2019 –20	2020 –21	2021 –22	2022 –23
NSW	6	6	5	5	5	6	6	7	10	9
VIC	9	8	8	10	8	6	6	7	7	7
QLD	4	6	3	3	3	3	5	3	5	5
WA	2	3	2	3	2	2	2	2	3	2
SA	n.a.	n.a.	n.a.	n.a.	n.a.	2	2	2	2	2
TAS	4	2	2	2	2	2	3	2	2	2
ACT	n.p.	n.p.	n.p.	n.p.	3	3	3	n.p.	n.p.	n.a.
NT	6	8	5	6	6	3	3	3	3	n.p.
National	**6**	**6**	**5**	**6**	**5**	**4**	**5**	**5**	**6**	**6**

n.a. refers to not available.
n.p. refers to not published.

Figure 22: Average seclusion duration (hours) in public hospital acute mental health services, states and territories, 2013–14 to 2022–23



5. Vulnerability factors

Certain members of the population may be at greater risk of seclusion and restraint. This could be due to experiencing mental illness at higher rates or greater severity than the general population, exposure to discrimination or difficulty accessing timely and appropriate treatment and care, leading them to seek help during mental health crises and emergencies. This section looks at data relating to these consumers, focusing on the demographic attributes of age, sex and cultural identity.

5.1 Age

As outlined in Table 6 and Figure 6 above, older persons are restrained at lower rates compared with adults. In 2023–24 the episodes per 1,000 occupied bed days were 5.4 for older persons and 12.0 for adults. This also applied to rates of seclusion, where episodes per 1,000 occupied bed days were 0.7 for older persons and 6.5 for adults in 2023–24 (Table 5 and Figure 5 above). This correlates with age-related changes in energy and strength as well as elements of natural maturation.

Child and adolescent consumers are restrained at a higher rate than the adult population. In 2023–24, there were 27.3 episodes of bodily restraint per 1,000 occupied bed days for child and adolescent consumers compared with 12.0 for adults. The difference in rates of seclusion between the cohorts is less significant. Apart from a spike in 2022–23, rates of seclusion for child and adolescent consumers have tended to be only slightly higher than for adult consumers and were lower in 2021–22.

Young people are still learning emotional regulation, and those admitted in mental health inpatient wards are generally developmentally impacted by illness. There is often a mismatch between emotional regulation, ability, intellectual development and physical size, especially in those with histories of trauma or significant neurodivergence. As such, highly sophisticated therapeutic engagement, early identification of distress and proactive de-escalation strategies are effective for reducing the risk of restrictive practices in this cohort.

5.2 Sex

As outlined in section 1.1, there is a difference in rates of bodily restraint and seclusion between sexes, with episodes being more frequent in males. For bodily restraint, most episodes were among 30- to 39-year-old men. There were 2,418 episodes among this group compared with 335 for 30- to 39-year-old females (Table 4 and Figure 4). In the 13- to 17-year-old aged group, females experienced a greater proportion of bodily restraints, likely reflecting use of bodily restraint for eating disorders. These differences broadly reflect known gender-based behavioural differences.

5.3 Cultural identity

5.3.1 Aboriginal peoples

Aboriginal peoples are more likely to experience restrictive practices. Table 27 shows 85 consumers, who identified as Aboriginal, were restrained in 188 episodes. In the same period, 1,448 consumers were restrained during 6,287 episodes. Almost 6% of all consumers restrained were Aboriginal peoples in 3% of all restraint episodes. Noting that Aboriginal peoples made up 1% of Victoria's population in the 2021 Census of Population and Housing,[3] these figures demonstrate they are over-represented in restraint episodes relative to the rest of the state's population.

There were 69 consumers, who identified as Aboriginal who were secluded in 150 episodes. This encompasses 7.6% of all consumers secluded and is 6.5% of all seclusion episodes.

Table 27: Episodes of seclusion and bodily restraint in acute inpatient units in 2023–24 for Aboriginal peoples

Restraint type	Number of episodes – Aboriginal peoples	Number of consumers – Aboriginal peoples	Number of episodes – total population	Number of consumers – total population
Bodily restraint	188	85	6,287	1,448
Seclusion	150	69	2,321	909

However, the rate of bodily restraint per 1,000 occupied bed days is lower for Aboriginal peoples (10.1) than the rest of the consumer population (15.1), as shown in Table 28 and Figure 23. This lower figure may be due to differences in the length of stay, whereby a longer length of stay for Aboriginal peoples is contributing to a lower rate of bodily restraint.

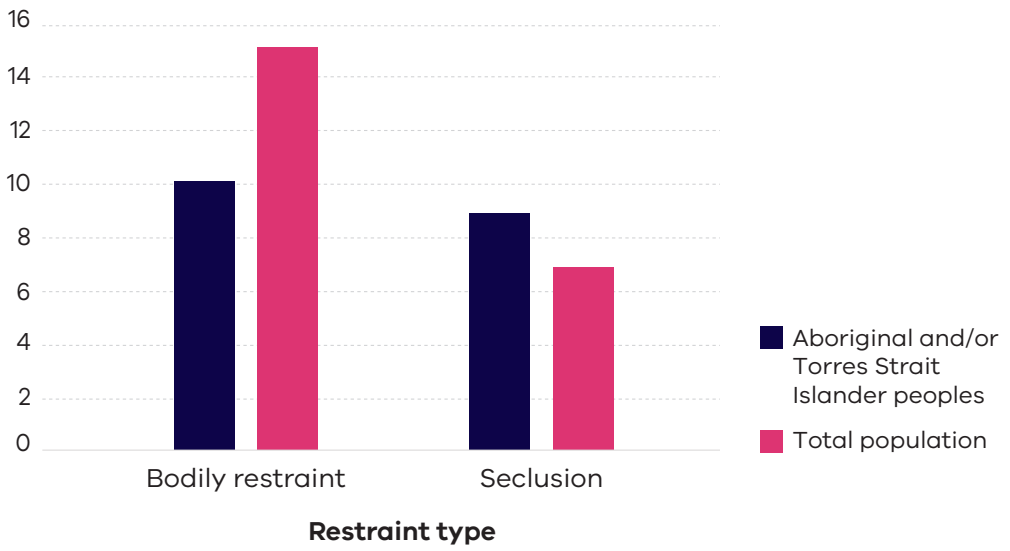
The rate of seclusion is higher for Aboriginal peoples compared with the total consumer population. In 2023–24 there were 8.9 episodes of seclusion per 1,000 occupied bed days for Aboriginal peoples compared with 6.8 for the total consumer population.

Table 28: Rates of seclusion and bodily restraint episodes per 1,000 occupied bed days in acute inpatient units in 2023–24 for Aboriginal peoples

Restraint type	Aboriginal peoples	Total population
Bodily restraint	10.1	15.1
Seclusion	8.9	6.8

3 Australian Bureau of Statistics, *Victoria: 2021 Census All persons QuickStats,* Australian Bureau of Statistics website, accessed 29 October 2025.

Figure 23: Rates of seclusion and bodily restraint episodes per 1,000 occupied bed days in acute inpatient units in 2023–24 for Aboriginal peoples



5.3.2 Culturally and linguistically diverse people

Table 29 shows there were 306 consumers with a culturally and linguistically diverse background who were restrained during 1,096 episodes in 2023–24. As a proportion, this is 21.1% of all consumers restrained and 17.4 % of all restraint episodes. In the 2021 Census, a non-English language was spoken in 30.2% of Victorian households.[4]

Table 29: Episodes of seclusion and bodily restraint in acute inpatient units in 2023–24 for culturally and linguistically diverse people

Restraint type	Number of episodes – CALD people	Number of consumers – CALD people	Number of episodes – total population	Number of consumers – total population
Bodily restraint	1,096	306	6,287	1,448
Seclusion	394	149	2,321	909

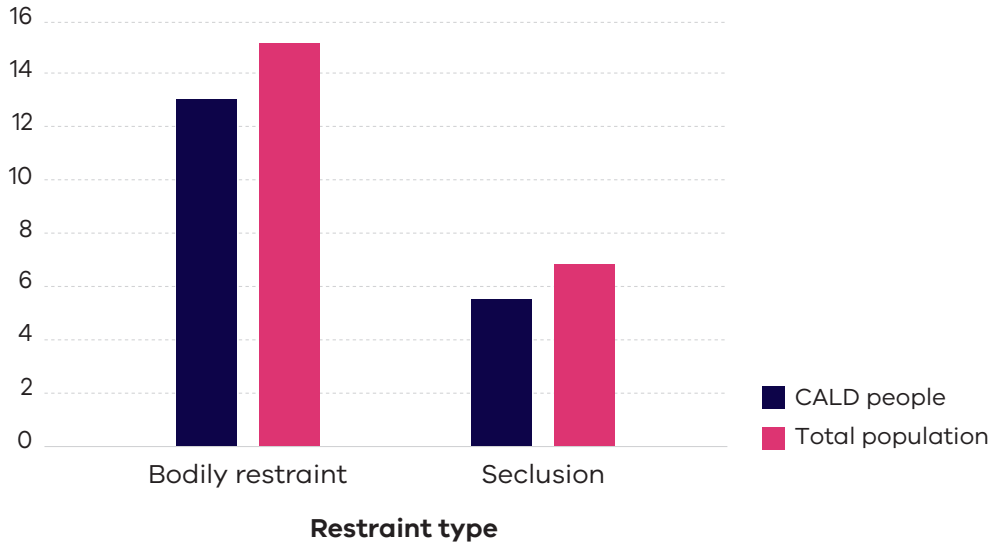
Table 30 and Figure 24 show that the rates of bodily restraint and seclusion are lower for culturally and linguistically diverse people than for the total population. In 2023–24 there were 13.0 episodes of bodily restraint per 1,000 occupied bed days for culturally and linguistically diverse people compared with 15.1 for the total population. There were also 5.5 episodes of seclusion per 1,000 occupied bed days for culturally and linguistically diverse people compared with 6.8 for the total population.

4 Australian Bureau of Statistics, *Victoria: 2021 Census All persons QuickStats*

Table 30: Rates of seclusion and bodily restraint episodes per 1,000 occupied bed days in acute inpatient units in 2023–24 for culturally and linguistically diverse people

Restraint type	CALD people	Total population
Bodily restraint	13.0	15.1
Seclusion	5.5	6.8

Figure 24: Rates of seclusion and bodily restraint episodes per 1,000 occupied bed days in acute inpatient units in 2023–24 for culturally and linguistically diverse people



6. Current activities to reduce restrictive interventions

The Department of Health is working to reduce restrictive interventions. The related activities are outlined below. They encompass lived experience initiatives and contributions involving leadership in restrictive interventions policy development, documentation processes, project work and promoting co-design processes.

6.1 Safer Care Victoria

6.1.1 Mental Health Improvement Unit

Safer Care Victoria's Mental Health Improvement Program is working on 4 priority initiatives that were outlined in recommendation 52 of the Royal Commission into Victoria's Mental Health System's final report:

1. Towards elimination of restrictive interventions
2. Improving sexual safety in mental health inpatient units
3. Implementation of the Zero Suicide Framework in all Victorian health services
4. 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 public mental health and wellbeing services are currently participating.

Safer Care Victoria has been working with services in the TERP Collaborative. The first phase of the Collaborative ran from November 2022 to June 2024. Sixteen mental health inpatient unit teams from 12 Victorian health services took part to learn the science of improvement and to apply this in incremental tests to achieve the collective aim of reducing seclusion, mechanical restraint and physical restraint by at least 20%. Phase 2 of the Collaborative began with learning session 1 in March 2025. Twenty-six mental health inpatient unit teams from 17 services are taking part in phase 2 and are aiming to spread the success of phase 1 and build on the results achieved.

6.1.2 The Chief Mental Health Nurse, Safer Care Victoria – Clinical Practice and Leadership

The office of the Chief Mental Health Nurse is leading the following initiatives:

- the continued rollout of Safewards
- the implementation of the Equally Well Framework.
- the Ligature Safety Tool.

More information about these initiatives can be found on the Chief Mental Health Nurse webpage <https://www.safercare.vic.gov.au/about-us/senior-officers/chief-mental-health-nurse>.

6.1.3 Safewards

Safer Care Victoria has also been implementing the Safewards <https://www.safercare.vic.gov.au/safewards/about> model. Safewards is a model of care that encourages nurses and clinical staff to:

- reduce conflict and containment in mental health services
- identify and address the causes of behaviours in staff and patients that may result in harm
- support a culture of safety, respect and inclusion.

Safewards was initially trialled at 7 mental health services between 2014 and 2016. By 2019 it was implemented at 18 public mental health services. For a detailed evaluation of Safewards in Victoria see the Outcomes of the Victorian Safewards trial article <https://onlinelibrary.wiley.com/doi/abs/10.1111/inm.12380>.

Meaningful and extensive inclusion of lived and living experience staff and consumers has been important in making Safewards and the TERP Collaborative effective in addressing the needs and challenges of consumers and staff to reduce restrictive interventions.

6.2 Chief Psychiatrist's Restrictive Interventions Committee

The Chief Psychiatrist's Restrictive Interventions Committee reviews data on restrictive intervention use. It provides expert advice to the Chief Psychiatrist to improve quality and safety in restrictive interventions.

The committee's guiding objective is to reduce and, where possible, eliminate restrictive interventions in mental health and wellbeing services.

The committee is made up of representatives from:

- the OCP
- the clinical workforce and its leadership
- the community (consumers and carers)
- peak bodies and unions
- academia.

6.3 OCP oversight and reporting via Performance and Commissioning Branch meetings

The OCP works with the Department of Health's Performance and Commissioning Branch in the Mental Health and Wellbeing Division to provide clinical advice and input to performance monitoring, evaluation, quality and safety, and service improvements processes. This enables service operational components to be integrated with clinical priorities, barriers and challenges.

The specific OCP role includes:

- representation at Performance and Commission Branch–managed program meetings with area mental services, focusing on operational matters that interface with clinical governance, risk management and client complexity that may be impacting on achieving service performance targets
- providing clinical data and interpretation to measure performance and ensure clinical data is understood in context
- providing clinical expert advice to resolve emerging operation matters that intersect with clinical governance and risk management in both bed-based and community service settings (for example, complex clients impact on targets and bed management issues)
- supporting risk management wherever risk is both clinical and operational – the OCP and Performance and Commissioning Branch provide immediate escalation points to any higher risk scenarios on the ground.

6.4 OCP quality and safety bulletin

The OCP issues a quarterly quality and safety bulletin to provide specialist advice on clinical practice issues raised by mental health and wellbeing services. The bulletins provide a mechanism to feed back to the sector and support good clinical governance and continuous improvement. The bulletins are on the OCP website <https://www.health.vic.gov.au/chief-psychiatrist/resources-reports-bulletins>.

6.5 OCP clinical forums

The OCP is hosting a series of mental health Quality and Safety Clinical Forums to engage the sector in the shared endeavour of enhancing thinking and care in quality improvement.

In March 2025 the OCP held the first of these forums on the theme of 'Emergency mental health'.

More than 150 senior leaders from mental health and emergency departments, as well as Victoria Police, Ambulance Victoria and sector partners, attended the forum.

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 carers
- a debate on whether people experiencing mental health distress should be seen in emergency departments.

The outcomes of the forum included the following:

- The forum reinforced our commitment to work with sector representatives to refine, update and release resources to support emergency department staff to report on chemical restraint.
- The Department of Health's Mental Health and Alcohol and Other Drugs Hubs team took away many new ideas to support their service design work and thinking about crisis care.
- Safer Care Victoria will continue to promote Mental Health Improvement Program initiatives.

6.6 OCP mental health service visits

The OCP visits designated mental health service across Victoria to strengthen relationships and engage the workforce, with a view to improving clinical practice. The visits typically involve:

- meeting with service executive directors and the lived experience workforce
- providing further support to services
- better understanding the challenges facing services
- gaining insights into how services are operationalising clinical guidance and reporting, and what approaches are being taken to implement best practice guidance
- finding ways to continue promoting the rights of people receiving 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.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