Quality and Safety Bulletin

Office of the Chief Psychiatrist

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OFFICIAL

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Message from Sophie

Dear Colleagues,

Welcome to the first Chief Psychiatrist's Quality and Safety Bulletin for 2026.

We hope this gives important information to guide clinical leadership in the mental health sector. Please forward this on to all staff so they can understand and contribute to quality and safety processes at every level.

Safety is everyone's business.

Best wishes,

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

News – Key updates

New factsheet: Co-ordination for mental health patient transport and community crisis responses

There is a new Office of the Chief Psychiatrist (OCP) factsheet published highlighting the importance of clinical advice in determining serious and imminent risk <https://www.health.vic.gov.au/chief-psychiatrist/mental-health-patient-transport-and-community-crisis-responses>. This factsheet is designed to be used by mental health clinicians in communicating with Police and Ambulance when all least restrictive efforts have failed and assistance with transport is required for safety.

Further details on the factsheet are provided in the Clinical Focus section of this bulletin.

Updated sexual safety reporting directive

The OCP has issued an updated directive on reporting sexual safety incidents in mental health and wellbeing services <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>. The reporting directive has new and strengthened requirements for services to be aware of, including:

- Sexual harassment is explicitly defined as illegal.
  - The updated guideline explicitly states that sexual harassment is an illegal act, strengthening expectations for response and documentation.
- Stronger guidance on discharge planning.
  - Services must now consider sexual safety as part of discharge destination planning, responding to coronial recommendations.
- Social media and technology are included as sexual safety risks.
  - A new section clarifies that sexual harassment, coercion or intimidation using social media, photography or technology is considered a sexual safety incident and must be treated the same as in person to person incidents.
- Enhanced expectations for gender diversity safety.
  - Updated guidance now includes an enhanced focus on the safety of gender diverse people, with explicit inclusive practices.
- Updated incident severity rating (ISR) rules.
  - Removal of the immediate reporting requirement, which was not practically achievable whilst maintaining within 24 hours reporting for ISR1 by email or phone.
  - Ongoing rating incidents involving minors as at least ISR2, initially with scope to downgrade once review undertaken.

New MHWA 147 Confinement Notification form

The OCP has issued a new MHWA 147 Confinement Notification form for reporting the practice of ‘confinement’.

Confinement is the practice of a consumer being restricted to a locked environment with other consumers without staff physically present.

The form can be found on the landing page of the OCP Data Sharing Portal in SharePoint <https://dhhsvicgovau.sharepoint.com/sites/OCP>.

To have permission to access the portal, please contact ocp@health.vic.gov.au.

Further information about this form is provided in the Clinical Focus section of this bulletin.

OCP quality and safety forums

Eating disorders forum – held 2 December 2025

On 2 December the OCP held an in-person quality and safety forum on the theme of eating disorders. The forum explored current challenges to providing care to people with eating disorders, how to make meaningful improvements in this area of health care and what a best practice clinical guideline on eating disorders should look like.

The forum brought together professionals across health disciplines, government bodies and people personally impacted by an eating disorder, including:

- psychiatrists, dietitians, eating disorder specialists, doctors, nurses, allied health professionals and lived experience health workers
- lived experience consumers and carers
- government agencies, including Safer Care Victoria and the Mental Health Tribunal
- non-government health organisations, including IMHA, CEED and Eating Disorders Victoria.

The program included:

- interactive case study sessions
- insights and discussion with lived experience consumer and carer representatives
- a speaker debate on the topic ‘We should abolish involuntary treatment in eating disorders’.

State-wide Complex Needs Advisory Panel (SCNAP) forum – held 18 February 2026

On 18 February the OCP's Complex Needs Team convened a quality and safety forum to strengthen system-wide collaboration in responding to people with complex mental health needs. The forum brought together leaders and clinicians from mental health, forensic, disability, alcohol and other drugs, and justice services; people with lived experience; and advocacy and non-government organisations. Discussions focussed on:

- fostering collaboration beyond a treating team, given it is critical for people with complex mental health needs
- increasing awareness of statewide and specialist services and how to access them
- providing practical opportunities for connection and shared problem-solving across sectors
- appreciating the essential role of lived and living experience in quality and safety and system improvement.

Highlights from the day include:

- Dr Partha Das and Emma Robertson from Austin Health presenting on their Secure Extended Care Unit research project, which outlined the interface challenges between acute services, rehabilitation, justice and community systems, and the need for system level responses to avoid people cycling between hospital, custody and homelessness
- A/Prof Andrew Carroll, Deputy Chief Psychiatrist, presenting on the S.H.A.R.E. approach as a strategy for collaborating with clients and multiple stakeholders when working in complex, high risk contexts
- Michelle Schroth and Kelly Stuart giving powerful lived experience presentations from consumer and carer perspectives that highlighted collaboration as a human, relational and ethical imperative and encouraged services to reflect on values, power and communication.

Insights and themes from the forum will inform ongoing work by the OCP to:

- strengthen guidance on collaborative practice, including high-risk panels and complex case discussions
- continue embedding lived experience in quality and safety initiatives

- convene an OCP-led quarterly SECU meeting to discuss bed occupancy and demand pressures, understand the different models of care that are currently in operation across the state, and encourage shared learnings and innovation.

The OCP's Complex Needs Team would like to thank all the presenters, participants and contributors for their commitment to improving outcomes for people with complex mental health needs.

Workshop: Sexual safety – 24 March

The OCP is holding a sexual safety workshop on Tuesday 24 March 2026. We encourage all designated mental health services to attend.

The purpose of the workshop is to:

- share the latest updates from the OCP and Safer Care Victoria and hear reflections from the sector
- support mental health services in identifying, reporting, and responding to sexual safety incidents through practical, real-world scenarios
- highlight innovations, quality improvements and best practice across Victoria.

Further details:

- *When:* Tuesday 24 March 2026 at 9am to 1pm.
- *Where:* In-person at the Melbourne Convention and Exhibition Centre.
- *Who should attend:* Clinical leaders, clinicians, people with lived and living experience, quality managers and others with responsibility for sexual safety in bed-based services.

Forum: Delivering culturally safe care across the mental health sector – 14 May

The OCP is partnering with the Victorian Aboriginal Community Controlled Organisation (VACCHO) to deliver an all-day forum on cultural safety and leadership in the mental health sector. The forum will be held on 14 May 2026 at the Aborigines Advancement League in Thornbury. The purpose of the forum is to deepen the understanding of the role of leaders in promoting culturally safe care in designated mental health services. We hope all senior leaders will prioritise attending.

The OCP will send out event details and a request for nominations in late March.

National mutual recognition of mental health orders

The Chief Psychiatrist has been taking part in the National Mutual Recognition Project, an initiative to establish the recognition of civil mental health orders across Australian jurisdictions. The mutual recognition of orders is intended to enable:

- seamless access to mental health services across states and territories for people subject to mental health orders
- the continuation of treatment that is most appropriate to people's needs
- improved arrangements for transferring people
- apprehension and return of people who are absent without leave.

In developing this framework, consideration will be given to each jurisdiction's respective privacy laws and when it is appropriate to share information across jurisdictions to support continuity of care.

Chief Psychiatrist's Annual Report 2024–25

The OCP has published the Chief Psychiatrist's Annual Report for the 2024–25 financial year <https://www.health.vic.gov.au/publications/chief-psychiatrists-annual-reports>.

The annual report outlines the leadership and oversight undertaken by the OCP to strengthen quality and safety in Victoria's designated mental health services while delivering on the reform envisaged by the Royal Commission into Victoria's Mental Health System. This includes providing information on restrictive practices, sexual safety incidents, electroconvulsive therapy and the deaths of people in the care of a designated mental health service.

This year's report shows that the OCP:

- received 1,903 mental health-related enquiries

- visited 18 of Victoria's 22 designated mental health services and 6 prisons to promote clinical best practice
- held 2 sector-wide quality and safety forums on the themes of (1) mental health care in emergency departments and (2) neurostimulation approaches and human rights
- issued bulletins addressing contemporary quality and safety concerns in mental health services.

It also shows that:

- there has been a 28% reduction in the use of bodily restraint over 5 years
- there is better reporting of sexual safety incidents
- reportable deaths remain stable
- the use of electroconvulsive treatment remains stable.
- seclusion episodes increased slightly on the previous year.

Site visits to designated mental health services

Thank you to services who have requested a Chief Psychiatrist site visit in 2026. Site visits are an opportunity for connection and collaboration between the OCP and designated mental health services and an opportunity for services to:

- showcase quality and safety improvements
- raise clinical and operational challenges
- discuss strategies and activities for supporting Aboriginal and Torres Strait Islander consumers
- raise any other matters service would like to discuss.

This year we have a focus on First Nations people and support in the tertiary sector. We strongly encourage services to invite Aboriginal and Torres Strait Islander mental health staff to join site visits, particularly Koori Mental Health Liaison Officers, Aboriginal mental health graduate clinicians and Aboriginal mental health trainees (for services that have these roles).

Specialist Dementia Care Units

The Specialist Dementia Care Program (SDCP) continues to deliver high-quality, tailored care for individuals with severe behavioural and psychological symptoms of dementia. The recent opening of two new units – at Bendigo Health and Martin Luther Homes, Boronia – represents significant progress in expanding specialist dementia care across Victoria.

The Bendigo Health SDCP unit commenced operations with its first admission in early April 2025. The unit is fully staffed and regularly supported by onsite geriatric and psychiatric expertise. Early outcomes are positive, with residents already benefiting from the specialised care and staff mix. Referral pathways are well-established, and the team is focused on ensuring the ongoing safety and wellbeing of both new and existing residents.

At Martin Luther Homes, Boronia, the 'Wattle' household has been transformed into a dedicated SDCP unit through Commonwealth grant funding. Renovations were guided by dementia-friendly design principles, resulting in open communal spaces, enhanced wayfinding, sensory gardens, and improved staff observation areas. All facility staff have received dementia-specific training, in turn strengthening overall service capacity and reducing reliance on agency staff. Admissions are being phased to support smooth transitions, and the unit has maintained a stable environment. Ongoing challenges, such as limited access to specialist in-reach services and allied health support, are being actively addressed.

Planning is underway for the establishment of the sixth SDCP unit in Victoria, with the Gippsland region identified for the next site. Provider engagement has been strong, and early discussions with potential in-reach teams are in progress to ensure timely access to specialist support. The anticipated launch of the sixth unit is scheduled for 2026, with a seventh unit planned to complete the statewide rollout, ultimately providing approximately 150 specialist dementia care beds.

The OCP will continue to monitor progress, support service improvement, and advocate for sustainable funding and access to specialist support across all SDCP units. Further updates regarding new unit allocations, operational timelines and service enhancements will be provided as they become available.

The OCP also chairs the 'Older Adults MHS Clinical Leaders' and the 'Specialist Dementia Care Program Community of Practice'. Interested service participants are welcome to join by emailing ocp@health.vic.gov.au.

Independent Mental Health Advocacy (IMHA) reporting of restraint

The IMHA report on opt-out register and non-legal advocacy service <https://www.imha.vic.gov.au/more-consumers-ever-have-access-mental-health-support-and-advocacy> highlighted the benefits of advocacy to strengthen mental health systems.

IMHA would like services to review their admin supports to these processes as the reporting of some of the most restrictive interventions have been delayed, impeding access to advocacy. Examples of recent delays included: 19 days for chemical restraint, 9 days for bodily restraint and 8 days for seclusion. Services have a responsibility to ensure timely notifications to IMHA as outlined under the Mental Health and Wellbeing Act.

New designated mental health service – Bayside Health

Bayside Health is a new designated mental health service, following the merger of several hospitals, including the designated mental health services at Alfred Health and Peninsula Health. There is no change in the function or practice of these services currently. In time it is hoped that amalgamations will bring greater sharing of resources, prioritisation of services and streamlined ways of working that benefit consumers and staff. This is the first amalgamation of health services under the Department of Health's reform program.

Forensic Leave Panel Annual Report 2024

The Forensic Leave Panel Annual Report 2024 <https://www.health.vic.gov.au/mental-health-services/forensic-leave-panel> was published in December 2025. It reflects the Department of Health's ongoing commitment to promoting respect, safety, responsiveness and human rights within Victoria's forensic mental health system.

During 2024, the Forensic Leave Panel (FLP) expanded its membership to improve access to hearings, create a more responsive system, reduce delays and support recovery-oriented practice. Engagement between the department, FLP and forensic services was strengthened to enhance the quality and safety of systems and processes, supporting improved decision-making and governance.

The FLP maintained a strong focus on procedural fairness, ensuring that patients and residents were supported to understand and participate meaningfully in leave decisions. These improvements have contributed to more timely, transparent and person-centred outcomes, while continuing to prioritise community safety.

Forensic Leave Panel transitioning to Mental Health Tribunal

From 1 September 2026, Victoria will move to a more streamlined and integrated approach to forensic leave decisions.

Under the *Mental Health Legislation Amendment Act 2025*, the functions of the FLP will formally transfer to the Mental Health Tribunal (the Tribunal). This shift brings all leave and transfer reviews into a single decision-making system, reducing duplication and creating a clearer pathway for patients, residents and clinicians.

A new forensic division of the Tribunal will hear applications for leave, special leave appeals and transfer reviews for forensic patients and residents.

Presiding members will be lawyers with experience in mental health law. They will be supported by forensic psychiatrists, psychologists, and community members who provide clinical and experiential expertise.

These changes aim to:

- support efficiencies in the systems and processes
- align with Royal Commission recommendations for better information sharing and integrated health and forensic services
- maintain strong public safety protections while supporting rehabilitation for patients and residents.

The Tribunal's experience in mental health proceedings will support trauma-informed, recovery-orientated practice, while maintaining a strong focus on community safety.

The Department of Health is working closely with the Tribunal, FLP and forensic services to ensure continuity and minimise disruption during the transition.

The FLP will continue its business as usual to 31 August 2026 until its functions transfer to the Tribunal on 1 September 2026.

Driving and mental health

Mental health clinicians have a role supporting safe driving for mental health consumers. This can be a difficult but important discussion to have with consumers and carers as part of treatment and recovery.

We share an example of driving guidelines developed by North-West Mental Health <https://media.nh.org.au/wp-content/uploads/2023/10/20133750/V6-Driving-Guidelines-Version-9-FINAL.pdf>. These have been in use across Northern Health and the Royal Melbourne.

The guidelines provide helpful considerations to promote safe driving for people experiencing a mental health condition, focussing on consumers who access public mental health services and present with a severe or complex mental health condition. The guidelines highlight the responsibilities of consumers as drivers and provide information that assists clinicians to educate consumers, family and carers about those responsibilities.

Key points to note about the guidelines:

- **Purpose:** Support services in balancing consumer autonomy with individual risk when addressing driving-related concerns.
- **Context**: Driving is an important developmental milestone for young people and a means of independence for older individuals or those with disabilities.
- **Access Disparities**: Geographic and financial barriers to OT driving assessments mean services may need to make tailored decisions.
- **Language and Evolution**: Some language is not patient-centred; services are encouraged to adapt and evolve the document for their communities.

The guidelines are not a formal compliance requirement from the OCP but a shared resource for adaptation to local needs. Please review and consider how these guidelines might be evolved for your service and communities.

Clinical focus

Principles of the Mental Health and Wellbeing Act

The Act outlines fundamental principles related to mental health and wellbeing. It requires mental health and wellbeing service providers to take all reasonable steps to adhere to these principles and thoughtfully consider them when making decisions under the Act.

As part of raising sector awareness of the principles, the Chief Psychiatrist will reflect on 2 principles in each issue of the quality and safety bulletin, highlighting key considerations from the standpoint of clinical practice.

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.*

Acting in a least restrictive way is a core principle of modern healthcare with a direct link to the foundations of medicine and the Hippocratic oath principle of non-maleficence or 'first, do no harm'. As autonomous agents, we all wish to assert autonomy over our own lives, and a sense of agency is required for human flourishing. This principle addresses the need to avoid arbitrary external authority over a human's care. Where the realisation of absolute freedom conflicts with other valuable goals tied to the provision of care, the protection of consumers from harm and upholding workplace and community safety, a solution should be sought that curtails freedom in the most minimal way possible.

Every time we limit someone's agency, we should only do so within existing legal constraints that serve as safeguards for people receiving care and have a good clinical rationale for our actions. We should be able to articulate the reasons where we do not fully uphold the right to autonomy and demonstrate we have chosen the least restrictive response under the prevailing circumstances. Above all, we should ensure the person's agency and wellbeing are supported as much as is possible, while also keeping them safe to have the future they desire, free from unnecessary intrusion.

The least restrictive principle involves a weighing of the basic human interest to be free with the ethical duty of health practitioners to provide the best possible care towards a person's recovery and maintain safety for all in a way that keeps sight of the many objectives that are fundamental to human flourishing.

After all, it is what we would all want for ourselves.

Supported decision making principle

> *Supported decision-making practices are to be promoted. Persons 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 given priority.*

Supported decision making is more than asking for preferences or telling people what is in their best interests or documenting why we cannot honour their preferences. It aims to create an environment with information and tools that empower people to make their own decisions. Vygotsky's zone of proximal development captures the value of supported decision making nicely, highlighting that an individual with growth capacity can do far more with a trusted teacher or parent than what they can do and learn alone. In addition, the individual's future capacity to undertake future decisional tasks is further enhanced with this support.

Supported decision making allows capacity building and, ultimately over time, the ability to make better, more authentic decisions and to reap the rewards of agency and personal growth. As we know, a sense of agency

contributes to recovery and wellbeing. It acknowledges that people should be able to make their own decisions when they have capacity and, where capacity is limited, they should still get as much opportunity as possible to contribute to or decide treatment choices that support future life, safety and wellbeing.

The Mental Health and Wellbeing Act allows us to use substitute decision making where the symptoms of mental illness interfere with treatment choices but not where mental illness coincides with difficult to understand choices made through authentic life values.

For example, a person whose delusions tell them that having their gangrenous leg amputated will allow a demon out and therefore refuses surgery should be protected from a life-ending decision because that decision is informed by the overriding symptoms of mental illness. However, a person who decides not to have a leg amputated because, despite depression, they still have capacity and have a lifelong authentic preference to avoid medical treatment, who also has end stage kidney disease from lifelong diabetes, should not have reactive substituted decision making but should have a supported decision making approach. They should be provided with psychoeducation about palliation, the likely ways of dying from gangrene and more peaceful or lesser ways to mitigate risk of death from sepsis so that they understand the extent of the risk they run in preferencing their dislike of medical treatment over the very high risk of a painful death.

All humans want their views to be given priority when it comes to their own life. The supported decision making principle enshrines the importance of those views and the need to have a default position of enabling and sharing decision making power with emphasis on the self-knowledge and values of the human over the expert knowledge about the condition.

The numbers of involuntary consumers under the Act with advance statements of preferences is currently woefully low. We need to think of new ways to create space for these to be completed proactively, possibly on initial recovery so that more people receiving mental health care have articulated their authentic preferences *before* they are too unwell to do so in a considered way.

New factsheet: Co-ordination for mental health patient transport and community crisis responses

The new OCP factsheet on coordinating transport highlights the importance of clinical advice in determining serious and imminent risk <https://www.health.vic.gov.au/chief-psychiatrist/mental-health-patient-transport-and-community-crisis-responses>. This factsheet is designed to be used by mental health clinicians in communicating with Victoria Police and Ambulance Victoria when all least restrictive efforts have failed and assistance with transport is required for safety.

The factsheet acknowledges the distinct roles, training and perspectives of police, protective services officers, paramedics and mental health clinicians, and outlines how mental health clinicians can work to articulate the risks and provide information to Victoria Police and Ambulance Victoria that supports the best outcomes for people experiencing a mental health crisis.

Key information in the factsheet includes:

- Responses must be health-led wherever possible, or health informed if police or protective services officers must lead. This supports culturally safe, person-centred care and reduces unnecessary police involvement.
- Clinical assessment of serious and imminent risk of harm is broader than immediate physical violence and may include psychological and medical risk.
- Clear, plain language communication of risks and least restrictive options between mental health clinicians, police and paramedics reduces delays and supports safe transport.

The Mental Health Critical Incident Escalation Pathway will be released soon. This document will be the first formal escalation pathway established jointly by Ambulance Victoria, Victoria Police and the OCP to support paramedics, police and mental health clinician's infield where differences in approaches or disputes arise.

In the meantime, we encourage Authorised Psychiatrists to contact their local Senior Sergeant when issues cannot be resolved without escalation. If this escalation does not resolve the situation, we encourage Authorised Psychiatrists to contact the OCP. The OCP can raise these issues at the monthly Statewide Emergency Services Liaison Committee.

New MHWA 147 Confinement Notification form – 12-month trial

Discussions were held last year with Authorised Psychiatrists, senior nursing leaders and other members of the mental health sector about the practice of consumers being left in locked rooms or enclosed spaces without staff physically present. This practice – which is distinct from seclusion – may occur in intensive care areas or high dependency units due to factors such as:

- aggression or behavioural risk
- staffing limitations
- accidents or emergency codes
- documentation requirements
- obtaining resources or attending to other essential tasks.

The practice, referred to as ‘confinement’, raises significant concerns regarding the care of consumers who require the highest level of supervision, observation, and treatment. Failure to observe and intervene early can lead to acute deterioration of the consumer and the therapeutic environment, resulting in serious clinical quality and safety incidents.

To understand the extent of this issue and identify safeguarding measures, the OCP is conducting a 12-month trial to monitor the use of confinement in designated mental health services. If more than one consumer is restricted to a locked environment without staff physically present, this is defined as confinement and must be reported. The OCP recently communicated this to Authorised Psychiatrists and Directors of Nursing via the circulation of a factsheet and Confinement Notification Form for reporting the practice.

Services will use the OCP Data Sharing Portal to lodge the forms and associated data will be collated and reported back to individual services and through the OCP Restrictive Interventions Committee. An annual summary will be completed and shared with the sector in 2027.

Monitoring confinement is a component of the safeguards under the Mental Health and Wellbeing Act designed to protect consumer rights, dignity and autonomy, and promotes clinical quality improvement in mental health services.

The Confinement form trial will commence on 1 March 2026.

Revised MHWA forms for restrictive interventions

In 2026, a comprehensive review of all restrictive intervention guidelines, reporting directives, practice directions and factsheets will begin through the Restrictive Interventions Committee. The review will aim to develop a suite of guidance documents and tools that are helpful for clinicians, reduce duplication and improve usability at the point of care. Broad consultation across the sector will be a key component of this review and more information will be provided to services once the review process is confirmed.

The new MHWA forms for restrictive interventions are on the website, but due to feedback from multiple services about their usability, we are progressing several changes. Services should continue to report through their current process and further advice will be disseminated to the sector once the new forms are finalised.

Seclusion and restraint report: Data synthesis and clinical relevance

In December last year, the OCP published the Seclusion and Restraint Report 2020–2024 <https://www.health.vic.gov.au/publications/ocp-seclusion-restraint-report-2020-24>.

The report 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.

The report is an important step towards transparency on restrictive intervention use, which was a key recommendation of the Royal Commission into Victoria's Mental Health System. 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.

In what follows, a synthesis is provided of the data and analysis in the report, focussing on key trends and the factors that have contributed to variations in rates of restrictive interventions across contexts.

Overall statewide trends

Between 2020–21 and 2023–24:

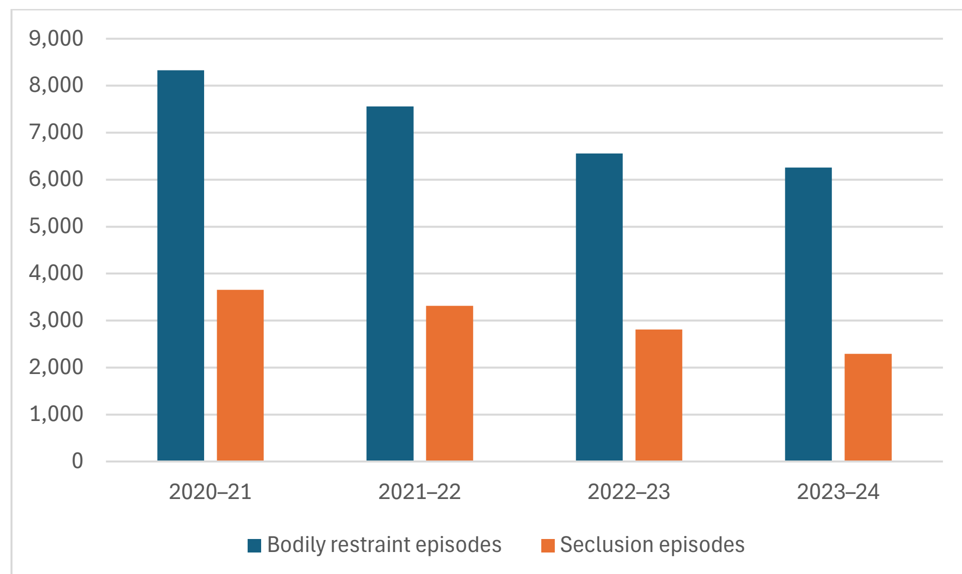
- bodily restraint episodes decreased from 8,329 to 6,257
- seclusion episodes decreased from 3,653 to 2,290 (Table 1 and Figure 1).

These declines occurred despite more inpatient beds, more frequent admissions, and improved reporting obligations under the *Mental Health and Wellbeing Act 2022*, making the reductions particularly significant. This shift can be attributed to quality improvement efforts, strengthened oversight by the OCP and collaborative work with Safer Care Victoria and people with lived experience of mental illness and psychological distress.

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



Patterns across age groups and demographics

Rates for different cohorts are shown in Table 2 and Figure 2 (for bodily restraint) and Table 3 and Figure 3 (for seclusion), with the following patterns being apparent:

- Adult units continue to account for the highest number of episodes, though rates are falling
- Older persons' units show very low and steadily decreasing restraint rates
- Child and adolescent units have higher rates of bodily restraint relative to adults, largely associated with high-acuity cases, eating disorders requiring life-saving interventions and the challenges of developmental, neurodivergent and emotional regulation needs.

Table 2: 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 2: Rates of bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24

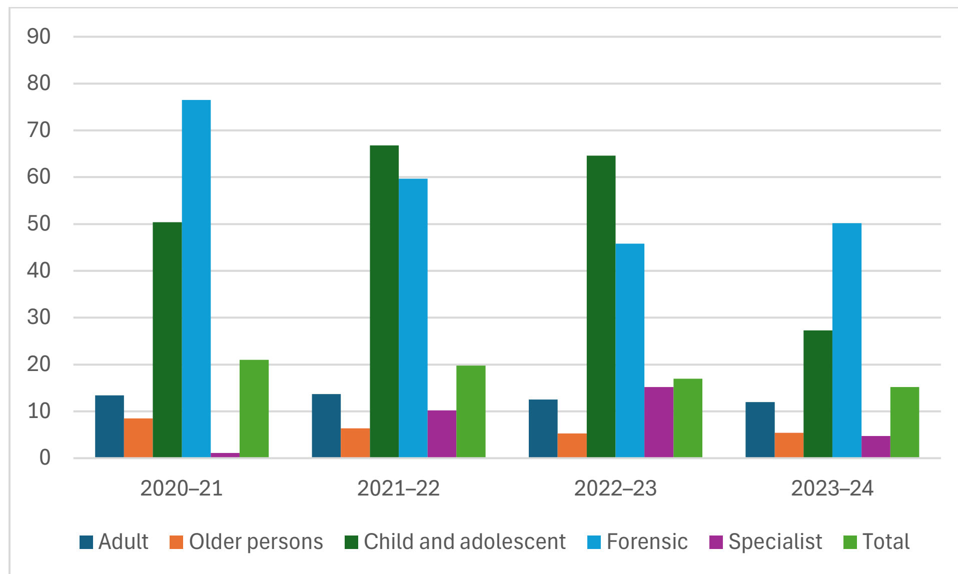
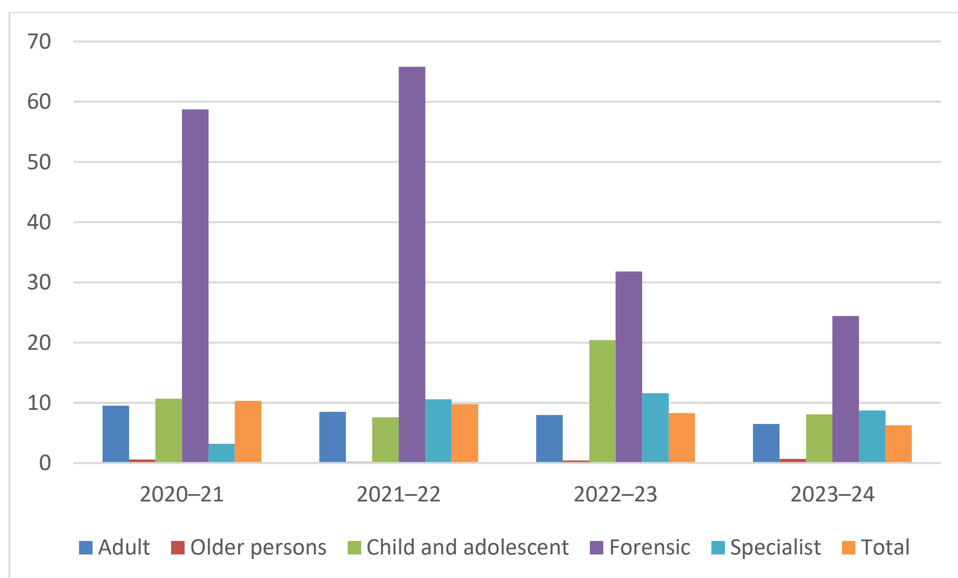


Table 3: Rates of seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2020–21 to 2023–24

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



Men are more likely to experience restraint and seclusion, particularly those aged 18–49. Females aged 13–17 show higher rates of restraint, often linked to eating disorder treatment (Table 4 and Figure 4 for seclusion and Table 5 and Figure 5 for restraint)

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

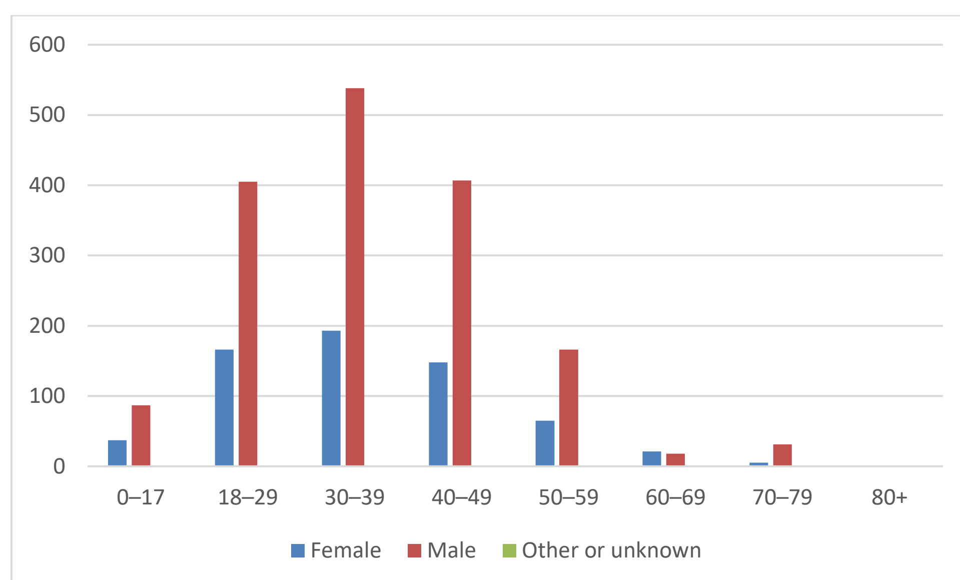
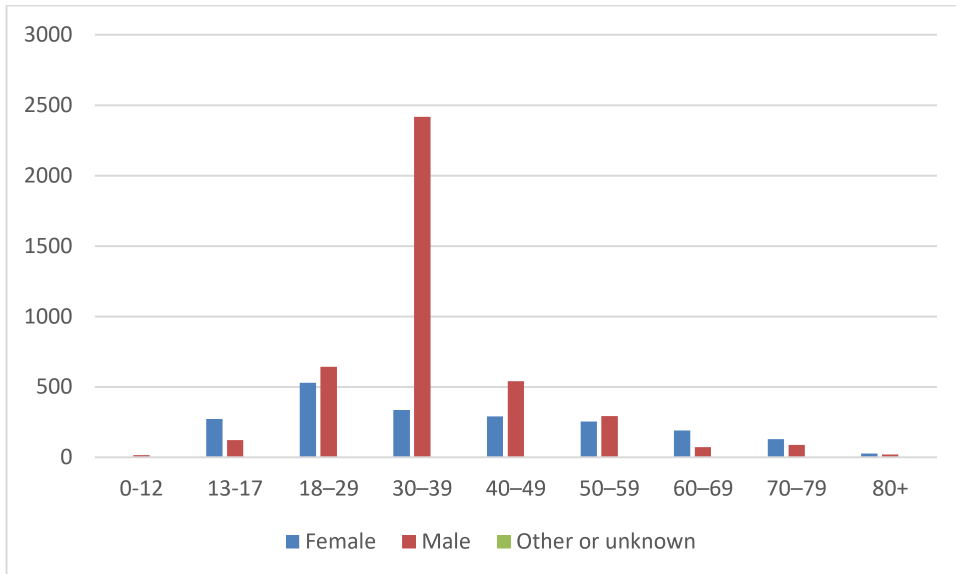


Table 5: Number of bodily restraint episodes in acute inpatient units, by age and sex, 2023–24

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

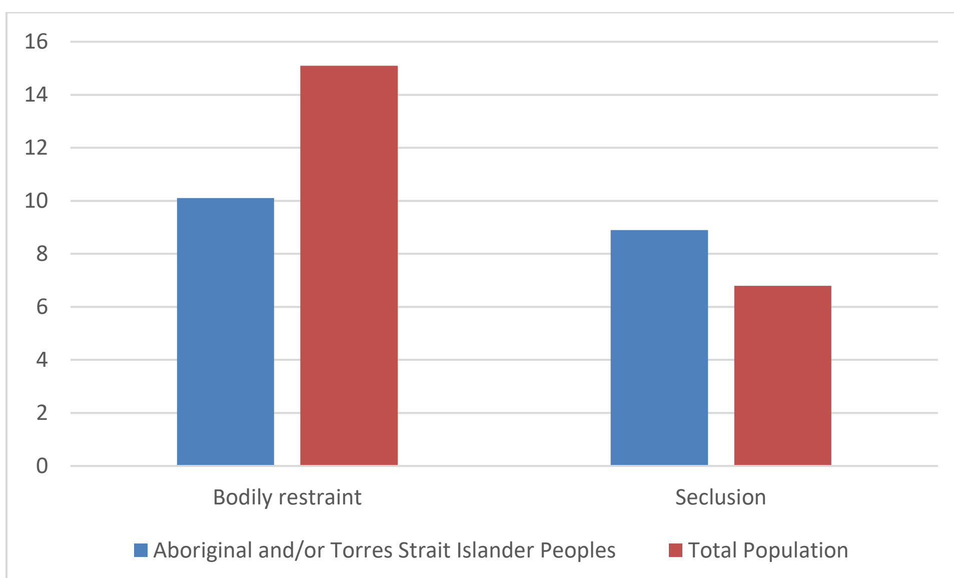


Aboriginal peoples are over-represented in rates of seclusion relative to population share (Table 6 and Figure 6).

Table 6: 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

Figure 6: Rates of seclusion and bodily restraint episodes per 1,000 occupied bed days in acute inpatient units in 2023–24 for Aboriginal peoples

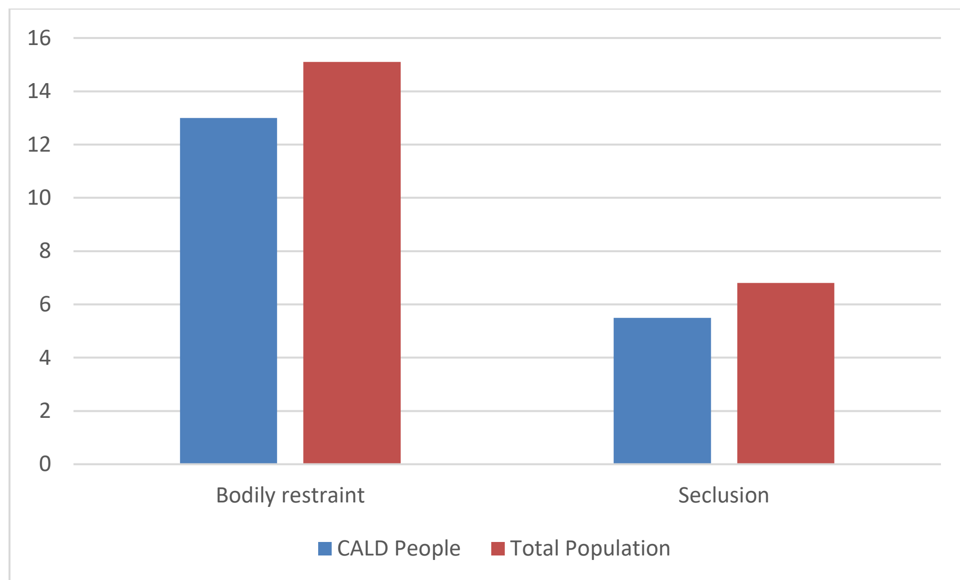


Culturally and linguistically diverse consumers experience lower-than-average rates of both seclusion and restraint when adjusted for bed-day occupancy (Table 7 and Figure 7).

Table 7: 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 7: 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



Service level variation

Rates vary significantly by service (Table 8 and Figure 8 for restraint in Adult units and Table 9 and Figure 9 for seclusion in Adult units).

This variation is influenced by:

- service size and bed configuration
- local infrastructure and intensive care area availability
- acuity of presentations
- workforce turnover, skill mix and after-hours senior coverage
- emergency department wait times
- prevalence of methamphetamine use
- homelessness, justice system referrals and delayed access to care.

However, most services demonstrate either stable or improving trends. Several services – e.g., Northern Health and Mercy Health – show particularly notable reductions linked to targeted improvement initiatives, leadership and Safewards implementation.

Table 8: 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
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 8: 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

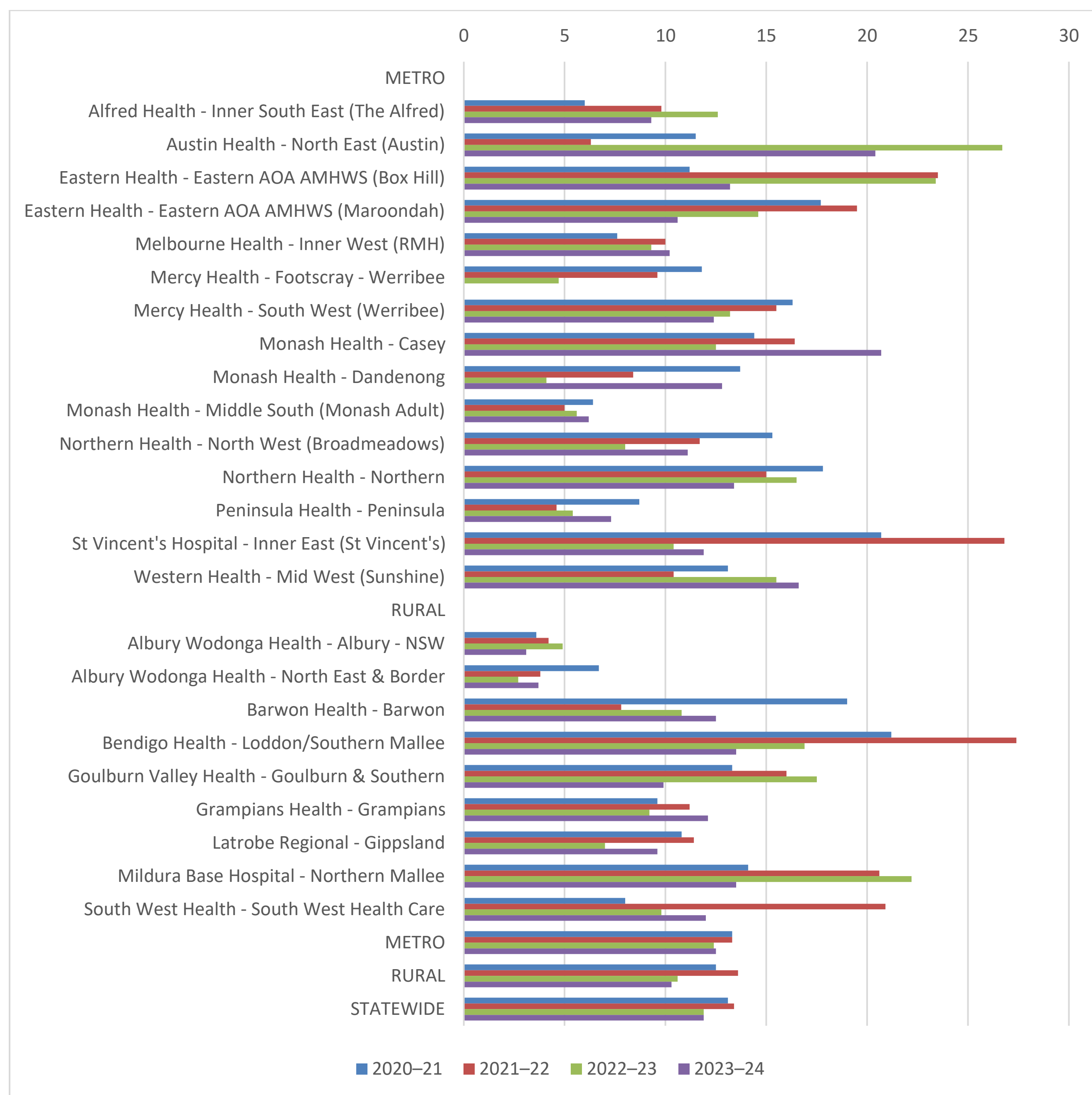


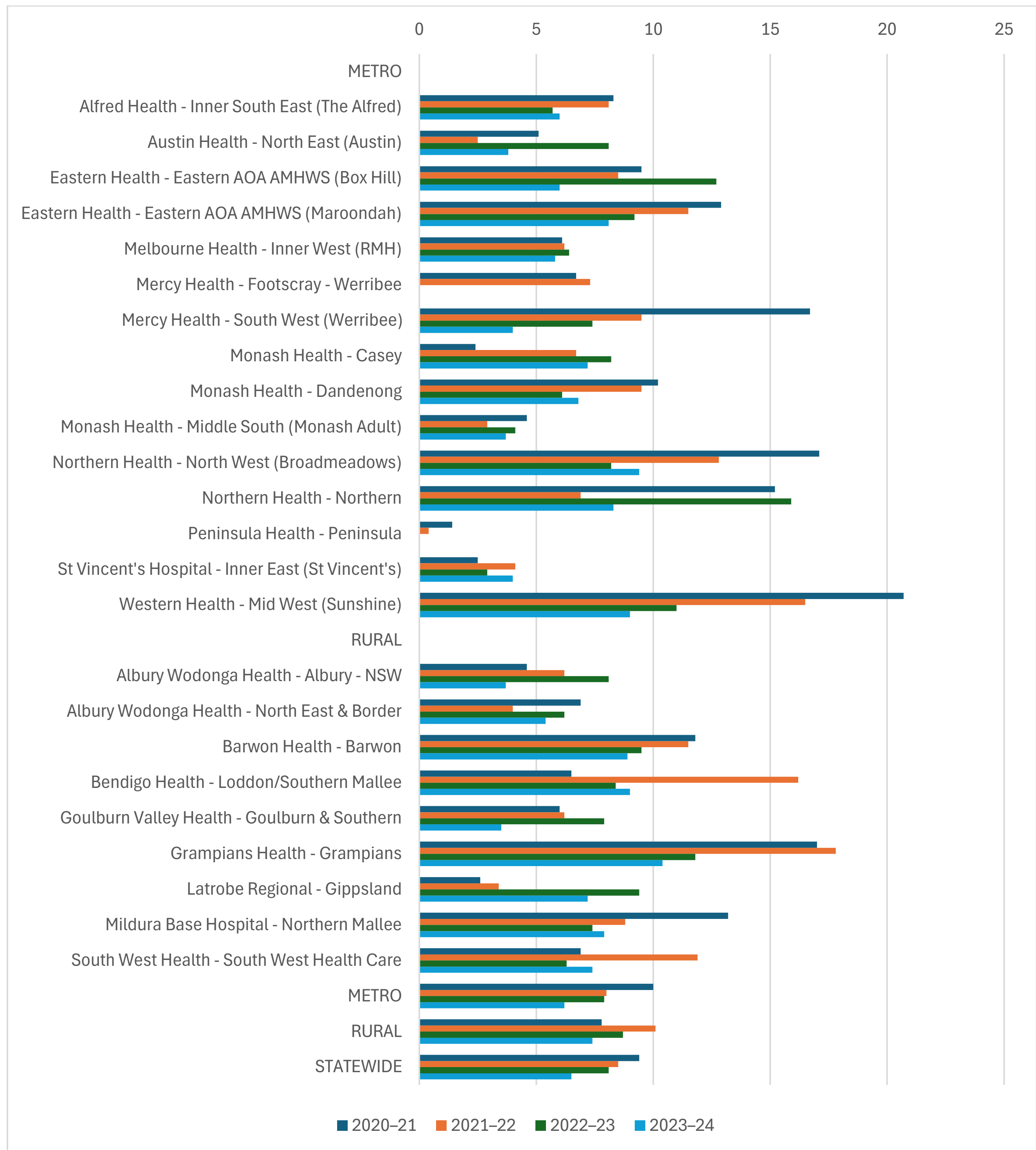
Table 9: Rates of ended seclusion episodes per 1,000 occupied bed days in adult inpatient units, by financial year, health service and campus, 2020–21 to 2023–24

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 9: 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



Differences by type of restrictive intervention

Physical Restraint

Physical restraint remains the most common form of bodily restraint. Its rate has steadily decreased statewide. It is generally brief and used primarily for safety during high-risk situations such as medication administration or preventing harm.

Mechanical Restraint

Mechanical restraint is infrequent and typically associated with emergency department settings or safe transport (e.g., for electroconvulsive therapy or when Ambulance Victoria safety protocols require it). Rates remain low across all service types, with further declines driven by strengthened oversight and staff training.

Seclusion

Seclusion rates have fallen significantly in adult units and remain extremely low in older persons' units, some of which have decommissioned seclusion rooms entirely. Child and adolescent units show variability year to year, largely reflecting the needs of a small number of very unwell young people.

Factors contributing to reductions

There are several system drivers that have supported positive change:

- Implementation of the *Mental Health and Wellbeing Act 2022*, which strengthened legislative safeguards.
- Safewards and other trauma-informed, person-centred practice models.
- Safer Care Victoria's TERP Collaborative, which has brought structured improvement methods to inpatient teams.
- Increased involvement of lived and living experience workforces in practice reform.
- Improved reporting, transparency and executive-level oversight.
- Infrastructure upgrades, particularly redesigns of intensive care areas.
- Ongoing sector forums, site visits and quality and safety bulletins led by the OCP.

Conclusion

Across 2020–24, substantial progress has been made to reduce the use of seclusion and restraint. While challenges remain – particularly workforce pressures and high acuity – the overall trajectory is one of improvement, driven by strong legislative settings, committed leadership, meaningful lived experience involvement and sustained quality-improvement efforts. The *Seclusion and Restraint Report 2020–24* details a system that is actively working to reduce coercion, improve safety and accountability and move steadily toward the Royal Commission's vision of eliminating restrictive interventions altogether.

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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Available at Office of the Chief Psychiatrist's website <https://www.health.vic.gov.au/chief-psychiatrist/resources-and-reports>