Chief Psychiatrist's annual report 2022–23

VICTORIA State Government | Department of Health

Acknowledgements

Acknowledgement of country

The Victorian Government 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.

Acknowledgement of lived and living experience

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

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Foreword from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist's annual report for 2022–23.

This year's report is somewhat briefer than usual, owing to the significant volume of work carried out by the Office of the Chief Psychiatrist to help the mental health and wellbeing sector prepare for the commencement of the new *Mental Health and Wellbeing Act 2022*.

At the time of writing this report, preparations for implementing the new Act were at their peak. This involved my office translating the legal requirements of the new Act into practical guidance for clinical mental health and wellbeing services, enabling them to better understand the changes they needed to make to meet their new compliance obligations. As part of this, the office has carried out work to update clinical guidelines, develop practice directives, build a new website, deliver information sessions to the mental health workforce, and respond to queries and concerns about what the new Act means for people who use, and work in, the clinical mental health system.

The Office of the Chief Psychiatrist has also been undertaking work to implement the recommendation from the Royal Commission into Victoria's Mental Health System to regulate chemical restraint. For the first time in Victoria, chemical restraint will fall under the definition of a restrictive intervention under the Mental Health and Wellbeing Act. In many respects, this is uncharted territory, with few places in the world successfully regulating chemical restraint.

Considerable practical constraints stand in the way, such as determining when the use of a medication is intended to control a person's movement as distinct from treating their mental illness. The Office of the Chief Psychiatrist has sought to address these implementation issues squarely so chemical restraint can be properly regulated in Victoria. We established and convened a chemical restraint expert advisory group made up of health clinicians and people with lived experience of mental illness. The diverse knowledge and experience in the group was drawn on to develop a regulatory regime that will allow chemical restraint to be identified, reported, monitored and used only as a last resort.

The Office of the Chief Psychiatrist also continued implementing the Royal Commission's recommendation to expand the functions and powers of the Chief Psychiatrist into custodial settings. This expanded jurisdiction for the Chief Psychiatrist role is also reflected in the Mental Health and Wellbeing Act. My office worked closely with partners in the Department of Justice and Community Safety to develop oversight processes suited to custodial settings so mental health treatment and care can be monitored and improved there as it is in other parts of the health system. This expansion of functions and powers is a major new responsibility for the team. It encompasses Victoria's adult prisons and youth justice centres, representing a substantial increase in service provision to be overseen by the office in a setting that is complex from a clinical, legal and governance standpoint.

Alongside this reform work, my office continued to support me with my statutory oversight and leadership functions across Victoria's clinical mental health services. These include monitoring restrictive interventions, electroconvulsive therapy and the deaths of people in the care of a mental health and wellbeing service. The team also continued to respond to serious clinical incidents and work with mental health and wellbeing services to improve the quality and safety of care they provide.

As always, I am grateful for the support the Office of the Chief Psychiatrist receives from people with lived and living experience of mental illness. Their input is invaluable in the office's day-to-day activities of enforcing compliance with the Act and instilling best practice in Victoria's clinical mental health and wellbeing services.

Neil Coventry
Chief Psychiatrist

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Overview

Aims of the report

The aims of this annual report are to:

- inform mental health consumers, carers, service providers and members of the public about the activities of the Office of the Chief Psychiatrist (OCP) in the 2022–23 financial year
- provide information about specific clinical practices that must be reported by health services to the Chief Psychiatrist under the *Mental Health Act 2014* (the Act)*
- contribute to ongoing improvement in the quality and safety of Victoria's mental health services.

Statutory framework and role of the Chief Psychiatrist

The Act aims to improve the experience of people using mental health and wellbeing services by actively involving and supporting them, and their families and carers, in making decisions about their treatment and exercising their rights.

The Act has several core principles and objectives, including that:

- assessment and treatment are provided in the least intrusive and restrictive way
- people are supported to make and take part in decisions about their assessment, treatment and recovery
- individuals' rights, dignity and autonomy are protected and promoted at all times
- priority is given to holistic care and support options that respond to individual needs
- the wellbeing and safety of children and young people are protected and prioritised
- carers are recognised and supported in decisions about treatment and care.

Under s 119 of the Act, the Secretary of the Department of Health (formerly 'Department of Health and Human Services'; abbreviated as 'the department' hereon) can appoint a Chief Psychiatrist. The role of the Chief Psychiatrist, as described in s 120 of the Act, is to:

- provide clinical leadership and expert clinical advice to mental health service providers
- promote continuous improvement in the quality and safety of mental health services
- promote the rights of people receiving mental health services
- provide advice to the designated minister and the departmental Secretary about mental health services.

Under the Act, 'mental health service providers' are designated mental health services (often public or denominational hospitals) and publicly funded mental health community support services. Often referred to jointly as 'public mental health services', these services include a range of hospital and community-based clinical mental health services and the Victorian Institute of Forensic Mental Health (known as 'Forensicare'). More information about the Act and how it relates to the role of the Chief Psychiatrist can be found on the department's website <https://www.health.vic.gov.au/practice-and-service-quality/mental-health-act-2014>.

* This report covers the period when the *Mental Health Act 2014* was still in force (July 2022 to June 2023). The *Mental Health and Wellbeing Act 2022* commenced on 1 September 2023 and will therefore apply to next year's annual report.

Commencement of the *Mental Health and Wellbeing Act 2022*

The Royal Commission into Victoria's Mental Health System recommended that the Victorian Government replace the *Mental Health Act 2014* with a new act. As part of this reform priority, the *Mental Health and Wellbeing Act 2022* was introduced by Victoria's Parliament in September 2022 and commenced on 1 September 2023. The new Act broadens the Chief Psychiatrist's oversight to encompass mental health and wellbeing services delivered in custodial settings and in the community, along with the regulation of chemical restraint. Next year's annual report will cover the period of the new Act's commencement, and so will report on the new aspects of the Chief Psychiatrist's expanded role.

Functions of the Chief Psychiatrist

The Chief Psychiatrist provides system-wide oversight of Victoria's public mental health and wellbeing services. Supported by the OCP, the role promotes quality and safety in services that are provided to some of the state's most vulnerable people. The functions of the Chief Psychiatrist, as summarised under s 121 of the Act, include a requirement to:

- develop, communicate and assist mental health service providers to comply with standards, guidelines and practice directions
- assist mental health services to comply with the Act, with regulations made under the Act and with codes of practice
- develop and provide information or training, and monitor service provision, to promote quality and safety
- conduct clinical practice audits and clinical reviews of mental health service providers and investigations in relation to service provision
- analyse data, undertake research and publish information about mental health services
- publish an annual report
- give directions to mental health service providers about service provision
- promote cooperation and coordination between mental health services and providers of health, disability and community support services.

Office of the Chief Psychiatrist and the Department of Health

The Act defines the statutory role of the Chief Psychiatrist, who also holds an executive officer role in the department, where they lead the OCP. As the department's quality and safety arm in guiding clinical mental health services, the OCP supports the Chief Psychiatrist's responsibility to provide clinical leadership to the sector. The OCP undertakes a wide range of activities including:

- monitoring restrictive and invasive interventions, which include seclusion, restraint and electroconvulsive treatment (ECT)
- responding to serious clinical incidents
- working with mental health and other service providers to improve care for individual consumers
- helping to embed new practices and models of care.

The OCP works closely with Safer Care Victoria to ensure mental health services are safe and of a high standard. In the new mental health and wellbeing system recommended by the Royal Commission, quality and safety governance is a responsibility shared between each body. The OCP undertakes its oversight activities alongside Safer Care Victoria's training and education activities to embed contemporary approaches to treatment and care. Regular meetings with Safer Care Victoria help align these activities and ensure mental health governance is integrated and effective.

A note on this year's annual report

At the time of preparing this year's annual report, the Office of the Chief Psychiatrist was supporting the mental health and wellbeing sector to prepare for the transition to the *Mental Health and Wellbeing Act 2022*. A considerable proportion of the office's resources were directed towards facilitating changes to practice and responsibilities required under the new Act. As a result, this year's annual report is less detailed than in previous years, covering mainly the information that must be reported as a statutory requirement under s 145 of the *Mental Health Act 2014*.

Clinical leadership activities in 2022–23

In the 2022–23 financial year, the OCP carried out the following clinical leadership activities:

- introduced oversight arrangements for sexual safety in clinical mental health services, including protocols for reporting sexual safety incidents and a clinical guideline on sexual safety
- supported the planning for the start of the Mental Health and Wellbeing Act in September 2023
- provided clinical advice into Department of Health activities to guide the transformation of the mental health service sector in response to the recommendations of the Royal Commission into Victoria's Mental Health System
- undertook research and consultation to revise existing Chief Psychiatrist guidelines and develop new ones to embody contemporary understandings of clinical best practice – this included a new guideline on restrictive interventions that outlines compliance obligations and best practice advice on using chemical restraint
- convened the Statewide Complex Needs Advisory Panel, providing pathways into mental health and wellbeing services for people who fall outside standard service responses and pose a serious risk to others or themselves
- convened an expert advisory group made up of health professionals and people with lived experience of mental illness to support the implementation of an oversight regime for chemical restraint by the Chief Psychiatrist
- convened a weekly statewide adolescent inpatient psychiatric unit huddle to support urgent inpatient care for adolescents through managing demand across services
- planned and designed the oversight of mental health services in custodial settings by the Chief Psychiatrist in collaboration with Forensicare, the Department of Justice and Community Safety, Corrections Victoria and the Commission for Children and Young People
- convened regular infant, child and youth clinical leaders' meetings with area mental health services to support coordination and care across the infant, child and youth sector
- convened regular older adults mental health service clinical leaders' meetings, fostering collaboration between services to improve treatment and care for older adults
- worked with authorised psychiatrists to identify issues in the clinical mental health and wellbeing system via a series of ongoing forums (topics included briefings on emerging reforms and compliance requirements relating to Royal Commission recommendations and the new Mental Health and Wellbeing Act)
- gave a keynote presentation at a Safer Care Victoria ligature safety forum on the need to balance safety with consumer rights in inpatient settings
- modernised systems to ease the administrative burden on services reporting clinical incidents and practices to the OCP
- redesigned and rebuilt a new OCP website to increase accessibility to information and resources vital for legislative compliance and protection of consumer rights.

Statutory reporting

Under the Act, mental health services must report to the Chief Psychiatrist about their use of ECT and restrictive interventions. They must also report the deaths of mental health consumers. The Chief Psychiatrist understands that the loss of a loved one or the use of restrictive practices has impacts on people, their families and the workforce and is working with services to improve consumers' physical wellbeing and minimise the use of restrictive practices.

The Chief Psychiatrist collects data to help monitor trends, identify issues and improve quality and safety in clinical services. This section of the report provides data and analysis for ECT, restrictive interventions and consumers' deaths in 2022–23.

The data in this section is grouped *female* and *male*. The OCP acknowledges that some people express their gender in ways that do not correspond with these binary differences. This includes people who are gender non-binary, gender queer, agender or gender fluid/diverse. The OCP data systems are operating under historical and current data-gathering methods, which typically group data according to categories of biological sex. The OCP acknowledges that this binary approach does not provide a full picture of the experiences of consumers and is currently working towards adopting a more inclusive approach that better captures the diverse ways people express their gender.

Electroconvulsive treatment

ECT is a safe, effective, evidence-based treatment for mood disorders, psychosis and catatonia. It may be recommended when other medical treatments have not worked, take too long to work or cannot be undertaken safely. It might also be recommended to people for whom the treatment has worked well previously.

ECT is now highly advanced and individually tailored to maximise its benefits and reduce side effects, including cognitive impairment. Adverse effects are minimised by preferentially applying stimulation to one side of the head (unilateral ECT) with the smallest possible dose of electrical stimulation. Bilateral ECT is used when clinically indicated. Treatments are typically administered on two or three occasions per week over a period of two or more weeks. A small proportion of people benefit from ongoing treatments to prevent relapse.

The Chief Psychiatrist and the Mental Health Tribunal oversee ECT. Services must inform the Chief Psychiatrist of each treatment, stipulating the type of treatment and the reason for its use.

Electroconvulsive treatment in public mental health services

In 2022–23, 884 people received ECT (Table 1), with 11,699 ECT treatments delivered. The rate of treatments delivered per person was 13.2.

Table 1: Number of treatments and people treated by ECT in public hospitals, 2018–19 to 2022–23

Measure	2018–19	2019–20	2020–21	2021–22	2022–23
Number of ECT treatments	12,991	12,107	11,982	11,947	11,699
Number of people receiving ECT	974	893	910	894	884

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

While the numbers of treatments administered vary from year to year, the variation from 2018–19 to 2022–23 may reflect changes in practice due to COVID-19. To reduce the risk of infection, some outpatient treatments (which account for about half of the total) were postponed, and access to theatre was sometimes constrained. A possible consequence of efforts to contain COVID-19 transmission during the pandemic might be a prolonged recovery for some mental health consumers or a greater vulnerability to relapse in others.

Mood disorders accounted for 60% of treatments in 2022–23, followed by schizophrenia and other psychoses (Table 2).

Table 2: Number of ECT treatments in a public hospital, by diagnosis, 2018–19 to 2022–23

Health conditions	2018–19	2019–20	2020–21	2021–22	2022–23
Major affective and other mood disorders	7,868	7,442	7,255	7,168	7,010
Schizophrenia, schizoaffective and other psychotic disorders	4,424	3,811	4,104	4,215	3,939
Other mental health disorders	226	233	167	214	335
No mental health diagnosis recorded	473	621	456	350	415

Table 3 shows that, overall, more women than men were treated with ECT across the life span.

Table 3: Number of ECT treatments, by age group and sex, 2022–23

Measure	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+	Total
Female	6	806	784	936	753	1,008	1,301	514	**6,108**
Male	34	607	808	882	1,149	927	759	413	**5,579**
Other or unknown	0	0	0	0	0	12	0	0	**12**

Deaths of people receiving mental health treatment

The death of a person receiving treatment or support for a mental illness is a tragic event. The Chief Psychiatrist collects data from mental health services to learn from each incident, with a view to improving the quality and safety of clinical practices and reducing the number of preventable deaths.

The Chief Psychiatrist must be notified of the deaths of all mental health inpatients where an inpatient is defined as any person, regardless of legal status, who:

- had been admitted to a mental health inpatient unit
- was on approved leave from an inpatient unit
- had absconded from an inpatient unit
- had been transferred to a non-psychiatric ward during a mental health admission
- had been discharged from a mental health inpatient unit within the previous 24 hours
- had been waiting in an emergency department for a mental health bed to become available.

In the case of deaths in the community, the Chief Psychiatrist must be notified of:

- all unexpected, unnatural or violent deaths (including suspected suicides) of people who are, or had been in the previous three months, a registered mental health consumer or who had sought care from a mental health provider even though it had not led them to being a registered mental health consumer
- all deaths of patients under community treatment orders or non-custodial supervision orders.

People are considered to be mental health consumers until their case is closed and they have been told of this change in status (or the service has made reasonable efforts to do so).

The Chief Psychiatrist is accountable for the following functions with respect to consumers' deaths:

- to maintain a database of reportable deaths
- to contribute to coronial inquiries and recommendations when requested by the coroner
- to review clinical reports provided by services to identify systemic issues that may have contributed to a person's death, including through the Chief Psychiatrists Sentinel Event Review Subcommittee
- to identify statewide issues and provide guidance to mental health services to reduce and prevent deaths and to provide safe and effective care.

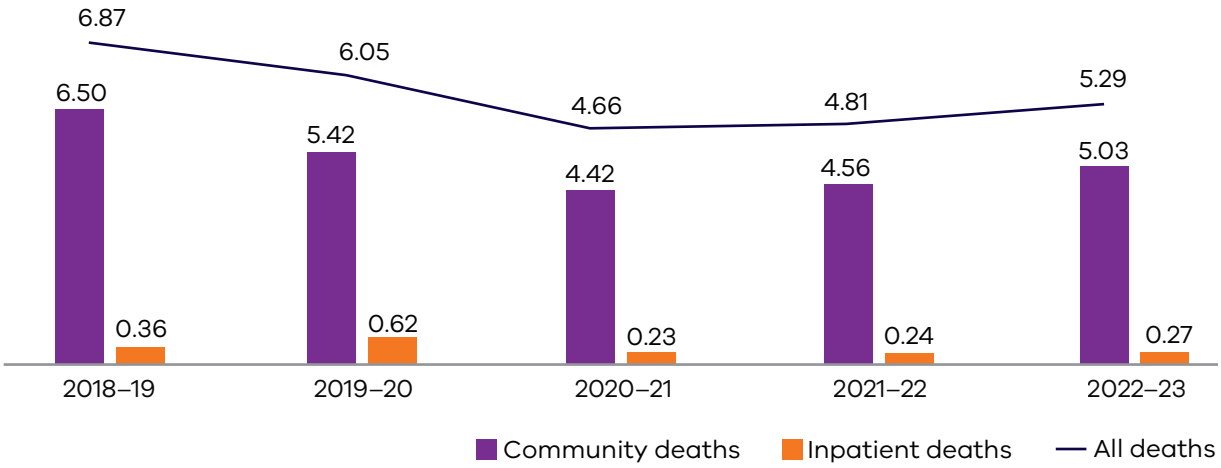
The Chief Psychiatrist works with the Coroners Court to match data and identify suicides of people who were recently discharged from a mental health service. This cross-checking of data is also used to detect suicide in specific areas or demographics, enabling the Department of Health to take early action in support of services responding to suicide clusters.

Reportable deaths in 2022–23

In 2022–23 mental health services reported 377 deaths, of which 19 were defined as 'inpatient deaths' (Table 5). Four of these 19 deaths were recorded as suicide. The overall number of inpatient deaths encompasses the deaths of people while on leave, shortly after their discharge or following their transfer to other types of wards.

When adjusted for population, rates of inpatient deaths have remained steady over the past three years and been on a downward trend since 2018–19. Community deaths have increased on the previous year but are lower over the long term (Figure 1 and Table 4). None of these deaths were known at the time of writing to have been directly the result of COVID-19, although six people tested positive for COVID at the time of death.

Figure 1: Reportable deaths per 100,000 Victorian population, 2018–19 to 2022–23



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

Table 4: Reportable deaths per 100,000 Victorian population, 2018–19 to 2022–23

Measure	2018–19	2019–20	2020–21	2021–22	2022–23	Average
Community deaths	6.50	5.42	4.42	4.56	5.03	5.19
Inpatient deaths	0.36	0.62	0.25	0.24	0.27	0.35
All deaths	**6.87**	**6.05**	**4.66**	**4.81**	**5.29**	**5.54**

Note: This table corresponds with the graph in Figure 1. It is included for purposes of accessibility.

Of the 377 notified deaths in 2022–23 (Table 5), the cause of death has yet to be determined in 31% of instances. Of the remainder, suicide and medical causes accounted for nearly equal proportions (35% and 28% respectively). Suicide data is cross-validated with data received from the Coroners Court. The OCP maintains an active interest in ongoing coronial investigations relating to reportable deaths. It receives and reviews the outcome of these as they arise and updates the data set. This may be several years after a death.

Table 5: Reportable deaths by category, 2022–23

Category	Community patient	Inpatient	Total	Proportion
Accident/misadventure	21	0	21	6%
Homicide	2	0	2	1%
Medical condition	97	9	106	28%
Not yet known	111	6	117	31%
Suicide	127	4	131	35%
Total	**358**	**19**	**377**	**100%**

Notes:
'Not yet known' figures relate to deaths that are under investigation by the Coroner and not yet determined. Some of these investigations may result in a finding of 'undetermined'.
Out of 377 notified deaths, seven were deemed out of scope. These encompass deaths in private hospitals and community upport services or where the death was not judged as not unexpected, unnatural or violent.
The 'medical condition' figures include several inpatient deaths due to medical events unrelated to acute mental health care and a small number of deaths that took place as part of an end-of-life pathway for terminal illness.
The percentages may not add to exactly 100% because of rounding.

The OCP views every suicide in care as potentially preventable. Each number represents a person who has suffered and left behind family and loved ones. Safer Care Victoria classifies all inpatient suicides as sentinel events; they trigger detailed reports from health services. These reports are reviewed by the Chief Psychiatrist's Sentinel Event Review Subcommittee supported by a panel of senior clinicians of various disciplines and consumer and carer representatives. The panel makes recommendations to services where indicated to reduce the possibility of a recurrence. The panel may also make recommendations to enhance the rigour of service review processes. Important lessons are communicated to services through the Chief Psychiatrist's *Quality and safety bulletin*.

Restrictive interventions

The Chief Psychiatrist is committed to reducing and eventually eliminating restrictive interventions as outlined in the Royal Commission's recommendations and the National Mental Health Commission's *Seclusion and restraint declaration*. For the year being reported on, the Chief Psychiatrist was the main authority in Victoria for overseeing restrictive interventions.

Restrictive interventions are defined in the Act as the use of seclusion or bodily restraint. Seclusion is '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' (s 3). Bodily restraint is 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs' (s 3).

The Mental Health Act provides that a person may only be placed in seclusion or restraint to prevent imminent and serious harm to the person or another person or, in the case of restraint, to administer treatment. The principles outlined in the Act specify that people receiving mental health services should be treated in the least restrictive way possible, meaning that seclusion and restraints can be applied only after all reasonable and less restrictive options have been tried or considered and found unsuitable.

The Mental Health and Wellbeing Act 2022 provides the regulatory framework to reduce and eliminate restrictive interventions in our mental health services over a 10-year period in line with Royal Commission recommendations. This new Act defines chemical restraint as a restrictive intervention and the mechanisms for reporting in the 2023–24 year have been established. Because the Mental Health and Wellbeing Act began on 1 September 2023, reporting on chemical restraint is outside of the scope of this year's annual report.

The Chief Psychiatrist has received advice that the term 'restrictive interventions' is offensive to some and has undertaken to increasingly adopt the term 'restrictive practices' to reflect the views of stakeholders, particularly those with lived and living experience. Restrictive practices are distressing and non-therapeutic, leaving the people who experience them with long-term impacts. The word 'intervention' may be seen to legitimise the practice as inherently therapeutic, and this understanding must be challenged.

The OCP continues to convene the Chief Psychiatrist's Restrictive Intervention Committee. This committee has regularly received updates on the work being done to develop the policy and strategy for reducing and eventually eliminating restrictive practices.

The OCP has a secure SharePoint site so health services can share data, ensuring they meet their reporting obligations. This allows the OCP to respond and provide feedback more efficiently in response to significant variations in practice.

Acute inpatient units

Table 6 shows the number of episodes of bodily restraint and seclusion in acute inpatient units over the past five years. The use of bodily restraint and seclusion decreased in 2022–23 compared with the previous year.

Table 6: Number of ended episodes of bodily restraint and seclusion in acute inpatient units, 2018–19 to 2022–23

Intervention	2018–19	2019–20	2020–21	2021–22	2022–23
Bodily restraint	10,359	8,269	8,329	7,557	6,540
Seclusion	3,182	3,575	3,653	3,316	2,810

In 2022–23 seclusion in acute inpatient units showed an age/sex difference, with females more likely to be secluded at younger ages and more males being secluded when aged 30–39 (Table 7).

Table 7: Number of ended seclusion episodes in acute inpatient units, by age and sex, 2022–23

Sex	0–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	188	291	267	111	81	12	n.p.	0
Male	91	510	628	370	169	65	8	n.p.
Other or unknown	8	7	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. This is done to protect the confidentiality of individuals.

For bodily restraint, most episodes were among the 30- to 39-year-old age group (Table 8).

There is a difference in seclusion and bodily restraint episodes between sexes, with each being more frequent in males, except in the 0- to 17-year-old age group, where it was more frequent in females.

The usual pattern of increased frequency in males for both bodily restraint and seclusion is not seen in the data this year. The Chief Psychiatrist will monitor this change with interest to see if it becomes a long-term feature.

Table 8: Number of ended bodily restraint episodes in acute inpatient units, by age and sex, 2022–23

Sex	0–12	13–17	18–29	30–39	40–49	50–59	60–69	70–79	80+
Female	0	726	875	423	252	426	121	98	42
Male	n.p.	56	740	1,813	334	322	87	86	35
Other or unknown	0	93	n.p.	0	0	0	0	0	0

Note: Some age groups have been further aggregated to protect the confidentiality of individuals.

Seclusion – acute inpatient units

Table 9 lists the numbers of episodes of seclusion per 1,000 occupied bed days. Rates have fallen in adult wards over the past five years and remain low in services for older people. The rate in child and adolescent units has increased, with a small number of people with complex combinations of mental illness and intellectual or developmental disability being represented in these figures.

Forensicare has undertaken extensive quality improvement activities in the area of restrictive practices, and it is pleasing to see the improvement in their figures over the past financial year (Table 9).

Table 9: Rate of ended seclusion episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2018–19 to 2022–23

Type of unit	2018–19	2019–20	2020–21	2021–22	2022–23
Adult	9.5	10	9.5	8.5	8
Older persons	0.7	0.6	0.6	0.2	0.4
Child and adolescent	12.2	14.6	10.7	7.6	20.4
Forensic	39.2	47.3	58.7	65.8	31.8
Specialist	0.4	0.5	3.2	10.6	11.6
Total	**8.8**	**10**	**10.3**	**9.8**	**8.3**

Note: The Alfred Psychiatry Intensive Care Statewide Service data is reflected in the 'specialist' data.

Table 10 shows that, when seclusion happened, it typically occurred only once within an admission to hospital. Multiple episodes of seclusion were less common. This pattern has remained consistent in recent years.

Table 10: Frequency of ended seclusion episodes within a single inpatient admission, 2018–19 to 2022–23

Frequency	2018–19	2019–20	2020–21	2021–22	2022–23
1	868	796	789	637	599
2	224	212	205	178	175
3	100	103	100	73	70
4	53	61	50	60	48
5	29	34	31	33	30
6	16	20	22	17	19
7+	64	85	80	60	63

Table 11 shows that in 2022–23 close to half of all episodes of seclusion lasted for four or fewer hours, consistent with most previous years. There was a significant reduction in the numbers of seclusions that went beyond 12 hours, which is a positive development. The occasions of seclusion beyond 12 hours are closely monitored.

Table 11: Duration of ended seclusion episodes in acute inpatient units, 2018–19 to 2022–23

Period	2018–19	2019–20	2020–21	2021–22	2022–23
≤ 4 hours	1,651	1,852	1,716	1,512	1,454
4–12 hours	715	726	767	580	611
> 12 hours	816	997	1,170	1,224	745

Restraint – acute inpatient units

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

Table 12 shows that bodily restraint episodes per 1,000 occupied bed days has decreased overall, with most types of units trending in this direction. The previous rise in rates of restraint in child and adolescent inpatient units appears to have plateaued.

Table 12: Rate of ended bodily restraint episodes per 1,000 occupied bed days, by type of acute inpatient unit, 2018–19 to 2022–23

Type of unit	2018–19	2019–20	2020–21	2021–22	2022–23
Adult	10.7	11.8	13.4	13.7	12.4
Older persons	6	8.9	8.5	6.4	5.2
Child and adolescent	37.2	42.3	50.4	66.8	63.4
Forensic	162.1	90.3	76.5	59.7	45.8
Specialist	0.5	0.8	1.1	10.2	15.3
Total	**25.8**	**20.7**	**20.9**	**19.8**	**16.9**

Note: The Alfred Psychiatry Intensive Care Statewide Service data is reflected in the 'specialist' data.

Physical only' restraint accounted for the vast majority of instances of restraint (Table 13). The number of episodes of mechanical restraint has decreased in 2022–23, as has physical only type of restraint. The number of episodes where mechanical and physical restraint were used simultaneously has increased, and the Chief Psychiatrist will monitor this.

Table 13: Number of ended bodily restraint episodes in acute inpatient units, by type of bodily restraint, 2018–19 to 2022–23

Restraint type	2018–19	2019–20	2020–21	2021–22	2022–23
Mechanical and physical	115	113	102	79	149
Mechanical only	381	399	394	561	337
Physical only	9,863	7,757	7,833	6,917	6,054

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

When restraint was applied, it was still most commonly a single occurrence within the whole of an admission (Table 14). However, multiple episodes of restraint are not uncommon, and this pattern has not significantly changed in recent years.

Table 14: Frequency of ended bodily restraint episodes within a single inpatient admission, 2018–19 to 2022–23

Frequency of episode	2018–19	2019–20	2020–21	2021–22	2022–23
1	960	1,008	1,048	934	851
2	274	321	364	343	306
3	133	142	163	154	119
4	69	86	101	81	88
5	53	58	59	49	48
6	32	33	45	41	44
7+	161	181	167	163	138

With respect to duration, there has been a significant decrease in the number of episodes of restraints lasting less than 15 minutes (Table 15). The trend from 2018–19 to 2022–23 shows a reduction of approximately 40 percent. Most restraints last less than three minutes and may reflect the use of restraint to administer medication or to guide a person towards a different space.

Table 15: Duration of physical, mechanical and combined bodily restraint episodes, 2018–19 to 2022–23

Duration	2018–19	2019–20	2020–21	2021–22	2022–23
Less than 3 minutes	6,082	5,365	5,738	4,966	4,381
≥ 3 to < 15 minutes	3,672	2,330	2,012	1,910	1,659
≥ 15 to < 30 minutes	198	165	207	193	189
≥ 30 to < 45 minutes	73	68	85	82	72
≥ 45 minutes to < 1 hour	45	49	66	84	43
≥ 1 to < 4 hours	217	202	158	243	167
≥ 4 to < 12 hours	46	55	45	57	14
≥ 12 hours	26	35	18	22	15

Secure extended care units

Secure extended care units, or SECUs, are inpatient bed units that cater to the needs of consumers facing complex challenges in light of limited options for community care. SECUs offer the means for consumers facing complex challenges to benefit from a longer length of stay with a rehabilitation focus.

Seclusion – secure extended care units

Table 16 shows that seclusion episodes per 1,000 occupied bed days in SECUs decreased in 2022–23 relative to the previous year but continues to be higher compared with 2018–19. It is likely that the years 2019 to 2022 reflect the effects of the pandemic including limitations on leave and access to visitors (including support staff), and staffing shortages. The SECU program is included in all the initiatives designed to bring a recovery focus to mental health treatments and to minimise the use of restrictive practices.

Table 16: Rate of ended seclusion episodes per 1,000 occupied bed days, secure extended care units, 2018–19 to 2022–23

Year	Rate
2018–19	1.8
2019–20	3.7
2020–21	4.0
2021–22	3.5
2022–23	2.2

Restraint – secure extended care units

There has been a downward trend with respect to restraint episodes since a peak in 2019–20 and, as above, is returning to pre-pandemic levels (Table 17).

Table 17: Rate of ended bodily restraint episodes per 1,000 occupied bed days, secure extended care units, 2018–19 to 2022–23

Year	Rate
2018–19	2.8
2019–20	4.0
2020–21	3.6
2021–22	3.2
2022–23	2.1