National Mental Health
Consumer & Carer Forum

Restrictive Practices in Australian Mental Health Services

Position Paper

by the National Mental Health Consumer and Carer Forum

June 2021 (Revised Edition)

Acknowledgements

The National Mental Health Consumer and Carer Forum (NMHCCF) would like to thank those consumers and families and carers who were interviewed by NMHCCF members and provided their often-harrowing insights into restrictive practices in mental health services. The NMHCCF also thanks the individuals and organisations who provided input to the consultation draft of this Statement.

In stating the NMHCCF position on restrictive practices, we acknowledge those clinicians who work to ensure their patients are cared for in a humane and respectful manner. The NMHCCF acknowledges that there are clinicians and mental health staff working in good faith towards the ending or significant reduction of restrictive practices. We value and encourage collaboration between mental health professionals, consumers and organizations families and carers to end involuntary treatment, seclusion and restraint.

However, the focus of this statement is the undeniable fact that restrictive practices continue to cause unnecessary harm to many consumers and families and carers. The NMHCCF has heard from its members and through their networks of many cases of distressing and traumatising use of restrictive practices in the broader mental health sector today. The data and research continue to highlight the continuing use of such practices, sometimes with very dire consequences. Without the testimony of this evidence, both from the lived experience and from the research, we would not be able to advocate for change on this very serious issue. We acknowledge the continuing work of those who work to uncover the reality of restrictive practices in this country and those who strive to end them.

The NMHCCF dedicates this to every consumer who has been the recipient of restrictive practices, and acknowledges those who have died as a result of experiencing seclusion or restraint.

We also acknowledge the trauma and impact on the families and carers/kin/friends of those subjected to restrictive practices.

Keywords: Restrictive Practices Seclusion Restraint Involuntary Treatment Mental Health

First published 2009; Reprinted with corrections and dedication 2010
Revised edition June 2021
Copies of this statement can be downloaded at www.NMHCCF.org.au
Suggested reference:
National Mental Health Consumer and Carer Forum (2020). Restrictive practices in Australian Mental Health Services. www.NMHCCF.org.au
Design: Snaffle

Contents

Foreword

The original Position Statement was prepared by the National Mental Health Consumer and Carer Forum (NMHCCF) Working Group on Seclusion & Restraint. The NMHCCF identified seclusion and restraint as a key priority focus for its 2007-08 Strategic Plan and this Statement followed that initial work. More than 10 years later, with many developments in this area across Australia, the NMHCCF has decided that it is necessary to update this work, producing a new Position Paper to reflect current practice and issues. In this new version, the decision was made to refer to restrictive practices which encompasses more than seclusion and restraint and is the term in current usage at the level of policy and decision making.

Since this position paper was first published in 2009, there has been increasing work towards the elimination of restrictive practices from mental health care. Data from the Australian Institute of Health and Welfare (AIHW) indicates that the incidences of seclusion and restraint have declined significantly over the past decade. Nonetheless, continuing episodes of involuntary treatment and recourse to the seclusion and restraint of people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality and therapeutic care. This happens in spite of the lack of evidence that these measures offer positive health outcomes. Indeed, restrictive practices are commonly associated with added trauma, risk of violence and potential human rights abuse.

There are many initiatives that have almost definitely contributed to some areas of lowering rates of restrictive practices. Significantly, in February 2009, the National Beacon Demonstration Sites produced data highlighting the impact of implementing best practice. There were significant reductions in seclusion and restraint incidents across the eleven sites. Data on the use of seclusion, mechanical and physical restraint by hospital was reported for the first time in December 2018.

All Australian jurisdictions have introduced laws, policies or guidelines, focusing on reducing seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint. They have all committed, through their Mental Health Acts and guidelines to the use of Involuntary Treatment Orders (ITOs) or Community Treatment Orders (CTOs) only under circumstances where it is deemed absolutely necessary to protect the person or others around them. There has also been a commitment to communicate with consumers, carers and families in a dignified, respectful, courteous and compassionate way about restrictive practices. This has been achieved through the development, with consumer and carer expert knowledge and advice, of the *National Principles for Communicating about Restrictive Practices with Consumers and Carers*.[1] Twelve national forums on restrictive practices have been held, the most recent in November 2018, to share results and support broader change efforts to shift seclusion and restraint out of mental health units entirely.

Since the first NMHCCF position paper on restrictive practices was published, the National Disability Insurance Scheme (NDIS) has been introduced. The National Disability Insurance Agency (NDIA) has produced a Positive Behaviour Support Capability Framework outlining the NDIS approach aiming,

amongst a number of purposes, to 'embed a clear commitment to the reduction and elimination of restrictive practices and a focus on proactive practice.'[2]

Importantly, as noted by a Victorian Government case study, 'peer support workers were identified as playing a crucial role in efforts to reduce restrictive practices, offering support and guidance within the inpatient units, across the service and in the community.'[3] The study also identified 'the key aspect of peer support work in providing lived experience insight into the experience of restrictive practices, so that staff can better understand and revise their practice.'[4] Furthermore, it was found that 'the services offered by peer support workers and consumer consultants were wide ranging, including participating in debriefing and reviews of restrictive practices, developing policy/recommendations and helping to identify and provide support for 'high-risk' consumers and their carers (such as those identified as likely to be readmitted in a 28-day period).'[5]

Recently, the Royal Commission into Victoria's Mental Health System called 'for a mental health and wellbeing system where services deliver high-quality and safe treatment, care and support, without the need for seclusion, restraint and other coercive.'[6] The Commission also strongly declared that 'compulsory treatment must only be used as a last resort.'[7] And it made reference to chemical restraint calling for the definition and defining and regulation of the use of chemical restraint under the mental health acts to 'protect consumers and enable this practice to be appropriately monitored.'[8]

It is apparent that all stakeholders support the reduction of the use of restricted and coercive practices.

It is apparent that all stakeholders support the reduction of the use of restricted and coercive practices.

The NMHCCF recognizes there may be specific, although very limited, circumstances where involuntary treatment, seclusion and restraint may be considered necessary for the "safety" of the individual and other people. However, this can only be justified as a measure of absolute last resort where all other interventions have been tried or considered and excluded. Under these circumstances, restrictive practices should be used within approved protocols by suitably trained professional staff in an environment where the safe care of consumers remains a priority. Involuntary treatment, seclusion and restraint cannot be substitutes for inadequate systems and insufficient resources (such as lack of community mental health provision or trained clinical staff).

In his preface to the 2009 first edition of this Statement, Professor Ian Hickie noted that, 'the underlying issue here is the ongoing failure to invest in any alternative models of care, particularly community-based services. The fact is that acute hospital care has become almost the only place where people with complex mental health problems can receive care.' And although there has been some evidence of improvement in this situation with the growth of step-up step-down community mental health services,[9] on the whole there is still a significant way to go.

What are Restrictive Practices?

Involuntary Treatment

Community Treatment Orders (CTOs) and Involuntary Treatment Orders (ITOs) are authorised in mental health legislation for the treatment of people without their consent. This happens when a person with a mental health condition is assessed as being in need of treatment, is considered a risk to themselves or others, and is judged as unable to make a decision about their own treatment, although capacity is not always stated as an issue.

Involuntary mental health treatment occurs in a variety of contexts. The most common type of involuntary mental health treatment is court-ordered detention at an inpatient mental health facility. Furthermore, involuntary treatment is allowed under some Mental Health Acts for certain periods of time with review in limited periods of time and there are also Mental Health Tribunal determined orders. Involuntary treatment can also include involuntary medication or other treatments including electro-convulsive therapy. Whether court-ordered or imposed by mental health professionals, treatment is imposed upon persons with mental health conditions in prisons and jails or as a condition of probation, supervision or parole, outpatient commitment, and the use of guardianship or conservatorship laws.[10]

The NMHCCF notes that CTOs or ITOs are coercive practices which and are sometimes used as a threat (what we would describe as emotional restraint) to ensure compliance. Coercive practices restrict the freedom of individuals to decide their own treatment and must only be used in the most limited, specific and regulated instances and never be used in a punitive or threatening way.

Seclusion

Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.[11] It is important to note that seclusion is not the same as the practice of “time out” where a consumer is asked to agree to voluntary social isolation for a period of time.

“Coercive practices restrict the freedom of individuals to decide their own treatment and must only be used in the most limited, specific and regulated instances and never be used in a punitive or threatening way.”

Restraint

Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical [or other} means.[12] There are five distinct types of restraint:

- **Physical Restraint**

  Physical restraint is the restriction of an individual's freedom of movement by using the application by health care staff of hands-on immobilisation techniques.[13]

- **Chemical Restraint**

  Chemical restraint occurs when medication that is sedative in effect is prescribed and dispensed to control a person's behaviour rather than provide treatment. 'Chemical restraint is not a form of treatment. Rather, it is medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition '[14] The NMHCCF acknowledges that Australian jurisdictions have legislated to remove chemical or pharmacological restraint as an intervention in their mental health services. However, the difficulty in defining chemical restraint remains in the fact that the use of medication to reduce agitation is often considered an acceptable alternative to seclusion and restraint, rather than a form of restraint in itself.[15]

- **Mechanical Restraint**

  Mechanical restraint involves the use of devices on a person's body to restrict their movement (for example, sheets or straps).[16]

- **Emotional Restraint**

  Emotional restraint in the mental health care system occurs when the individual consumer is conditioned to such an extent that there is a loss of confidence in being able to express their views openly and honestly to clinical staff for fear of the consequences.[17] Emotional restraint can be coercive and threatening in nature (e.g. a consumer being told if they will not calm down they will be secluded). It is also referred to as psychological restraint. Emotional restraint can include harassment and verbal put downs, threats and provocation, bullying behaviour and manipulation where people feel they are being forced to act in a certain way for fear of reprisal. *The Department of Social Services' National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) has named this a form of restraint using "power-control strategies."[18]

- **Environmental Restraint**

  Environmental restraint restricts a person's free access to all parts of their environment, including items or activities.[19] Under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* certain restrictive practices are subject to regulation. These include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint which is sometimes called environmental control. Environmental restraint refers to restricted access to a room or part of a person's own home which can include: locked cupboards or fridges; not being able to access one's own possessions without permission; rooms that are locked and can't be accessed without permission; being denied visitors and not being able to access the community.[20]

The NMHCCF Position on Restrictive Practices

The NMHCCF agrees with the United Nation's *Principles for the protection of persons with mental illness and the improvement of mental health care* which declares that 'Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.'[21]

Restrictive practices with their inherent coercion, control and compulsion, immobilisation and isolation do not achieve what must be the main goal of mental health systems everywhere, and that is to support consumers towards recovery. They do not, as Mental Health America has noted, 'alleviate human suffering. They do not change behavior. And they do not help people with serious mental illness better manage the thoughts and emotions that can trigger behaviors that can injure them or others.'[22]

It is the position of the NMHCCF that it must be the aim of Australia's mental health services to work towards the elimination of restrictive practices and that they only be used as "safety" measures as an absolute last resort under extremely strict guidelines and by appropriately trained staff. It is clear that they:

- Can be considered abuse of human rights.[23]
- Cause short- and long-term emotional damage to consumers.[24]
- Can re-traumatize people who have already had far too much trauma in their lives.[25]
- Contribute to the stigma of mental health clients.[26]
- Are still currently used at unacceptably high levels in mental health services.[27]

The NMHCCF believes that, with regard to involuntary treatment - in the form of Involuntary Treatment Orders (ITOs) and Community Treatment Orders (CTOs) - as noted by the NSW Mental Health Commission, 'a high number of ITOs, in hospital or in the community, means that we are not helping people early enough when they experience mental distress or increasing illness. Treatment in hospital should be a last resort for people and their families. Involuntary treatment can be very traumatising or re-traumatising for the person involved.'[28]

In addition, it is the position of the NMHCCF that restrictive practices and involuntary treatment:

- Highlight a failure in care and treatment where they are used.
- Are not evidence-based therapeutic interventions.
- Are avoidable and preventable practices.
- Epitomise a workplace culture of tension and antagonism between consumers and families and carers and clinical staff.
- Preclude the development of trust and respect between consumers and families and carers and clinical staff, leading to fear and distress among consumers and a breakdown of therapeutic relationships.

Despite the work done in the area of restrictive practices across the country, the NMHCCF contends that both the prevalence and use of involuntary treatment, seclusion and restraint remain far more widespread and insidious than can be justified as last resort emergency (safety) measures.

These practices not only violate the fundamental human rights of people with mental ill-health, but also impact significantly on their physical and ongoing psychological health.

The Reality of Restrictive Practice 1

This is a true story provided by a member of the NMHCCF. Names have been changed to protect privacy.

Warning

This story contains elements that may cause emotional distress. If you are disturbed by what you read here, you can contact:

Lifeline 13 11 14, or
BeyondBlue 1300 22 4636

Consumer account of restraint upon admission

I was admitted to an acute hospital emergency department. Due to my behaviour and wanting to abscond I was put under restraint by being shackled. Most of the time I was in a room by myself and had delusions about World War three starting. I was screaming and crying constantly. It is hard to recollect but I believe I was shackled by a number of security guards approximately three times. I know it was my perception but it seemed to me that the doctors were asking me riddles and I got the wrong answer so I was shackled. At one stage I was pinned down and I was given a sedatory injection with no knowledge of what it was. In emergency they missed two of my doses of Clozapine and this made it necessary to start from scratch to put the Clozapine back into my system 25 milligrams at a time.

My local service, where I regularly receive my medication, closed the clinic at short notice. This meant that, not receiving my regular Clozapine at the clinic, and being very unwell, I did not collect my medication and missed one dose which is very unusual for me as I religiously take my medication unless I am very unwell and I forget.

I stayed in hospital emergency for two days and due to the restraint and injections I can't recall the Saturday at all and apparently when my father called I was unaware that I was in hospital because I was so sedated. When I "woke up" out of sedation I realized that I had bruises on my arm. I wasn't completely aware of how it happened except being held and restrained by security guards which really upset me as I was experiencing a fear of being touched. I felt it was very invasive and I was really upset and traumatised.

The hospital probably had their reasons for restraining me but I don't know. I was out of control, having psychotic mania but was it the only way? It was so traumatising and I believe it added to my stress.

I got into the closed ward after two days in the Emergency Department and was very depressed. Later I was moved into the open ward. Sometime in that period I rang up the Community Visitor Scheme and made a complaint about the Clozapine clinic and the restraint shackling, especially because of the bruises on my arm. A manager spoke to me while I was in hospital about my complaint and she said that she was sorry but the restraint was necessary. I also spoke to a manager at The Area Health Service and she also apologised about the decision the service had made to close the Clozapine Clinic.

The hospital, at that time, had a "no visitor" policy and that resulted in a lack of connection to natural supports. I was there for three weeks due to the Clozapine taking longer to get back into my system. I had such a traumatic experience that I am amazed I survived. I never want to be shackled again. I am so upset about my treatment and want this to change. That is why I have written this account of my experience.

Prevalence and Patterns of Restrictive Practices

Working towards eliminating the use of restrictive practices is a policy priority in Australian mental health care and has been supported by changes to legislation, policy and clinical practice from the start of the 21st century. Reduction efforts have also been supported by the Australian Health Ministers' Advisory Council, through its key mental health committees, the Safety and Quality Partnership Standing Committee (SQPSC) and Mental Health Information Strategy Standing Committee (MHISSC). All Australian jurisdictions have introduced laws, policies or guidelines, focusing on reducing restrictive practices, particularly seclusion and restraint events, time spent in seclusion and trauma associated with all restrictive practices. Community services peak bodies and community managed mental health providers have also continued to promote the reduction of seclusion and restraint.[29]

With the advent of the *National Disability Insurance Scheme (NDIS) another set of guidelines and processes have been produced. Under the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* certain restrictive practices are subject to regulation. These include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.[30]

Despite this proliferation of guidelines, processes, policies and laws across Australia, the NMHCCF contends that episodes of restrictive practices are still more frequent than is considered "reasonable" by consumers and families and carers. Areas of particular concern to the NMHCCF are involuntary treatment and chemical or pharmacological restraint.

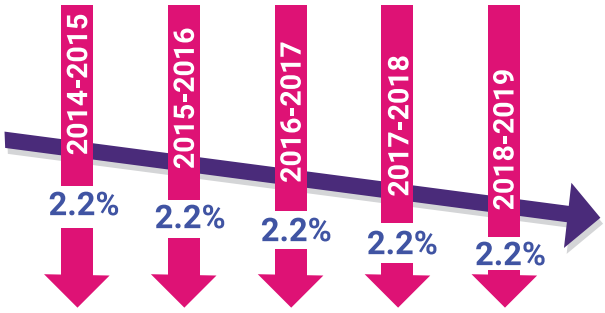
There has been a reduction in the rate of seclusion from 4.8 per 1,000 bed days in 2016-172 to 4.3 per 1,000 bed days. During that same period, restraint increased from 4.5 per 1,000 bed days to 5.1 per 1,000 bed days. (AIHW 2020)

The AIHW informs us that 'data on the use of seclusion, mechanical and physical restraint by hospital was reported for the first time in December 2018. Public reporting enables services to review their individual results against other states and territories, national rates and like services, thereby supporting service reform and quality improvement agendas.'[31]

The (AIHW) has found:

National Reduction in Seclusion

- Over the period from 2014–15 to 2018–19 there has been an average annual reduction in the rate of national seclusion events of 2.2%.[32]

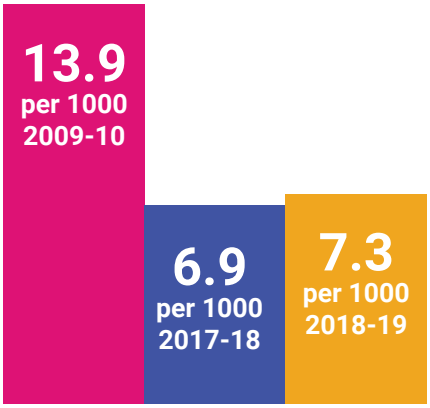


Duration

- 4.2 hours was the average seclusion duration in 2018–19.

Restraint

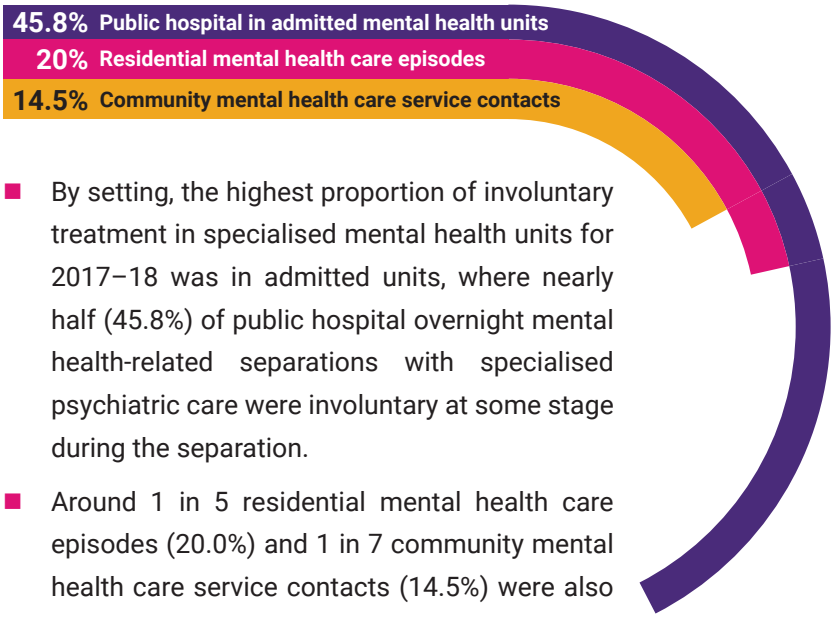
- 11.3 physical restraint events per 1,000 bed days and 0.6 mechanical restraint events per 1,000 bed days were reported in 2018–19.



Frequency

- 7.3 seclusion events per 1,000 bed days were reported for acute specialised mental health hospital services in 2018–19, down from 13.9 in 2009–10.
- In 2018–19 there were 11,944 seclusion events nationally in public sector acute mental health hospital services, which represents 7.3 seclusion events per 1,000 bed days. This is an increase from 11,316 seclusion events, or 6.9 seclusion events per 1,000 bed days in 2017–18.[33]

Settings



- By setting, the highest proportion of involuntary treatment in specialised mental health units for 2017–18 was in admitted units, where nearly half (45.8%) of public hospital overnight mental health-related separations with specialised psychiatric care were involuntary at some stage during the separation.
- Around 1 in 5 residential mental health care episodes (20.0%) and 1 in 7 community mental health care service contacts (14.5%) were also involuntary in 2017–18.

Australian jurisdictions continue to use CTOs at high but varying rates, despite unresolved questions about their role and impact. According to a research article by Edwina Light of the University of Sydney Health Ethics, School of Public Health, 'Transparency and accountability around their use would be improved by regular and nationally uniform public reporting of CTO data. Further research into how and why CTOs are used may also provide opportunities to respond to factors driving their use and thereby reduce the use of coercion in mental health care.'[34]

There is currently no data that is openly transparent, easily accessible and comparable across jurisdictions relating to intake and length of stay in psychiatric intensive care units (PICUs) or Mental Health Intensive Care Areas (MHICAs). While the intention of services is to support the "safety" of consumers and staff, it cannot be denied that these kinds of interventions represent seclusion events and that people are secluded in intensive care units on an involuntary basis.

The Australasian College for Emergency Medicine has identified the need to include reporting on practices in emergency departments. They have noted that:

- 'People with mental health issues are "16 times more likely than people with other emergency medical conditions to arrive at Emergency Departments via police or correctional services vehicles, and nearly twice as likely to arrive via ambulance or helicopter rescue and more commonly rated by ED staff as requiring urgent care on the ATS.'[35]
- 'They are also more likely to identify as Aboriginal and Torres Strait Islander than other patients. While Indigenous Australians make up around 3 per cent of the population, they comprise 11 per cent of all Emergency Department mental health presentations across the country.'[36]

The NMHCCF is aware that current data on restrictive practice is not wholly reliable. We are in the early years of data collection in the area of restrictive practices and it is fair to state that there are gaps in data collection. The AIHW notes that:

- States and territories have different policy and legislative requirements regarding restraint practices and therefore different systems in place for collecting data, and differences in the types of restraint that are reported. In addition, the reporting of restraint data is still a novel exercise, with the first release of data occurring in May 2017. It is expected that data quality will improve over time as information systems are refined and definitions are better understood by the sector. As such, caution should be exercised when interpreting this data and comparing results between states and territories and over time.[37]

There are many issues that remain to be addressed including:

- The question of unclear and diverse definitions across jurisdictions, especially in the area of chemical restraint.
- The potential for clouding of restriction events, particularly in Emergency Departments where a person may be placed alone in a secluded room for a long period of time and this is not recorded as seclusion.
- The practice of "specialing" which has been described as having 'a personal prison warden'[38] by some consumers, even though it is meant to provide extra care for consumers who are particularly vulnerable. Consumers indicate that sometimes this works well, but that sometimes

it is a method of getting around having to record a seclusion event.

The National Mental Health Commission has recommended that seclusion and restraint practices and interventions are evaluated. The Commission states that 'There is a need to develop the evidence base for strategies that reduce seclusion and restraint. For example, when an intervention is used to reduce seclusion and restraint, there is often no publicly available data concerning what occurred or a rigorous evaluation of it. An analysis of the research literature indicated that there is little high-quality empirical evidence relating to factors that may reduce the use of seclusion and restraint. This should also involve consumer led research and involvement in local evaluations and system research.'[39]

Researchers Piers Gooding et al. make the point that 'Future research should focus on mental health care policies targeted at support and treatment that respect people's dignity and autonomy as well as promoting reductions of institutional coercion.'[40] The NMHCCF agrees that it is important to obtain data that reinforces positive practice and also increased research on what works and how, and the evaluation of interventions.

The NMHCCF agrees that it is important to obtain data that reinforces positive practice and also increased research on what works and how, and the evaluation of interventions.

The Reality of Restrictive Practice 2

This is a true story provided by a member of the NMHCCF. Names have been changed to protect privacy.

Warning

This story contains elements that may cause emotional distress. If you are disturbed by what you read here, you can contact:

Lifeline 13 11 14, or
BeyondBlue 1300 22 4636

Ann's Story

'Mum, mum, I love you mum. Mum, I'm so sorry', he kept saying as he sobbed and fell into my arms.'

His friends had called me in the middle of the night- 'he's been taken to hospital' – 'he's not good' – 'he's lost the plot'. As I dashed to the emergency department that cold dark night, I saw my son running away from the hospital with two police officers in pursuit of him. Stopping my car in the middle of the road, I leapt out and ran to him.

I held my boy, and told him it was going to be OK. I told him he needed to go back to the ED. I was holding my hand up to the police, asking them to back off. 'Please son, let's go back to the ED and get you some help. I love you.'

The police moved closer and pulled out their handcuffs. I put my hand up again, they kept coming. He saw them out of the corner of his eye. In a flash, he turned and pulled a chain from his pocket and swung it at an officer.

It was instantaneous, they grabbed him and slammed him face first into the dirt. They handcuffed him. 'You are being detained under the Mental Health Act. We are taking you back inside.'

'I had this,' I screamed. 'I was convincing him to go back inside. Why didn't you respect me?' They dragged my boy upright, his face was bleeding, he had tears streaming down his face. 'Help me mum, I'm scared.' I watched, helpless and horrified as he was being dragged by the police back to the ED.

Shaking, afraid, and not knowing what was happening, I ran into the ED after parking my car. I found him handcuffed to a bed. The police officer explained he was being detained under the Mental Health Act, and could now be charged with assaulting a police officer. My boy was 17.

I had held it together as long as I could. Tears welled, then spilt. I didn't understand. 'Why didn't you listen to me? I was convincing him to go back inside.' I kept repeating. I sat looking at my son with his bloodied face, his dirty and scuffed clothes from the dirt he had been throw into, and his eyes full of fear, hurt, confusion and pain.

I listened as he told me he wanted to take his own life. I told him we could get help. He pleaded for the handcuffs to be removed. They stayed on. The doctor eventually let me take him home with me after a long night - it was daylight when we walked out of the hospital. I knew he wasn't well. I wanted him to seek help somewhere else. He refused because he didn't want to be treated like he was that night. We managed to get him voluntarily admitted to a ward where restraint and seclusion wasn't allowed.

As a mother, it hurts to see a child unwell. As a mother, I wanted to be able to fix him. As a mother, witnessing him being slammed to the ground, handcuffed, dragged unwillingly and restrained

to a bed was heartbreaking and a rolling set of images I will never forget. Those police officers showed no patience or respect for a mother trying to soothe her son, nor any trust that I could convince him to willingly go back to ED. This experience of a shared and highly distressing incident was something we should never have had to endure. A trauma that has been relived in my head many times over the years. If they had listened, it would have never happened. If they had listened, my son would not have lost his trust in seeking help from the mental health system.

This experience of a shared and highly distressing incident was something we should never have had to endure.

Strategies to End Restrictive Practices

In 2009, in the first edition of this Statement, the NMHCCF listed six key strategies which it described as vital to ending seclusion and restraint in Australian mental health services. These were:

1. **Better Accountability**
2. **Implementation of Evidence Based Approaches to Ending Seclusion and Restraint**
3. **Adherence to Standards and Public Reporting**
4. **Support for Mental Health Professionals Towards Cultural and Clinical Practice Change**
5. **Better Care Planning**
6. **Review Relevant Mental Health Legislation**

These strategies remain important and relevant but, ten years later, there has been significant progress in the development of policies, procedures and guidelines for seclusion and restraint across Australia. All jurisdictions and most community-managed organisations have developed and put in place policies, frameworks, guidelines, toolkits and other processes for the reduction of restrictive practices.

The AIHW notes that:
Working towards eliminating the use of seclusion is a policy priority in Australian mental health care and has been supported by changes to legislation, policy and clinical practice. Reduction efforts have been supported by the Australian Health Ministers' Advisory Council, through its key mental health committees, the Safety and Quality Partnership Standing

> *...ten years later, there has been significant progress in the development of policies, procedures and guidelines for seclusion and restraint across Australia.*

Committee (SQPSC) and Mental Health Information Strategy Standing Committees. Twelve national forums on restrictive practices have been held, the most recent in November 2018, to share results and support broader change efforts to shift seclusion and restraint out of mental health units entirely.[41]

There has also been an ongoing commitment by the National Mental Health Commission to support the elimination of restrictive practices in Australian mental health systems. The Commission has produced a number of documents, reports, principles and collaborative work including a major project with the Australian College of Mental Health Nurses (ACMHN) to undertake work aimed at reducing restrictive practices and ensuring both safety in care and safety for staff in Australian mental health services. This project extended previous work undertaken by the ACMHN in the 2017 NMHC funded project, Supporting Mental Health Nurses towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in inpatient mental health settings in Australia.[42]

It is also important to note that the NDIS Quality and Safeguards Commission, an independent agency established to improve the quality and safety of NDIS supports and services, has developed and has oversight of the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.[43]

NMHCCF is satisfied that there has been a concerted effort at all levels to reduce restrictive practices, but believes that there is no room for complacency. There has clearly been an improvement in use of restrictive practices over the past 10 years, but this 'improvement' remains inconsistent. While the AIHW has reported a decrease in restraint, there is still a question mark around the use of chemical restraint and involuntary treatment is still too high. The NMHCCF believes that the prevention of ongoing restrictive practices and the avoidance of uneven adherence to good practice requires a commitment by all funders and providers to the following updated strategies.

The NMHCCF calls for a renewed commitment to:

1. The participation of people with lived experience (consumers, families and carers), including the engagement of specialised peer workers – those who have experienced restrictive practices.

The Seclusion and Restraint Project commissioned by the National Mental Health Commission and undertaken by the Melbourne Social Equity Institute of the University of Melbourne involved: an international literature review; consultations with people with lived experience of mental illness, families and carers, mental health professionals and members of the police; analysis of legal and regulatory frameworks; and an online survey and focus groups with people with lived experience of mental ill health. In a Position Paper developed following the completion of the project the Commission made it clear that the project 'was designed from the beginning to involve the active contributions of people with lived experience and their supporters.'[44] It is by now a recognised fact that consumers and families and carers are essential to "getting it right" in the design and execution of policy in the mental health arena.

The researchers for a paper which presents the results of ten focus group discussions with people with lived experience of mental health issues, including family members and carers and support persons, found that seclusion and restraint in mental health settings were viewed as 'unnecessarily overused, exacerbating problems for individuals, families and carers, staff and the broader system of care.'[45] The NMHCCF notes that, while many services and organisations espouse the need to collaborate with consumers and families and carers in service provision, the reality does not always match the rhetoric.

The Australian College of Mental Health Nurses has suggested that 'a number of integrated and comprehensive strategies, with all members of the mental health team, including family and carers/kinship groups, working collaboratively, with organisational support, to adopt them have been shown to be most successful.'[46] Organisational support is a key factor in achieving best practice.

Families and carers

There has been formal recognition in government policy stating that and families and carers must be included as partners in the development of recovery treatment plans. There is some doubt this is happening as a matter of course in many situations and, in some cases, remains a tokenistic effort at best. Part of the reason for this is that although 'Current programs to train specialist mental health staff and CMO employees contain components related to carer engagement,'[47] this does not necessarily translate into the majority of service settings meeting national, state and territory policies of carer engagement. There is also a lack of education and training programs across all jurisdictions for families and carers to build understanding and knowledge. This should include developmentally aligned information for young family members and carers.

Apart from working in collaboration with consumers in their own care, organisational support should include some initiatives specifically for family, friends, support persons, kinship groups (carers nominated by consumers):

- Commitment to facilitating the involvement of families and carers to provide feedback and to contribute to service planning and decisions.[48]

- Extending effective and prompt support for any impact or harm to families and carers as well as consumers and staff.
- Providing education and advice from mental health professionals and carer organisations about the carer role and how to ensure the best way forward for their own wellbeing, as well as that of the person they care for.
- Most importantly, providing information about the specific treatment plan being put in place in order that the carer, family member and/or supporter can contribute effectively to the plan and to overall recovery.[49]

There is much discussion about the engagement of people with lived experienced and families and carers in decision-making, co-designing safe environments and practice and providing input at every level of mental health services, but this does not always happen. The NMHCCF believes that it is time to match the action to the rhetoric. Furthermore, it is also critical that delivering care to consumers and support to families and carers includes the provision of consumer and family and carer support workers and/or peer workers.

Peer support workers

The NMHCCF believes that the employment of specialised peer support workers with lived experience of restrictive practices is a vital tool in the elimination of restrictive practice. They offer a range of services both in a clinical and a community context that is vital, but currently lacking, in reviews of restrictive practices, debriefing after seclusion and restraint events, development of policy/recommendations as well as de-escalation and support for consumers in mental health services. In short, peer support workers:

- Offer a unique understanding of the traumatic effects of coercive interventions.
- Assist in the creation of a space of empathy and understanding in a highly stressful environment.
- Have the potential to influence practice and lead change more widely.

A Victorian study identified peer support workers as 'playing a crucial role in efforts to reduce restrictive practices, offering support and guidance within the inpatient units, across the service and in the community. Also discussed was the key aspect of peer support work in providing lived experience insight into the experience of restrictive practices, so that staff can better understand and revise their practice… And also helping [consumers] on the ward understand the organisation and the system.'[50]

During the 12th Towards Eliminating Restrictive Practices Forum one presenter reported the employment of 'a consumer and a carer peer in one of our acute units, which had the highest rates of seclusion and restraint. And they worked, full-time on the inpatient unit, and worked directly with staff and with consumers and carers around what's most helpful for them, and provided a different type of support to people really. And we saw the rates of restrictive interventions plummet within weeks.'[51]

2. Recovery-oriented, person-centred and person-led, trauma-informed and human-rights based practice

The NMHCCF proposes that a recovery-oriented approach must encompass person-led, trauma-informed and human-rights based practice reinforcing the importance of self-determination and operating from a positive and strengths-based perspective. Such a service delivery approach would by definition preclude the use of interventions 'being done to' people without their consent. A high priority of all four principles of practice is respect for self-determination and the individual journey and desires of the consumer, operating from a positive and strengths-based perspective. This should translate into practice that unreservedly supports the adoption of "no-force" forms of care and support.

A Melbourne University literature review found 'some over-arching themes, namely: the value of recovery-oriented and trauma-informed practices; laws to reduce coercive practices; "peer-led" initiatives, family- or social network-directed initiatives; crisis resolution responses in hospitals, respite centres and home-based support; advance planning to improve crisis responses; the use of non-legal "advocacy"; supported decision-making; low-medication or no-medication alternatives; and culturally appropriate mental health support.'[52]

Person-led practice

Person led care means starting with the person as an individual with strengths, preferences, aspirations and needs, and acknowledging that they are at the centre of the process of identifying these needs.[53] It must also recognise and be respectful of the diversity of consumers and families and carers and particular groups that require specific consideration to meet their needs and to enhance the effectiveness of any services provided. These groups include:

- Aboriginal and Torres Strait Islanders
- People with physical and cognitive disabilities
- People from cultural and linguistically diverse backgrounds, including refugees
- LGBTIQ+ communities
- People from rural and remote areas
- Children and adolescents
- Older persons

A truly person-centred and person-led service is firmly embedded in recovery-oriented practice because it promotes autonomy and self-determination. It also requires direct input into policy and program development and active partnership of services with consumers and families and carers in this work. Mental Health Australia (MHA) notes that the Fifth National Mental Health and Suicide Prevention Plan:Implementation Plan identifies consumer and carer co-design as a 'key commitment, and as a critical success factor. Despite this, very little funding has been allocated to achieve it. At present, there is limited capability for active and diverse consumer and carer engagement and participation due to a lack of well-resourced infrastructure to enable this. Properly resourced arrangements for consumer and carer participation, engagement, and co-design are key enablers to improving mental health outcomes of all Australians.'[54]

Trauma history and re-traumatisation

It is recognised that there is a high prevalence of traumatic experiences for people with mental health

issues. Trauma-informed practice emphasises the understanding of and response to the effects of all types of trauma as well as ensuring that practice does not result in re-traumatisation. In its report, Trauma-Informed Care and Practice in Mental Health Services,[55] the NSW Government Agency for Clinical Innovation has cited research which finds that:

- Childhood trauma is the single most significant predictor that an individual will have contact with the mental health system.
- Nine out of 10 people accessing mental health services have experienced trauma at some stage in their life.
- Two in three people presenting at emergency departments, inpatient or outpatient mental health settings have experienced underlying complex trauma secondary to childhood physical or sexual abuse.
- Experiencing trauma can influence brain development which may lead to problems with mood, self-esteem, emotions, learning and memory.
- The risk of being subjected to seclusion, restraint and enforced medication in mental health units is increased with trauma experience.
- Experiencing trauma leads to an increased risk of developing a psychotic disorder.
- There is the significant risk of re-traumatisation for people who are secluded and restrained or subjected to involuntary treatment.

The conclusions arrived at by the Agency for Clinical Innovation are consistent with findings from other studies focused on the perspectives of people who have experienced coercion, contributing to a growing body of evidence that coercive practices, such as restraint and seclusion, are harmful.

One issue that seems to be rarely raised is that of the need for security staff with dedicated training in dealing with mental health consumers. As pointed out by the UTS Health Faculty:

Then there's the quality of security guards. Health is a unique environment where traditional security measures can be counter-productive. For instance, if guards use inappropriate communication when people are anxious and stressed, they can increase the chance of a situation escalating.[56]

And they can certainly contribute to re-traumatisation.

Human rights based

A submission from Mental Health Carers NSW (MHCN) points out that, 'Numerous inquiries have noted the use of restrictive practices and involuntary care of people living with a mental illness as a systemic human rights issue.'[57] It is not possible to attain the highest standard of mental health care without supporting human dignity and rights for consumers and families and carers.

The United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez, has called for 'an absolute ban on all forced and non-consensual medical interventions. He has stated that 'both prolonged seclusion and restraint may constitute torture and ill-treatment' and that 'there can be no therapeutic justification for the use of them in psychiatric institutions.'[58]

In 2013, the United Nations special rapporteur on torture, Juan E. Méndez, called for: an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities… in all places of deprivation of liberty, including in psychiatric and social care institutions.

While the statement is not legally binding in Australia, it indicates that, from a human rights perspective, these practices are no longer acceptable.[59]

An article reviewing independent monitoring within the Optional Protocol for the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) framework makes the strong point that 'it has been recognised that torture and ill treatment in international law encompass a range of practices and experiences that were previously overlooked. The idea that routine practices in care settings might be characterised as "torture" is controversial because these actions are generally thought to be motivated by the need to cure, help or protect people in care. This article analyses the contemporary definitions of torture in the context of social, disability health and health care settings, arguing that the Convention on the Rights of Persons with Disabilities (CRPD) is prompting further expansion of the definition of torture and ill-treatment.'[60] Under this analysis, enforced treatment, which is often unjustified, could be described as "torture."

The NMHCCF believes that restrictive practices undermine the human rights of consumers and, by extension, families and carers. A true human rights approach is one that enshrines self-determination and collaborative relationships and protects consumers from "unsafe" services or treatments. Furthermore, it is becoming clearer that "torture" is not limited to the most severe examples we are all familiar with. Torture can also refer to the long-term neglect of basic human needs, and painful and degrading behavior modification techniques or restrictive practices. Although there is not a high risk of this "worst scenario" outcome in Australia, it is of particular relevance to people with cognitive disability and co-occurring mental health conditions and for people with mental health conditions in prisons.

3. Stronger safeguards around chemical restraint

The NMHCCF would like to see a renewed effort to eliminate chemical restraint through a comprehensive review of the blurred line between "medication" and restraint. The NMHCCF especially believes that voluntary admissions to treatment and services should be made more truly voluntary, and the use of advance directives/crisis plans/advanced health care directives/Ulysses agreements should be implemented. The NMHCCF proposes that:

- Care planning must be done in collaboration with the consumer and their carer/family member to ensure that individual consumer needs, preferences and experiences are considered.
- The adoption of prevention and early intervention practices which must include access to consumer and carer peer worker support.
- Consumers have a qualified right to refuse treatment. The NMHCCF believes that medication must not be imposed involuntarily unless rigorous standards and procedures are met. Those procedures should include an impartial decision maker focused on the best medical interest of the individual, not the interests of the institution seeking compulsory treatment.
- All medications pose some risks and many pose quite serious risks to the health of the persons who take them, particularly when medications are taken for extended periods. Apart from the risks, side-effects can have extremely deleterious consequences in the lives of consumers. For these reasons and because of its commitment to the autonomy and dignity of persons with mental health conditions, the NMHCCF strongly believes that consumers have a right to refuse medication.

- Work needs to be done to support both consumers and families and carers to understand the human rights aspects of treatment. Supporting consumers in preparing advance directives, with the involvement of families and carers is one way of addressing any conflicting points of view.
- Clinical decisions must take into account the rights of consumers to refuse and to receive treatment as well as respecting consumers' preferences, including by way of advance care directives. There must be the assurance that preferences of consumers can only be overridden in limited circumstances. The NMHCCF believes that this can only happen on extremely rare occasions and debriefing should demonstrate transparent and clear accountability and rationale.

4. A concerted drive to reduce involuntary treatment

An Involuntary Treatment Order (ITO) or Community Treatment Order (CTO), means that under the law, a person can be treated for their mental illness without their permission. Having a CTO means that clinicians can provide treatment without consent for individuals with severe mental health problems who are living "in the community". If a person on a CTO does not follow the treatment then he or she can be forcibly taken to a designated facility or inpatient unit. Although CTOs are used throughout the world (including the United States, some Canadian provinces, New Zealand, Israel and England, Scotland and Wales), CTO use in Australia is high by international standards.[61]

Compulsory treatment in the community is enabled by Mental Health Acts in Australian states and territories. The Royal Australian and New Zealand College of Psychiatrists has noted that there is great divergence between the various state and territory Mental Health Acts as to the criteria that must be applied for involuntary treatment to be enacted, and also in the processes that subsequently review compulsory treatment orders.[62]

Each Australian state and territory have mental health review boards or tribunals which also vary across jurisdictions and can, in the worst-case scenario, contribute to escalation leading to CTOs. During consultations for a review conducted following a disastrous seclusion event in NSW, consumers reported that 'Mental Health Review Tribunal hearings can feel intimidating, adversarial, and sometimes like a trial… The review team also heard from consumers and families and carers and staff that Tribunal hearings can sometimes precipitate disagreements between consumers, their carers and families and the treating team. Consumers, carers, families and staff gave examples of where this conflict had directly contributed to escalation of aggression followed by restraint and/or seclusion.'[63]

The NMHCCF believes that the implementation of ITOs and CTOs in Australian mental health systems are often terrible reminders of the involuntary practices of institutional treatments of the past. On the whole, they represent infringements of human rights and social justice principles. Due to the removal of personal agency and self-determination, alongside the added stigma and discrimination, involuntary treatment can be described as a hindrance to recovery and well-being. Overall, there has been no convincing evidence for the effectiveness of involuntary treatment orders in achieving the social or economic benefits claimed for their implementation.

A study by Light et al. demonstrates that,
Failings in the mental health system may be correlated with increasing CTO rates. This is highly significant because it resonates with concerns about the inappropriateness of attempts to increase coercion to compensate for under-resourced services and about the expectations placed by CTO policies on the state to provide adequately organised, resourced community mental health and other social services, and to ensure that the treatment provided under CTOs is focused on the patient's needs. It also lends weight to concerns that the mental health system may 'rely' on unnecessary coercion in community-based care, and is not sufficiently concerned with appropriately resourcing non-coercive efforts to engage patients in treatment.[64]

It is of note that these issues are the focus of the Mental Health Commission of NSW's recommendation for policy reform aiming to decrease the rate of CTO use. The Commission argues that high rates of involuntary orders 'is a marker of a system which is not intervening early or effectively. It indicates a need to rebalance the system and move away from a reliance on coercive forms of care.'[65]

The implementation of involuntary treatment is recognised as a challenge to human rights frameworks. One researcher notes that, 'Calls for reforms to policy by human rights advocacy groups such as Justice Action are also not uncommon with CTO's considered to be inefficient, ineffective and a challenge to privacy, autonomy, self-determination, human rights and social justice.'[66] The same researcher found that:

- Although significant changes have been made to involuntary treatment of inpatients, CTOs have largely remained untouched.
- The power to make CTOs has been retained by the Mental Health Acts enacted in all jurisdictions. Policy information around CTOs, principles and objectives are hidden from information publicly available.
- The seeming invisibility found within policies highlights issues with transparency and accountability of mental health systems.
- Involuntary treatment can contribute to further entrenching the discrimination and marginalisation of those living with mental illness and as such is counter to social justice and human rights.[67]

CTOs are mainly used to ensure medication adherence and monitoring. In a study commissioned by the NMHCCF, it was found that 'the heavy burden of neuroleptics results in many consumers opting to not take these drugs as prescribed, or at all, which is commonly framed by clinicians as "non-compliance" and seen as reflective of a lack of insight and evidence of "mental illness". For these reasons, consumers are reported to be reluctant to discuss discontinuation with clinicians due to a fear of judgement or the threat of being placed on a compulsory treatment order.'[68]

The study notes that the 'goals of clinical recovery continue to be privileged over personal recovery, and the disabling effects of neuroleptics… are often positioned as preferable to hearing voices or the other 'symptoms' of psychosis.'[69] This 'privileging of clinician perspectives is reflected in the paternalistic notions of "compliance" and "adherence", where the decision not to take medication is often viewed as a symptom of 'illness' and non-existent insight.'[70]

It is important to acknowledge, as noted by Mental Health Carers NSW, that 'many carers view involuntary treatment as necessary to ensure their own safety, as well as the safety of their family.'[71] There is some debate among consumers and families and carers

as to whether involuntary treatment should be used and if so under what circumstances. There are also some very rare cases where involuntary treatment might appear to be warranted but the current over-reliance on CTOs will only decrease with sufficient and responsive community supports. Nonetheless, consumers and families and carers generally agree with the view of the Australian College of Mental Health Nurses that 'particular care needs to be taken to ensure the highest quality of treatment for people subject to involuntary care, due to the substantial power imbalances involved. No person should be forcefully subjected to poor quality or abusive treatment which makes them worse and inflicts additional trauma.'[72]

There are a number of approaches that may be used as an alternative to involuntary treatment and neuroleptic drugs. In their review of neuroleptic drugs, Dorozenko et al. conclude that:
Common to Soteria, Open Dialogue, Hearing Voices Network, harm reduction and shared decision-making approaches is the centering of lived experience and the conceptualisation of the individual as an active agent in their own recovery. We note that despite emerging research demonstrating positive outcomes, these approaches remain on the periphery and inaccessible to many consumers and families. This has implications for the ability of consumers and families to make fully informed decisions regarding treatment. We are curious as to the mechanisms that support the dominance of neuroleptics as a response to psychosis where safer and potentially more effective alternatives exist.[73]

An article examining CTOs and supported decision making (SDM) notes that SDM 'gives expression to the wishes and preferences of consumers and is contrasted with substitute decision-making, when other people have power to make decisions for consumers, regardless of their wishes.' This is a shift which is influenced by the recovery approach to mental health practice, policy and law. "The emphasis on the fundamental themes of hope, social inclusion, and empowerment in the recovery approach appears to contrast with the ongoing and increasing use of involuntary outpatient treatment in Australia through Community Treatment Orders (CTOs). CTOs are controversial in many respects, including concerns about their effectiveness and impact. However, they remain entrenched in mental health service delivery.'[74]

"There are also some very rare cases where involuntary treatment might appear to be warranted but the current over-reliance on CTOs will only decrease with sufficient and responsive community supports."

5. Early intervention and prevention strategies

The NMHCCF believes that early intervention and prevention strategies can be put in place or extended and appropriately implemented across different environments. The NSW Mental Health Coordinating Council (MHCC)[75] proposes some prevention strategies including:

- Taking a detailed history of past experiences of consumers and families and carers about the triggers to aggression and how these are best managed.
- Working in partnership with consumers and, wherever possible carers and family members, from the very beginning, to identify effective care mechanisms and possible alternatives for managing distress and aggression when it arises.[76]

Mental Health Carers NSW has made the valid point that although current policy in NSW (and elsewhere) recommends the engagement of carers and families in all aspects of care, this does not always happen. Furthermore, there is little education of carers and family members around policy and practice, de-escalation and how to support consumers who are in crisis.[77] The involvement of carers and families is a critical prevention strategy, and carers and families need to be resourced to provide the support required.[78]

The NMHCCF also believes that a significant prevention strategy is community-based mental health services providing effective early access for individuals and families. The best and least restrictive environment is care in the community where a person has direct connections to family, culture, social supports, work, education and community. This is inherent to recovery-oriented practice, with the non-coercive approach of community-based treatment essential to its effectiveness in promoting recovery and the long-term autonomy and self-determination.

Other early intervention and prevention approaches include:

- Increased community-based crisis services, hospital diversion and step-down supports. Traditionally, mental health policy has been organised in many parts of the world into two categories of support: hospital or community-based care. The hospital is typically presented as a site for acute treatment while the "community" is presented as a site for non-urgent psychosocial support and prevention. A review by Piers Gooding et al., suggests that a more constructive and accurate distinction might be between crisis resolution and general support. 'Crisis resolution' which includes hospital-based support, could also include crisis respite houses, intensive home-based support, and residential programmes.[79]
- More non-hospital residential alternatives. For the prevention of hospitalisation, residential settings are needed to respond to people experiencing psychosis, in the form of "step up" facilities. These can provide help to consumers to work through a mental health acute episode rather than resorting to needing to "manage" a person in mental health crisis.
- Once a person is hospitalised, staff can work with consumers to help identify their triggers and to manage or de-escalate the behaviour without resorting to restrictive practices through the development of a safety plan. This cannot happen when a person is acutely distressed but can be done as part of assessment and care

planning. These care plans and safety plans are not always visible or easily found and are often not current or given a review date. It is important that individual care and safety planning 'must occur in a more systematic, consistent and comprehensive manner with greater involvement of consumers, and families and carers and community and inpatient teams.'[80]

- 'Considering the specific requirements for consumer and carer involvement in seclusion and restraint reduction, both in individual cases and in policy and strategic implementation, the Australasian College for Emergency Medicine Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities found 'little evidence that meaningful, sustained and systematic engagement with consumers and carers was taking place across the system.'[81]
- The Australasian College for Emergency Medicine Review also noted substantial evidence for the 'importance of consumer and carer peer-worker participation in the mental health workforce generally, and in efforts to prevent seclusion and restraint specifically.'[82]
- Other restraint and seclusion prevention tools within the hospital setting can include activities and plans for promoting self-regulation, occupational therapy, the use of sensory modulation interventions and self-soothing and calming tools like stuffed toys and weighted blankets.

The Reality of Restrictive Practice 3

This is a true story provided by a member of the NMHCCF. Names have been changed to protect privacy.

Warning

This story contains elements that may cause emotional distress. If you are disturbed by what you read here, you can contact:

Lifeline 13 11 14, or
BeyondBlue 1300 22 4636

A Peer Worker experience

I was new to this ward that day. Attending orientation and handover, the nursing staff were pleased to report that the ward was 'settled' without any areas of concern.

Michael was being escorted along the corridor from the bedrooms, with a nurse walking either side of him. 'Let me get my Coke,' he asked, the nurses continued to walk and told him he could wait until afterwards and Coke wasn't good for him anyway. I could see Michael becoming more and more upset. As a peer worker, I seem to have a great ability to pick up when things are not going so well for my peers. 'Please, let me get my Coke now,' he asked again, with his tone becoming harder and his body starting to shake. As a peer worker, I knew, from my own personal experiences, that Michael was becoming quite angry, and unless he felt heard by the nurses, then it was likely he was facing some consequences to his behaviour (probably at least a dose of meds, at worse a session in the seclusion room). For the third time, in a very loud voice he demanded that he be allowed to go and get his Coke. And then it started....

Michael was forced to the ground in a restraint hold. It is so hard watching something like this and not being able to do anything. All I could do was stand by and observe the process. It was like watching a well-rehearsed manoeuvre. All staff came running. Some nurses set up a screen around what was happening, others directed their attention to the other consumers on the ward and took them off to the group room. Some went to the medication room to collect an injection.

'Michael,' said one nurse holding him down, 'we can give you an option here- are you going to calm down, or do we need to give you an injection?' Michael pleaded for the injection - 'I can't do this by myself now', at the same time he said that he was only angry because he wasn't allowed to get his Coke. All the nurses involved were calm, quiet and respectful as they told Michael what they were doing (sliding down his pants, giving him the injection and waiting until it worked). At all times they were respectful of not exposing too much of his body (even though this was behind the screen).

Michael was then taken to the seclusion room. He stayed there for a couple of hours. During that time, on the ward, the staff directly involved in the restrictive practice were taken for a debriefing session by the Senior Ward Nurse. The other consumers on the ward were also undergoing a debriefing about what had happened to Michael and how they had felt about it. Many said they were upset for Michael, and added they appreciated how the staff how "covered it up" so they couldn't see it and Michael's dignity was protected.

When Michael came out of seclusion, his nurse for the shift collected him and me, in the role of

a peer worker, to review and debrief on what had happened, and to look at his Crisis (Care) Plan in the light of it, and to consider making changes.

Michael was upset at what had happened, and apologised. He also expressed being angry he wasn't allowed to go back to his room to collect his Coke which would have avoided the entire episode in the first place. Through discussion, it was agreed Michael would be permitted to collect a personal belonging if he requested to in the future.

Michael's Crisis (Care) Plan was revised and re-printed to reflect his wishes. Despite being an observer and bystander for much of this process, and putting aside the traumatic response I had as it triggered my own experiences, I was impressed with the smooth teamwork involved in screening the event, and the provision of debriefing for everyone on the ward at the time, and the attention to the revision of Michael's plan to include his wishes.

...I was impressed with the smooth teamwork involved in screening the event, and the provision of debriefing for everyone on the ward at the time, and the attention to the revision of Michael's plan to include his wishes.

I do not in any way condone the use of restrictive practices. They are traumatising and punitive, and feel like a "punishment" rather than a therapeutic intervention. In my many years as a peer worker, this is possibly the most positive, respectful and choice-driven practice I have experienced. The well-oiled machine of the nursing staff to protect Michael's dignity and the other consumers was to be commended, and the fact that they changed his care plan after a debrief and review was a welcome and practical approach to eliminating the use of restrictive practices in the mental health ward.

In Conclusion

The NMHCCF notes that consumers of mental health services, persons with mental health conditions and persons with psychosocial disabilities are particularly vulnerable to breaches of their human rights through involuntary treatment, seclusion and all forms of restraint. A comprehensive approach is needed to ensure the protection of their autonomy and dignity as well as the other human rights guaranteed by the United Nations Convention on the Rights of Persons with Disabilities. The Australian Government ratified the Convention in 2008, inclusive of an interpretive declaration that retains involuntary treatment where necessary but only as a last resort and subject to comprehensive safeguards.

The NMHCCF believes the following principles and strategies are vital to ending involuntary treatment, seclusion and restraint in Australian mental health services:

- All mental health treatment programs should provide recovery-oriented, person-centred, trauma-informed and human rights-based care.
- Consumers and families and carers must be at the centre of decision-making, planning and the development of processes (and their evaluation) that impact on them. Co-design principles are an important component in genuine reform and engagement and participation. Consumer and carer peer workers must be widely employed to support early intervention and prevention efforts in the clinical and community setting.
- Sufficient and accessible community-based services providing options and culturally-sensitive and responsive services must be provided to consumers in their communities.
- Coercive outpatient treatment must be avoided as a strategy that can drive people away from long-term treatment. Mandatory involuntary treatment has been shown to diminish the effectiveness of community mental health services and, indeed, may interfere with recovery by compromising personal responsibility and lowering self-esteem.[83]

It is important to go beyond what Mental Health Carers NSW call the 'culture of crisis management and risk prevention, which contributes to the use of more restrictive forms of care and therefore the abuse of human rights in service settings.'[84] A big step forward will be effected by adopting prevention and early intervention measures, including the employment of peer support workers more widely and helping families and carers in the community to understand and therefore be more supportive of the people they care for. Finally, after decades of reform, there remains little evidence for the benefits of restrictive practices and no cohesive therapeutic program in mental health facilities across Australia. A Melbourne University literature review looking at the prevention and reduction of "coercion" in mental health services found that 'Overall, many studies suggest that efforts to prevent and reduce coercion appear to be effective. However, no jurisdiction appears to have combined the full suite of laws, policies and practices which are available, and which taken together might further the goal of eliminating coercion.'[85] This reflects the point of view of the NMHCCF – the drive towards elimination of restrictive practices has begun but there is still work to be done.

About the National Mental Health Consumer and Carer Forum

The National Mental Health Consumer and Carer Forum (NMHCCF) is a combined national voice for mental health consumers and families and carers. We listen, learn, influence and advocate in matters of mental health reform.

The NMHCCF was established in 2002 by the Australian Health Ministers' Advisory Council. It is funded through contributions from each state and territory government and the Australian Government Department of Health. It is currently auspiced by Mental Health Australia.

NMHCCF members represent mental health consumers and families and carers on a large number of national bodies, such as government committees and advisory groups, professional bodies and other consultative forums and events.

Members use their lived experience, understanding of the mental health system and communication skills to advocate and promote the issues and concerns of consumers and families and carers.

Actions with Impact:

Listen:

- to the issues and concerns of consumers and families and carers.

Learn:

- to identify and promote good and ethical mental health practices and initiatives;
- about mental health services and programs, national and jurisdictional plans, Acts and strategies;
- by developing an understanding of what is happening in mental health in each jurisdiction, and nationally/internationally.

Advocate:

- by providing an informed, strong and unified voice to government, the mental health sector and other identified stakeholders;
- ensuring that issues and concerns are acknowledged and addressed as part of the national policy
- development process in Australia.

Influence:

- by enhancing, promoting and progressing genuine national partnerships and inclusion
- the capacity of individuals to advocate for and participate in all decisions that impact on their lives.

The NMHCCF aims to:

- Be a powerful, respected and combined national voice for mental health consumers and families and carers.
- Focus on recovery as essential to promoting hope and wellbeing for people with mental illness.
- Ensure policies and practices reflect social inclusion and human rights principles, and all services are inclusive
- Promote mental health consumers and About the families and carers are actively involved in co-design and decisions that impact on their lives
- Ensure stigma and discrimination is acknowledged and eliminated
- Identify important and innovative ideas to bring about positive change within the mental health system and our broader community

One of the most urgent priorities identified by consumer and family and carer representatives of the NMHCCF is that of the elimination of restrictive practices and coercion in mental health services.

The NMHCCF will continue to work towards a mental health system where consumers and families and carers are true partners in their own health care through genuine participation in the reduction and eventual elimination of these often abhorrent practices.

References

1 Restrictive Practice Working Group of the Safety and Quality Partnership Standing Committee (2016), *National principles for communicating about restrictive practices with consumers and carers*, https://www.mentalhealthcommission.gov.au/getmedia/1c6caf3a-a0bc-4aed-ba22-e71e973280c4/National-Principles-for-Communicating-about-Restrictive-Practices

2 NDIS Quality and Safeguards Commission (2019), *Positive behaviour support capability framework: For NDIS providers and behaviour support practitioners*, Penrith: NDIS Quality and Safeguards Commission, p. 7, https://www.ndiscommission.gov.au/sites/default/files/documents/2019-06/ndis-commission-pbs-capability-framework-v4-may-2019-final-june-publication-v50.pdf

3 B McKenna, D Sutton, L E Sweetman & W Miner-Williams (2018), *The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices: a case study*, Melbourne: Department of Health and Human Services, p. 31, https://www2.health.vic.gov.au/about/publications/researchandreports/assisting-mental-health-services-reduce-restrictive-practices

4 B McKenna, D Sutton, L E Sweetman & W Miner-Williams (2018), Ibid.

5 B McKenna, D Sutton, L E Sweetman & W Miner-Williams (2018), Ibid.

6 Royal Commission into Victoria's Mental Health System (2021), *Final Report, Volume 4: The fundamentals for enduring reform*, p. 298, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/03/RCVMHS_FinalReport_Vol4_Accessible.pdf

7 Royal Commission into Victoria's Mental Health System (2021), Ibid., p. 363.

8 Royal Commission into Victoria's Mental Health System (2021), Ibid., p. 335.

9 Hanh Ngo, Priscilla Ennals, Serhat Turut, Elizabeth Geelhoed, Antonio Celenza & Keren Wolstencroft (2020), Step-up, step-down mental health care service: evidence from Western Australia's first – a mixed-method cohort study, *BMC Psychiatry*, Volume 20, article no. 214, https://doi.org/10.1186/s12888-020-02609-w

10 Edwina M Light, Michael D Robertson, Philip Boyce, Terry Carney, Alan Rosen, Michelle Cleary, Glenn E Hunt, Nick O'Connor, Christopher J Ryan, Ian H Kerridge (2017), How shortcomings in the mental health system affect the use of involuntary community treatment orders, *Australian Health Review*, 2017, Volume 41, pp. 351-356, http://dx.doi.org/10.1071/AH16074

11 AIHW (2020), *Mental health services in Australia: Restrictive practices*, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices

12 AIHW (2020), Ibid.

13 AIHW (2020), Ibid.

14 Tasmania Department of Health and Human Services (2017), *Chemical restraint chief civil psychiatrist clinical guideline 10*, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/252751/CCP_Clinical_Guideline_10_-_Chemical_restraint.pdf

15 Mental Health America (2015), *Position statement 22: Involuntary mental health treatment*, https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment

16 AIHW (2020), Op. cit.

17 Cathy Roper, Bernadette McSherry, Lisa Brophy (2015), Defining seclusion and restraint: legal and policy definitions versus consumer and carer perspectives, *Journal of Law and Medicine, Volume 23*, pp. 297–302.

18 Australia Department of Social services (2014), *National framework for reducing and eliminating the use of restrictive practices in the disability service sector*, https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf

19 NDIS Quality and Safeguards Commission (2018), *Regulated restrictive practices*, https://www.ndiscommission.gov.au/regulated-restrictive-practices

20 NDIS Quality and Safeguards Commission (2018), Ibid.

21 Mental Health America (2015), Op. cit.

[22] Mental Health America (2015-2020), *Position statement 24: Seclusion and restraints*, https://www.mhanational.org/issues/position-statement-24-seclusion-and-restraints

[23] Advocacy for Inclusion (2017), *Response to Australian Human Rights Commission OPCAT in Australia Consultation Paper*, p. 5, https://humanrights.gov.au/sites/default/files/06.%20Advocacy%20for%20Inclusion%20OPCAT%20sub%2019%20July%202017.pdf

[24] Lisa M Brophy, Catherine E Roper, Bridget E Hamilton, Juan José Tellez & Bernadette M McSherry (2016), Consumer and carer perspectives on poor practice and the use of seclusion and restraint in mental health settings: Results from Australian focus groups, *International Journal of Mental Health Systems*, Volume 10, no. 6, https://pubmed.ncbi.nlm.nih.gov/26855669/

[25] The Improvement Hub (ihub), Healthcare Improvement Scotland (2019), *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care*, p 34, https://ihub.scot/media/5508/sp-sp-iop-from-observation-to-intervention.pdf

[26] The Improvement Hub (2019), Ibid; p 34.

[27] AIHW (2020), Op. cit.

[28] Mental Health Commission of NSW, (2020), *Indicator 9: Involuntary treatment orders*, https://nswmentalhealthcommission.com.au/indicator-9-involuntary-treatment-orders

[29] There are many examples of this advocacy including the Mental Health Coordinating Council (2017) *Submission: Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*, Lilyfield NSW: Mental Health Coordinating Council, https://www.mhcc.org.au/wp-content/uploads/2018/05/mhccsub_nswhealth_secrestraint2017.pdf

[30] NDIS Quality and Safeguards Commission (2018), Regulated restrictive practices.

[31] AIHW (2020), Op. cit.

[32] AIHW (2020), Op. cit.

[33] AIHW (2020), Op. cit.

[34] Edwina Light (2019), Rates of use of community treatment orders in Australia, *International Journal of Law and Psychiatry*, Volume 64, pp. 83-87, https://doi.org/10.1016/j.ijlp.2019.02.006

[35] Australasian College for Emergency Medicine (2018), *The long wait: An analysis of mental health presentations to Australian emergency departments report*, https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[36] Australasian College for Emergency Medicine (2018), Ibid.

[37] AIHW (2020), Op. cit.

[38] Madeline Kelly (2005), Bipolar and the art of roller coaster riding, Two trees media, p. 78.

[39] National Mental Health Commission (2015), *A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services*, p. 11, https://www.mentalhealthcommission.gov.au/getmedia/63e1d2e6-79fe-45ea-aeab-145f1d9b269a/Position-paper-on-seclusion-and-restraint

[40] Piers Gooding, Bernadette McSherry, Cathy Roper & Flick Grey (2018), *Alternatives to Coercion in Mental Health Settings: A Literature Review*, Melbourne: Melbourne Social Equity Institute, University of Melbourne, p. 117, Commissioned by the United Nations Office at Geneva to inform the report of the United Nations Special Rapporteur on the Rights of Persons with Disabilities, https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf

[41] AIHW (2020), Op. cit.

[42] Australian College of Mental Health Nurses (2017), *Supporting mental health nurses towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in inpatient mental health settings in Australia*, https://www.parliament.nsw.gov.au/ladocs/other/11090/Project%20Summary.pdf

[43] NDIS Quality and Safeguards Commission (2018), Op. cit.

[44] National Mental Health Commission (2015), *A case for change*, p. 18.

[45] Lisa M Brophy et al. (2016), Op. cit.

[46] Australian College of Mental Health Nurses (2019), *Safe in care, safe at work: Ensuring safety in care and safety for staff in Australian mental health services*, p.9, https://www.mentalhealthcommission.gov.au/getmedia/1871cc65-e51d-43fb-b2d5-7346a17248a9/Safe-in-Care-Safe-at-Work-Abridged-version

[47] *A practical guide for working with carers of people with a mental illness* (2016), Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia, p. 8, https://mhaustralia.org/sites/default/files/docs/a_practical_guide_for_working_with_carers_of_people_with_a_mental_illness_february.pdf

[48] Australian College of Mental Health Nurses Inc. (2019), Op. cit; p.16.

[49] Royal Australian and New Zealand College of Psychiatrists (2012), *Supporting carers in the mental health system: Position statement 76*, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/supporting-carers-in-the-mental-health-system

[50] Brian McKenna, D Sutton, L E Sweetman & W Miner-Williams (2018), *The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices: a case study*, Department of Health and Human Services, Melbourne, p. 31, https://www2.health.vic.gov.au/Api/downloadmedia/%7B73FDD82C-FA58-4A79-9CA5-05A03FF1521A%7D

[51] Brian McKenna (2018), *Comparing efforts across jurisdictions in assisting mental health services toward elimination of restrictive practices: Two case studies*, Towards Eliminating Restrictive Practices, Hobart, 7th and 8th November 2018,

[52] Piers Gooding et al. (2018), Op. cit; p.9.

[53] Mission Australia (2016), Recovery Oriented Practice Framework, available at: https://www.missionaustralia.com.au/publications/resource-sharing-hub

[54] Mental Health Australia (2020), *2020-21 Pre-Budget submission*, p. 4, https://mhaustralia.org/sites/default/files/docs/mental_health_australia_pre-budget_submission_2020-21_-_final_31_jan.pdf

[55] NSW Agency for Clinical Innovation (2019), *Trauma-informed care and practice in mental health services*, Chatswood NSW, https://www.aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services

[56] UTS Health Faculty (2019), Beefing up security not the only way to make hospitals safer, *News in Health*, https://www.uts.edu.au/about/faculty-health/news/beefing-security-not-only-way-make-hospitals-safer

[57] Mental Health Carers NSW (2019), Cheap and unequal; Australia's approach to human rights and mental health; MHCN's contribution to *Free and Equal: An Australian conversation on human rights*, p. 2, https://www.mentalhealthcarersnsw.org/wp-content/uploads/2019/12/4.1-Mental-Health-Carers-NSW-Submission.pdf

[58] United Nations Human Rights Council (2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Juan E. Méndez. A/HRC/22/53, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

[59] Juan E. Méndez (2013), *Human Rights Council Twenty-second session Agenda item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

[60] Penelope Weller (2019), Preventing abuse in detention: Effective independent monitoring within the OPCAT framework, *Australian Journal of Human Rights* Volume 25, pp. 130-149, https://doi.org/10.1080/1323238X.2019.1588056

[61] Health Talk Australia (2020), *Community Treatment Orders*, https://healthtalkaustralia.org/supported-decision-making/community-treatment-orders/

[62] Royal Australian and New Zealand College of Psychiatrists (2017), *Powers and duties of psychiatrists in Australian and New Zealand Mental Health Acts: A literature review*, https://www.ranzcp.org/files/resources/college_statements/mental-health-legislation-tables/powers-and-duties-of-psychiatrists-in-australian-a.aspx

[63] Australasian College for Emergency Medicine (2017), *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*, p. 40, https://acem.org.au/getmedia/166a00bf-7a3e-4b01-9798-b5da0573bf14/2017_Dec_FINDINGS_report-seclusion-restraint-observation

[64] Edwina M Light, Michael D Robertson, Philip Boyce, Terry Carney, Alan Rosen, Michelle Cleary, Glenn E Hunt, Nick O'Connor, Christopher J Ryan, Ian H Kerridge (2017), *How shortcomings in the mental health system affect the use of involuntary community treatment orders.*

[65] Mental Health Commission NSW (2020), Op. cit.

[66] NursingAnswers,net (2019), *Mental health standards for involuntary Community Treatment Orders: Essay*, https://nursinganswers.net/essays/mental-health-standards-for-involuntary-community-treatment-orders.php

[67] NursingAnswers,net (2019), Ibid.

[68] Kate Dorozenko & Robyn Martin (2017), *A critical literature review of the direct, adverse effects of neuroleptics* *also known as antipsychotics essential information for mental health consumers, carers, families, supporters and clinicians, school of occupational therapy and social work*, Curtin University, p. 4,

[69] Kate Dorozenko & Robyn Martin (2017), Op. cit: p. 13.

[70] Kate Dorozenko & Robyn Martin (2017), Op. cit: p. 41.

[71] Mental Health Carers NSW (2019), Op. cit: p. 17.

[72] The Australian College of Mental Health Nurses Inc. (2019), *Safe in Care, Safe at Work: Ensuring safety in care and safety for staff in Australian mental health services*, Op. cit.

[73] Kate Dorozenko & Robyn Martin (2017), Op. cit: p. 56.

[74] Lisa Brophy, Renata Kokanovic, Jacinthe Flore, Bernadette McSherry & Helen Herrman (2019), Community Treatment Orders and Supported Decision-Making, *Frontiers in Psychiatry*, https://doi.org/10.3389/fpsyt.2019.00414

[75] Mental Health Coordinating Council (2017), *Submission to the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*, Rozelle NSW, NMHCC, https://www.mhcc.org.au/wp-content/uploads/2018/05/mhccsub_nswhealth_secrestraint2017.pdf

[76] Mental Health Coordinating Council (2017), *Submission to the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*, Rozelle NSW, NMHCC.

[77] Mental Health Carers NSW (2017), *Submission to the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*, Woolloomooloo, NSW, https://www.mentalhealthcarersnsw.org/wp-content/uploads/2015/01/Seclusion-Restraint-Submission-Mental-Health-Carers-NSW-2017.pdf

[78] Mental Health Carers NSW (2017), *Submission to the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities.*

[79] Piers Gooding, et al. (2018), Op. cit; p. 116.

[80] Australasian College for Emergency Medicine (2017), Op. cit; p. 35.

[81] Australasian College for Emergency Medicine (2017), Op. cit; p. 35.

[82] Australasian College for Emergency Medicine (2017), Op. cit; p. 33.

[83] Mental Health America (2015), Op. cit.

[84] Mental Health Carers NSW (2019), Op. cit; p.2.

[85] Piers Gooding, Bernadette McSherry & Cathy Roper (2020), Preventing and reducing 'coercion' in mental health services: an international scoping review of English language studies, *Acta Psychiatrica Scandinavia*, https://onlinelibrary.wiley.com/doi/full/10.1111/acps.13152

Position Paper by the National Mental Health Consumer and Carer Forum

For further information on this Position Paper please contact:

NMHCCF Secretariat
nmhccf@mhaustralia.org

National Mental Health
Consumer & Carer Forum