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INSTITUTE

SECLUSION AND RESTRAINT PROJECT

Overview

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1. INTRODUCTION

1.1 About This Overview

This document provides an overview of the research findings and options for reform relating to reducing and eliminating the use of seclusion and restraint on people with mental health issues. A more extensive and detailed Report has been provided to the National Mental Health Commission (NMHC).

1.2 The Importance of This Project and Its Findings

In 2012, one of ten key recommendations made by the National Mental Health Commission (2012, p. 13) was to ‘reduce the use of involuntary practices and work to eliminate seclusion and restraint’. The NMHC stated (2012, p. 14) that it would call for evidence of best practice in reducing and eliminating seclusion and restraint and help identify good practice treatment approaches.

This project builds upon the previous work of the National Mental Health Seclusion and Restraint project known as the Beacon project (Australian Institute of Health and Welfare, 2012) and a series of annual National Mental Health Seclusion and Restraint forums. It also draws upon efforts by governments at the national, state and territory levels to improve public reporting of seclusion data and to introduce strategies to reduce the use of seclusion and restraint in mental health services.

People with lived experience of mental health issues are often marginalised and their views discredited or ignored. If certain legal criteria are made out, they can be subjected to involuntary mental health treatment which means other people can make important decisions on their behalf. It was important, therefore, that their views were actively canvassed throughout this project.

The voices of people with lived experience of mental health issues and, in particular, those with lived experience of seclusion and restraint, as well as their carers, family members and support persons were heard via membership of two project Advisory Groups, targeted focus groups and through responses to an online survey.

This project makes a significant contribution to the evidence base as to how best to reduce and eliminate seclusion and restraint by analysing current literature as well as canvassing and analysing the perspectives of different groups on this issue. Discussions in focus groups and responses to an online survey, which proactively sought the views of people with lived experience of mental health issues, highlighted a number of barriers to and strategies for reducing and eliminating seclusion and restraint.

The research findings offer new evidence of a consensus between people with lived experience of mental health issues, their carers, family members and support

persons, as well as mental health practitioners, that the use of seclusion and restraint is:

- not therapeutic
- breaches human rights
- compromises the therapeutic relationship/trust
- can be reduced

There was overwhelming agreement amongst focus group and survey participants for change in current practice. These findings are significant in creating an evidence base that has not been previously available.

Any initiatives for reform need to be based on the principles of recovery, trauma-informed care and human rights as outlined in Section 1.7 below. Options for reform, which are based on the key findings, are set out in Part 3 of this Overview.

1.3 What is Meant by Seclusion and Restraint?

Seclusion and restraint are interventions currently permitted for use in mental health services and other settings to control or manage a person's behaviour. Different types of restraint involving bodily force, devices or medication are also used on people with mental health issues in prisons, remand centres, emergency departments and by police and emergency transport providers.

Currently, there are no agreed, uniform definitions of seclusion and restraint across Australia. The Report explores definitional inconsistencies, the challenges arising from these inconsistencies and how those with lived experience of seclusion and restraint and their carers, family members and support persons understand these terms.

To provide some consistency throughout this research project, the research team relied on the definitions used in Tasmania's *Mental Health Act 2013*:

- *seclusion*: 'the **deliberate confinement** of [a person], alone, in a room or area that [the person] cannot freely exit'

The Tasmanian Act defines three different types of restraint:

- *physical restraint*: '**bodily force** that controls a person's freedom of movement'
- *chemical restraint*: '**medication** given primarily to control a person's behaviour, not to treat a mental illness or physical condition'
- *mechanical restraint*: '**a device** that controls a person's freedom of movement'

The research project also addressed emotional restraint, a concept which has been defined by the National Mental Health Consumer and Carer Forum:

- *emotional restraint*: ‘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’ (National Mental Health Consumer and Carer Forum, 2009, p. 6)

1.4 The Terms of Reference for the Project

At the end of June 2013, the NMHC commissioned the research team to investigate and identify instances of ‘best practice’ in reducing and eliminating the practices of seclusion and restraint in relation to people with mental health issues.

The Terms of Reference for the fourteen-month project were:

- ‘An international Call for Evidence on best practice in reducing and eliminating the seclusion and restraint of people with mental health issues to help identify good practice approaches.
- The Call for Evidence must provide opportunities for direct input of people with lived experience of mental health issues and their families, friends and supporters and key service delivery and workforce interest groups.
- A global literature review of evidence relating to the use of seclusion and restraint including published, peer-reviewed and grey research.
- An assessment of key areas of debate, concern or contention in the literature, and as it applies to the Australian context.
- What success looks like and what factors drive changes in services that have eliminated or significantly reduced seclusion and restraint, and what can we learn from these leading sites.
- Understanding the mechanisms, recording and reporting of the current utilisation of seclusion and restraint in Australia, extending to the facility level where available, and indicating how this compares with other countries.
- The adequacy of current compliance, monitoring and reporting arrangements in Australia, including commitments under international and national human rights obligations.
- Engagement with people with lived experience, families, friends and supporters.’

1.5 About the Research Team

An interdisciplinary research team was brought together by the Melbourne Social Equity Institute at the University of Melbourne. The twelve members of the team have research expertise in different disciplines including social work, nursing, psychology, psychiatry, education and law. The team includes experts in qualitative and quantitative data analysis and also includes researchers with mental health consumer and carer experience and associated expertise.

1.6 What the Research Team Did

In order to gather the required information and identify examples of ‘best practice’ in reducing and eliminating the practices of seclusion and restraint, the research team:

- established two advisory groups, one consisting of people who have experienced seclusion or restraint themselves and another consisting of carers, family members and support persons of people who have experienced seclusion or restraint
- spoke to people with lived experience of mental health issues, their carers, family members and support persons as well as mental health practitioners and members of the police and ambulance services
- analysed the legal and regulatory framework in Australia and other comparative countries for the use of these interventions
- conducted a review of the literature relating to the reduction and elimination of seclusion and restraint
- collected data from an online survey and focus groups which targeted the views of people with lived experience of mental health issues
- took the findings of the research to the Core Reference Group and the two project Advisory Groups for discussion and advice in developing the report

The project passed through a rigorous ethics approval process at the University of Melbourne (Ethics ID 1340647), being considered first by the Population and Global Health Human Ethics Advisory Group and then by the Health Sciences Human Ethics Sub-Committee.

1.7 Drivers for Change in Mental Health Treatment and Care

Mental health policy in Australia, as in many other countries, is increasingly influenced by the ‘recovery approach’ to treatment and care (Skuse, 2012). In 2008, the National Mental Health Policy set out that mental health services should adopt a recovery-oriented approach (Australian Health Ministers, 2009) and there is now a National Framework for Recovery-Oriented Mental Health Services (Australian Health Ministers' Advisory Council, 2013).

Recovery emphasises:

- connectedness
- hope and optimism about the future
- rebuilding or redefining a positive identity
- pursuing a meaningful life
- empowerment through personal responsibility (Leamy et al., 2011)

In addition to the impact of recovery, there is a developing emphasis on trauma-informed care and practice (Mental Health Coordinating Council, 2013; Substance Abuse and Mental Health Services Administration, 2014). This involves the recognition of the high prevalence of traumatic experiences in people with mental health issues and this approach emphasises understanding and responding to the effects of all types of trauma as well as ensuring that practice does not result in re-traumatisation.

There are eight foundational principles of trauma-informed care (Mental Health Coordinating Council, 2013, p. 10):

- understanding trauma and its impact
- promoting safety
- ensuring cultural competence
- supporting consumer control, choice and autonomy
- sharing power and governance
- integrating care
- healing happens in relationships
- recovery is possible

An emphasis on human rights is also shaping mental health reforms in many countries (McSherry and Freckelton, 2013; McSherry and Weller, 2010).

Human rights are the basic rights and freedoms to which all human beings are entitled. Human rights are often expressed and guaranteed by law, in the forms of international treaties and other sources of international law.

Australia has ratified the *United Nations Convention on the Rights of Person with Disabilities* which includes rights for persons with 'mental impairments'. The United Nations Committee on the Rights of Persons with Disabilities has recognised the use of seclusion and restraint as a human rights violation and has recommended that Australia 'take immediate steps to end such practices' (Committee on the Rights of Persons with Disabilities, 2013, p. 36).

The importance of complying with international law also provides impetus for this research project. The United Nations Committee on the Rights of Persons with Disabilities monitors the implementation of the *Convention* and individuals who

claim to be victims of a violation of their human rights may bring communications to the Committee.

Work has already been undertaken for a number of years in the Australian mental health sector to reduce the use of seclusion and restraint. The Beacon Project (Australian Institute of Health and Welfare, 2012), which ran from 2007 to 2009, targeted eleven key sites around Australia, all of which implemented strategies aimed at reducing and, where possible, eliminating the use of seclusion and restraint in public mental health services.

At present, there is no formal, routine, nationally agreed data collection and reporting framework for the use of seclusion and restraint. However, the Australian Health Ministers' Advisory Council's Safety and Quality Partnership Standing Committee, in partnership with the relevant state and territory authorities, does collect some data on seclusion events from acute mental health services in public hospitals.

Recently, the Chief Executive Officers of the Australian Health Ministers' Advisory Council decided that this data on seclusion events should be publicly reported on an annual basis via the Australian Institute of Health and Welfare's Mental Health Services' website. The first of these releases occurred in July 2013 (showing four years of national data up to 2011-12). The second release of data occurred in November 2013. National seclusion event data as a rate per 1,000 bed days for 2008-09 to 2012-13 is now publically available at <http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/>

The data indicate that the national seclusion rate has fallen since 2008-09 from 15.6 seclusion events per 1,000 bed days in 2008-09 to 9.6 events in 2012-13, representing an average annual reduction of 11.3% over the 5 year period (Australian Institute of Health and Welfare, 2014).

While there is thus a downward trend in seclusion rates overall in acute mental health services (Allan and Hanson, 2012; Australian Institute of Health and Welfare, 2013), rates can vary considerably across facilities, jurisdictions and age groups. There is a need for a broader range of data to be collected to ensure progress can be measured in identifying how best to reduce and eliminate both seclusion and restraint.

The Australian Institute of Health and Welfare is currently working with the Australian Health Ministers' Advisory Council's mental health committees to collect data on restraint practices in order to facilitate the potential development and reporting of a 'national restraint indicator'. It is expected that data on restraint events will be publicly released for the first time at the end of 2014.

The Australian Health Ministers Advisory Council's mental health committees are in the process of formalising the current 'ad hoc' Safety and Quality Partnership Standing Committee's seclusion data collection process. The Mental Health Information Strategy Standing Committee is also working with the Australian Institute of Health and Welfare to develop an aggregate seclusion and restraint Data Set Specification to standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015–16 collection period.

2. KEY FINDINGS

2.1 How Seclusion and Restraint are Currently Regulated

Seclusion and various forms of restraint are regulated in different countries in different ways. They may be regulated through

- legislation – this is mainly used in Australia, New Zealand and Ireland
- policy – this is used in conjunction with legislation in many Australian states and in England, Wales and Scotland
- accreditation – this is used in the United States. Hospital accreditation standards which include standards dealing with seclusion and restraint are set by the Centers for Medicare and Medicaid and The Joint Commission (an independent body)

Seclusion and some (but not all) forms of restraint are regulated under different laws and policies throughout Australia. Numerous policies, guidelines, standards and procedures exist internationally as well as across Australia aimed at reducing seclusion and mechanical restraint. Gaskin (2013, p. 4), for example, analysed 133 such documents from 17 organisations in Victoria alone and found (2013, p. 6) that most of them ‘contain strategies for seclusion and restraint reduction’ and ‘vary in the strength of their opposition to restrictive practices’.

The fact that there are so many documents available indicates that, at the very least, there is a commitment to managing the use of seclusion and restraint. The drawback is that having so many documents available makes it difficult to identify the weight to be assigned to them in terms of a ‘hierarchy’ of regulation. The research team therefore focused on governing laws and policies that apply on a national or state and territory-wide basis. A table of these laws and policies can be found in Appendix One to the Report.

Seclusion and mechanical restraint are subject to the most regulation:

- seclusion is regulated by mental health legislation, except in New South Wales which has a policy on its use
- mechanical restraint is regulated under policies and/or legislation across Australia
- physical restraint is regulated under policies and/or legislation in five states and the Australian Capital Territory, but is not regulated at all in the Northern Territory and Western Australia

- chemical restraint is not regulated under legislation except in Tasmania. New South Wales has a policy on it
- emotional restraint is not referred to in laws or policies in Australia. Other jurisdictions such as Pennsylvania in the United States regulate ‘psychological restraints’ which are defined in section 13.9 of the Pennsylvania Code as including ‘those therapeutic regimes or programs which involve the withholding of privileges and participation in activities’

Where there is regulation, laws and policies differ in relation to:

- the criteria limiting when seclusion and restraint can be used
- who has authority to seclude and restrain
- restrictions on the duration of seclusion and mechanical restraint
- recording and reporting the use of seclusion and restraint
- treatment of the person while in seclusion or under mechanical restraint
- special provisions for certain groups perceived to be ‘vulnerable’
- concurrent use of seclusion and mechanical and/or chemical restraint

2.2 How Seclusion and Restraint Could be Regulated

Greater uniformity is an essential direction for future reform. Regulation through legislation has the advantage of:

- making the use of seclusion and restraint a matter of last resort
- setting clear and consistent standards
- clarifying the circumstances in which a breach occurs
- giving policies a legislative structure
- making the regulatory framework easy to locate

Policies, procedures, standards and guidelines have the advantage of being:

- comprehensive and specific
- generally more accessible and understandable than legislation
- able to create uniformity between states and territories where national guidelines are used
- able to offer practical and useful advice
- flexible and easily adapted to local conditions
- able to take into account the latest developments

Accreditation has the advantage of providing a financial incentive to comply with regulations.

A combination of laws, policies and accreditation may constitute ‘best practice’.

In mid-April 2014, the Commonwealth Government finalised a National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector (Australian Department of Social Services, 2014). The National Framework contains a number of high-level principles and core strategies (based on the six core strategies). This could be adapted for use in services relating to people with mental health issues. **What is perhaps of most importance, however, is the need for uniformity in definitions across Australia as well as requirements for reporting and oversight of seclusion and restraint.** Efforts are currently underway to seek national consensus on definitions for data collection. At present, however, there is no national and consistent legislative platform to ensure best practice in reducing and eliminating seclusion and restraint.

2.3 Current Literature on How Best to Reduce Seclusion and Restraint

There is a lot of what is sometimes referred to as ‘grey’ literature on reducing seclusion and restraint. This literature is not published and therefore typically not subject to peer review (or external validation) of content. It can take the form of government reports, conference papers, policy documents and material on websites. Much of this literature is aimed at informing mental health practitioners about how best to reduce the use of seclusion and restraint.

For example, in the United States, where there may be financial and accreditation consequences for breaches of federal time restrictions on seclusion and mechanical restraint, two bodies have training guides and a wealth of material aimed at reducing seclusion and restraint freely available via their websites:

- National Association of State Mental Health Program Directors (NASMHPD) – Training Curriculum for the Reduction of Seclusion and Restraint (2006): <http://www.nasmhpd.org/index.aspx>
- Substance Abuse and Mental Health Services Administration (SAMHSA) – Roadmap to Seclusion and Restraint Free Mental Health Services (2005): <http://www.samhsa.gov/>

In its training curriculum, NASMHPD uses six core strategies which were developed in 2005 by the National Technical Assistance Center. These six core strategies has been used by Eastern Health (Sivakumaran, George and Pfukwa, 2011); St Vincent’s Mental Health in Melbourne (Hamilton and Castle, 2008), Te Pou in New Zealand (Te Pou, 2013) and Ontario Shores Centre for Mental Health Sciences in Canada (Riahi, 2014; Riahi, Dawe and Klassen, 2012).

The six core strategies are:

- ‘Leadership towards organisational change’—articulating a philosophy of care that embraces seclusion and restraint reduction

- ‘Using data to inform practice’ — using data in an empirical, ‘non-punitive’ way to examine and monitor patterns of seclusion and restraint use
- ‘Workforce’ — developing procedures, practices and training that are based on knowledge and principles of mental health recovery
- ‘Use of seclusion and restraint reduction tools’ — using assessments and resources to individualise aggression prevention
- ‘Consumer roles in inpatient settings’ — including consumers, carers and advocates in seclusion and restraint reduction initiatives
- ‘Debriefing techniques’ — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience

In relation to the six core strategies, the most tested strategy is that of leadership.

Much of the literature on this topic deals with the importance of top-down organisational leadership *in conjunction with* local level leadership (for example, at ward level) in order to create and maintain culture change. It may be that the emphasis on leadership as a strategy for change reflects the fact that a lot of the research in the field is management rather than consumer driven. Many seclusion reduction projects feature the strategy of staff training, and the use of new assessment, review and debriefing tools. Very few reported projects incorporate consumer roles, as recommended in the six core strategies.

In England, the Safewards model (Bowers et al., 2014) has identified aspects of working in psychiatric wards that are known to create potential ‘flashpoints’ and has developed ten interventions aimed at helping staff manage those flashpoints to reduce conflict. The Victorian Government (Premier of Victoria, 2014) has announced that this model will be trialled and evaluated at seven Victorian metropolitan and regional health services in order to test its effectiveness.

After an extensive search, 33 directly relevant peer-reviewed research studies were identified for review. Many of these studies had limitations in terms of study design, length of trial periods and settings.

The peer-reviewed literature concentrates on the *reduction* rather than the *elimination* of seclusion and/or restraint. Only one non peer-reviewed book (Murphy and Bennington-Davis, 2005) refers to a model for eliminating the use of seclusion and restraint.

The 'grey' literature and 33 empirical research studies analysed by the research team suggest the following interventions may reduce the use of seclusion and restraint:

- national oversight
- organisational culture change through an emphasis on recovery, trauma-informed care and human rights
- independent advocacy directed at public opinion, politicians, policymakers and service providers

One further intervention that does not appear in the six core strategies that shows promise as an intervention relates to:

- physical changes to the environment

Borckhardt and colleagues (2011) have observed that **physical changes to the environment** are some of the easiest changes to implement. Changes to the environment that helped reduce the use of seclusion and restraint by over 82.3% in a state run hospital in the south-eastern United States included 'repainting walls with warm colors, placement of decorative throw rugs and plants, and rearrangement of furniture....along with replacing worn-out furniture and continuing with environmental changes...' (Borckardt et al., 2011, p. 479).

There is also some indication that sensory-based approaches such as the use of **sensory modulation rooms** can help reduce levels of distress (Chalmers et al., 2012; Champagne and Sayer, 2003; Te Pou, 2010) thereby preventing the need to use seclusion or restraint. Sensory modulation tools can include the use of audio and video equipment, weighted blankets, soft materials and pleasant aromas (Te Pou, 2010, p. 3). These sensory-based approaches are included in some studies of the six core strategies as outlined in the Report. Sensory modulation equipment is now being trialled in Victoria (Premier of Victoria, 2014).

Of the studies that looked at **multiple interventions** such as the six core strategies, it is not possible to tell which particular factors led to a reduction in seclusion and/or restraint. In some of the literature, there was either no pre-testing or the data was not compared with data from settings that did not undertake interventions.

Overall, **the empirical evidence points to certain multi-intervention strategies being effective**. There are, however, clear gaps in the research literature and while there is a lot of 'grey' literature available, there is a need for rigorous evaluation of interventions being used in Australian facilities.

2.4 Results from the Online Survey

Reflecting a high level of community interest, 1,451 people responded to an online survey over a two month period. 211 responses were not analysed because the participants were below 18, not residing in Australia or had not given their consent to the study. This left 1,240 participants whose responses were analysed.

The survey was anonymous and for ethical reasons, the majority of questions were not mandatory to complete. As a result, the number of responses varied slightly from one question to the next, but a majority of participants answered all questions.

2.4.1 Who Participated

Participants were asked to identify their background, in relation to seclusion and restraint. Due to the number of different backgrounds and potential for participants to identify themselves as having multiple roles, many response options were not mutually exclusive. For example, someone who had personally experienced seclusion or restraint in relation to a mental health issue could also identify as a carer.

- just under a third of participants (369 people, or 31%) indicated they had personally experienced seclusion or restraint in relation to a mental health issue
- forty per cent (502 people) of participants reported having a personal experience of receiving treatment for a mental health issue
- nearly half of the participants (597 people, or 48%) identified as a carer
- just under a third (30%) of participants identified as a nurse (366 people) or as a mental health practitioner such as a psychiatrist, psychologist or social worker (350 people, or 28%)
- participants from all states and territories responded, with 63% of respondents residing in a capital city, 27% residing in regional centres, and 10% residing in rural or remote areas
- the majority of participants were highly educated, with 69% of participants (857 people) indicating that they had completed tertiary education
- the majority of participants were female (886 people, or 74%); relatively few participants were aged under 25 years (78 people, or 6.5%) and only 20 participants identified as Indigenous (1.6%)

2.4.2 *Where There was Agreement*

- between 80 and 90% of participants, when asked if the use of seclusion and restraint infringed human rights, responded that seclusion and the four different forms of restraint would always or often infringe human rights
- a similar proportion (between 75-89%) believed that the use of seclusion and the four different forms of restraint would result in either always or often compromising the therapeutic relationship/trust
- ninety per cent of participants (773 out of 830), when asked about effective strategies to reducing the negative effects of seclusion and restraint indicated that taking a person-centred approach to assessment and treatment would be an extremely effective or effective strategy
- of the strategies suggested to survey participants to reduce seclusion and restraint, the three strategies thought to be extremely effective or effective, were:
 - having better access to counselling and other ‘talking and listening’ opportunities (683 out of 810 people, or 84%)
 - changes to the environment in which seclusion and restraint might occur (683 out of 811 people, or 84%)
 - staff training in de-escalation strategies (671 out of 781 people, or 86%)
- the majority of participants responded that eliminating emotional restraint was both possible (72-84% across all groups agreed) and should be eliminated (62-73% across all groups agreed) from current practice

2.4.3 *Where There was a Difference in Responses*

- there was a lack of agreement as to the meaning of seclusion and restraint amongst survey participants, with the majority of responses (46%) given by those answering questions about definitions being only ‘somewhat similar’ to those supplied which were derived from the *Tasmanian Mental Health Act 2013* (physical, chemical and mechanical restraint) and the National Mental Health Consumer and Carer Forum (emotional restraint)
- the main difference related to the *purpose* of seclusion and restraint, with some participants highlighting safety issues. The percentages of the different groups of participants that quoted ‘prevent harm’ as a purpose for seclusion and restraint were:
 - practitioner 54%
 - carer 25%

- consumer 16%
 - other 5%
- in response to questions about whether seclusion and the various forms of restraint *should* be eliminated, a wide range of participants (19-84%) – depending on their personal relationship to the topic, and the form of seclusion or restraint – believed that these practices should be completely eliminated. However, a similar range of participants (9-75%) responded that seclusion and the various forms of restraint should not be eliminated
 - the open-ended responses showed a trend towards concern for safety should seclusion and restraint be completely eliminated

2.4.4 Overall Findings

As set out in detail in the Report, while there was considerable variation in responses and not all groups saw the total elimination of seclusion and restraint as feasible or desirable, there was overwhelming agreement for change in current practice.

2.5 Results from the Focus Groups

Five focus groups for carers, family members and support persons and five focus groups for people with lived experience of mental health treatment were conducted in Melbourne, Shepparton, Perth, Brisbane and Sydney. The carer focus groups consisted of 36 carers, family members and support persons (29 women and seven men) who had experienced a family member or person close to them being secluded or restrained. The lived experience focus group consisted of 30 adults, 13 men and 17 women, all of whom had lived experience of mental health service provision and all of whom had either experienced seclusion or restraint directly, or had witnessed or advocated for those who had.

The focus groups were all conducted in English but participants indicated a variety of ethnic and cultural backgrounds including Vietnamese, Italian, Greek, Dutch and other European backgrounds. The participants ranged in age from 20 years old to one participant who was in her late 70s. No Indigenous Australians attended but people involved in supporting Indigenous people did attend.

The overall aim of the focus groups was to give people an opportunity to share their perspectives on how seclusion and restraint could be reduced or eliminated.

Participants focused on three main topics:

- their understanding of seclusion and the different forms of restraint and their impact

- their observations about poor practice and what contributes to it
- their ideas and recommendations regarding strategies to reduce or eliminate seclusion and restraint

In relation to their understanding of seclusion and restraint and its impact, participants:

- described a continuum of coercion of which seclusion and restraint were viewed as examples
- emphasised the practices of chemical and emotional restraint and a lack of recognition of them
- identified seclusion and restraint as not therapeutic, anti-recovery and an abuse of human rights
- emphasised the traumatic impact of seclusion and restraint and how this can be long lasting

In relation to their observations about poor practice, participants referred to:

- poor leadership
- poor communication
- a lack of time for staff to talk with those with mental health issues
- inadequate staff training
- a lack of accountability
- a general lack of resources
- stressful environments

Participants emphasised the following strategies to reduce or eliminate seclusion and restraint:

- the importance of services and treatment being person centred, such that every effort is made to try to keep someone from being in crisis or involuntarily detained in hospital in the first instance
- the need to improve the quality of mental health services and staff through emphasising interpersonal skills to improve therapeutic relationships without resorting to the use of coercion
- the need to improve the environment in which services are offered to ensure people with mental health issues feel secure and safe. Suggestions ranged from having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed, to ensuring doors to the main wards are unlocked and the removal of seclusion rooms altogether

- the need to ensure accountability
- the value of peer workers and family members to support people in crisis and on inpatient units

Other matters that are worth noting are that some participants raised:

- the issue of drugs and alcohol misuse complicating mental health treatment, particularly regarding increased incidences of seclusion and restraint and its common use as an intervention while waiting for the intoxication or drug effects to dissipate
- the need to recognise the specific challenges for people in rural and remote areas of Australia and also for Indigenous and culturally and linguistically diverse populations
- the concurrent use of different forms of seclusion and restraint

These are all areas that need further exploration.

Overall, focus group participants clearly identified that the current situation or status quo needs to change and there is urgency for action in this regard. There was a strong call for the development of, and investment in, a range of peer roles inclusive of direct support, staff development, governance and organisational change.

2.6 Limitations of the Research Project

2.6.1 *Restricted Focus*

The terms of reference for the fourteen-month project were limited to researching 'best practice' in reducing the use of seclusion and restraint on people with mental health issues. The terms emphasised that the project should provide opportunities for the direct input of people with lived experience of mental health issues.

During the course of the project, it became clear that there is a great deal of community concern about the use of seclusion and restraint in the disability and aged care sectors, as well as a perception that these practices are over-used on children and amongst Indigenous Australians and certain cultural groups.

Because of the enhanced ethical expectations and resources required to undertake research with Indigenous peoples and culturally and linguistically diverse groups, plus the time constraints of a fourteen-month project, the research team was unable to explore these issues.

It also needs to be recognised that the use of an online survey targets those who have access to computers and the internet. Some organisations did agree to give

their clients access to computers, but the fact that the majority of survey participants were highly educated and urbanised indicates that further targeted and culturally sensitive research strategies are required.

2.6.2 *Restricted Literature*

The literature available primarily focuses on the use of seclusion and restraint in inpatient units and emergency departments. While contact was made with representatives from the police and those involved in community, custodial and ambulatory settings, there was only a small amount of literature available about strategies to reduce the use of seclusion and restraint in these settings. Documents that were provided to the research team from ‘first responders’ largely focused on devices for mechanical restraint and how to apply them.

In addition, the NMHC and the research team agreed that the project would focus on international English-language literature and regulatory frameworks from across Australia, the United Kingdom, Ireland, Europe, New Zealand and the United States. It is highly likely that relevant material exists in other languages and further directed research would be useful in this regard.

2.7 *Significant Contributions of the Research Project*

2.7.1 *Engagement of Those with Lived Experience, Carers, Family Members and Support Persons*

The terms of reference emphasised the direct input of and ‘engagement with people with lived experience, families, friends and supporters’. The research team therefore focused on gaining the perspectives of these individuals through the focus groups and through the two advisory groups for the project.

It became clear that, apart from the report by Foxlewin (2012), there is still very little consumer and carer led research into possible interventions to reduce seclusion and restraint. This project’s focus on the perspectives of those with lived experience of mental health issues and the use of seclusion and restraint, as well as the perspectives of carers, family members and support persons concerning how best to reduce the use of seclusion and restraint provides a way forward for further research.

2.7.2 *Online Survey*

For the first time, a comprehensive survey on seclusion and restraint was developed and made available online. The fact that there were participants from every state and territory and that so many people took the time to respond to the survey indicates that there is a great deal of interest in, and concern about, seclusion and restraint.

The survey enabled the participation of ‘key service delivery and workforce interest groups’ as required by the terms of reference, with 30% of participants identifying as nurses and 28% as a psychiatrist, psychologist or social worker. This meant that there was a diverse range of perspectives canvassed.

The analysis of 1,240 people’s responses to questions about how best to reduce or eliminate seclusion and restraint and the barriers to this occurring has turned up a rich source of data for further exploration.

2.7.3 *Gaining Perspectives on How Best to Reduce and Eliminate Seclusion and Restraint*

While there may not be enough solid evidence as to what is ‘best practice’ in reducing and eliminating seclusion and restraint, this research project has identified that there is substantial agreement regarding interventions that may reduce the use of seclusion and restraint. At the very least, this will assist in setting future research and practice agendas.

3. OPTIONS FOR REFORM

3.1 Introduction

Human rights and the principles embedded in the recovery approach and trauma-informed care and practice (set out in 1.6 of this Overview) should inform future strategies to reduce and eliminate seclusion and restraint. A person-centred approach is central to these principles.

In the disability services sector, there already exists a National Framework for Reducing and Eliminating the Use of Restrictive Practices. This Framework provides an example of high level guiding principles that could be adapted for other settings that are relevant to people with mental health issues.

As a response to the key findings of this research project, the following sections outline a number of options for reform.

3.2 Uniformity in Regulatory Frameworks Across Australia

To ensure uniformity in definitions of seclusion and restraint and the regulation of these practices, model legislation and guidelines could be drafted for adoption by each state and territory.

Model legislation could:

- define seclusion and all forms of restraint, as well as emergency sedation or rapid tranquillisation used to manage behaviour and/or to facilitate transport to health services
- provide clear limits to the use of these practices
- clarify that seclusion and restraint must be a last resort and in what exceptional circumstances they may be applied as a matter of last resort
- require that seclusion and restraint must end as soon as the intervention is no longer needed
- require continuous or regular intermittent monitoring to assess whether the seclusion or restraint should be continued
- impose specific time limits and timeframes for assessment
- require recording and reporting
- provide penalties for breaching legislation and mechanisms to enforce them

- clarify liability issues
- establish effective complaints procedures

There is a multitude of policies, standards, guidelines and procedures available at present aimed at managing or reducing the use of seclusion and restraint. This may lead to confusion as to which are relevant and/or legally binding.

Model national guidelines which supplement model legislation could assist in clarifying the current situation by providing comprehensive practical advice. For example, the Department of Health in the United Kingdom (2014) has produced a 'guidance framework' for how to reduce seclusion and restraint:

<https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions>

Guidelines should clarify that the regulation of seclusion and restraint should not be interpreted as justifying their use and that continuous efforts have to be made towards their reduction and elimination.

In particular, guidelines could:

- set out key principles
- clarify the involvement of people with lived experience of mental health issues and carers, family members and support persons in policy development, care planning and training as well as during post-intervention debriefing processes
- clarify the employment of peer supporters or advocates in settings where seclusion and restraint frequently occur
- set out alternatives to using seclusion and restraint through outlining the use of prevention and de-escalation strategies
- clarify that only appropriately trained staff can use seclusion and restraint and only as a matter of last resort
- set out who needs to be notified during and after the use of seclusion and restraint
- set out requirements for continuous or regular intermittent observation and re-assessment by appropriately trained staff to ensure that interventions apply for the shortest time possible
- set out practical protocols for post-intervention debriefing and internal review processes
- set out uniform and practical protocols for incident recording and reporting

- clarify safety measures during instances of seclusion and restraint
- provide guidance on changes to the physical environment

The challenge for this option is to provide model laws and national guidelines acceptable for adoption by all states and territories.

3.3 Changes in Reporting and Oversight

While there have been a number of national initiatives to reduce seclusion and restraint and data concerning seclusion rates is now being collected and reported, it is difficult, if not impossible, to find data on rates of physical, mechanical and chemical restraint across Australia.

One option to ensure national oversight of the use of seclusion and restraint and the collection of data to inform practice would be to empower a national body to:

- gather and receive data on coercive practices
- provide reports on the use of coercive practices
- have powers of inspection and powers to impose warnings and fines
- co-ordinate training and education for workforce professional development
- facilitate and support research

The Dutch Health Care Inspectorate provides one example of a national body that monitors, inspects and collects data on the use of coercive practices in general, including the use of medication given without consent.

The benefit of following this Dutch model is that such a body could oversee the use of seclusion and restraint across mental health, aged care and disability sectors. It would, however, need significant resourcing in this regard.

A less resource intensive option may be to ensure an existing body such as the Australian Institute for Health and Welfare or the Safety and Quality Partnership Standing Committee, in partnership with the relevant state and territory authorities, gather and disseminate data on all coercive practices. This approach was adopted in securing the collection, analysis and public reporting of seclusion data in 2013.

In the disability sector, it is foreshadowed that a quality assurance and safeguards system will be implemented as part of the National Disability Insurance Scheme and that this will include responsibilities for oversight of and reporting on the use of restrictive practices by disability services. This system may have the potential to carry over to the mental health sector.

Another option would be to follow the example of the United States in having an accreditation model whereby facilities would lose accreditation or face financial

penalties if there are breaches of the law. This option may not be entirely feasible given the very different healthcare systems in the United States and Australia, although the Australian Commission on Safety and Quality in Health Care might potentially have a role in this regard.

The National Standards for Mental Health Services (Australian Department of Health, 2010, p. 9) include a criterion dealing with safety which sets out that mental health services should reduce and where possible eliminate the use of seclusion and restraint. It is noted that the NMHC is working with the Australian Commission on Safety and Quality in Health Care in relation to improving the uptake of these standards. Financial penalties for failing to take action to reduce and where possible eliminate the use of seclusion and restraint would at the very least provide a measure of accountability.

In order to measure success in the reduction and elimination of seclusion and restraint, it is also important that a national body facilitate standardised, effective reporting and data collection which allows for comparisons at local, state and national levels as well as intra-agency and inter-agency comparisons.

3.4 Filling the Gaps in the Literature

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 which may reduce the use of seclusion and restraint.

One option here would be to encourage governments and services to ensure that every time an intervention is used to reduce the use of seclusion and restraint, an independent evaluation must be built into the process and the results made publicly available.

The Australian Research Council, and/or the National Health and Medical Research Council, could also have a role in prioritising research into the strategies for the reduction and elimination of seclusion and restraint across the mental health, criminal justice/forensic, disability and aged care sectors, as well as supporting targeted and culturally sensitive research strategies on the topic.

A research program should involve people with lived experience of mental health issues and include specific projects on:

- how consumer leadership and involvement in initiatives may reduce seclusion and restraint
- how peer support roles may reduce seclusion and restraint

- how carers, family members and support persons' involvement may reduce seclusion and restraint
- the incidence of and effect of the concurrent use of different forms of seclusion and restraint
- whether alcohol or other drug use in conjunction with mental health issues may lead to people being secluded and restrained
- the physical impact of the environment
- the effect of specific models of care
- similarities and differences in the use of seclusion and restraint across the criminal justice/forensic, disability, aged care and mental health sectors
- specific strategies that may be needed to reduce the use of seclusion and restraint:
 - in rural and remote areas
 - in community, custodial and ambulatory settings
 - taking into account the specific needs of Indigenous peoples and culturally and linguistically diverse groups
- strategies suggested from literature in languages other than English
- the effect of multi-intervention strategies including those outlined in the next section

3.5 Adoption of Multi-Intervention Strategies

The research literature indicates that certain multi-intervention strategies are effective, while single intervention strategies are not. However, multi-intervention strategies have predominantly been implemented in inpatient settings and there remains a need to explore whether such strategies can carry across to custodial and community settings. Participants in the project emphasised that priority should be given to the following specific strategies discussed below.

3.5.1 Improving Organisational Culture

From the qualitative analysis of the survey results and from the focus group discussions, it appears that there was a strong perception that because of a lack of resources and shortage of staff, there was far too limited opportunity for consumers to be able to talk with practitioners about how they were feeling and to receive a compassionate response. There was a perception by focus group participants that good communication helped prevent conflict and that emphasis should be placed on conflict preventive measures and de-escalation techniques.

As the research literature indicates, senior personnel have an important role to play in setting new practice expectations, changing organisational policies and enabling internal data collection and reporting. This may be complemented by ‘top-down’ and ‘bottom-up’ leadership, an element that was seen as a priority by participants in the project.

Training in a recovery-oriented and trauma-informed model of mental health care may assist in improving organisational culture and ensuring a person-centred approach. It is important that training be ongoing and not simply about risk management. The Safewards model (Bowers et al., 2014) being trialled in Victoria may also provide a basis for changing ward culture by reducing conflict in inpatient settings.

As this appears to be a systemic workplace issue, more resources to ensure the recruitment of enough properly trained staff who are able to respond appropriately to people in crisis appears to be essential.

3.5.2 Changes to the Environment

One of the key findings from the research project was that many current environments do little to encourage feelings of security and safety. Physical changes to the environment may be some of the easiest changes to implement.

Some options for changes to the environment may be relatively minor in nature such as:

- painting walls with warm colours
- using comfortable furniture
- using decorative throw rugs and plants
- allowing more natural light in

Other changes could include:

- the use of sensory modulation rooms and sensory modulation tools
- more space being made available in wards
- unlocking main ward doors
- removing seclusion rooms
- providing quiet spaces, particularly in emergency departments, for use by persons in crisis or distress

As with most interventions, there is a lack of research evaluation on environmental change, but Borckhardt and colleagues (2011, pp. 481-482) suggest that an *‘inviting, calm unit environment may help set the tone for patients’ and staff members’ behavior on psychiatric hospital units’*. The Safewards model (Bowers et al., 2014) also emphasises the importance of wards being as welcoming as possible.

3.5.3 Workforce Development

Participants in the project pointed to a lack of staff and a lack of time as barriers to the reduction of seclusion and restraint. It appears that any reduction in the use of seclusion and restraint requires a commitment to workforce development so that there is a high ratio of staff to consumers as well as education, supervision and accountability of both staff and management.

Ongoing staff education that involves consumers is one option that needs further attention. Foxlewin (2012) highlights how consumers were involved in the design, development and delivery of Early Support and Intervention Team training at the Canberra Hospital. This provides a starting point in this regard.

Recovery and trauma-informed care are guiding policy in the mental health sector with the aim of providing person-centred care and safe environments. Creating cultural change in practice using these approaches should be a priority.

3.5.4 Leadership

The research literature emphasises the importance of leadership both at a national and local level in reducing seclusion and restraint. 'Top-down' and 'bottom-up' leadership was seen as a priority by participants in the project.

O'Hagan and colleagues (2008, pp. 6-7) point out that the style of leadership must:

- *'champion reduction and make it a clear priority*
- *include all major stakeholders in the process: staff, service users, families and advocates*
- *keep up constant dialogue with staff and other stakeholders*
- *entice staff with reasons reduction will benefit them, such as a more pleasant work environment and evidence of increased safety*
- *create a supportive, respectful, non-coercive milieu for staff that models the milieu they need to create for service users*
- *use language that models recovery values*
- *rewards and celebrate successes in reduction with staff'*

3.5.5 Consumers' Involvement

There was a clear theme that consumers needed to be involved in policy development and training as well as in relation to incident evaluation. Peer support should be readily available on psychiatric wards.

While the focus groups emphasised the need for peer support and advocacy, there is a dearth of literature as to the importance of consumer leadership as a factor in reducing and eliminating seclusion and restraint.

As mentioned above, the Canberra Hospital seclusion reduction intervention project (Foxlewin, 2012) provides one example of a consumer-led strategy which has helped lead to a reduction in the use of seclusion. It also 'paved the way for lasting consumer advocacy, support and other roles regarded as expert contribution by others' (Foxlewin, 2012, p. 69). This project could serve as a model for adoption in other places. However, there is a need for further strategies and evaluation in this regard.

The inclusion of consumer expertise is an under-utilised element in projects to date using the six core strategies. This represents an important opportunity, particularly because consumers and carers have expressed throughout this research project a clear and powerful commitment to change. Opportunities for consumer leadership in research, policy development and staff training should be developed. Consumer expertise provides compelling content to training, organisational goal setting and event reviews as well as to associated problem solving.

There was also a perception that consumers have no effective avenues to challenge current practice or make complaints that result in change or compensation. The Victorian Mental Health Complaints Commissioner established under the *Mental Health Act 2014* (Vic) may serve as a model for complaints processes in this regard.

3.5.6 Carers, Family Members and Support Persons' Involvement

The focus groups raised the issue of a lack of communication with carers, family members and support persons in general, as well as in relation to the use of seclusion and restraint. There was a perception that carers, family members and support persons were not consistently listened to or actively engaged and that such involvement could help avoid stressful situations that led to the use of seclusion and restraint.

To date, perhaps because of perceived privacy issues and a lack of staff skills as to family involvement, the potential for involving carers, family members and support persons in assisting to reduce the use of seclusion and restraint has gone untapped.

One option here is to ensure that carers, family members and support persons have access to the consumer and be included in every phase of reduction initiatives and throughout any crisis prevention planning process and, in parallel, to develop staff skills in family inclusion. There is also the possibility of including carers, family members and support persons in the development of 'exit plans' for individuals being treated in inpatient settings.

4. CONCLUSION

During the fourteen-month project, the research team was struck by the difference between the passion and emotions expressed on the topic by those with lived experience of mental health issues, carers, families and support persons when compared to the more muted view expressed in the literature on seclusion and restraint. Despite the focus of the project on finding evidence of best practice in reducing and eliminating seclusion and restraint, members of the team were contacted by many people wanting to tell the researchers about their experiences.

While it needs to be acknowledged that this research project found differences in opinions about whether or not seclusion and restraint can be eliminated, **there is strong agreement that the use of seclusion and restraint is not therapeutic, breaches human rights, compromises the therapeutic relationship/trust and that it can be reduced.** In the case of emotional restraint, there was consensus that it both could and should be eliminated from current practice.

There is also a need for human rights and the principles embedded in recovery and trauma-informed care and practice to inform future strategies to reduce and eliminate seclusion and restraint. A person-centred approach is central to these principles.

As set out above, participants in the research project have suggested a number of strategies as to how best to reduce the use of seclusion and restraint and the literature points to multi-intervention strategies as the best way forward.

The focus should now be on providing uniformity in the regulatory framework, changing reporting and oversight mechanisms, filling the gaps in the literature as well as introducing or continuing multi-intervention strategies and evaluating the outcomes.

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