SECLUSION AND RESTRAINT PROJECT

Report

August 2014

PREPARED FOR THE

NATIONAL MENTAL HEALTH COMMISSION

University of Melbourne Research Team

Professor Bernadette McSherry: Foundation Director, Melbourne Social Equity Institute and Adjunct Professor, Melbourne Law School, the University of Melbourne

Associate Professor Janet Clinton: Director of the Centre for Program Evaluation, Melbourne Graduate School of Education, the University of Melbourne

Associate Professor Carol Harvey: Director, Psychosocial Research Centre, Department of Psychiatry, the University of Melbourne; Consultant Psychiatrist, North West Area Mental Health Service and Director, Board of Governance, Prahran Mission

Associate Professor Stuart Kinner: Principal Research Fellow, Justice Health, Centre for Health Policy, Melbourne School of Population and Global Health, the University of Melbourne

Dr Bridget Hamilton: Senior Lecturer, Department of Nursing, School of Health Sciences, the University of Melbourne and Clinical Nurse Consultant, St Vincent's Mental Health

Dr Lisa Brophy: Senior Research Fellow, Centre for Health Policy, Melbourne School of Population and Global Health, the University of Melbourne and Director of Research, Mind Australia

Ms Cath Roper: Consumer Academic, Centre for Psychiatric Nursing, the University of Melbourne

Dr Annegret Kaempf: Post-doctoral Research Fellow, Melbourne Social Equity Institute, the University of Melbourne

Dr Piers Gooding: Research Associate, Melbourne Social Equity Institute, the University of Melbourne

Ms Hadeel Al-Nawab: Research Assistant, Centre for Program Evaluation, Melbourne Graduate School of Education, the University of Melbourne

Ms Kay Wilson: Research Assistant, Melbourne Social Equity Institute and PhD candidate, Melbourne Law School, the University of Melbourne

Mr Juan Jose Tellez: Research Assistant, Melbourne Social Equity Institute, the University of Melbourne

Acknowledgements

Suggested Citation

Melbourne Social Equity Institute (2014) *Seclusion and Restraint Project: Report*, Melbourne: University of Melbourne

Contents

1. INTRODUCTION

1.1 Purpose

In 2012, one of ten key recommendations made by the National Mental Health Commission (NMHC) (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.

Under a contract dated 26 June 2013, the NMHC commissioned the University of Melbourne 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.'

The NMHC also asked for information to be obtained from 'beyond the health and hospital system and facilities (such as inpatient units and emergency departments) to include the use of seclusion and restraint in community, custodial and ambulatory settings (such as remand facilities and patient transport services) and by first responders (such as police)'.

1.2   Outline of Research Project

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; and

- took the findings of the research to the Core Reference Group and the two project Advisory Groups for discussion and advice in developing this report.

1.3   Structure of this Report

An **Overview** of the key findings and options for reform has been prepared as a separate document and provided to the NMHC.

This chapter provides a background to the current use of seclusion and restraint in Australia and outlines some of the developments that have taken place in recent years to reduce their use.

It examines why there is impetus for change and outlines the approach taken by the research team to gather information about 'best practice' in reducing and eliminating seclusion and restraint.

Chapter Two outlines the regulatory framework for the use of seclusion and restraint.

Chapter Three reviews the current national and international literature on these practices.

Chapter Four sets out the results of the online survey.

Chapter Five sets out the results of the focus group discussions.

Chapter Six provides a discussion of the ways in which seclusion and restraint can best be reduced and eliminated as well as the key areas of concern, contention and debate.

Chapter Seven sets out some options for reform and **Chapter Eight** makes some concluding observations.

1.4   Background

1.4.1   *Defining 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. Restraint is also used on individuals with mental health issues in prisons, remand centres, emergency departments and by police and emergency transport providers.

Seclusion is generally defined in mental health legislation. For example, section 3 of the *Mental Health Act 2013* (Tas) defines seclusion as 'the deliberate confinement of [a person], alone, in a room or area that [the person] cannot freely exit'.

The Terms of Reference for this Report refer to restraint as 'when someone's movements are restricted by the use of straps or belts … or sedation'. However, in the literature and in mental health legislation, restraint is referred to in different ways. Section 3 of the Tasmanian *Mental Health Act 2013* for example, 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'; and

- mechanical restraint: '**a device** that controls a person's freedom of movement'.

A position statement by the National Mental Health Consumer and Carer Forum also refers to:

- 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).

To further complicate matters, material such as the Australian Capital Territory Health Directorate's guidelines on *Restraint of Patients* (2011a, p. 1) use the term 'environmental' restraint instead of 'seclusion' to refer to 'a safe space in a single room to ensure other people's safety while de-escalation can occur'. Environmental restraint has also been used to refer to a person's normal access to a particular environment being restricted, with seclusion being seen as a particular category of environmental restraint (O'Hagan, Divis and Long, 2008). As explored in Chapters Four and Five, participants in this research project also had attached different meanings to seclusion and restraint, particularly in relation to the purpose of these practices.

Throughout this Report, where relevant, restraint is referred to with an adjective in front of it in order to clarify as much as possible which form of restraint is being discussed. Chapter Two explores some of the definitional inconsistencies in the regulatory framework for these practices.

1.4.2 Attempts to Reduce the Use of Seclusion and Restraint in Australia

Serious concerns about the use of seclusion and restraint in mental health care have been raised at least since 1993 (Australian Human Rights and Equal Opportunities Commission, 1993). Academic literature has noted a number of adverse consequences for those subjected to seclusion and restraint (Frueh et al., 2005; Gerace et al., 2014) and raised concerns with human rights breaches (Kumble and McSherry, 2010).

In 2005, all Australian health ministers agreed to reduce the use of seclusion and restraint (National Mental Health Working Group, 2005). A national mental health seclusion and restraint project (known as the Beacon project) was established two years later and ran until 2009 (Australian Institute of Health and Welfare, 2012). The Beacon project targeted eleven key sites around Australia, all of which introduced strategies with the aim of reducing and, where possible, eliminating the use of seclusion and restraint in public mental health services. The project developed a set of key principles and guidelines for the use of seclusion and restraint by mental health services, but did not recommend any specific legislative changes (Kumble and McSherry, 2010). The literature resulting from this project is outlined in Chapter Three.

Many mental health practitioners, consumers and carers have also embraced the aim to reduce and, where possible, eliminate seclusion and restraint. For example, in 2010, the Royal Australian and New Zealand College of Psychiatrists released a position statement on the prevalence of seclusion and restraint of people with a mental illness (2010). The position statement states:

> Seclusion and restraint are generally used in the hope of preventing injury, and reducing agitation, but qualitative studies have reported substantial

deleterious physical, and, more often, psychological effects on both patients and staff (p. 2).

It concludes:

The RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way which supports good clinical practice and provides safe and improved care for consumers (p. 3).

The National Mental Health Consumer and Carer Forum recognises:

There may be specific circumstances where involuntary seclusion and restraint are required for the safety of the individual and other people. Involuntary seclusion and restraint should only ever be used as a last resort emergency safety measure and in those instances carried out in a respectful way, with checks and balances, by appropriately trained staff (p. 7).

As explored in Chapter Two, the regulatory frameworks for seclusion and restraint have undergone substantial reforms in recent years. These reform measures include:

- developing knowledge and skills on how to reduce coercion and the use of seclusion and restraint and implementing recovery-oriented mental health practice;

- limiting the permissible duration of seclusion and restraint, providing internal and external oversight of their use and requiring continuous or regular observation and medical examination; and

- improving the standard of care, organisational change and consumer involvement in care planning and advance directives.

Certain state and territory governments have also worked on strategies to reduce the use of seclusion and restraint. For example, in 2006, the Victorian Quality Council, the Chief Psychiatrist and the Quality Assurance Committee developed a project entitled *Creating Safety: Addressing Restraint and Seclusion Practices* which aimed to reduce the use of seclusion and restraint in six adult acute inpatient services in Victoria. It culminated in a report that indicated 'the most critical success factor in reducing the use of seclusion and restraint is the commitment of executive-level leadership to this aim' (Victorian Department of Health, 2009, p. 5).

The Victorian Department of Health has since established a *Reducing Restrictive Interventions* project (Mental Health and Drug and Alcohol Office, 2013b) and the South Australian Government has been working on a number of relevant policies under the title of *Pathways to Care* (South Australia Health, 2014a, b).

Many of these endeavours reflect the strategies set out in a 2005 document entitled *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* which was released by the National Technical Assistance Center in the United States (2005).

These strategies are:

1. 'Leadership towards organisational change'— articulating a philosophy of care that embraces seclusion and restraint reduction;

2. 'Using data to inform practice' — using data in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use;

3. 'Workforce' — developing procedures, practices and training that are based on knowledge and principles of mental health recovery;

4. 'Use of seclusion and restraint reduction tools' — using assessments and resources to individualise aggression prevention;

5. 'Consumer roles in inpatient settings' — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and

6. 'Debriefing techniques' — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience.

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/

Table 1 indicates 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).

Table 1: Seclusion Rates in Acute Mental Health Services in Public Hospitals
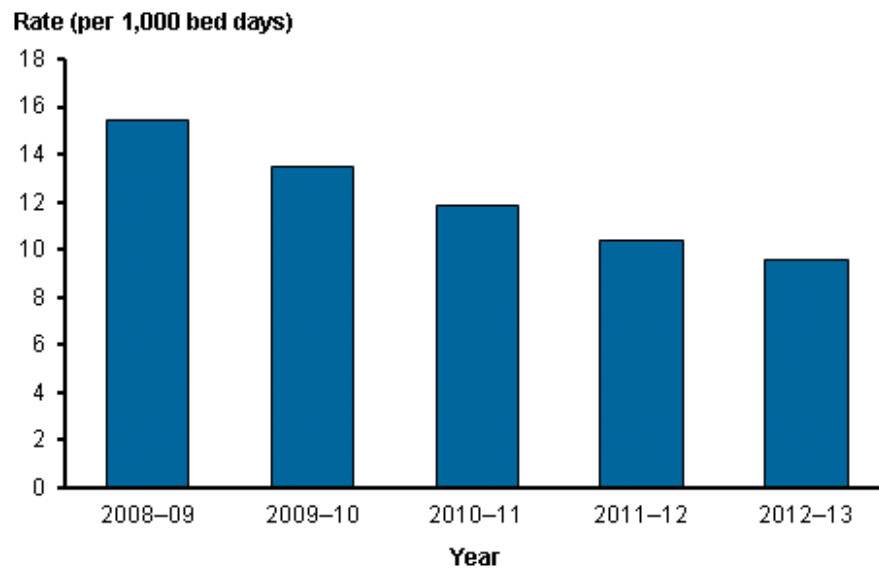
Source: (Australian Institute of Health and Welfare, 2014, p. 12)

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 and between jurisdictions with a high of 25.7 events per 1,000 bed days in the Northern Territory to 0.7 in the Australian Capital Territory. There are also varying rates amongst population groups with a rate of 20.9 events per 1,000 bed days in child and adolescent units in comparison to 1.6 events per 1,000 bed days for older persons.

Whether or not rates of restraint are being reduced is difficult to ascertain because of differences in definitions and no uniform requirements for reporting (Holmes, Walton and Muir-Cochrane, 2002). In the United States, there is evidence that the states with the highest use of physical and mechanical restraint are Minnesota, Washington, South Dakota, Tennessee and New Hampshire, but that rates vary markedly between facilities, with some reporting a very high use of restraint while some reported no use of restraints at all (Chedekel, 2014).

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.

While it may be difficult in Australia to obtain accurate data concerning the rates of seclusion and restraint, it is nevertheless clear that there have been attempts by governments and mental health organisations towards implementing multi-level strategies to reduce the use of seclusion and all forms of restraint.

1.5 Drivers for Change in Mental Health Treatment and Care

1.5.1 The Recovery Approach, Trauma-Informed Care and Practice and the Awareness of Adverse Effects of Seclusion and Restraint

Mental health policy in Australia, as in many other countries, is increasingly influenced by the tenets of the 'recovery approach' (Skuse, 2012).

In 2008, the National Mental Health Policy set out that mental health services should adopt a recovery-oriented approach (Australian Health Ministers, 2009b). The Fourth National Mental Health Plan for the years 2009-2014 places social inclusion and recovery on top of the agenda for collaborative government action (Australian Health Ministers, 2009a, p. iv) and sets specific targets for service improvement. The National Standards for Mental Health Services 2009 (Australian Department of Health, 2010) and the National Framework for Recovery-Oriented Mental Health Services 2013 further guide mental health practitioners and services as to how to translate the recovery approach into practice (Australian Health Ministers' Advisory Council, 2013a).

At the heart of the new framework for recovery-oriented mental health services lies the recognition that consumers' self-determination is a vital part of successful treatment and recovery and that continued efforts to reduce coercion, seclusion and restraint maximise consumers' self-determination (Australian Health Ministers' Advisory Council, 2013b, p. 4).

The literature on recovery describes this approach as 'a set of ideas and principles derived from the experiences of people with mental health problems' (Boardman and Shepherd, 2012, p.6).

There are five key themes in the literature on recovery (Leamy et al., 2011):

- connectedness;
- hope and optimism about the future;
- rebuilding or redefining a positive identity;
- pursuing a meaningful life; and
- empowerment through personal responsibility.

In addition to the impact of recovery, there is a developing emphasis on trauma-informed care and practice (Mental Health Coordinating Council, 2013). 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; and
- recovery is possible.

There are now efforts to incorporate these principles in practice. For example, the Missenden Unit at the Royal Prince Alfred Hospital in Inner Sydney is currently implementing this model of trauma-informed care (Mental Health Coordinating Council, 2013, p. 51). Personal communications with senior practitioners at the Missenden Unit confirm that seclusion rates have fallen and that data is now being collected concerning the use of various forms of restraint. However, it is unclear whether it is trauma-informed care that has caused a reduction in seclusion rates or whether this downward trend is a result of multiple interventions including requirements for constant one-to-one nursing observation for the first hour of seclusion, customised de-escalation training for all nursing staff and the employment of a project officer who focused on reducing seclusion and restraint across the district.

Negative consequences of the use of seclusion and restraint have been identified in several studies. These include:

- detrimental effects on the therapeutic relationships in health care settings (Larue et al., 2013; Steinert et al., 2013);

- perceived pressure and procedural injustice by individuals with mental health problems when there is insufficient complaint or monitoring mechanisms (O'Donoghue et al., 2011);

- short and long-term psychological and physical harm of individuals with mental health problems and staff resulting from the use of restraint (Bonner et al., 2002;

Fisher, 1994; Frueh et al., 2005; Haw et al., 2011; Robins et al., 2005; Sailas and Fenton, 2000); and

- preventable injury or even death (Lazarus, 2001).

Those who have experienced such interventions have reported decreased self-esteem, fear of readmission and a sense of loss of credibility (Bonner et al., 2002; Hassan, 2012; Katsakou et al., 2012) and some of them perceive the use of seclusion or restraint as a form of punishment for bad behaviour (Larue et al., 2013; Mason, 1993). These factors may deter people from seeking health services on a voluntary basis and may be detrimental to a continuous course of treatment (Hassan, 2012).

Seclusion in acute units may also be related to an increase in the length of hospital stay which has negative cost implications (Legris, Walters and Browne, 1999; Tunde-Ayinmode and Little, 2004). A New Zealand study has found that the use of seclusion had a negative emotional impact on those who are secluded and those who carry out such interventions (El-Badri and Mellsop, 2008).

The adverse effects of seclusion and restraint identified in these studies are incompatible with recovery and trauma-informed care and practice.

1.5.2 *The Importance of Human Rights and International Human Rights Law*

In tandem with the recovery movement, an emphasis on human rights is 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.

In 1993, a National Inquiry into Human Rights and Mental Health found that there were serious human rights breaches and widespread discrimination against people with mental health problems (Australian Human Rights and Equal Opportunities Commission, 1993). Over a decade later, the Senate Select Committee on Mental Health's Final Report (2006) urged that the National Mental Health Strategy be reformed to:

> Guarantee the right of people with mental illness to access services in the least restrictive environment, to be actively engaged in determining their treatment and to be assisted in social reintegration … (p. 6).

At the international level, the United Nations has recognised the use of seclusion and restraint as a human rights violation. Australia has ratified the *United Nations Convention on the Rights of Persons with Disabilities* (the CRPD) which protects a person's freedom from torture and cruel, inhuman or degrading treatment or

punishment (Article 15) and emphasises that '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others' (Article 17). Article 1 states that 'persons with disabilities' includes 'those who have long-term … mental … impairments … which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. The CRPD adopts a broad understanding of the term 'impairment' not linked to diagnostic criteria and thus applies broadly to people with mental health issues.

The United Nations Committee on the Rights of Persons with Disabilities is concerned about restrictive practices such as chemical, mechanical and physical restraint and seclusion with respect to a person's freedom from torture and cruel, inhuman or degrading treatment or punishment (Committee on the Rights of Persons with Disabilities, 2013). This United Nations Committee has recommended that Australia 'take immediate steps to end such practices' (p. 36) and withdraw its interpretative declarations which state that Australia understands that the CRPD allows for some interventions if they are 'necessary, as a last resort and subject to safeguards' (p. 8). This emphasises governmental obligations to *eliminate* the use of seclusion and restraint on the basis of mental impairment.

Article 12 of the CRPD sets out the right to equal recognition before the law and refers to the right to 'enjoy legal capacity on an equal basis with others in all aspects of life'. This includes being able to make decisions and have them respected such as entering into contracts relating to employment, marriage, property, wills and the like as well as making decisions about medical treatment (McSherry, 2012).

Article 12 requires countries that have ratified the CRPD to 'provide access by persons with disabilities to the support they may require in exercising their legal capacity'. The Committee on the Rights of Persons with Disabilities (2014, p. 4) has referred to 'support' in a broad sense to include having trusted support persons assist those with disabilities in exercising their legal capacity for certain types of decisions, or using peer support and advocacy as well as engaging in advance planning such as through making 'advance directives'. The emphasis on supported decision-making is now finding its way into mental health service delivery.

The United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Méndez, 2013, p. 4) stated in 2013 that:

> Despite the significant strides made in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment and the authoritative guidance provided by the CRPD, severe abuses continue to be committed in health-care settings where choices by people with disabilities are often overridden based on their supposed 'best interests', and where serious violations and discrimination against persons with disabilities may be masked as 'good intentions' of health-care professionals.

The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint constitute torture and ill-treatment. In my 2012 report (A/66/88) I addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment.

There is therefore an added impetus to find ways of reducing and working to eliminate the use of restrictive practices in order to ensure compliance with international human rights law. 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.

1.5.3   Identifying Barriers to Reducing and Eliminating Seclusion and Restraint

Despite efforts to reduce seclusion and restraint, these practices persist, perhaps because they are perceived as a last resort to manage aggressive behaviour. For example, one study suggests that when confronted with aggression or violence, emergency department nurses may consider the use of seclusion appropriate and some fear legal liability for not intervening (van der Zwan et al., 2011).

An early study indicated that the use of seclusion and restraint may prevent injuries to individuals subjected to these interventions and reduce agitation (Fisher, 1994). A few studies have also indicated that people who have been secluded or restrained have retrospectively approved of the use of seclusion and restraint for their own safety and wellbeing (Haw et al., 2011; Katsakou and Priebe, 2006), particularly when there was follow-up engagement with the individual concerned (Larue et al., 2013). A small number have reported feelings of security in seclusion (El-Badri and Mellsop, 2008; Kontio et al., 2012).

There is a perception that efforts to reduce the use of seclusion and restraint may be associated with an increased risk of harm to other patients and staff (Khadivi et al., 2004). However, a recent Finnish study indicates that:

> Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behavior. A similar reduction may also be feasible under less extreme circumstances (Putkonen et al., 2013, p. 850).

Part of the impetus for this project is therefore to discover the barriers to reducing and eliminating the use of seclusion and restraint and to gain an idea of why some people perceive that these practices cannot be eliminated.

1.6   Project Methodology

Given the limitations associated with a fourteen month project, the research team used a 'convergent parallel' design instead of a sequential mixed methods approach. This involved document analysis, an online survey, informal consultations with stakeholders and ten focus groups, all of which aimed to identify the ways in which seclusion and restraint have been reduced or eliminated and any barriers to this. A mixed methods approach occurs when the research team implements quantitative and qualitative strands of research concurrently and only mixes the results during the overall interpretation (Creswell and Clark, 2011).

In general, there are five distinct purposes for mixing research methods: triangulation, complementarity, development, initiation and expansion (Greene, 2007). Data triangulation refers to the use of different sources of information in order to increase the validity of the findings (Klassen et al., 2012) and was used for this project. It is ideal for using different methods in order to measure the same phenomenon, in this case the reduction of seclusion and restraint practices in Australia (Greene, 2007).

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.

The project proceeded in three stages as depicted in Figure 1.1.

Figure 1.1: Project Framework

(Adapted from the Centers for Disease Control and Prevention (1999) Framework for Program Evaluation)
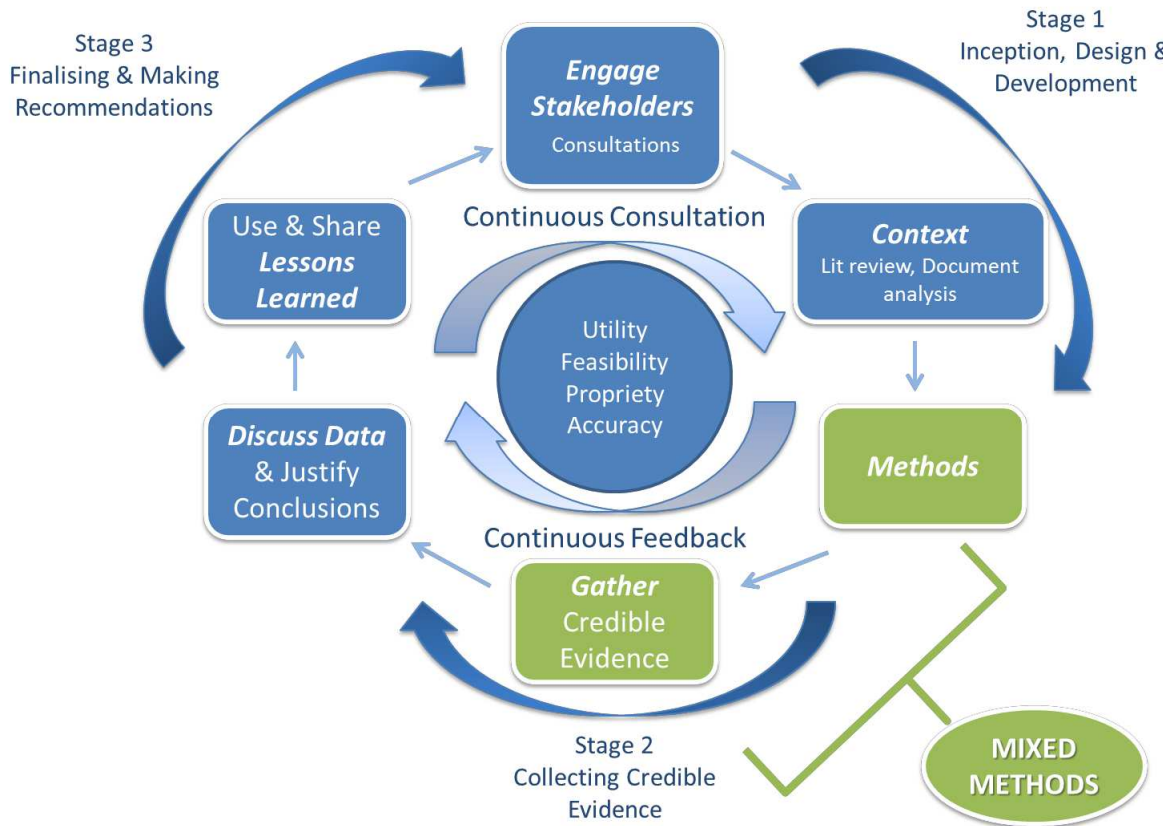
1.6.1 Online Survey

An anonymous online survey targeted key personnel in primary health care, hospitals, custodial and ambulatory settings, as well as individuals with lived experience, their carers, family members and support persons. The survey was designed to identify and assess options to reduce seclusion and restraint and their feasibility. Participants were asked to indicate in a check box at the beginning of the survey if they have experienced the use of seclusion and/or restraint while living or working in Australia. The survey adopted a mixed-methods design, including both quantitative multiple choice and qualitative open-ended questions. All questions were written in plain language to minimise the risk of excluding potential participants for reasons of literacy or comprehension.

The survey asked participants questions on demographics, the use of seclusion and restraint in practice and their views on strategies for reducing these practices. Studies indicate that people who have been diagnosed with a mental illness can be presumed to be capable of giving informed consent to research (Gupta and Kharawala, 2012; Roberts, 2002), in particular when they are not experiencing acute symptoms and when adequate plain language information is provided.

The survey was promoted via email distribution lists, discussion forums, appropriate websites, the media, individual networks, relevant newsletters and stakeholders identified through the project. It was advertised via the Melbourne Social Equity Institute's website and the website of the NMHC. Networks circulated information about the survey and smaller subgroups were deliberately targeted to optimise our strategy of recruiting participants. The aim was to recruit as many survey participants as possible, with a minimum of 500 responses. People over 18 years of age who were interested in commenting on seclusion and restraint were invited to complete the survey. The survey was also open to the general public because a wide range of people in the general public have experience with mental health service provision and may have experiences with the use of seclusion and restraint. Stratified sampling was not used because the survey did not aim to analyse the opinions of these target subgroups *specifically.* Rather, while the survey was designed to be open to various subgroups, the survey questions were designed to allow for analysing thematic responses.

1.6.2 Focus Groups

Focus group participants were recruited via an invitation to participate through contacts in each State with a maximum of ten participants for each focus group. In each location, one of the focus groups consisted of carers, family members and support persons who have experienced a family member or person close to them being secluded or restrained. The other focus group consisted of adults with lived experience of mental health service provision that has included seclusion and/or restraint. The researchers attempted to have focus groups that included a mixture of age, gender, cultural background (although all participants were required to be able to participate in the focus groups in English).

The questions posed to the focus groups were designed to be consistent across the groups. 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; and

- their ideas and recommendations regarding strategies to reduce and eliminate seclusion and restraint.

The sessions were audio-taped, transcribed and analysed using the NVivo qualitative data analysis software.

1.6.3 Overview of Advisory Groups and Contacts with Stakeholders

Two advisory groups were established to guide the researchers in developing their methodology and to direct them to appropriate resources. The People with Lived

Experience Advisory Group consisted of six members (one from each state) and met three times, the first and last were face-to-face and the second was via teleconference. The Carers, Family Members and Support Persons Advisory Group consisted of six members from NSW, QLD, SA, VIC and WA and met three times, the first and last meetings were face-to-face and the second was via teleconference.

In order to ensure a comprehensive review of the literature, 33 stakeholders identified via the NMHC and the project team's research networks were contacted by telephone or email on an informal basis. These stakeholders were asked to direct the project team to any information available about definitions of seclusion and restraint and their rates of use, as well as whether there was any information available about measuring changes in practice and barriers to changing current practice. These informal contacts enabled the project team to gain access to guidelines, unpublished reports and conference presentations.

1.6.4   Themes from the Data

Once all the data were collected, the project team met to discuss the main themes and to see if factors leading to best practice could be identified. Chapter Six sets out the themes that emerged from the data. Limitations of the project's methodology and suggestions for further research are taken up in Chapters Six and Seven.

The next Chapter provides an overview of the regulatory framework for seclusion and restraint.

2.2.5   Two Approaches: Restrictions on Use and Alternatives

The regulatory framework for the use of seclusion and restraint can be divided into two separate (but related) approaches. Provisions may:

- **restrict** the circumstances in which seclusion and restraint can be used and **provide safeguards** around that use; and/or

- **provide alternatives** to seclusion and restraint so that the latter are seen as very much a last resort; and

- having provisions that provide alternatives tends to be the approach of newer legislation and policies.

These two approaches are closely related because restrictions on the use of seclusion and restraint may lead to the provision of alternatives. This is especially the case where restrictions are resource intensive and create disincentives for staff to use them for reasons other than safety (such as staff convenience, or to compensate for staff shortages).

For example, the Centers for Medicare and Medicaid Services in the United States initially required that a person must be medically examined by a doctor within the first hour of seclusion and restraint. When this requirement was relaxed to allow the examination in the first hour to be conducted by non-medical practitioners, the change was criticised by consumer advocates as making the use of seclusion and restraint 'more convenient for hospitals' (Anonymous, 2007, p. 1).

This chapter is concerned primarily with the regulatory framework with regard to restrictions on the use of seclusion and restraint. The next chapter which deals with the literature on seclusion and restraint looks further at some of the measures that have been introduced to provide alternatives to the use of these practices.

2. THE REGULATORY FRAMEWORK FOR SECLUSION AND RESTRAINT

2.1 Introduction

This chapter analyses a range of Australian and international laws, policies and procedures in order to identify the best regulatory framework for the reduction or elimination of seclusion and restraint.

While no jurisdiction has completely banned the use of seclusion and restraint, attempts have been made to restrict their use and to find effective and less restrictive alternatives. This chapter outlines the regulatory frameworks in all Australian states and territories and draws on examples of recent regulatory reforms in the United Kingdom, Ireland, the Netherlands, Germany, New Zealand and the United States.

There are numerous policy documents, guidelines, standards and procedures available which aim to reduce or manage the use of seclusion and 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. This chapter therefore focuses on governing laws and policies that apply on a national or state and territory-wide basis. Links to some of the main policy documents are set out in **Appendix One.**

Overall, there is wide international acceptance that seclusion and restraint:

- are not generally regarded as therapeutic interventions;

- should not be used as a punishment or threat;

- should not be used for staff convenience or discipline; and

- should not be used to compensate for staff shortages and resource constraints.

Statements to this effect are contained in almost every regulatory framework examined.

The regulatory framework for the use of seclusion and restraint tends to be most well-developed in the mental health sector although seclusion and restraint are used in a range of contexts, including in:

- **the disability sector** (see, for example, the Disability Act 2006 (Vic) and the Disability Services (Restrictive Practices) and Other Legislation Amendment Act 2014 (Qld));

- **child protection** (see for example the Children and Young Persons (Care and Protection) Act 1998 (NSW));

- **corrections** (see for example clauses 13-16 of the *Corrections Regulations 2009* (Vic)); and

- **aged-care** (the *Aged Care Act 1997* (Cth) while not specifically containing provisions dealing with seclusion and restraint, sets out accreditation and service standards related to the health, welfare and lifestyle of service users).

In comparison, the regulatory framework in the disability sector is less developed:

> Whilst some jurisdictions have legislation or policy that regulate the use of restrictive practices, minimum requirements in relation to restrictive practices, including reviews and monitoring are not explicitly identified in every State and Territory. (Australian Department of Social Services, 2014, p. 1)

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 (the 'National Framework'). The National Framework contains a number of high level principles and core strategies (based on the six core strategies set out in 1.4.2 of this Report). The Commonwealth, State and Territory Disability Ministers endorsed the National Framework at a Disability Reform Council meeting on 21 March 2014. The National Framework will also operate as an 'interim step' in the development of a quality assurance and safeguards framework by the National Disability Insurance Scheme. A national voluntary reporting system will be developed by 2018.

While the National Framework only applies to institutional and community care sectors:

> Future opportunities may arise through the evaluation of the National Framework, for expansion of these six core strategies to be integrated into other mainstream service sectors that support people with disability such as health, education and criminal justice. (Australian Department of Social Services, 2014, p. 13).

2.2 Overview of the Regulatory Framework for Seclusion and Restraint

Each jurisdiction has a different mix of legislation, policies, procedures and guidelines regulating seclusion and restraint. This mix tends to differ between countries and can be broadly referred to as:

- the Legislative Model;

- the Policy Model; and

- the Accreditation Model.

- **Appendix One** summarises the regulatory framework for Australian states and territories, New Zealand, England, Wales, Scotland, Ireland and the United States.

2.2.1 The Legislative Model

In general, in the Legislative Model, seclusion and restraint are regulated primarily by the various Mental Health Acts, although there is also some legislation regulating the use of seclusion and restraint in the wider contexts of disability, child protection and corrections. This model is primarily used in Australia, New Zealand and Ireland.

In most Australian states and territories, the regulation of seclusion and restraint is contained in legislation, with Queensland and Tasmania having the most comprehensive statutory regimes. Some states and territories, such as Victoria, the Australian Capital Territory and South Australia, supplement their legislation with policies, procedures and guidelines.

New Zealand has legislative authority for seclusion in its Mental Health Act supplemented by a policy and the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.

The Irish model has legislative authority for seclusion and restraint but empowers its Mental Health Commission to make binding rules (which it has done for Seclusion and Mechanical Restraint) and non-binding codes of practice (which it has done for Physical Restraint).

2.2.2 The Policy Model

New South Wales, England, Wales and Scotland tend to follow the Policy Model. In the Policy Model, seclusion and restraint are not governed by legislation. The power to seclude and restrain in the Policy Model resides in codes of practice, policies, procedures and guidelines, rather than legislation. A full list of policy, procedures and guidelines relating to seclusion and restraint can be found in **Appendix One.**

In England, Wales and Scotland, the power to seclude and restrain is based on the common law power of hospitals to manage patients and arises from the fact of detention under the relevant Mental Health Act itself (*Pountney v Griffiths* [1976] AC 314 (HL)). Policies relating to seclusion and restraint must comply with the *European Convention on Human Rights (Bartlett and Sandland, 2007)* and the use of seclusion and restraint on people detained outside of the Mental Health Act is regulated by the *Mental Capacity Act 2005* (England and Wales) which establishes deprivation of liberty safeguards.

2.2.3   The Accreditation Model

In the United States, the Accreditation Model is used to regulate seclusion and restraint through hospital accreditation standards. These are set by the Centers for Medicare and Medicaid for public health services and the Joint Commission, an independent body which accredits and certifies more than 20,000 health care organisations and programs across the United States.

Policies have been developed by various professional bodies including the:

- American Psychiatric Association;

- National Association of State Mental Health Program Directors (NASMHPD);

- Substance Abuse and Mental Health Services Administration (SAMHSA); and

- American Psychiatric Nurses Association.

- The NASMHPD and the SAMHSA have a number of documents relating to the reduction of seclusion and restraint on their websites (http://www.nasmhpd.org/index.aspx; http://www.samhsa.gov/) including training documents and guidelines (for example, National Association of State Mental Health Program Directors, 2006; Substance Abuse and Mental Health Services Administration, 2005).

There are also some state-based regulatory codes such as the Pennsylvania Code that include regulations concerning seclusion and restraint. One study indicates that the Pennsylvania Code has led to significant reductions in seclusion and restraint (Recupero et al., 2011).

2.2.4   The Scope of the Regulatory Framework

The focus of most regulatory frameworks in mental health is on the seclusion and restraint of those in inpatient units, although some frameworks apply more broadly to emergency departments and assessment centres. The use of seclusion and restraint is generally limited to involuntary patients, and where it is permitted on voluntary patients, an evaluation of their legal status is usually required soon after

the event (see for example, clauses 15.34-15.36 of the Code of Practice for the *Mental Health Act 1983* (England and Wales) (Department of Health (UK), 2008)).

There is, however, a clear international trend in expanding the scope of the regulation of seclusion and restraint beyond mental health in-patient care. For example, regulatory frameworks in England and Wales (National Health Service (NHS) Protect, 2013) and the United States (Centers for Medicare and Medicaid Services, 2008, 482.13(e)(1)(i)(A)) include all people exhibiting challenging behaviour in all health-settings.

Appendix One sets out the regulatory framework for seclusion and restraint in a number of jurisdictions.

Appendix Two sets out the scope of application and coverage of relevant Mental Health Acts.

2.3 Restrictions on the Use of Seclusion and Restraint

Some regulatory frameworks, especially in Australia, impose specific restrictions or prohibitions on the use of:

- medication for certain purposes (for example, sections 86 and 87 of the *Mental Health Act 2007* (NSW) prohibit the overuse of excessive or inappropriate drugs and sections 57(3) and 95(3) of the *Mental Health Act 2013* (Tas) and section 7(h) of the *Mental Health Act 2009* (SA) prohibit the use of medication as a punishment or for the convenience of others);

- certain devices for mechanical restraint such as:

  – hand-cuffs (Mental Health and Drug and Alcohol Office (NSW), 2012b, Appendix 2, p. 32);

  – cage beds and metal chains (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment, 2013, p. 59);

  – tape or clothing to tie a person to some part of a building or its fixtures: (Department of Health (UK), 2008, para 15.31);

  – the use of devices that have not been approved by the chief psychiatrist: *Mental Health Act 2013* (Tas), s 57(1)(d);

- the use of physical holds to deliberately inflict pain (Mental Health Commission of Ireland, 2009a, clause 605);

- seclusion and restraint on people from particular groups such as children, the elderly and Aborigines and Torres Strait Islanders (Mental Health and Drug and Alcohol Office (NSW), 2012b, Appendix 6).

While there are concerns about the risks associated with the use of prone (face-down) physical restraint, most jurisdictions have not banned it, but advise that it should be used with caution by people with appropriate training (see for example (Mental Health Commission of Ireland, 2009a, clause 6.7).

2.3.1   Forms of Seclusion and Restraint that are Regulated

Seclusion and mechanical restraint are subject to the most regulation both in Australia and internationally and these forms of intervention are generally regulated via legislation.

In comparison, in some jurisdictions, chemical and physical restraint are not defined or regulated. For example, physical restraint is not regulated in the Northern Territory and Western Australia and most jurisdictions do not refer to chemical restraint in their legislation (Tasmania has recently regulated this in its *Mental Health Act 2013*).

The definitions of seclusion, mechanical restraint and physical restraint differ slightly across jurisdictions, with particular discrepancies concerning whether or not 'time-out' constitutes seclusion and whether mechanical restraint also encompasses protective equipment, such as bed rails, clothes, deep chairs and chairs with trays.

The New Zealand Health and Disability Services (Restraint Minimisation and Safe Practices) Standards (New Zealand Standards Council, 2008, p. 6) point out that '[i]t is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention'.

It thus appears appropriate to define mechanical restraint in terms of the purpose and effect of the way in which the device is used rather than to list particular devices.

Chemical restraint is not regulated in many jurisdictions and where it is regulated, definitions may not be very clear. The New Zealand Health and Disability Services (Restraint Minimisation and Safe Practices) Standards (New Zealand Standards Council, 2008, p. 5), for example, prohibit the use of chemical restraint, but section 110A of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) permits sedation.

Tasmania is the only state to define chemical restraint in its mental health legislation. Section 3 of its *Mental Health Act 2013* states:

> **chemical restraint** means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition.

The New South Wales policy (Mental Health and Drug and Alcohol Office (NSW), 2012b, p. 5) states:

'Chemical restraint' is a term used to describe a pharmacological method used solely to restrict the movement or freedom of a consumer. Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW. Medication used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Emergency sedation or rapid tranquillisation that is used to manage disturbed behaviour resulting from a mental disorder or mental illness is not considered chemical restraint in NSW. Sedative medication can be appropriately used for management of disturbed behaviour. It is important that this practice is safely managed by adherence to evidence based guidelines.

The distinction between what is 'chemical restraint' and what is 'emergency sedation' or 'rapid tranquillisation' from this explanation seems to depend upon the intention of the clinician.

The difficulty in defining chemical restraint lies in the fact that the use of medication to reduce arousal and agitation is often considered an acceptable alternative to seclusion and restraint, rather than a form of restraint in itself. The National Institute for Clinical Evidence (NICE) Guidelines for England and Wales (2005) provides the following definition of 'rapid tranquilisation' which is not regarded as 'chemical restraint':

Rapid tranquillisation (also called urgent sedation): the use of medication to calm/lightly sedate the service user and reduce the risk to self and/or others. The aim is to achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place, whilst allowing comprehension and response to spoken messages throughout (p. 10).

'Emotional restraint' which was identified by the National Mental Health Consumer and Carer Forum as being of concern (see Chapter One) has received scant regulatory attention. The Mental Welfare Commission for Scotland (2013b, p. 7) has also raised concerns that ''softer' methods of limiting freedom such as verbal control, psychological pressure or social exclusion can have just as restraining an effect on a person's behaviour as direct physical intervention'.

One regulating code that does cover this area is the Pennsylvania Code (Legislative Reference Bureau (US), 1996). Section 13.9 of this Code regulates 'psychological restraints' which are defined as including 'those therapeutic regimes or programs which involve the withholding of privileges and participation in activities'. Psychological restraints are seen in this Code as part of a continuum in relation to methods used to control behaviour. Section 13.9(c) states that psychological restraints should only be used when they 'are therapeutically based, clinically justified and made part of the treatment plan'.

Given that the general direction of reform in the mental health field is on improving understanding, communication and therapeutic relationships, concerns about emotional restraint may already be indirectly addressed. However, if emotional restraint is to be acknowledged in the regulatory framework, the Pennsylvania Code serves as an example in this regard.

2.3.2   Criteria Limiting when Seclusion and Restraint Can be Used

While there is variation in the circumstances when seclusion and restraint can be used in the mental health sector, most jurisdictions restrict their use as a safety measure where it is 'necessary and reasonable' to prevent harm to the person or to others.

In Australia, seclusion and restraint may also be used to:

*   prevent persistent property damage;

*   to facilitate treatment; and

*   to prevent absconding (sections 61(3), 62(3) of the *Mental Health and Related Services Act 1998* (NT)).

In England and Wales seclusion and restraint may be used where there is:

*   'dangerous, threatening or destructive behaviour' (para 15.8 of the Code of Practice); and

*   'extreme and prolonged over-activity that is likely to lead to physical exhaustion' (para 15.8 of the Code of Practice).

In New Zealand, seclusion and restraint may be used in response to:

*   'disturbance of behaviour as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgement' (New Zealand Standards Council, 2008, p. 6); and

*   'to reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness' (New Zealand Standards Council, 2008, p. 6).

In most jurisdictions, the use of seclusion and restraint is required to be the 'least restrictive alternative' (for example sections 9 and 162M of the *Mental Health Act 2000* (Qld)) and a genuine 'last resort' (for example, section 7(h) of the *Mental Health Act 2009* (SA)). However, these concepts are not usually defined.

More recent approaches to limiting the use of seclusion and restraint include:

- the need to consider, try and exclude all other alternatives (for example, section 105 of the *Mental Health Act 2014* (Vic)); and

- weighing the risks of restraint against the risks of not restraining or of using a different form of seclusion or restraint (Mental Welfare Commission for Scotland, 2007, p. 4).

There is some controversy over whether some forms of seclusion and restraint should be preferred to others. For example, the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment (2013, p. 60) warn that seclusion can cause considerable anxiety and disorientation and should not automatically be preferred over other forms of restraint, such as chemical or mechanical forms of restraint. Further, 'automatic resort to mechanical or chemical restraint is not called for in cases when a brief period of manual control combined with the use of psychological means of calming the person down would suffice' (2013, p. 59).

Conceptions of reasonableness and proportionality in the use of restrictive interventions feature in some regulatory frameworks. For example, in New South Wales (Mental Health and Drug and Alcohol Office (NSW), 2012b, p. 12) 'all actions undertaken by staff' must be ' justifiable and proportional to the consumer's behaviour' and for the 'minimum necessary time.'

In Scotland (Mental Welfare Commission for Scotland, 2007, p. 4) and in the disability context (for example, section 141(2)(b) of the *Disability Act 2006* (Vic)), the use of seclusion and restraint must have some benefit for the person, although exactly what that benefit might be is not adequately explained.

2.3.3 Authority to Seclude and Restrain

In most jurisdictions, the authority to seclude and restrain is limited to a medical practitioner, usually a psychiatrist. In circumstances (usually emergencies) where it is authorised by a senior nurse or other mental health practitioner, the decision to seclude or restrain must be confirmed by a doctor as soon as practicable (for example section 162L of the *Mental Health Act 2000* (Qld); section 111 of the *Mental Health Act 2014* (Vic)).

In Tasmania, the use of chemical or mechanical restraint must be approved by the Chief Civil Psychiatrist and physical restraint must be approved by the Chief Civil Psychiatrist, a medical practitioner or a registered mental health nurse (section 57(1)(b) of the *Mental Health Act 2013*). In the Australian Capital Territory, the Chief Psychiatrist 'may subject the person to…restraint that is necessary and reasonable' (section 35(2)(c) of the *Mental Health (Care and Treatment) Act 1994*). Restraint is defined in the Australian Capital Territory policy on restraint (Australian Capital Territory Health Directorate, 2011a, p. 4) as 'as any device, medication or action used

for the purpose or intent of restricting the free movement or decision-making abilities of another person'. The Standard Operating Procedure on restraint in the Australian Capital Territory also states that the 'decision to use restraint should be a collaborative decision involving the patient, medical staff, nursing staff and other relevant healthcare providers' (Australian Capital Territory Health Directorate, 2011c, p. 4).

The disability context differs from the mental health context in that the use of seclusion and restraint is often required to be incorporated as part of a behaviour management plan that must be reviewed by an external supervisor and can be reviewed by a tribunal (see for example, sections 140-141 of the *Disability Act 2006* (Vic)). Seclusion and restraint may be used outside that plan in an emergency, but those instances must be reported to an external supervisor (section 147 of the *Disability Act 2006* (Vic)).

One drawback to the pre-approval of the use of seclusion and restraint in a behaviour support plan is that this could be used to justify more episodes of seclusion and restraint than necessary. As noted in the European Committee for the Prevention of Torture (CPT) Standards (2013, p. 60):

> It is imperative that every single case of resort to means of restraint be authorised by a doctor or, at least, brought without delay to a doctor's attention in order to seek approval for the measure. In the CPT's experience, means of restraint tend to be applied more frequently when prior blanket consent is given by the doctor, instead of decisions being taken on a case by case (situation by situation) basis.

However, care planning and the use of advance directives in consultation with the individual concerned is part of most policy approaches to the reduction of seclusion and restraint in the mental health sector. The creation of a formal legal framework for their use may be beneficial in reducing the use of seclusion and restraint.

2.3.4 *Restrictions on the Duration of Seclusion and Mechanical Restraint*

Most jurisdictions aim to ensure that the duration of seclusion and mechanical restraint is for the shortest time possible. As indicated in 2.3.1, not all jurisdictions regulate physical, chemical or emotional restraint.

Common measures to limit seclusion and mechanical restraint in regulatory frameworks are:

- a requirement that seclusion and mechanical restraint be ended as soon as it is no longer needed;

- imposing specific time limits (usually ranging from 2 to 7 hours);

- requiring continuous or regular intermittent observations which are used as an opportunity to assess whether the seclusion and/or mechanical restraint should be continued;

- requiring medical examination within certain timeframes (usually ranging from 1 to 4 hours) which are used as an opportunity to assess whether the seclusion or mechanical restraint should be continued;

- requiring staff to formulate an 'exit plan', that is, a plan for when the seclusion or mechanical restraint should end as soon as the seclusion or mechanical restraint is commenced;

- use of continuous communication and de-escalation techniques;

- providing post-intervention debriefing for staff and the individual concerned to understand the triggers and underlying causes that culminated in the intervention and to provide the opportunity to discuss more acceptable ways for the 'issue' to be addressed rather than resorting to intervention;

- providing support to promote the return of the person to the ward and prevent future incidents; and

- internal and external review processes.

Most jurisdictions also have requirements for the notification of certain people such as:

- the chief psychiatrist;

- the inspectorate of mental health services (in Ireland);

- the public advocate; or

- the relevant mental health tribunal.

It is often unclear what the purpose of this notification is and whether there is any obligation on those parties to intervene or provide support or advice. However, external notification creates a certain amount of transparency and external oversight that would presumably alert these parties to anything unusual and it may facilitate regional and national review of the use of seclusion and restraint.

2.3.5 Recording and Reporting

Most jurisdictions contain a recording and reporting regime to document the use of seclusion and restraint in a central registry and on the individual's clinical file. The collection and use of data is a well-recognised regulatory strategy to help reduce the use of seclusion and restraint. The literature on this is considered in Chapter Three.

2.3.6 Treatment while in Seclusion or Subject to Restraint

There are regulations concerning how individuals should be treated while they are in seclusion or subject to mechanical restraint. These include ensuring that a person's basic physical needs are met (food, drink, access to toilet facilities, medical treatment).

Other requirements may include:

- a means to draw the attention of staff when necessary;

- adequate light and ventilation;

- physical aids;

- the recognition of special needs (cultural, spiritual and gender concerns);

- reassurance and social contact;

- appropriate staff training (especially in applying restraints);

- provision of information (including reasons for decision, feedback about how behaviour affects others, circumstances of release, what will happen during the intervention and legal status under the relevant Mental Health Act);

- being able to see a clock;

- an entitlement to personal items as long as they do not compromise safety; and

- access to emergency equipment, including defibrillators within 3 minutes.

Some jurisdictions have specific provisions to protect the privacy and dignity of persons in seclusion and restraint, especially in relation to retaining their own clothing, CCTV recording and respectful staff attitudes.

2.3.7 Vulnerable Persons

Some jurisdictions such as Victoria, Tasmania, New South Wales and Queensland, have special provisions in relation to the use of seclusion and restraint of people from certain vulnerable groups such as:

- children;
- the elderly;
- Aborigines and Torres Strait Islanders;
- people with other disabilities and medical conditions (including pregnancy);
- people who are at risk of self-harming;
- people who have experienced trauma;

- people from culturally and linguistically diverse (CALD) backgrounds; and
- people who are at risk of suicide.

For example:

- in Queensland 'the use of seclusion should be avoided for patients who represent a suicide risk or who, as a consequence of their cultural background or life experience, may be high risk for trauma, suicide or self-harm if placed in seclusion (for example, members of the Aboriginal and Torres Strait Islander communities, victims of torture and trauma)' (Mental Health, Alcohol and Other Drugs Branch, 2014, 13-8);

- in Victoria, seclusion should not be used for children under 12 years (with a clear separation between seclusion and time-out). Children and young people should be assessed by a trained child and adolescent clinician to determine other appropriate de-escalation strategies. Restraint should also be avoided for children and elderly people because of their developing skeletal musculature and frail bones. In the case of children 'special consideration should also be given to risks when neuroleptic medication is used to sedate a child or adolescent who has a developing central nervous system, especially when antipsychotic medication is given to children and adolescents who are not psychotic' (Office of the Chief Psychiatrist (Vic), 2011b, pp. 13-14);

- in New South Wales, children may be secluded and restrained with their parent's consent if it is to facilitate routine medical treatment, or as an involuntary psychiatric patient where they are exhibiting persistent behavioural problems (Mental Health and Drug and Alcohol Office (NSW), 2012b, p. 12);

- in Tasmania, the seclusion and restraint of a child requires approval from the Chief Civil Psychiatrist (sections 56(1)(b) and 57(1)(b) of the *Mental Health Act 2013*).

Many regulatory frameworks include provisions about training to ensure that staff understand and respect individual and cultural differences and use interpreters where necessary.

However, it is often unclear what should be used in place of seclusion and restraint for people from these vulnerable groups, or how seclusion and restraint should be modified for them. For example, the New South Wales policy provides no alternatives, while in Victoria it is suggested that in these situations one to one nursing should be used in preference to seclusion (Office of the Chief Psychiatrist (Vic), 2011b, p. 13). The Queensland policy specifies that where seclusion cannot be avoided for people in vulnerable groups, it should be for the briefest period and with continuous observation as well as access to a support person or a cultural advisor (Mental Health, Alcohol and Other Drugs Branch, 2014, 13-8 and 13-9).

2.3.8   Concurrent Use of Seclusion and Restraint

Some jurisdictions have provisions that prevent the use of seclusion while a person is subject to a particular form of restraint. For example:

- in New South Wales a person cannot be subject to mechanical restraint in a locked room (Mental Health and Drug and Alcohol Office (NSW), 2012b, p. 13);

- people who have been given rapid tranquilisation must be observed closely (or continuously) and monitored for side-effects if they are also secluded. Seclusion should end once the tranquilisation takes effect (National Institute for Clinical Excellence (NICE), 2005, para 1.8.3.6);

- the consciousness of people physically restrained prior to seclusion should be closely observed (Mental Welfare Commission for Scotland, 2007, p. 8).

The regulation of the concurrent use of seclusion and multiple forms of restraint is an issue that requires further consideration and reform.

2.4   'Best Practice' in Regulating Seclusion and Restraint

As the Mental Welfare Commission of Scotland (Mental Welfare Commission for Scotland, 2007, p. 1) points out, there is a 'paradox' in trying to regulate practices like seclusion and restraint as the very existence of a guideline 'can be construed as supporting the practice.'

The use of a strict legislative structure (sometimes with penalties for non-compliance as in Queensland) 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.

As (Brookbanks, 2005, p. 199) argues:

> Given its impact upon patient autonomy and freedom of movement and association, a strong case may be made for carefully defining the use of seclusion by legislation. Defining legislative rules governing seclusion removes it from the realm of mere patient management and elevates it to an intentional practice for which the clearest justifications must exist. In this way the interests of patients are better protected while practitioners are able to use the procedure provided the statutory limits for its use are carefully observed.

However, 'softer' forms of regulation in the forms of policies, procedures and clinical 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 easy adapted to local conditions;

- able to take into account the latest developments.

Many policies, procedures and guidelines do not purport to regulate a particular institution at all and simply provide directions or a 'minimum standard' that the institution can use to produce their own 'local' policies. This means that some local policies may be permitted to depart from the overarching code 'for good and cogent reasons.' For example, in *Munjaz v United Kingdom* (Application no. 2913/06, ECtHR, 17th July 2012), the European Court of Human Rights upheld the decision of the House of Lords that Ashworth, a maximum security hospital, was entitled to depart from the standards in the Code to the English and Welsh Mental Health Act in its treatment of a patient who spent long periods in seclusion because his behaviour was aggressive and violent.

The Legislative Model of creating a legislative framework that is supplemented by policies and guidelines may be the best way of offering the flexibility and practicality of softer regulation with legislative backing. Kumble and McSherry (2010, p. 551) have noted in relation to combining such types of regulation that:

> This option is useful because it provides a more comprehensive framework for clinicians to operate within and it imposes penalties on clinicians for behaviour which breaches legislative provisions.

However, the down-side of the combined approach is that it may make regulation more complex and difficult to locate.

The Accreditation Model, by relying on standards set by agencies that 'accredit' hospitals, has the advantage of providing a financial incentive to compliance with standards. Guidelines by professional bodies appeal to the desire of professionals to conform to professional standards.

Recupero and colleagues (2011, p. 474) observe in the context of seclusion and restraint reduction in the United States:

Experience has shown and research has confirmed that attempts to reduce or eliminate R&S [restraint and seclusion]… by means of regulation alone are unlikely to produce overall beneficial changes in the therapeutic milieu. Success stories from the literature illustrate the importance of comprehensive treatment-improvement strategies rather than attempting to enforce blind compliance with strict regulations.

This suggests that regulation alone, no matter in what form, is insufficient to reduce and eliminate the use of seclusion and restraint.

Ultimately, a combination of all three options in regulatory structure may constitute 'best practice'. What is perhaps of most importance is the need for uniformity in regulatory frameworks across Australia.

2.5   Conclusion

As well as differing forms of regulatory structure, there is currently a lack of uniformity in relation to:

- definitions of restraint;
- what types or restraint are regulated;
- what services are regulated; and
- powers to seclude or restrain individuals in services on a voluntary basis.

Greater uniformity than is presently the case is an essential direction for future reform. This is discussed further in Chapter Seven.

3. LITERATURE REVIEW

3.1 Introduction

This chapter provides an overview of the literature focusing on interventions aimed at reducing and eliminating the use of seclusion and restraint in mental health care settings. It draws on previous Australian literature reviews (for example, Gaskin, 2013; Gaskin, McVilly and McGillivray, 2013; Livingstone, 2007) and includes references to international material wherever relevant.

The literature presented in this section sits within the broader topic of coercion in mental health care. Coercive practices and related laws and policy developments have generated considerable debate in the recent decade, reflected in a large quantity of published material. The broader literature embraces conceptual and ethical arguments, legal debates and opinions, in addition to empirical research. Empirical studies range from epidemiological and smaller observational studies of current practices, to investigations of attitudes and experience among consumers, the workforce and wider community. This broader material is acknowledged for the context it provides, but attention is paid here to the work that directly informs change in the specific coercive practices of 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 and/or eliminate the use of seclusion and restraint.

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. This book states that an 'Engagement Model' of care, based on trauma-informed practice, led to the use of mechanical restraint being eliminated and 365 episodes of seclusion in a year being reduced to 1 in two years in an acute care psychiatric unit at Salem Hospital, Oregon. This unit, however, no longer exists, as the hospital in which it was housed has been rebuilt.

It should be noted that when stakeholders were asked to direct the project team to any literature about how best to reduce seclusion and restraint, there was often anecdotal evidence provided, but publicly available data or rigorous evaluation of the particular intervention used was unavailable. For example, a number of stakeholders referred to the Beacon Project (see 1.4.5) which aimed to develop and test resources that could be used to support long-term changes in practice leading to a reduction in the use of seclusion and restraint. There was a surprising lack of publicly available

material evaluating the outcomes of this project. One peer reviewed article about the project (Happell and Koehn, 2010) reviewed the use of seclusion at intervention sites to look at demographic risk factors rather than the outcomes of a particular reduction strategy and another (Ching et al., 2010, pp. 16-17) which examined staff attitudes to reducing seclusion at one of the Beacon sites, states:

While this study clearly demonstrates that the reduction of seclusion use in an Australian psychiatric hospital is possible, it does not allow any definitive answers as to the mechanisms underlying this change or which of the interventions introduced was most effective.

A report on a consumer-led intervention by (Foxlewin, 2012) at one of the Beacon Project sites is presented as a case study below.

As indicated in the previous chapter, there are numerous policies, guidelines, standards and procedures available relating to the regulation of seclusion and restraint. There are links to some of these set out in Appendix One. These documents, however, are not the same as research studies that evaluate strategies aimed at reducing seclusion and restraint. For that reason, this chapter focuses on peer-reviewed literature.

The lack of publicly available and/or intervention evaluation studies is a major hurdle to finding reliable examples of 'best practice' in reducing and eliminating seclusion and restraint. This has been recognised by other researchers (for example, Ching et al., 2010, p. 740; Gaskin, 2013, pp. 15-16).

3.1.1 Search Strategy

The search for documents to include in the review consisted of structured searches of peer-reviewed literature and grey literature (especially project reports in the public domain) and sourcing of other documents from contact with stakeholders as outlined in 1.6.3 of this Report.

Peer-reviewed publications were sourced from Medline ISI and Psycinfo database searches in November 2013, using the search terms 'seclusion', 'restraint', 'interven*', and 'mental' or 'psych*'. The search was further limited to peer-reviewed papers in the English language, dated from 2006 to the present day. The year of 2006 was chosen to capture more recent literature than that included in two earlier structured review papers (Gaskin, Elsom and Happell, 2007; Stewart et al., 2010). Titles of 1,020 papers were read and 785 papers were excluded, resulting in 235 titles (where restraint referred to restraint of food intake or to animal studies, Medline in particular generated a high proportion of animal behaviour studies). The relevant study abstracts were sourced and reviewed and literature was further reduced to 185 abstracts.

The research papers included in the final review were divided into two groups: core papers that provide evidence regarding **interventions for reducing** seclusion and/or restraint; and secondary papers that contain useful information about **interventions with potential** to reduce seclusion and restraint. Papers reporting data about actual practices and with interventions intended to reduce seclusion and restraint were in the minority.

Searches of scholarly sources were complemented by electronic searches of 'grey' literature, in order to bring forward as much local Australian evidence as possible. This search included policy documents, guidelines, discussion papers and governmental and organisational reports. Several project reports were sourced via the Australian experts including project reports and papers from the nationally funded Beacon Project referred to above.

In addition, as outlined in 1.6.3, the project team contacted stakeholders in Australia and internationally by email or telephone and invited them to contribute literature and documents. Advice from experts and members of the NMHC's Core Reference Group for the project gave rise to eight more papers for inclusion in the literature review.

Details about the 33 studies reviewed are tabled in **Appendix Three** to the report.

3.1.2   *Structure of Chapter*

The next section describes the current literature on seclusion and restraint using the National Technical Assistance Center's six core strategies (National Technical Assistance Center, 2006) (which were referred to in Chapter One at 1.4.2) to organise the literature into common intervention categories. In brief these strategies are:

1.   'Leadership towards organisational change'

2.   'Using data to inform practice'

3.   'Workforce development'

4.   'Use of seclusion/restraint reduction tools'

5.   'Consumer roles in inpatient settings'

6.   'Debriefing techniques'.

Section 3 provides an overview of the literature dealing with changes to the environment. While this topic is not included in the six core strategies, it is an emerging area for research.

The final section discusses the literature in terms of specific themes, such as how multi-interventions show promise and the importance of top-down and local level

leadership. It also points out some limitations of the literature and foreshadows where more research is needed.

3.2 The Literature Organised According to the Six Core Strategies

The six core strategies set out at 1.4.2 provide a useful, integrated and effective framework for organisational change and have been used by services such as the Peter James Centre, Eastern Health in Melbourne (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).

In the United States, decreases in seclusion and restraint rates have been reported from 70 facilities that have used these strategies. Reductions range from 47% to 92% (Barton, Johnson and Price, 2009; LeBel et al., 2004; Lewis, Taylor and Parks, 2009; Smith et al., 2005; Sullivan et al., 2005). The robustness of the project evaluations vary, but many are published as peer-reviewed research reports.

A small number of studies use stronger experimental designs, producing more robust evidence. Putkonen and colleagues (2013) carried out a randomised controlled trial in a secure psychiatric facility in Finland using the six core strategies to determine whether seclusion and restraint could be prevented in men diagnosed with schizophrenia, without a subsequent increase in violence. Four high-security wards were stratified by coercion rates and randomly assigned to an intervention or control group. The intervention group (consisting of staff, doctors and patients) were trained in using the six core strategies over a six month period, with the ensuing intervention period lasting for a further six months. The incidence of seclusion and restraint decreased during the supported intervention from 30% to 15% of total patient time in the intervention wards (p. 852). The time spent in seclusion and restraint decreased from 110 to 56 hours per 100 days for intervention wards, yet increased from 133 to 150 hours for control wards (p. 853). Patient-to-patient violence and self-mutilation did not increase in the intervention wards, while severity of violence decreased in the intervention wards. These results are encouraging, particularly given the short timeframe of the study.

3.2.1 Leadership towards Organisational Change

This particular strategy overarches the entire set of six core strategies, with the aim of ensuring substantial, concrete and sustained commitment at a senior level, within mental health organisations that seek to reduce their use of seclusion and restraint. This strategy points to the need for substantial strategic investment to achieve and sustain this type of organisational change.

An earlier review of reduction interventions by Gaskin, Elsom and Happell (2007) indicates that organisational commitment and leadership are required to set new

practice expectations, model desired practice, change policy, resource changes, and enable new data and reporting. This conclusion was echoed in a more recent systematic review of effective restraint reduction by Bak and colleagues (2012) who identify 'high level administrative endorsement' (p. 88) as an ingredient in the better quality studies and the more effective interventions.

The role of organisational leadership is detailed within the core strategies, including:

- articulating a vision, values and philosophy that supports the reduction of seclusion and restraint;

- developing, implementing and ensuring accountability for a targeted facility or unit-based action plan;

- oversight of every event by senior management that includes the daily involvement of the Chief Executive Officer or Chief Operating Officer in all seclusion and restraint events to investigate causality, to revise facility policy and procedures that may instigate conflicts, to monitor and improve workforce development and to engage administration with direct care staff; and

- any action plan developed needs to be based on a public health prevention approach.

The actual application of the elements of this core strategy is less evident in published studies. In the report of the cluster randomised control trial conducted by Putkonen and colleagues (2013) 'leaders of the hospital' were noted to be 'members of a steering group' (p. 851). The involvement of senior organisational personnel was not described in any detail. Instead, the most senior personnel identified as active in the project team were a senior nurse and a cultural anthropologist. The ward level leaders were supported by these personnel and a psychologist, via individual and group counselling (one hour per week) and daily post-event analyses.

Similarly, in the randomised control trial conducted by Bowers and colleagues (2010) to reduce conflict and use of strategies for containment, including seclusion and restraint, the role of senior institutional leaders was confined to support/consent for the organisation participating in the trial. In this trial, the leadership of the project across the 10 participating organisations centred on key staff at the unit level acting as champions of each discreet component of the 'Safewards' intervention.

Several United States case studies using the six core strategies provide some detail regarding the strategy of organisational leadership (Azeem et al., 2011; Chandler, 2012; Pollard et al., 2007). Senior management of one large adolescent facility prioritised a goal of reducing seclusion and restraint, developed a plan for reducing seclusion and restraints and allocated resources for removing barriers to the plan. Seclusion and restraint data became a standing agenda item in hospital leadership

and medical executive meetings, and best practices were recognised and rewarded throughout the hospital, demonstrating continuing commitment to the goal (Azeem et al., 2011).

Pollard and colleagues (2007) report on a seclusion and restraint reduction project organised around the implementation of new practice standards, as disseminated from the national accreditation agency. This project involved: organisational leaders producing a video communicating senior leaders' commitment to a restraint free environment; consulting with clinicians about implementation and alternative practices; senior clinicians being required to review all use of restraints; increased data gathering; and, monthly performance review. Chandler (2012) describes senior leadership commitment to education and new resources in one adult acute unit, creating a culture of empowerment for staff.

In England, a seclusion reduction project was conceived as an activity of clinical governance improvement (Qurashi et al., 2010). Seclusion events were reviewed at medical audit meetings. To promote transparency of practice and accountability, these meetings were attended by senior clinicians and governmental and organisational leaders, such as Mental Health Act Commissioners, Trust executives and non-executive directors.

In contrast, in a report of the nationally-led seclusion reduction project in the Netherlands, the researchers reflect that a lack of clear leadership (that is the absence of a strong vision and communication of reduction goals) may have been a weakness leading to only modest changes in the use of seclusion (Vruwink et al., 2012).

In one Australian project where a tertiary hospital undertook a two year seclusion reduction program (Hamilton and Castle, 2008), commitment was demonstrated at the senior organisational level to the extent that reducing seclusion rates was adopted as a Key Performance Indicator for the specialist mental health service and also for the larger healthcare agency as a whole. Such embedding of coercion reduction goals in KPI processes may help to sustain practice change beyond the life of a specific project, since reverting to previous practice is a problem which is common in quality improvement initiatives.

No studies suggest that senior management involvement in leadership of change is sufficient without local level leaders, and some evidence suggests that senior commitment without other core strategies is insufficient to sustain change. However, this strategy is valued particularly for early 'set up' aspects of setting goals and vision, communicating strong messages regarding practice change goals, addressing organisational, policy and industrial barriers to change, and resourcing new practices, including infrastructure and training. The ongoing role of leaders may shift to incident oversight and intermittent refreshment of goals/targets. Since coercive practices in

mental health are framed by high levels of law and societal risk management agendas, there is demand for ongoing senior attention and influence.

3.2.2   Using Data to Inform Practice

Like the first strategy, the second of the six core strategies, using data to inform practice, is a common feature in practice improvement initiatives. This strategy has additional merit in the area of reducing coercion, because focusing on data can be a particularly potent means of addressing practices that may have been previously under-scrutinised. This core strategy uses data locally in an 'empirical and non-punitive way', including such details as:

- continuous and rich data that is readily analysed and sensitive to change, including details of patients, causation events, times of day, duration;

- prospective investigation of all seclusion episodes to set realistic improvement goals and comparatively monitor use of seclusion and any changes in usage over time;

- root cause analyses of seclusion episodes to identify and articulate triggers and early warning signs to develop strategies that can be used to avoid seclusion episodes; and

- records and analyses of 'near misses' (events that could have resulted in the use of seclusion, but did not).

As Scanlan (2010, p. 414) reports in his review of 29 observational studies of seclusion and restraint reduction projects undertaken before 2009:

> This strategy provides staff with an effective feedback loop, allows for benchmarking, promotes healthy 'competition' between units and highlights the organizational commitment to change (especially where data are widely reported, both within the service and to the broader community).

There are two major considerations in regard to use of this strategy. The first is accessing or producing high quality data and the second is harnessing and sharing data, to support the goal of seclusion and restraint reduction.

3.2.3   Accessing or Producing High Quality Data

The availability, quality and accuracy of data are crucial to effective reporting and monitoring of practices such as the use of seclusion and restraint. A sound and consistent approach to data is also vital for intra-agency reporting (for example between units), and for cross service comparisons in larger jurisdictional programs of monitoring. Yet, coercive practices are dogged with poor quality data and

inconsistent reporting of data (Bowers et al., 2010). As noted by the Australian Institute of Health and Welfare (2013), there presently exists no routine nationally agreed data collection and reporting framework for seclusion and restraint, despite the many ongoing initiatives at local, state and national levels. Many projects internationally rely on data gleaned from clinical file audit, a process that is time consuming, prone to errors depending on data quality and file design, and resulting in data sets that are intermittent rather than ongoing. Across all eight Australian jurisdictions, mental health services are required to record data for each event of seclusion and of mechanical restraint and to routinely report on these events to government. No such reporting is mandated for physical restraint. Dutch researchers have reported that hospitals using and analysing electronic records generate more reliable data than those using paper records of coercive practices (van de Sande et al., 2011).

Some seclusion and restraint reduction projects have made a priority of developing good data. In a state level quality and safety initiative called Creating Safety, beginning in 2007 in Victoria (Victorian Department of Health, 2009), the decision was made to standardise seclusion reporting to 'events per 1,000 occupied bed days', in line with research recommendations (Bowers, 2000). The use of data in this Victorian project enabled more effective comparison of practices between units of different sizes and levels of occupancy across the state. Once established, the state-wide data set has been of ongoing beneficial use in high level Key Performance Indicators. Data are reported to each organisation on a quarterly basis, with de-identified comparators and reduction targets set by government. The establishment of a formal, routine and nationally agreed data collection and reporting framework for seclusion and restraint would enable accountability, benchmarking, learning and change in Australian practice.

One caution regarding the positive effects of particular projects relates to data quality. Some experimental studies in this field are not using the strongest data and analytic approaches. This issue is underlined in Möhler and colleagues' systematic review (2012) of six randomised cluster controlled trials of restraint reduction. These researchers state that 'baseline imbalances were found in four studies' (p. 3072), suggesting that differences in outcomes could be related to sample group differences. When aiming to identify 'best practice' it is important to note such limitations which are more common in observational studies. Reported positive effects may not stand up to scrutiny, when effective comparisons of baseline and post intervention conditions are made. Caution is required when drawing conclusions about observational case studies with small samples, in terms of units, populations and time periods.

3.2.4 The Use and Sharing of Data

Current literature suggests that the use of good data is also variable, at the local level and between services to inform practice change. Several studies of effective reduction in coercive practice provide instructive detail about their use of data.

The largest national program reporting systematic use of data to support change is in the Netherlands (Vruwink et al., 2012). This project commenced in 2006 and entailed co-funding by local services and central government via the Dutch Health Care Inspectorate (DHCI). In the Netherlands, coercive practices that are mandatorily reported to the DHCI include involuntary admissions, seclusions and administration of involuntary medications (usually by intramuscular injection). Services were funded via the project to implement a local seclusion reduction plan. The key role of the DHCI in this project was to provide participating hospitals with collated quarterly reports of the use of coercive measures starting from 1998 and to analyse and report quarterly on enhanced data collected on the use of coercion from 2006, analysing trends before and after seclusion reduction interventions. The analysis showed significant national reduction annually in seclusion use over three years, but an increase in involuntary medication in this same time period. The authors also reported two weaknesses in the use of data: first, the DHCI lacked capacity to centrally analyse and report progress at the per-service level; secondly, they considered that the baseline data may have been of a poorer quality (i.e. that the use of seclusion and involuntary medication may have been under reported in the pre-project period). This study illustrated the need for investment in high quality data collection, monitoring and reporting systems.

More studies report data use at the service level, as a tool for practice change. The Te Pou project guidelines in New Zealand stipulate standard features of data to be collected regarding seclusion, restraint and medications and detail the way data should be used and displayed, to reduce coercive practice (Te Pou, 2013). The application of these guidelines can be seen in the reporting of a seclusion audit project in an older adolescent unit in New Zealand (Swadi and Bobier, 2012). This study reported comprehensively on three years' of data, and this was used to inform a targeted seclusion prevention effort for these young people.

An Australian study within an aged care acute psychiatry unit began with a systematic data review (Sivakumaran, George and Pfukwa, 2011). Current practices were investigated by the leadership team, using routine data gathered from 2005 to project commencement in 2007, about the use of seclusion and restraint in the acute unit. Also, a random audit of patient files was carried out in order to understand details of practice before and after the use of such procedures.

Several international seclusion reduction case studies detail specific sharing of data among clinicians. In an adolescent hospital of 26 beds, data were shared in clinical teams, in all staff meetings, and posted monthly on the respective units. Data display

was considered helpful in monitoring progress and creating healthy competition between the three units (Azeem et al., 2011). In instances where data is communicated with teams, it appears to have the greatest impact if the data is recent and specific to the teams and work units.

A small scale study by Sclafani and colleagues (2008) illustrates the intensive use of data to change restraint practices. A restraint reduction project was undertaken in a 35-bed medium term unit in New Jersey for people with mental illness and developmental disabilities. It is unclear from the study as to what type of restraint was being used at the unit. There is reference to a bedroom which was used as a 'patient restraint area' (2008: p. 34), indicating that 'restraint' could mean 'seclusion' or it could refer to the use of mechanical restraint.

A consultation team joined the unit staff to consult regarding two patients in particular who had been subject to high levels of restraint. The consultation team gathered data by observing and talking with the patients, reviewing charts and participating in team discussions. The data gathered regarding these two patients was also used to explore barriers to non-coercive practices with all the patients in the unit. Over a sixteen-month period, the unit reported a decrease in the use of restraint with all patients from 36 episodes per months to nil as a result of practice changes. This study also contributes to the evidence for the fifth core strategy of involving consumers in inpatient settings.

3.2.5 *Workforce Development*

This strategy focuses on creating a treatment environment which is less coercive through developing procedures, practices and training that are based on the knowledge and principles of mental health recovery and trauma-informed care. In their study of the effectiveness of the six core strategies in reducing seclusion and restraint in a child and adolescent psychiatric facility, Azeem and colleagues (2011) describe how staff education and training were based around trauma-informed care and the principles of recovery, which included 'person-centered care, respect, dignity, partnerships, and self-management' (p. 13). Recovery was integrated into job descriptions, performance evaluations and other competencies. While Azeem and colleagues do not report on the effectiveness of individual core strategies, the reduction of seclusion and restraint in this study was attributed to 'the collaborative and concerted effort of staff' (p. 14) and notably 'the positive results of the techniques were achieved relatively quickly and sustained over a long period of time' (p. 15).

Qurashi and colleagues (2010) analysed all episodes of seclusion and assault in a high security psychiatric hospital in England over a five-year period. They observed a 'progressive and sustained reduction in seclusion use with over a sixty per cent reduction in the number of seclusion episodes' (p. 109), with no subsequent increase in adverse events. This came after a series of measures were introduced and

observed as part of a clinical governance program. The measures built upon existing frameworks and were primarily aimed at reducing seclusion episodes and duration. Workforce development came in the form of education and training on neurocognitive and psychosocial approaches, with specific training on de-escalation methods and seclusion awareness for new staff.

Qurashi and colleagues report that even though the implemented measures have been associated with reductions of seclusion in other studies in the past, seclusion reduction in their study may have been related to other factors such as patient characteristics or populations. Further, it was impossible to state that a single strategy caused a reduction. Rather, the 'provision of clinical staff training, for example, depends not only on the adequacy of the training but also on the adequacy of implementation by clinical staff' (p. 114), reflecting an inherent complexity when implementing and evaluating a set of strategies in a framework.

3.2.6   *Use of Seclusion and Restraint Reduction Tools*

Various assessment forms and tools have been integrated into the treatment protocol for individual consumers, as well as treatment facility policies and procedures to reduce seclusion and restraint.

The systematic review of Gaskin, Elsom and Happell (2007) identifies the involvement of patients as active participants in treatment as a common type of intervention in studies that successfully reduced seclusion use in psychiatric facilities. This typically involved staff engaging with patients in mutually deciding a crisis management plan, or obtaining information from patients using a risk assessment tool, helping to identify and improve awareness of stressors (for example interpersonal or environmental) that may lead to conflict (Gaskin, Elsom and Happell, 2007; Huckshorn, 2004).

Lee and colleagues (2010) completed a six-month pilot study on a 30-bed psychiatric unit, involving 43 service users that aimed to review the use of sensory modulation strategies and a risk assessment safety tool. The safety tool comprised a two-page questionnaire which guided clinicians for 'interviewing service users about stress triggers and warning signs, calming strategies and seclusion history, details which could be included in safety plans' (Lee et al., 2010, p. 85). The study indicated promising results for the use of the safety tool, with only 26% of service users requiring seclusion after completing a safety tool, compared with 65% who had been previously secluded either in a previous or current admission before completing the tool. Approximately 70% of the unit staff gave feedback on the interventions, with 76% of respondents stating the safety tool should become a part of unit routine practice. Staff felt that the tool should be implemented on admission whenever possible and a debriefing session should occur with the service user post-seclusion to discuss how future reoccurrences could be avoided.

Georgieva and colleagues (2010) aimed to investigate the efficacy of a non-coercive form of management in a newly opened psychiatric intensive care unit (PICU). The intervention aimed 'to find a balance between ensuring security needs and creating an environment where patients are offered a level of autonomy in making decisions' (Georgieva et al., 2010, p. 33). While the study retrospectively evaluated a multiple-therapeutic approach to the reduction of coercive measures and thus did not specifically look at the effect of singular components, Georgieva and colleagues did postulate that patient involvement in the development of personal treatment and crisis-management plans contributed to the reduction of admission days spent in seclusion from 40% pre-PICU, to 0.1% during the PICU stay. While this study has various limitations, including design (it was a non-randomised control trial) and a small participant sample, the substantial reduction of coercive measures is worth noting.

Other research has raised the importance of including persons with lived experience in planning their treatment through advance care planning, which refers to a variety of decision-making arrangements (for example, advance statements; psychiatric advance directives (PADs); joint crisis plans) between service users, family members and service providers. These arrangements usually consist of oral or written instructions that set out a person's preferred method of treatment if they were to become unwell. The overarching goal for advance care planning is to empower patients through autonomous decision-making, while reducing potential coercive interventions such as seclusion and restraint during mental health crises (Swanson et al., 2008). Swartz, Swanson and Hannon (2003), in a survey of 85 mental health professionals and 104 service users with schizophrenia-related disorders, reported that a reluctance to seek outpatient treatment with associated fear of coerced interventions in 36% of service user respondents was 'significantly more likely in subjects with a lifetime history of involuntary hospitalisation, criminal court mandates to seek treatment, and representative payeeship' (p. 459). The analyses of the same study concluded that mandated forms of treatment are 'modestly associated' with certain barriers to treatment (p. 471). Swanson and colleagues (2008) found that completion of a facilitated psychiatric advance directive was significantly associated with fewer coercive crisis interventions in comparison to the control group over a 24 month period. Potential reasons for this reduction put forward by Swanson and colleagues (2008) include:

- documenting treatment preferences could motivate service users to be more engaged with regular treatment, reducing the need for future coercive interventions;

- PAD preparation could improve service user-clinician collaboration, and may lead to increased clinician advocacy for PAD instructions, which may in turn reduce coercive interventions;

- authorisation of a proxy decision-maker could provide a more solid legal basis to avoid coercive interventions; and

- information in PADs such as treatment history and emergency contacts could aid clinicians in making treatment decisions without invoking coercive interventions.

3.2.7 Consumer Roles in Inpatient Settings

According to the United States National Technical Assistance Center (2006, p. 8), this strategy aims 'to assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of seclusion and restraint'. The policy provides for substantial engagement with consumers at the levels of advisory committee action and also direct paid work in peer support roles. However, the published evidence regarding implementation and effect of the six core strategies, does not match this policy.

'Consumer roles' specific to seclusion and restraint reduction projects appears to be the least developed strategy, in terms of the level of detail provided in research publications or even in longer project reports, such as the Te Pou report from New Zealand (O'Hagan, Divis and Long, 2008). The relevant section in this report makes reference to 'developing service user coping skills', 'asking people what they find helpful' and inviting the 'fresh perspective' of 'service users who are not currently using the unit' (2008, p. 9). Sclafani and colleagues (2008) engaged with consumer views at the unit level by inviting the opinions of current consumers in the wards, but this study showed no evidence of involving people with lived experience of mental health issues in planning, oversight or review of strategies. Where the strategy of 'consumer roles' are listed in other specific projects that make use of the six core strategies, details of the actual outworking of this strategy are lacking.

Including Consumer Voices to Reduce Seclusion at the Canberra Hospital

A seclusion reduction intervention project was conducted at the Canberra Hospital Psychiatric Services Unit beginning in 2009 (Foxlewin, 2012). The Psychiatric Services Unit at the Canberra Hospital was one of eleven sites targeted by the national Beacon Project (mentioned in 1.4.2). In the background section of the project report, Foxlewin notes other features of the six core strategies that were employed at Canberra Hospital from 2006- 2009, including the formation of a Seclusion and Restraint Working Group in line with the strategy of Organisational Leadership and the involvement of many key staff investigating reduction possibilities, through learning and travel to sites in the United States, the United Kingdom and Europe. The project report centres on a further and distinctive change in that setting, which was the introduction of a Seclusion and Restraint Review Meeting, a substantially consumer driven and detailed discussion between consumers and staff about each seclusion event in the unit. The report (Foxlewin, 2012, p. 6) states that 'the lived experience of both consumers and clinicians [was] the central

---

driver for cultural change in relation to seclusion reduction'.

The focus of the review meeting discussions was on any recent seclusion and restraint events, with a dual process of thoroughly hearing all perspectives and exploring in detail what could be done differently. The report does not plainly state who facilitated the review meetings, either in the initial implementation phase or ongoing. However, it is clear that the voices of both consumers and consumer representatives were vital and prominent in the discussions. The project report identifies that use of seclusion was declining prior to the review (from 8.5% of patients admitted in 2007/8 to 6.9% in 2008/9), but that these meetings drove seclusion to be classified as a rare event (to less than 1% in 2010/11). Seclusion came to be viewed by the organisation as a service failure. Although this project report is not peer reviewed, it is valuable for the added description of a consumer-led strategy.

The approach taken in the Australian Capital Territory is somewhat aligned with the approach taken in four units of John Hopkins Hospital, Maryland (Lewis, Taylor and Parks, 2009) which employed the six core strategies. The report of this project included a description of two activities that increased consumer profile in prevention and problem-solving of situations that might be triggers for seclusion and restraint. The Daily Safety Focused Community Meetings were not consumer facilitated, but did engage all parties in problem solving discussions to ensure that everyone's safety concerns were addressed. This strategy was paired with a Family Style Meals program that brought staff and consumers together sharing a meal, creating greater human connection and fostering an environment in which a person could more easily ask for help. As noted in earlier sections, this project resulted in a 75% decrease in the use of seclusion over a three year period.

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 is focusing on how staff can manage those flashpoints to reduce conflict. This model has ten possible interventions and includes two strategies that are targeted at consumer/peer support roles, among the people who are consumers in acute settings. The strategy of the 'mutual help meeting' and the discharge messages handbook are both intended to recognise and enhance the mutual support that consumers provide as a strategy that can prevent conflict and enhance coping. This intervention does not explicitly engage with the consumer or peer workforce, a component of the core strategies.

As reflected in the Position Statement by the National Mental Health Consumer and Carer Forum (NMHCCF), consumers and carers express unequivocally strong views about the harms of seclusion and restraint (National Mental Health Consumer and Carer Forum). They are inclined to advocate for stronger measures and to aim for more ambitious change in practice, compared to other stakeholder groups, such as

clinicians or clinician researchers who have led most of the published intervention studies. In the position statement the National Forum presses for elimination of seclusion and restraint from Australian practice, which has not been the explicit target of any published study to date. This statement illustrates the important place of consumers and carers in setting a vision for change regarding coercive practices, and invites reflection on systematic gaps in implementation of the core strategies to date.

3.2.8 Debriefing Techniques

These techniques involve conducting an analysis of why a particular occasion of seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience. The primary goals of debriefing are twofold: to inform practices, policies and procedures aimed at reducing future coercive events; and, to mitigate the negative traumatising effects of seclusion and restraint for staff, consumers and other witnesses (Huckshorn, 2004). Azeem and colleagues (2011) outlined two types of debriefing used in their study. The first debriefing session occurred immediately post-event and centred on the emotional wellbeing and support of the patient and staff, while assessing whether changes in the treatment plan were required. The second and more formal debriefing session typically occurred 48 to 72 hours post-event and used a root-cause analysis to determine 'what went wrong, what could have been done differently, and how to avoid similar incidents in the future' (Azeem et al., 2011, p. 13). Interventions were then decided upon and implemented accordingly.

Lewis and colleagues (2009) described their study as an evidence-based crisis-prevention management program undertaken at The Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital in Baltimore, to prevent episodes of seclusion and restraint. Early results indicated a 75% reduction in coercive events with no increase inpatient or staff injuries. While patient debriefing was a standard part of tertiary level prevention in the clinic, there was minimal information collected that could help prevent future episodes. A multi-faceted witnessing program was established to elevate every episode to a critical event which was then thoroughly examined. It was decided that clinical staff such as experienced and advance practice nurses should act as witnesses rather than administrators, as they could guarantee more valuable results. Similar to Azeem and colleagues (2011), the program implemented two main debriefing sessions consisting of a post-event interview and formal root-cause analysis. The purpose of the post-event interview was to gather data on 'the triggers and contributing factors in the event, what interventions were attempted, and what barriers were present to impede the success of the interventions' (Lewis, Taylor and Parks, 2009, p. 162). Usually, an on-call charge nurse from a unit other than the one involved in the seclusion and/or restraint event would lead the interview. Information gathered at this point would inform the second part of the debriefing process which was led by an on-call clinician or a specifically trained nursing clinical

expert. This stage typically involved a chart review, patient interview and conference with the nursing team involved in the incident. The aim here was to understand the contributing factors to the coercive event, discuss alternative actions and identify any individual or systemic issues. This process was viewed as a 'learning opportunity' (p. 162) to be undertaken in a non-punitive and collaborative environment. Lewis and colleagues remarked that 'in addition to the individual patient benefiting, the consultation process benefits other patients, identifies clinical issues before they are crises, and promotes a greater understanding of the challenges nurses confront on each of the inpatient units' (p. 163).

Use of a Decision-Making Framework – One Case Study

Being aware that seclusion and restraint practices have been deeply embedded in Australian mental health settings, Hyde and colleagues (2009) set out to develop and implement a best practice decision-making framework around the use of seclusion in The Prince Charles Hospital, an acute mental health facility located in the Northside Mental Health Service District, South East Queensland. Both consumers and staff had previously expressed concerns about the performance of the facility. According to data collected by the Northside Mental Health Service District, the average percentage of patients secluded in a month was 8.8%, while 79.6% of these patients were secluded for more than four hours. This result was significantly above the national average and became the impetus for the framework implementation. Before implementation could begin, the research team was required to collect and analyse data to inform the framework. This was done in a series of cycles involving forums and workshops where staff could contribute knowledge and feedback about the process. While the paper did not report any findings as to the efficacy of the framework due to insufficient available data, Hyde and colleagues believed they had been successful for a number of reasons. Strong clinical leadership, as well as clinician and nursing involvement, created an environment where staff were able to participate and contribute ideas. Nursing staff gave feedback on the development and implementation of the framework, which they saw as adding value to their clinical practice. Apart from core strategy five 'Consumer roles in inpatient settings', the decision-making framework encompassed the approach of the six core strategies and is an encouraging example of how an integrated and collaborative approach could potentially benefit staff and patients alike in acute psychiatric facilities.

3.3 Changes to the Physical Environment

In the United States, Borckardt and colleagues (2011) examined the systematic implementation of interventions designed to reduce seclusion and restraint in a state-funded hospital in the southeastern United States over a 3.5 year period. Out of a variety of interventions, Borckardt and colleagues reported that there was a significant reduction (by 82.3%) in the rate of seclusion and restraint after changes to

the physical characteristics of the therapeutic environment were made. These changes 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). It was observed that physical changes to the environment were some of the easiest changes to implement, although the researchers could not explain why these changes reduced seclusion and restraint. They suggested that 'physical changes to the inpatient units served as consistent reminders to staff of the commitment to behavioral change and the dedication of the institution to eliminating use of seclusion and restraint' (p. 481). Practice change in this case occurred from a very high baseline use of seclusion of restraint. It may be that such environmental interventions are most potent in settings where reductions efforts are just commencing.

Van der Schaaf and colleagues (2013) collected data over a one-year period from 92 admission wards, 35 forensic wards and 92 non-admission wards across the Netherlands. The purpose of the study was to ascertain the relationship between ward design features and the use of coercive measures. Data sources included a multicentre study on building quality and safety of 77 psychiatric hospitals and a study on the use of coercive measures in 16 psychiatric hospitals. Van der Schaaf and colleagues reported that 'design features such as more 'total private space per patient', a higher 'level of comfort' and greater 'visibility on the ward', decreased the risk of being secluded' (van der Schaaf et al., 2013, p. 142). The findings indicated that the physical environment had a significant effect on being secluded after admission, even after taking into account staff, patient and ward characteristics. Patient-centred notions of privacy, reassurance, normality and identity are recommended to be taken into consideration by van der Schaaf and colleagues when designing intensive psychiatric care environments.

Sensory-based approaches which identify environmental triggers and help service users better manage their mental health are considered important in reducing the need for seclusion and restraint (Champagne and Stromberg, 2004). Multi-sensory environments (for example, sensory modulation rooms) have been used with different populations and age groups for individual and group activities that promote therapeutic self-expression and/or containment (Champagne, 2003, Champagne and Stromberg, 2004). Champagne and Sayer (2003) found the use of a multi-sensory room in an inpatient psychiatric unit had positive effects in reducing self-perceived stress levels for 98% of participants, while 10% reported no change and 1% reported a negative change. The largest reduction in stress levels came from participants who had the highest levels of perceived stress prior to using the room.

Over a three-year period, Chalmers and colleagues (2012) developed and implemented a range of sensory-based approaches at the Mercy Mental Health Psychiatric Unit in Victoria, Australia. These approaches included:

- modification of the physical environment;
- consumer personal safety plans;
- sensory awareness group;
- supervised sensory room;
- staff education and training; and
- a high-dependency unit (HDU) engagement program for consumers.

Preliminary findings indicated a 'significant reduction in inpatient distress levels, as per consumer and clinician ratings … [and] a significant reduction was also found for acute arousal ratings, pre to post, for the HDU engagement program' (Chalmers et al., 2012, p. 35). Chalmers and colleagues emphasise the importance of cultural change in underpinning the implementation of sensory-based approaches, achieved through staff training and input into the interventions.

3.4   Discussion of the Literature

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.

Both the Six Core Strategies from the United States and Safewards from England show promise in reducing restrictive interventions, although more rigorous evidence is needed in this regard.

The 'grey' literature and 33 empirical research studies analysed by the research team also 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; and

- 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.

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. 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.

Perhaps one of the most important emerging themes is that both top-down *and* local-level leadership (that is at the ward level) is important in order to create and to maintain culture change. There is some indication that leadership should include peer involvement for ultimate effectiveness.

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.

4. RESULTS OF THE ONLINE SURVEY

4.1 Introduction

As outlined in Chapter One, an online survey was designed to identify and assess options to reduce and eliminate seclusion and restraint.

The survey was anonymous in order to minimise response bias, 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 the majority of participants responded to all relevant questions.

This chapter outlines the design of the survey and the demographic characteristics of participants. This is followed by the results of the quantitative and qualitative data analysis. A summary is provided at the end of the chapter.

4.1.1 Survey Objectives

The survey's specific objectives were to:

- gather evidence from people with lived experience as to how to reduce or eliminate seclusion and restraint;

- draw on the perspectives of mental health practitioners and, in particular, mental health nurses on the use of seclusion and restraint;

- fill some gaps in the literature, for example, relating to people's views on the effectiveness of legislation;

- consider participants' views regarding whether it is possible and/or desirable to eliminate seclusion and/or restraint practices;

- identify best practice in reducing/eliminating seclusion and restraint; and

- gather evidence of strategies for and barriers to reducing and eliminating seclusion and restraint.

4.1.2 Survey Timing

On 19 March 2014 the survey was launched through the online platform 'Survey Monkey' and closed on 17 May 2014.

4.2 Survey Design

To design the survey questions, a 'Qualitative Exploration' approach was adopted to ensure appropriate topics were included. Key stakeholders were asked for their perspectives on what should be included in the survey, which were then combined

with the information gathered from a preliminary literature review. This was vital to ensure the survey addressed a topic that has rarely been subjected to empirical scrutiny. A second pivotal consideration in designing the survey was the need to ensure an ethical approach, and in particular the imperative to minimise the risk that the survey could cause distress for participants, for example through triggering past traumatic experiences. The survey received approval from the University of Melbourne's Population and Global Health Human Ethics Advisory Group and the Health Sciences Human Ethics Sub-Committee.

The final survey consisted of a mix of Likert scale (multiple-choice) questions as well as opportunities to respond to open-ended questions. The Likert scale questions generated responses that are comparable across all participants, allowing researchers to combine participants' responses and draw conclusions about perceptions and attitudes. The open-ended questions provided participants with a chance to elaborate on their survey responses, and provide information that the researchers may not have thought to enquire about. Throughout the survey, most multiple-choice questions were complemented by an open-ended question. In addition, participants were asked to respond to a number of stand-alone open-ended questions.

4.2.1   Participant Recruitment

The survey targeted key personnel in primary health care, hospitals, custodial and ambulatory settings, as well as individuals with lived experience, their carers, family members and support persons. It was promoted via email distribution lists, discussion forums, appropriate websites, the media, individual networks, relevant newsletters and individual stakeholders. It was also advertised via the project's website and the National Mental Health Commission (NMHC) website and via other advertising opportunities such as the NMHC eNews updates.

Participants were initially asked to read a Preamble and Plain Language Statement as set out in **Appendix Four** to confirm their understanding of what the survey entailed. For ethical reasons, only participants aged 18 years or over were allowed to participate. Any potential participant who did not agree with the survey terms or declared their age to be less than 18 years was automatically redirected to the end of the survey and thanked for their interest.

4.3   Data Analysis

Conducting a large online survey such as this one requires a clear protocol for data management and cleaning, and it is important for the processes associated to be outlined and justified in order to facilitate understanding. As noted earlier in this report, more than 1,450 individuals responded to the online survey, a much higher number of participants than originally anticipated. Thus, it was essential for effective processes to be conducted so as to manage the large amounts of data collected. The

following paragraphs discuss the processes that were associated with data management, coding and cleaning, in addition to analysis.

In order to correctly manage the data collected in the survey, an Excel database was developed and tested prior to the end of the survey period. Cleaning and coding protocols were also developed alongside the database. This included undertaking necessary actions for missing or invalid data and assigning codes for each of the response options. A member of the survey team was given the task of test coding the responses, using a sample of data during the survey period. Random tests were also conducted on the participant identifications (generated by SurveyMonkey) from the original data downloaded to make sure no data were placed incorrectly, and that the identification responses aligned in the database.

As there were multiple responses within the survey, two distinct approaches to analysis were adopted. The Likert responses were coded and exported to a statistical package (Statistical Package for the Social Sciences known as SPSS) for analysis. Descriptive statistics where used to determine responses from specific groups, thus providing for comparison. Percentage responses were listed for each question and, where feasible, comparisons among subgroups of participants were made.

The analysis of the open-ended comments was undertaken using a 'general inductive approach' to Thematic Analysis (Thomas, 2006). This approach was chosen as it allows for qualitative findings to emerge from the recurrent or important themes inherent in raw data, without the restrictions imposed by structured methodologies. It does not require a researcher to impose any explicit theory on the data in a test of a specific premise. Rather, the data is allowed to 'speak for itself' by the emergence of conceptual categories and descriptive themes. The comments were then coded against common themes, which were later reported on in terms of frequency of comments against each theme.

4.4 Survey Results

4.4.1 Inclusion Criteria

A total of 1,451 people responded to the survey. This response was well in excess of the expected 500 participants. For responses to be included in the survey analysis, participants had to meet the following criteria:

- confirm that they had read and understood the Preamble and Plain Language Statement;

- give their consent to participate;

- indicate that they were aged 18 years or over; and

- indicate that they were currently residing in Australia.

This resulted in 1,240 participants whose responses were analysed for the purposes of this report. Sixty-two participants indicated that they lived overseas; five did not indicate their location, and as such were removed from the analysis. The small number of overseas participants means that a detailed comparison of overseas and Australian participants was not appropriate.

The selection and screening process for participants is outlined in Figure 4.1.

Figure 4.1: Participant Inclusion Process
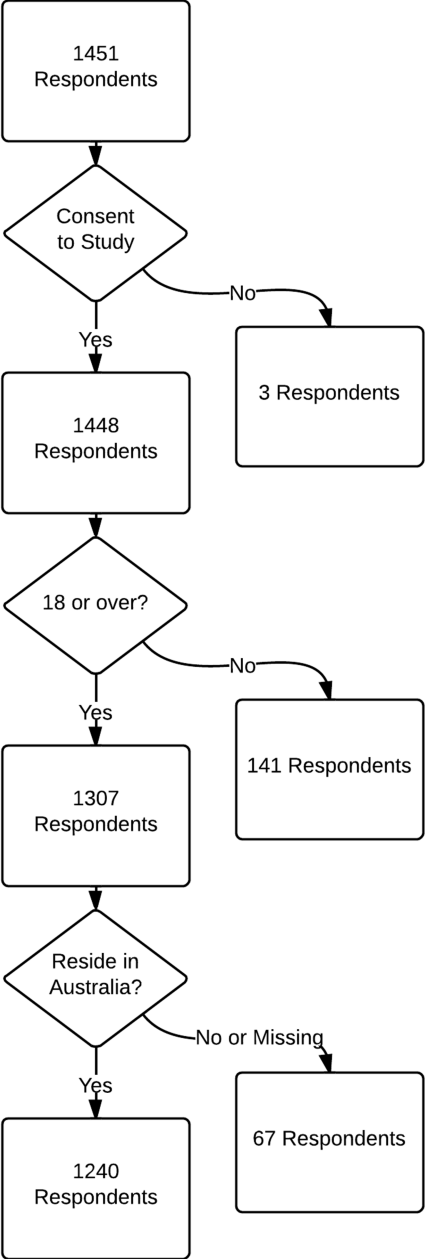
4.4.2 Demographics

In order to permit characterisation of the sample, participants were asked to report their sex, age group, Indigenous status and ethnicity, state and region of residence, and highest level of education. Table 4.1 describes the participants by age range, sex and Indigenous status. 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%).

Table 4.1: Participants by Age Group, Indigenous Status and Sex

Age	Indigenous		Non-Indigenous		Other Gender (n=3)
	Male (n = 8)	Female (n = 12)	Male (n = 294)	Female (n = 874)	
18-24	12%	8%	2%	8%	0%
25-30	0%	17%	6%	13%	0%
31-40	25%	8%	17%	22%	33%
41-50	51%	42%	25%	24%	0%
51-60	12%	8%	33%	24%	67%
61 or over	0%	17%	17%	11%	0%

Note: 1, 191 participants answered these questions. Columns sum to 100%

Participants residing in Australia were categorised according to their state or territory and region of residence. A breakdown of the participants' location within Australia is provided in Figure 4.2. Just over 60% of participants indicated that they were located in a capital city and the remainder were primarily located in regional centres, with just under 10% of participants residing in rural or remote areas. Accordingly, the responses that follow should be considered largely indicative of the views of people living in urban areas. In order to examine the views and experiences of people living in regional and remote areas, targeted research will be necessary.

Figure 4.2: Location of Participants within Australia

State	Capital City	Regional	Rural	Remote
VIC (n = 399)	69%	22%	10%	
NSW (n = 313)	53%	36%	8%	
QLD (n = 166)	45%	46%	6%	
SA (n = 143)	68%	18%	13%	
WA (n = 86)	86%	9%		
NT (n = 36)	64%	17%	11%	8%
ACT (n = 33)	97%			
TAS (n = 18)	39%	33%	28%	

■ Capital City ■ Regional ■ Rural ■ Remote
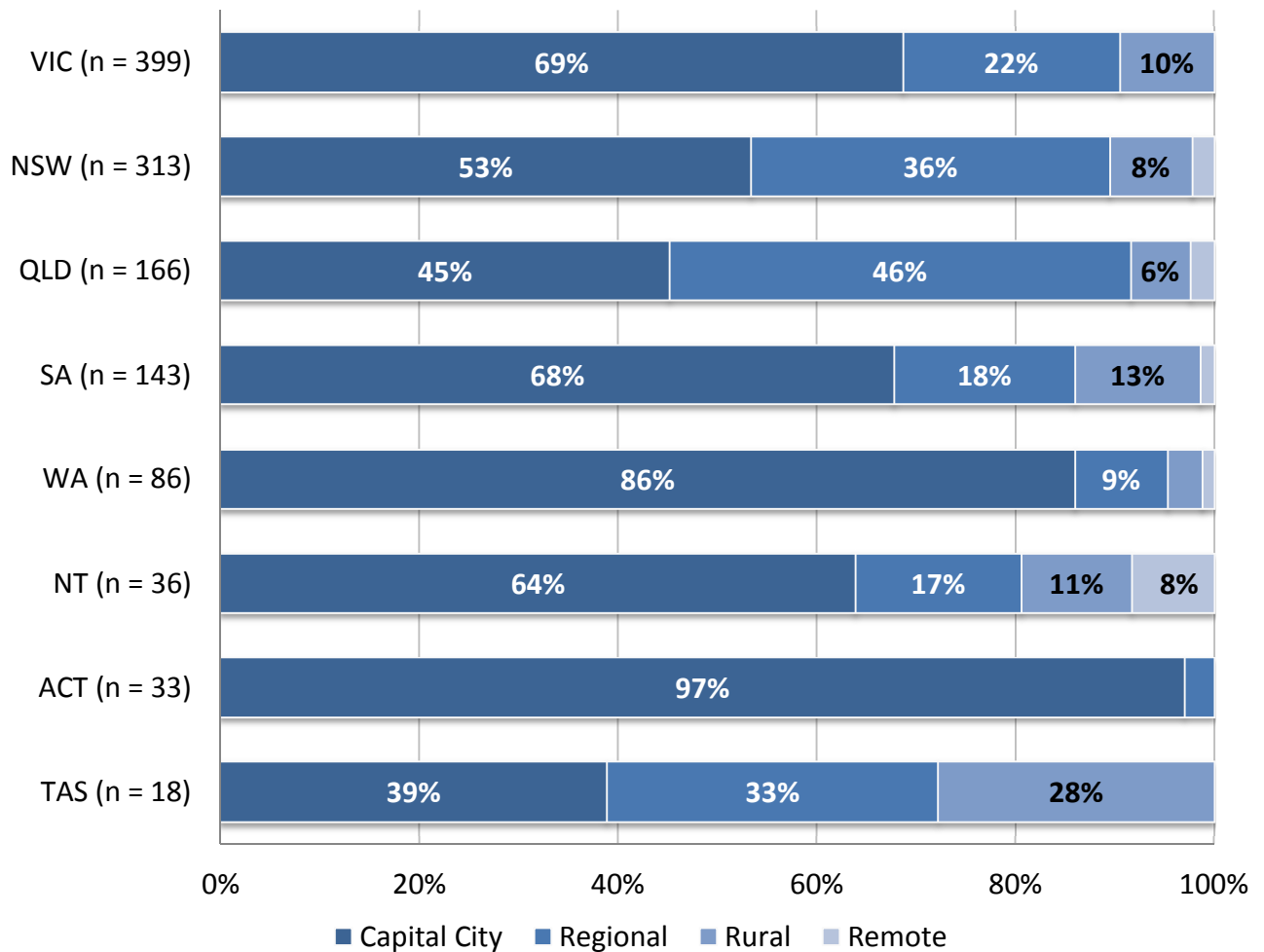
Notes: 1,194 participants answered this question. To improve presentation, values < 5% are not labelled in the figure.

As indicated in Figure 4.3, the majority (69%) of participants had completed tertiary education and only 1% had less than Year 10 education. Overall, the majority of participants were highly educated and urbanised; the average participant was a tertiary educated, urbanised, non-Indigenous female aged between 30 and 50 years. Despite considerable efforts to recruit Indigenous participants, Indigenous people were under-sampled, comprising 1.6% of participants compared with approximately 3% of the general population. In order to fully capture the views and experiences of Indigenous people separately, targeted and culturally sensitive research strategies will be required.

Figure 4.3: Participants – Highest Level of Education

Tertiary Educated (n = 857): 69%
Diploma/Certificate (n = 224): 18%
Year 12 (n = 60): 5%
Year 10 (n = 52): 4%
Below Year 10 (n = 11): 1%
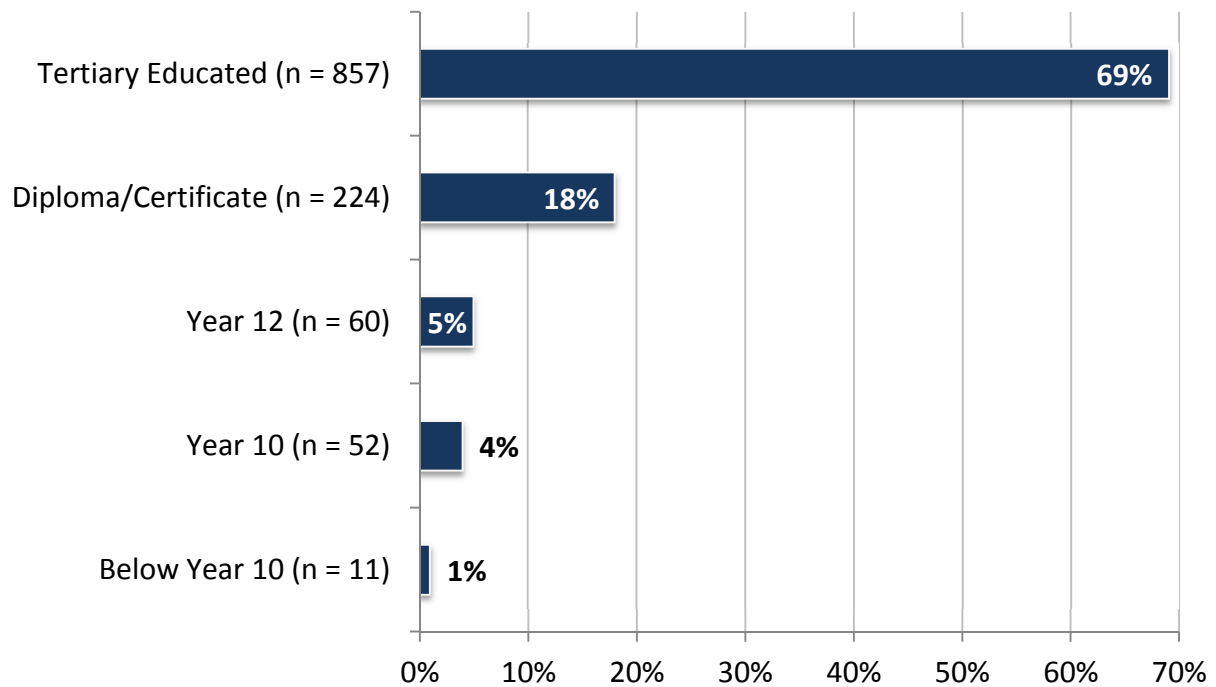
Note: 1, 204 participants answered this question

4.4.3 Connection to Topic

The survey aimed to draw on the expertise of participants; however the concept of expertise was not restricted to professional expertise. Those with lived experience and their carers, family members and support persons have significant expertise on the use of seclusion and restraint. Therefore it was important to be able to contextualise the responses according to participants' connection with the topic of seclusion and restraint. Participants were asked to identify their connection to the topic, by selecting as many of the following options as applied to their personal situation:

• I have personal experience of receiving treatment for a mental health issue (Consumer)

• I have personal experience of caring for, supporting or being a family member of someone with a mental health issue (Carer)

• I am a mental health practitioner (for example, psychiatrist, psychologist, social worker) (Mental Health Practitioner)

• I am a nurse (Nurse)

- I am not a mental health practitioner, but frequently encounter people with mental health issues in the course of my work (for example police officer, ambulance officer, correctional officer, security guard) (Working Exposure)

- I am someone employed due to my lived experience of mental health issues. (Lived Experience)

- I am a manager or leader of a mental health service, general health service or emergency response service (Manager/Leader)

The proportion of participants in each category is shown in Figure 4.4. Almost one in two participants (48%) identified as a carer; 40% reported personal experience of receiving treatment for a mental health issue and almost one in three identified as a nurse (30%) and/or mental health practitioner (28%).

Figure 4.4: Participant Connection to Topic
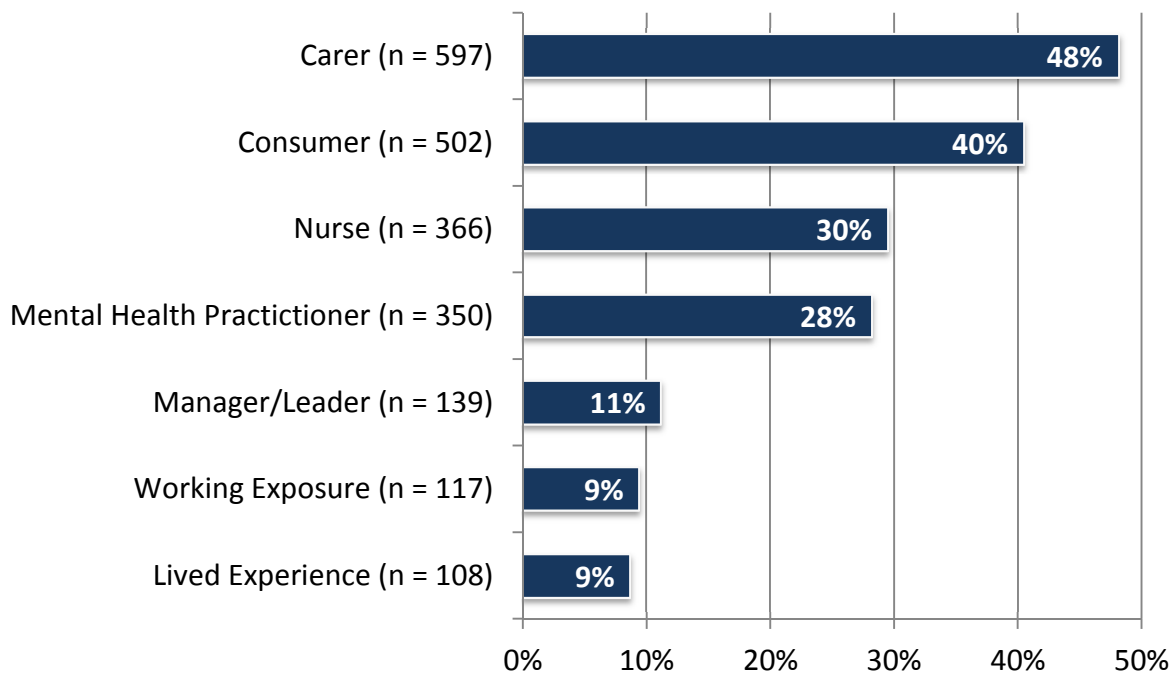
Note: Response options were not mutually exclusive.

4.4.4 *Personal Experience of Seclusion and Restraint*

Participants were asked if they had ever personally experienced seclusion or restraint in relation to a mental health issue. 369 participants (31%) indicated that they had personally experienced seclusion or restraint in relation to a mental health issue; with 817 participants (69%) indicating that they had not personally experienced seclusion or restraint in relation to a mental health issue. 54 participants did not answer the question.

For participants who reported personal experience of seclusion or restraint, Figure 4.5 shows how long ago these experiences occurred. Roughly equal proportions reported experiencing seclusion and restraint in the past year, between one and five years ago, and more than 5 years ago.

Figure 4.5: Nature of Lived Experience by Time Frame
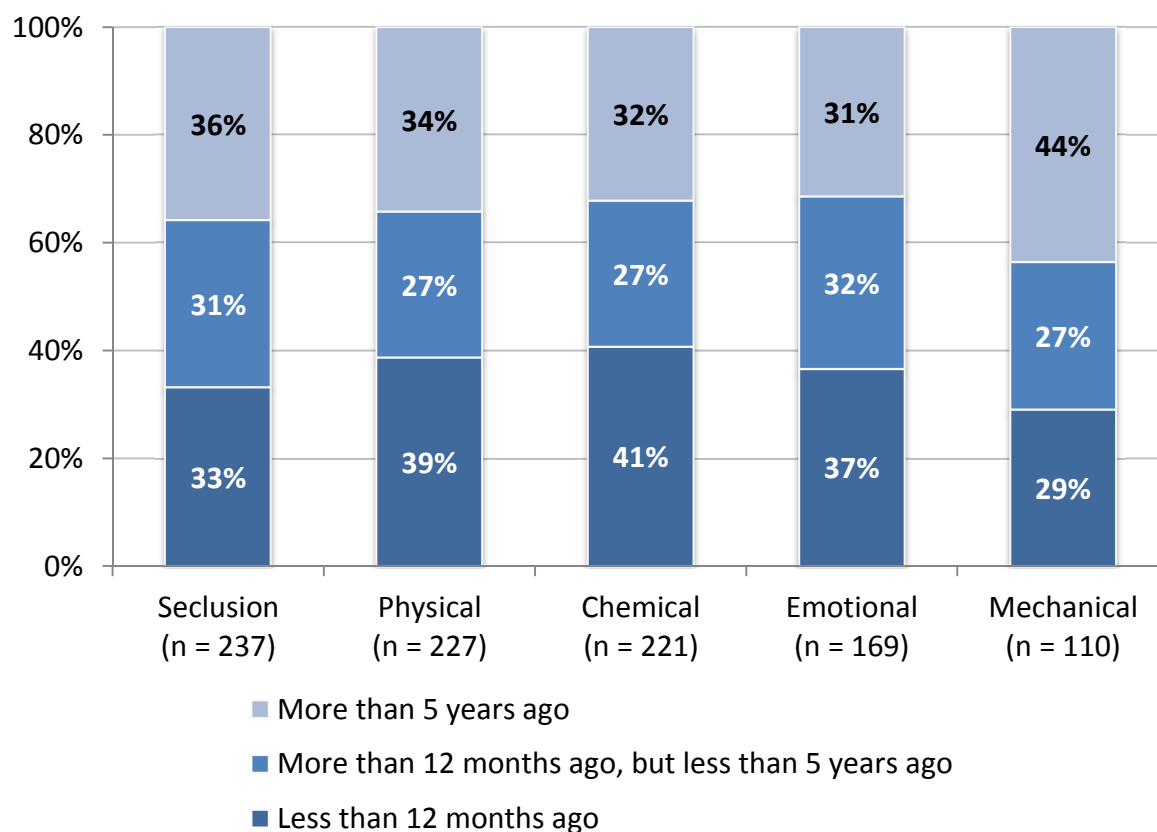
Table 4.2 sets out the location in which the personal experience of seclusion or restraint occurred.

Table 4.2: Nature of Personal Experience – by Location and Context

	Physical Restraint (n = 226)	Seclusion (n = 217)	Chemical Restraint (n = 205)	Emotional Restraint (n = 154)	Mechanical Restraint (n = 110)
Mental health service (inpatient)	78%	89%	84%	79%	50%
Hospital emergency department	40%	22%	44%	38%	40%
In transit (for example with police, ambulance)	26%	7%	13%	16%	32%

	Physical Restraint (n = 226)	Seclusion (n = 217)	Chemical Restraint (n = 205)	Emotional Restraint (n = 154)	Mechanical Restraint (n = 110)
In the community* with police attending	26%	2%	3%	12%	19%
In the community* with paramedics attending	15%	1%	9%	7%	15%
Mental health service (outpatient)	12%	6%	24%	36%	5%
In the community* with mental health practitioners attending	10%	2%	9%	19%	10%
Police watch house	8%	8%	0%	5%	9%
Prison or youth justice facility	8%	6%	3%	5%	11%
In the community* with security guards attending	4%	1%	1%	5%	2%
General health facility	4%	2%	11%	18%	8%

Notes: * 'Community' refers to any community location, not necessarily a community mental health service or any other prescribed location.
As answers were not mutually exclusive, each column does not add up to 100%. The n value for each column is the total number of participants; many of whom selected multiple locations for each form of restraint.

4.4.5 *Observation of or Being Affected by Others' Experience of Seclusion and Restraint*

Participants were asked whether or not they had observed or been affected by somebody else being secluded or restrained in relation to a mental health issue. The majority (79%) of participants reported at least one such experience, and these participants were asked to indicate how long ago these experiences occurred, and in which of the following contexts they occurred:

- as a carer, supporter or family member of a person who has been secluded or restrained (Carer)

- as a mental health practitioner caring for a person who has been secluded or restrained (Practitioner carer)

- as a mental health practitioner directly responsible for secluding or restraining a patient (Practitioner responsible)

- as a mental health practitioner responsible for making the decision to seclude or restrain a patient (Practitioner deciding)

- as a co-client or patient witnessing someone else being secluded or restrained (Patient Witness)

- other

The results are shown in Table 4.3. A substantial proportion of participants reported observing or being affected by someone else being secluded or restrained, either as a Carer or as a Patient Witness.

Table 4.3: Nature of Observed Experience by Time Frame

Context	In the past 12 months	In the past 5 years	More than 5 years ago
Practitioner Carer	6%	4%	2%
Practitioner responsible	8%	9%	9%
Practitioner deciding	12%	13%	11%
Carer	17%	10%	9%
Patient Witness	18%	12%	11%
Other	32%	19%	11%

Note: 982 participants answered this question.

There were a couple of recurring themes within the narrative comments made by some of the participants that picked 'other'. The first related to witnessing a seclusion or restraint while '*visiting a consumer*' at a healthcare facility. For example, one Consumer/Carer stated that they had observed or been affected by seclusion and or restraint while '*visiting friend for whom I don't have on going responsibility*'.

Secondly, some participants indicated that they observed someone being secluded or restrained through their work roles, but not as mental health practitioners. For example, one Carer stated that they had their experience because they are '*the lawyer for a secluded or restrained client*'.

4.4.6   Defining Seclusion and Restraint

Early on in the survey, definitions of the various types of seclusion and restraint were introduced to the participants. A link back to those definitions was provided throughout the remaining pages to allow the participants to refer back to them. Throughout the survey, participants were asked to respond to questions about seclusion and restraint with respect to the provided definitions, rather than their own definitions. This was essential so that participants' responses could be combined for analysis purposes. Nonetheless, survey participants were given an opportunity to define the terms *physical restraint, mechanical restraint, chemical restraint, emotional restraint* and *seclusion* in their own words. This was done to afford them the opportunity to express what they mean by those terms should they disagree with those supplied. It also allowed for the further contextualisation of their other responses and the analysis of interesting trends. The resulting definitions were then coded using the general inductive approach in order to assess the similarity of participants' definitions to the definitions provided within the survey itself.

The survey-supplied definitions were thematically coded against three key areas: *mode* (method of implementation/enactment), *purpose* (of the seclusion or restraint type) and *tone* (of the definition/response). Table 4.4 provides more detail as to the results of the coding:

Table 4.4: Coding of Survey-Supplied Definitions of Seclusion and Restraint Terms

Term	Definition	Mode	Purpose
Physical Restraint	*Physical restraint* occurs when bodily force is used to control a person's freedom of movement	Bodily Force	Control Behaviour/ Restrict Movement
Chemical Restraint	*Chemical restraint* occurs when medication is given primarily to control a person's behaviour but not to treat an ongoing mental illness or physical condition	Pharmaceuticals/ Medication	Control Behaviour/ Restrict Movement
Emotional Restraint	*Emotional Restraint* occurs when a person is conditioned to such an extent that there is a loss of confidence in being able to express his or her views openly and honestly to clinical staff, for fear of the consequences	Psychological/ Threats/Verbal	Control Behaviour/ Restrict Movement

Term	Definition	Mode	Purpose
Mechanical Restraint	*Mechanical restraint* occurs when a device that controls an individual's freedom of movement is used	Device	Control/ Manage Behaviour
Seclusion	*Seclusion* is the deliberate confinement of a person, alone, in a room or area that the person cannot freely exit from	Confinement	Nil

Based on this coding, the participant responses were coded and analysed. This allowed for the 'Similarity' analysis between the survey-supplied definitions and participant responses.

Table 4.5: Definition Tones

Tone	Description	Example Quote
Negative	Response has connotations of negative emotions	… holding me down, holding me so I can't run away or move. It feels like abuse and assault (Consumer)
Unbiased	Response has both negative and positive emotional language, OR has neutral connotations (as commonly found in policy documents)	… physically holding a person for the purposes of controlling behaviour/restricting movement (Carer and Practitioner)
Positive	Response has connotations of positive emotions	… holding someone to prevent them from harming themselves or others (Practitioner).

Coding and Analysis Example

One definition of physical restraint was provided by a participant as *'Being held against will by another person/people - force used to immobilize one'*. This definition was assessed and categorised according to Mode, Purpose and Tone:

Mode: Bodily Force

Purpose: Restrict movement

Tone of Definition: Unbiased

Following this preliminary analysis, a Similarity Rating between survey-provided and participant-provided definitions was created and is presented below:

Similar: Mode and Purpose match

Somewhat: Mode or Purpose match

Not Similar: No match found

The coding for tone of definition was done in order to facilitate exploration of possible trends that may provide further insight into the data collected.

Overall, while the majority of definitions with an unbiased tone pertained to mechanical restraint, a negative tone was used predominantly in relation to emotional restraint.

4.4.7   Definitions of Physical Restraint

From a total of 940 text answers provided, six were excluded due to the fact that no definition could be inferred from them, leaving 934 definitions for similarity analysis. The largest number of definitions was found to be 'somewhat similar' to the survey-supplied definition, followed by 'similar' and finally, 'not similar'.

Generally, most definitions had an unbiased tone, distantly followed by positive tones and negative tones. However it should be noted that the majority of definitions with an 'unbiased' tone were given by participants who had not had personal experience of seclusion or restraint.

Participant Definitions – Coding of 'Purpose'

The code of 'purpose' refers to the reasoning or rationale for the implementation of physical restraint. The results of the coding of this item are presented in more detail below.

Some of the definitions of 'physical restraint' did not have an identified purpose. That is, the coder could not identify why the participant thinks the restraint is used. For example, '*A person or persons restraining another person by use of their own* body' (Consumer/Practitioner). Meanwhile, other definitions listed 'restriction of movement' as a purpose of physical restraint:

'*… another person using bodily force to restrict someone's movement'* (Consumer)

'*… being held down, prevented from moving'* (Consumer)

'*Laying hands on a patient in order to restrict their movement'* (Practitioner)

A smaller number of participants noted 'prevention of harm' as a purpose of physical restraint, with one practitioner participant defining this as '*being safely held (by a team hopefully) during a period of distress with the aim of preventing harm to self or others*'.

Finally, the remaining definitions provided other purposes for physical restraint ranging from 'control behaviour' to 'containment', such as '*when they [restrainer] physically touch a person and forcibly hold them down on the ground or carry them into seclusion*' (Consumer).

Participant Definitions – 'Prevent Harm' as a Purpose

Where the purpose was categorised as 'prevent harm', one third of responses were given by participants who noted they had personal experience of seclusion and restraint in relation to a mental health issue. Moreover, almost half of responses were given by participants who resided in a capital city, while 26% were given by participants residing in a regional area and 14% by those residing in a rural area.

A majority of responses were given by participants who indicated that they had observed or been affected by someone else being secluded or restrained. The following figure shows a 'word cloud' with the most recurring words that were found in responses categorised with 'prevent harm' as a purpose. A word cloud is a graphical illustration of word frequency in a given data set that gives greater distinction to words that appear more frequently in the source text. The larger the word within the word cloud, the more commonly the word occurred in the data set.

Figure 4.6: Word Cloud – 'Prevent Harm' as Purpose (Physical Restraint)

Participant Definitions – Coding of 'Mode'

The code of 'mode' refers to the manner in which physical restraint is implemented or carried out. Over 69% of participants responding to this question detailed 'bodily force' as the primary mode of physical restraint, in line with the definition provided within the survey. Example definitions included:

> '*Bodily force is used to control a person's freedom of movement. Such as a person or persons holding another person*' (Carer)

> '*Body contact to hold or prevent someone from voluntary action*' (Practitioner).

The majority definition with the mode of 'bodily force' was followed by 12% of responses identifying 'physical means' as the mode of physical restraint. This was defined by one participant as '*Confining someone by physical means (for example, holding down all limbs)*' (Practitioner). It is interesting to note that 7% of definitions did not list a mode of physical restraint at all.

One participant stated that physical restraint could also be defined as '*being prevented from moving*' without elaborating on the manner of enactment. Five per cent of responses listed the use of a 'device' as a mode of implementing physical restraint, as one participant stated: '*device used to make a person stay in the same place.*' (Practitioner/Carer/Consumer).

The remaining 7% presented a range of modes of implementing physical restraint, including some kind of 'force', or 'environmental aids', demonstrated by responses

that showed physical restraint can relate to being '*stopped from entering or exiting areas freely due to physical barriers (for example, locked doors)*' (Consumer/Practitioner).

4.4.8   Definitions of Mechanical Restraint

A total of 896 text answers were provided in response to this question. However, 31 of these responses were excluded because no definition could be inferred from them. The exclusion left 865 definitions for similarity analysis. The majority (57%) of definitions were deemed to be 'somewhat similar' to those supplied within the survey. This was followed by 39% that were considered 'similar' and finally, 5% that were considered 'not similar'.

The tone of the definitions varied greatly. An overwhelming majority had an unbiased tone to their definition (91%) while 6% had a positive tone, and 3% had a negative one. Examples of negatively toned items included:

'*Being handcuffed and sprayed with capsicum spray*' (Consumer)

'*Tied spread eagle on bed in emergency ward on public display*' (Consumer/Carer)

Items with an unbiased or ambivalent tone included '*a person being restrained by use of an object like a strap*' (Practitioner/Carer), to '*keep someone who is uncontrolled and behaving dangerously using some mechanical vehicles such as belt to prevent harm to himself/herself or others*' (Practitioner) or '*being strapped to a bed or chair by legs or arms to stop a person from leaving or becoming violent*' (Consumer).

Those responses with a positive tone cited prevention of harm as a purpose for mechanical restraint and focussed on the safety of the consumer, staff, and witnesses.

Participant Definitions – Coding of 'Purpose'

This code refers to the reasoning or rationale for the implementation of mechanical restraint. Forty-five per cent of the definitions provided by participants demonstrated no identifiable purpose of the enactment of mechanical restraint. One participant defined this type of restraint as '*being forced into a position of restraint with mechanics or fixed objects'* (Consumer). This percentile is followed closely by the 41% that noted 'restriction of movement' as the purpose for using mechanical restraint, such as '*being stuck on a bed with leather straps binding your hands and feet to the bed, preventing you from moving, or a straight-jacket*' (Consumer). Six per cent of definitions noted 'containment' as a purpose for mechanical restraint.

One carer defined containment as 'restraining someone by means of mechanical devices in order to restrict movement from a place or space'. Interestingly, only 4% of

definitions listed 'prevent harm' as a purpose for mechanical restraint, a figure much lower than that of physical restraint. One practitioner participant stated that mechanical restraint included the '*use of devices only to restrain a mentally ill person for the purpose of avoiding self-harm and harm to others*'.

The remaining responses noted a range of other purposes including 'abuse', 'control behaviour', and 'administer medications'. Example definitions included '*the use of an inanimate device to control a person*' (Practitioner); '*to use objects to abuse by force*' (Other) and finally, '*strapping the person into a machine or mechanism (including electrotherapy chair) with or without their consent to administer medication*' (Carer).

Participant Definitions – 'Prevent Harm' as a Purpose

It is interesting to note that responses stating that the purpose of mechanical restraint was to 'prevent harm' came primarily from nurses, followed closely by carers, supporters and/or family members. Moreover, those who identified their age range to be between 51 and 60 years of age, as well as those who resided in a capital city, were also likely to have stated 'prevent harm' to be the main purpose of mechanical restraint. The following figure shows the word cloud of the definitions of mechanical restraint with 'prevent harm' as purpose.

Figure 4.7: Word Cloud – 'Prevent Harm' as Purpose (Mechanical Restraint)

Participant Definitions – Coding of 'Mode'

This code refers to the manner in which mechanical restraint is implemented. The majority (92%) of participants noted 'device' as the mode of implementation within the category of mechanical restraint, which is consistent with the survey-supplied definition.

One consumer defined mechanical restraint as '*a device is used to control freedom of movement*' (Consumer). The remaining responses noted a range of modes including 'mechanical means', 'environmental aids', and 'clothing', such as '*physically restraining someone by mechanical means- tying them to the bed for example*' (Practitioner/Carer).

Interestingly, less than 2% of responses did not have a mode of implementation, with one participant defining mechanical restraint as '*being bodily restricted against one's will in ability to move physically as and/or when desired*' (Consumer/Carer).

4.4.9 Definitions of Emotional Restraint

From a total of 868 text answers provided, 82 were excluded due to the fact that no definition could be inferred from them, leaving 786 definitions for similarity analysis. Fifty-eight per cent of definitions were found to be 'not similar' to the definition of emotional restraint as supplied by the survey. Thirty-one per cent were 'somewhat similar', and 11% were found to be 'similar'. However, the 'tone' of the definitions did not vary as much as those of the other terms. Sixty-two per cent of responses had a negative tone, while 35% had an unbiased tone, followed by 3% with a positive tone.

Examples of negatively toned responses included:

'*Being emotionally blunted/shut down and intimidated*' (Consumer)

'*Degrading a person or overwhelming them or pressuring them into a response*' (Practitioner)

'*Being restrained from showing emotions*' (Consumer)

'*When you feel you have to hide your own emotions*' (Consumer)

'*When the emotions expressed are ignored and disregarded*' (Consumer)

'*When a person is unable to speak and say what they want in their treatment. Or not listened to. Their voice doesn't count*' (Practitioner).

Unbiased or ambivalently toned definitions included '*controlling one's feelings so they do not hurt oneself or other people*' (Carer)

Participant Definitions – Coding of 'Purpose'

This code refers to the reasoning or rationale for the implementation of emotional restraint. The majority (78%) of definitions had no identifiable purpose, such as '*a person feeling so emotionally powerless that they are restricted in their thoughts and feelings about their own treatment*' (Carer). This was followed by 18% of responses that listed 'control behaviour' as the purpose of emotional restraint. One practitioner

defined this as '*preventing a person from expressing his or her thoughts/feelings for the purposes of bringing their behaviour under control*' (Practitioner).

The remaining responses noted 'containment', 'restriction of movement' and 'prevent harm' as purposes for emotional restraint. This included:

'*Reducing someone's sense of control and self to the point where they are unable to exercise their own ability to move or leave*' (Practitioner)

'*Keeping someone in an environment where it is deemed wrong to move in a certain way or leave the area, making them feel as if they have to stay even if they don't want to*' (Consumer)

'*Use as a de-escalation t*echnique' (Practitioner/Carer)

Participant Definitions – 'Prevent Harm' as a Purpose

The following information pertains to the emotional restraint definitions with the purpose categorised as 'prevent harm'. The majority of those that quoted 'prevent harm' as the main purpose of emotional restraint were identified as carers, supporters and/or family members, with an age range of 51-60 years who reside in a capital city. Upon text analysis of these responses, it was noted that similar recurring words were present here as those shown in the previous word clouds set out in Figures 4.6 and 4.7.

Participant Definitions – Coding of 'Mode'

This code refers to the manner in which emotional restraint is implemented. Consistent with the fact that most definitions of emotional restraint did not match the survey-supplied definition, a wide range of modes were noted. Twenty-five per cent of definitions did not have an identifiable mode of implementation, such as '*being handed the rules you must follow otherwise you will be sorry*' (Consumer).

Meanwhile, 18% of participants noted forms of 'psychological means' as the main mode of implementing emotional restraint. Example definitions included '*influencing someone's emotional psychological self to prevent them from doing something or to influence a decision*' (Practitioner) and '*Using conditioning to change someone's behaviour*' (Consumer).

This was closely followed by the 11% of responses that noted 'fear' tactics as the main mode of using emotional restraint, defined by one practitioner as '*being unable to freely express concerns and ideas for fear of consequences*' (Practitioner). Eighteen per cent of participants listed 'threats' and/or other 'verbal' means as the main modes of using emotional restraint. One participant defined emotion restraint as including:

'Covert and overt threats, use of the power imbalance to intimidate, subtle or overt use of language that is designed to coerce or belittle so the restrainer can influence the patients behaviour' (Consumer/Carer).

The remaining responses noted a variety of other modes including 'manipulation', 'institutionalisation', 'negotiation and bargaining', and 'peer pressure', such as *'playing on the person's emotions or being manipulate to make them comply/subdue'* (Carer); *'systematic 'institutionalisation' of people so that they will be compliant, quiet and easy to look after while they are in care'* (Practitioner); *'bargaining with a patient to gain cooperation'* (Carer/Practitioner), and finally, as *'pressure bought upon you by friends or family'* (Consumer).

4.4.10 Definitions of Chemical Restraint

A total of 933 text answers were provided, 14 of which were excluded due to the fact that no definition could be inferred from them, leaving 919 definitions for similarity analysis. Forty-nine per cent of responses were found to be 'somewhat similar' to the definition of chemical restraint supplied in the survey. This was closely followed by 45% that were deemed 'similar' and finally, 6% that were considered 'not similar'.

Seventy-four per cent of definitions had an unbiased tone to them, which is followed by 14% with a negative tone and 11% with a positive tone. Examples of unbiasedly toned definitions included:

'Administering or dispensing medication to sedate patient in order to restrict movement' (Practitioner)

'Administering drugs to a person involuntarily to change their behaviour and restrain them, but not specifically to treat the mental illness' (Consumer)

Negatively toned responses stated that *'drugs are used to control a person's freedom of movement'* (Carer); *'to sedate someone by chemical agents and lead to being robotized'* (Practitioner) and *'to make managing them more 'convenient' for staff'* (Carer/Practitioner).

Positively toned responses related to the use of chemical restraint as a temporary strategy for managing behaviours that had the potential to harm the individual or those around, and included *'where medication is used to reduce behaviour when this behaviour is detrimental to others'* (Practitioner) and *'using drugs, usually sedative to control a person's behaviour as a temporary strategy to protect themselves or others against harm'* (Consumer/Carer).

Participant Definitions – Coding of 'Purpose'

This code refers to the reasoning or rationale for the implementation of chemical restraint. Forty per cent of responses listed 'control behaviour' as the primary

purpose for using chemical restraint, such as '*being given medication to control your behaviour*' (Consumer). Thirty per cent of definitions had no identifiable purpose for using chemical restraint, for example, 'a *person being restrained through use of medication*' (Carer/Practitioner). Twelve per cent of definitions noted 'sedation' as the main purpose for chemical restraint, such as '*being given forced medication against a person's will to sedate them*' (Consumer).

Only 10% of definitions indicated 'restrict movement' as the main purpose for chemically restraining someone. One carer defined this as the '*administration of drugs which alter the person's chemical state so as to reduce mobility or immobilize a person.*' Only 7% of responses indicated 'prevent harm' as the purpose for using chemical restraint, such as '*medication used to reduce/limit potentially harmful behaviour/actions*' (Practitioner).

The remaining responses listed 'containment' and 'treatment' as the purposes for chemical restraint. This included '*sedating a person to contain them*' (Practitioner) or giving medication in a '*bid to manage him or her, for the purposes of treatment*' (Practitioner).

Participant Definitions – 'Prevent Harm' as a Purpose

The majority of those that wrote 'prevent harm' as the main purpose of chemical restraint were identified as nurses, whose age range fell between 51 and 60 years, and resided in a capital city. Upon text analysis of these responses, it was noted that similar recurring words were present here as those shown in the word clouds in Figures 4.6 and 4.7.

Participant Definitions – Coding of 'Mode'

This code refers to the manner in which chemical restraint is implemented. Ninety per cent of definitions suggested the use of 'pharmaceuticals/medication' as the main mode of implementing chemical restraint. For example:

'*Being given medication to control your behaviour*' (Consumer)

'*Administration of drugs which alter the person's chemical state so as to reduce mobility or immobilize a person*' (Carer)

The remaining responses specifically noted a range of modes including 'chemical means', 'injection', and 'sedatives', stating that: chemicals '*are used to render a person incapable of harming themselves and others*' (Consumer/Carer) and '*to sedate and control*' (Consumer).

Other definitions included '*sedating a person with the intent of keeping those in a subdued state beyond the chemicals therapeutic effects*' (Practitioner).

Less than 2% of responses had no identifiable mode of using chemical restraint such as '*modifying someone's behaviour and restricting their ability to make informed decisions or give/deny informed consent*' (Consumer/Carer/Practitioner).

4.4.11 Definitions of Seclusion

A total of 934 text answers were provided, 8 of which were excluded due to the fact that no definition could be inferred from them, leaving 926 definitions for similarity analysis. Fifty-three per cent of definitions were found to be 'somewhat similar' to the definition of seclusion supplied within the survey. While 38% were 'similar', with only 9% 'not similar'.

The majority of responses (70%) had an unbiased tone and were distantly followed by 30% with a positive tone, and 11% with a negative tone. Example definitions that were deemed to have unbiased tones included:

'*A person being locked in a confined space for a period of time*' (Carer)

'*An individual being isolated in a room away from normal social contact*' (Practitioner)

'*Being confined to a room or location in isolation from other people*' (Consumer)

'*To place someone in a room, which can be locked or left open for the person's safety and/or the safety of those around them*' (Practitioner)

Negatively toned items included '*left without contact*' and '*ignoring their presence or their opinions*' (Practitioner).

Participant Definitions – Coding of 'Purpose'

This code refers to the reasoning or rationale for the implementation of seclusion.

The bulk of definitions had no identifiable purpose within them, such as '*a patient is in a locked space, on their own, from which they are unable to leave*' (Practitioner); while some provided only 'isolation' as the purpose of seclusion. Interestingly, others noted 'isolation' to be the mode of seclusion, such as '*being placed in a room to isolate you from contact*' (Consumer).

Eleven per cent of responses listed to 'prevent harm' as the main purpose for secluding someone. One participant explained this as '*being isolated from other people mainly to prevent harm to self and others*' (Consumer/Carer).

The remaining responses noted a variety of purposes for seclusion including 'control behaviour', 'lower stimulus' and 'restrict movement', with responses such as '*confining a person to a room they cannot exit from to limit their freedom and control behaviour*' (Practitioner); '*giving someone time out in a low stimulus environment*'

(Practitioner) and '*placing a person in an area that restricts their movement, freedom*' (Practitioner) listed by survey participants.

Participant Definitions – 'Prevent Harm' as a Purpose

The majority of those who identified 'prevent harm' as the main purpose of seclusion were identified as nurses in the age range of 51-60 years who resided in a capital city. Upon text analysis of these responses, it was noted that similar recurring words were present here as those shown in the word clouds in Figures 4.6 and 4.7.

Participant Definitions – Coding of 'Mode'

This code refers to the manner in which seclusion is implemented.

Sixty-three per cent of definitions listed 'confinement' as the main mode of implementing seclusion, such as '*any confinement in a space of which someone cannot freely exit*' (Carer/Practitioner).

Thirty per cent noted 'isolation' as the main mode of seclusion, such as '*being isolated from other people*' (Carer).

The remaining responses were split between noting the use of the physical 'environment' as the mode for secluding someone, and having no identifiable mode, such as '*being put in a room with no objects other than a mat*' (Consumer) and to '*reduce the personal space and take away freedom*' (Carer).

4.4.12 *Possible Effects of the Use of Seclusion and Restraint*

In order to examine perceptions of the effects of seclusion and restraint, participants were asked to consider how likely each of a list of effects was to occur as a consequence of seclusion or restraint for a mental health issue. Participants were presented with nine potential effects and, for each, were asked to indicate whether they thought the effect would occur always, often, rarely or never. The list of potential effects included:

- traumatisation or triggering of past trauma experiences (trauma)

- worsening of the person's mental health issue (worse mental health)

- increased safety of the person secluded or restrained (increase consumer safety)

- increased safety for staff or others (increase staff safety)

- compromised therapeutic relationship/trust (compromised trust)

- compromised family relationship (compromised family relationships)

- infringement of human rights, or negative feelings such as humiliation, stigma or disempowerment, anger or fearfulness (consumer rights infringement)

- setting of boundaries on inappropriate or violent behaviour (set behaviour boundaries)

- serious physical harm to the person secluded or restrained (consumer harm)

Participants were asked to respond separately with respect to physical restraint, mechanical restraint, chemical restraint, emotional restraint and seclusion. Responses to this series of questions are summarised in Figures 4.8 to 4.12.

Responses with respect to physical restraint are summarised in Figure 4.8. Just over half of participants believed that the rights of the consumer were always infringed when physical restraint was employed, and almost all believed that physical restraint always or almost always compromised therapeutic relationships/trust.

Figure 4.8: Participant Perceptions of the Likelihood of Specific Effects of Physical Restraint

Consumer rights infringement (n = 805)	Always 51%	Often 39%
Compromised trust (n = 800)	40%	46% — Rarely 13%
Trauma (n = 834)	24%	65% — 10%
Worse mental health (n = 821)	23%	53% — 22%
Compromised family relationships (n = 759)	14%	50% — 31%
Increase staff safety (n = 805)	13%	50% — 31%
Set behaviour boundaries (n = 781)	12%	40% — 36%
Increase consumer safety (n = 813)	48%	36%
Consumer harm (n = 803)	44%	46%

■ Always ■ Often ■ Rarely ■ Never
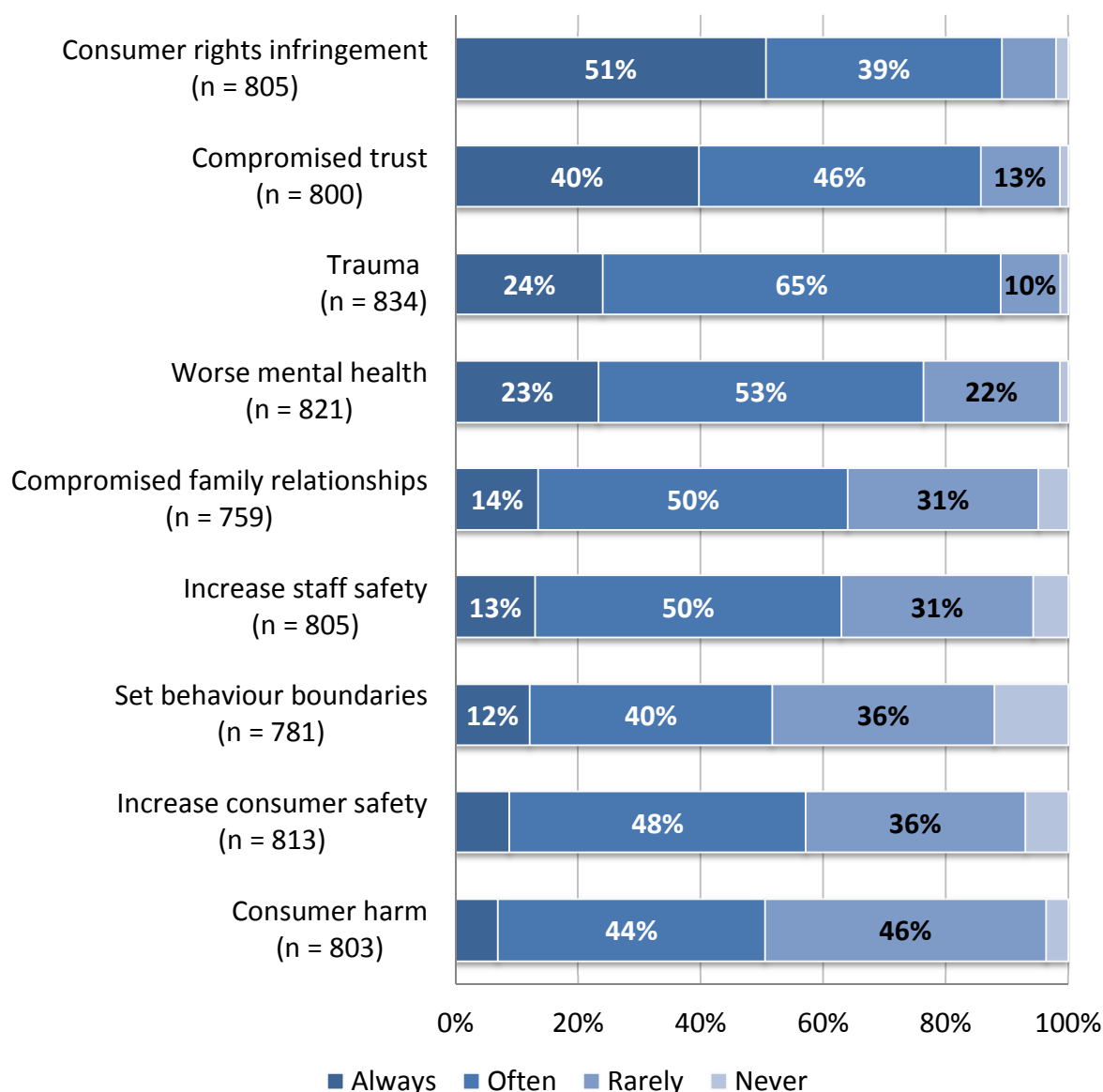
Note: To improve presentation, values < 10% are not labelled in the figure.

At the same time, however, more than half also believed that physical restraint always or almost always increased the safety of the person being secluded or restrained, and increased safety for staff or others.

A similar tension was evident in responses with respect to mechanical restraint (Figure 4.9) and chemical restraint (Figure 4.10), although only 39% of participants believed that chemical restraint 'always' infringed the rights of consumers. With respect to emotional restraint (Figure 4.11), 90% of participants reported that this practice always or almost always infringed upon the rights of consumers. However, only around one in four believed that it increased consumer safety. Finally, the majority of participants believed that seclusion 'always' infringed upon the rights of

consumers, while just over half believed that seclusion always or almost always increased the safety of consumers when it was implemented (Figure 4.12).

Figure 4.9: Participant Perceptions of the Likelihood of Specific Effects of Mechanical Restraint
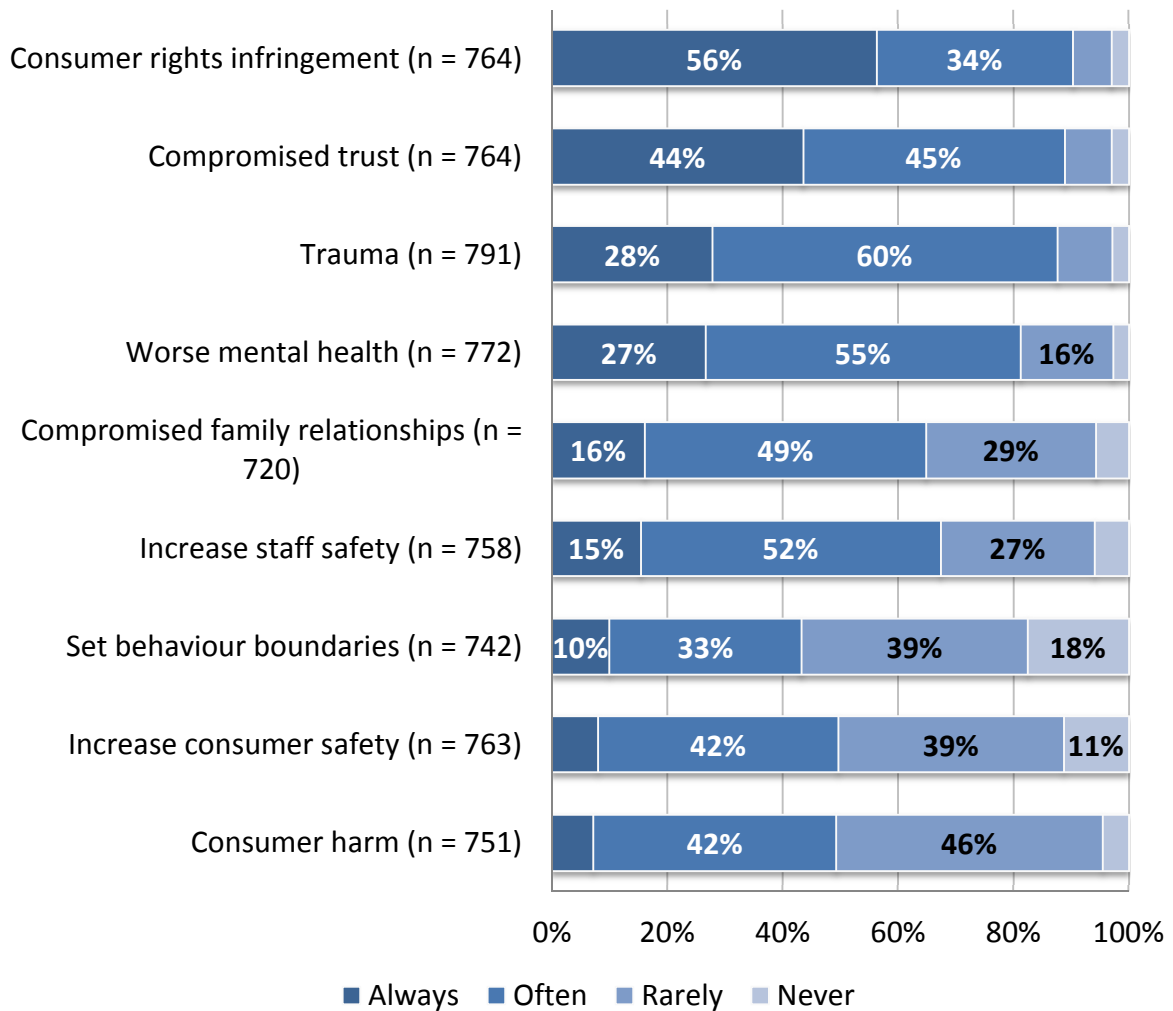
Note: To improve presentation, values < 10% are not labelled in the figure.

Figure 4.10: Participant Perceptions of the Likelihood of Specific Effects of Chemical Restraint

	Always	Often	Rarely	Never
Consumer rights infringement (n = 792)	39%	41%	17%	
Compromised trust (n = 791)	28%	47%	24%	
Increase staff safety (n = 789)	16%	60%	20%	
Worse mental health (n = 807)	15%	43%	38%	
Trauma (n = 810)	13%	50%	34%	
Compromise family relationships (n = 745)	12%	47%	35%	
Increase consumer safety (n = 794)	10%	54%	29%	
Set behaviour boundaries (n = 765)		35%	40%	18%
Consumer harm (n = 779)		33%	54%	
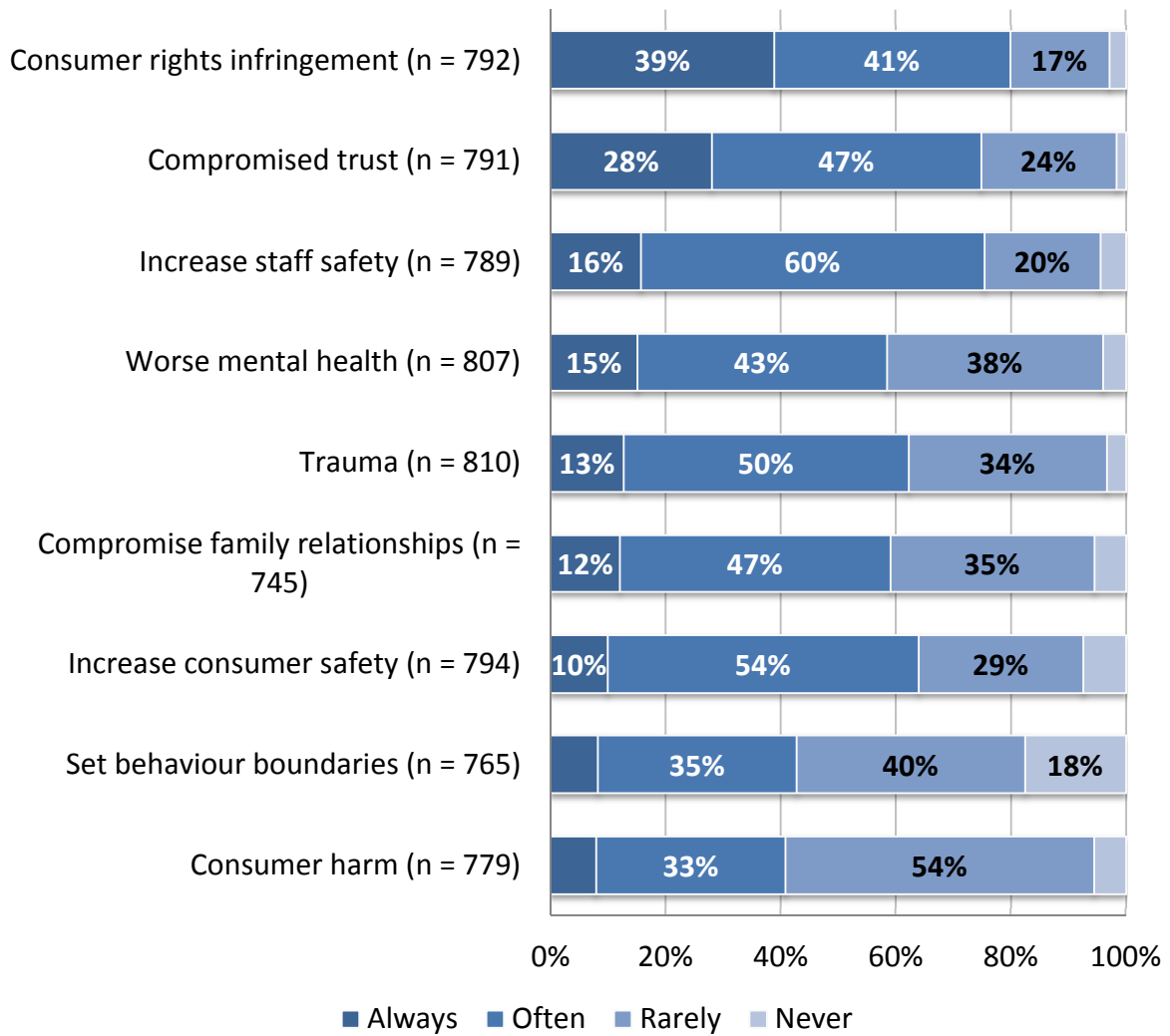
Note: To improve presentation, values < 10% are not labelled in the figure.

Figure 4.11: Participant Perceptions of the Likelihood of Specific Effects of Emotional Restraint
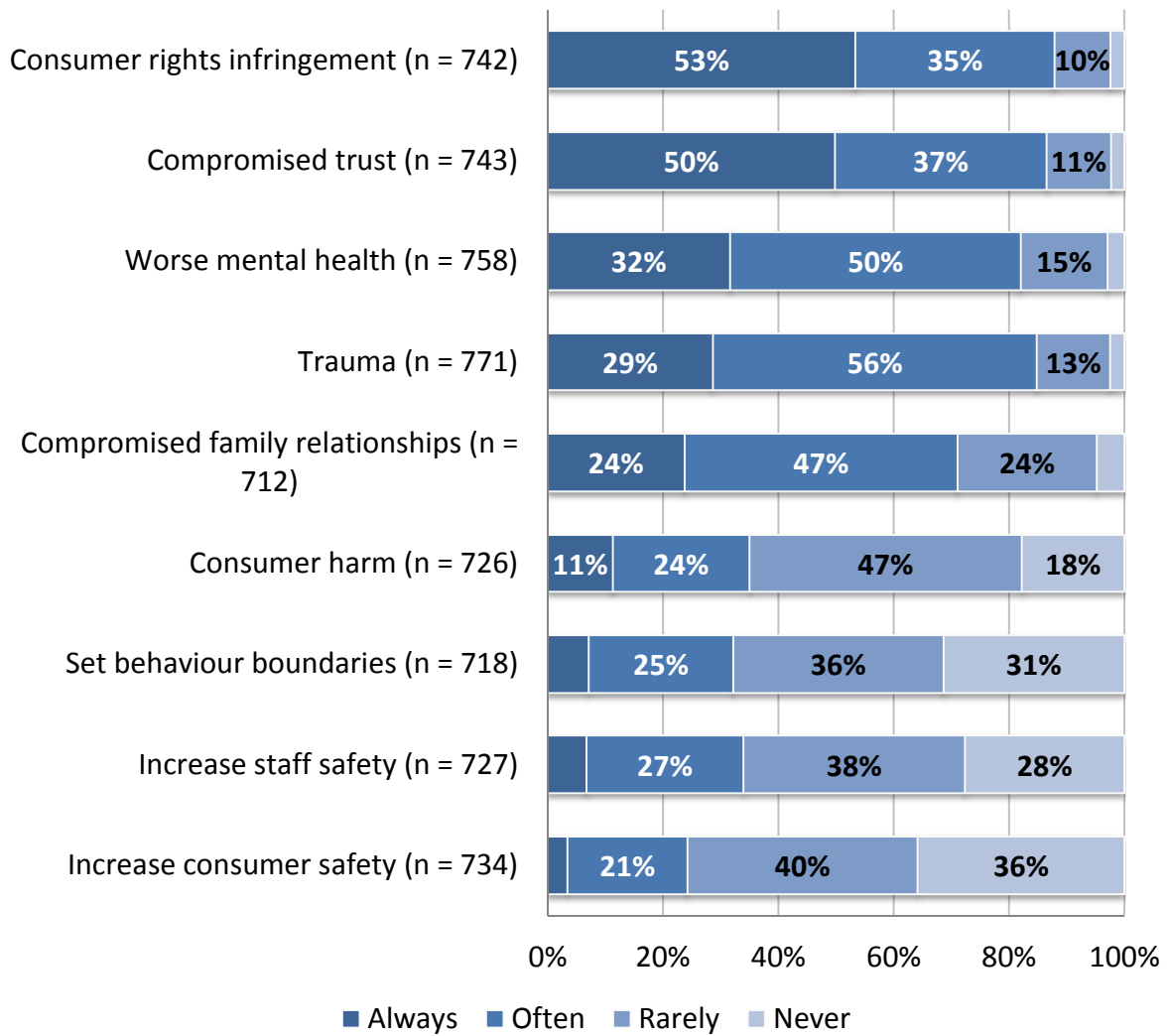
Note: To improve presentation, values < 10% are not labelled in the figure.

Figure 4.12: Participant Perceptions of the Likelihood of Specific Effects of Seclusion

Effect	Always	Often	Rarely	Never
Consumer rights infringement (n = 797)	51%	37%	10%	
Compromised trust (n = 792)	37%	47%	14%	
Trauma (n = 824)	29%	56%	13%	
Worse mental health (n = 813)	26%	51%	22%	
Increase staff safety (n = 788)	22%	49%	23%	
Compromised family relationships (n = 755)	17%	50%	28%	
Set behaviour boundaries (n = 772)	13%	40%	34%	13%
Increase consumer safety (n = 796)	10%	45%	35%	10%
Consumer harm (n = 792)		31%	55%	

■ Always ■ Often ■ Rarely ■ Never
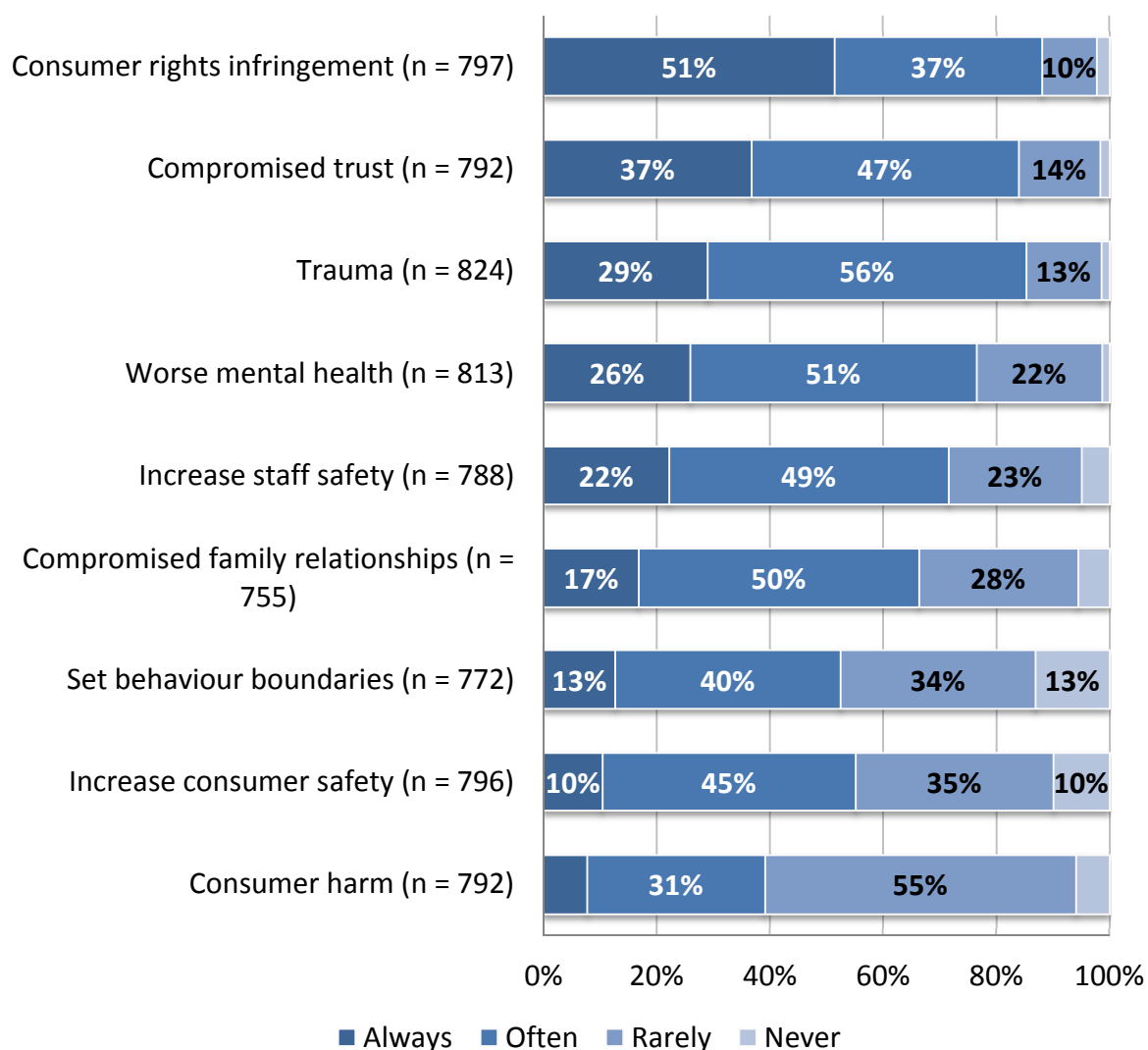
Note: To improve presentation, values < 10% are not labelled in the figure.

4.4.13 Main Effects of Seclusion and Restraint

Participants were asked to share their own understanding of the main effects of seclusion and restraint. The survey team, in posing this question, was interested in gaining insight into participants' understanding of the consequences of seclusion and restraint, regardless of whether these were considered to be negative or positive. The survey team was also interested in understanding more about what can lead to these consequences. Fifty-six per cent of participants provided a response to this question, however slightly fewer than 5% of those were excluded because no 'main effect' could be identified. The main effects were coded under the categories: 'negative effect', 'unbiased effect', and 'positive effect'.

Table 4.6 provides a sample of this coding for the main effects of seclusion. Furthermore, a word cloud was generated highlighting the words most used in these text responses. Following the analysis of the main effects, the text responses on the causes of those effects were also examined and thematically analysed.

Table 4.6: Main Effects of Seclusion - Coding Sample

Nature of Effect of Seclusion	Quote
Negative	Adds to emotional turmoil: sense of abandonment, loss of control, fear or terror, humiliation, disorientation re-traumatising for many
Unbiased	Depending on the nature of mental illness suffered, it can exacerbate their condition and cause isolation within the clinical setting. It may also provide a useful 'time' out, but I deeply feel that this is patient specific
Positive	Safety of Client

4.4.14 Main Effects of Seclusion

The majority of responses (74%) indicated that the main effects of seclusion are negative in nature, with some participants indicating that the main negative effects included the consumer becoming aggravated and/or experiencing low self-esteem. Some participants also noted that seclusion may cause great harm and damage to the relationship between staff members and consumers, which is counterproductive to treatment and mental health care goals. Interestingly, the bulk of those responses came from participants identified as practitioners in the mental health industry followed closely by consumers. More information can be seen in the following figures, which present a conceptual overview of the main effects of seclusion.

Figure 4.13: Word Cloud of the Main Effects of Seclusion – All Participants

Figure 4.14: Word Cloud of the Main Effects of Seclusion – Consumers Only

Figure 4.15: Word Cloud of the Main Effects of Seclusion – Practitioners Only

4.4.15 Main Effects of Restraint

In a similar manner to the main effects of seclusion, the predominant nature of the effects of restraint were categorised to be negative, with 75% of responses indicating this. Also, the majority of the responses came from participants categorised as mental health practitioners. The following figures show the word clouds that illustrate the most recurring terms used within the participants' comments on the main effects of restraint.

Figure 4.16: Word Cloud of the Main Effects of Restraint – All Participants
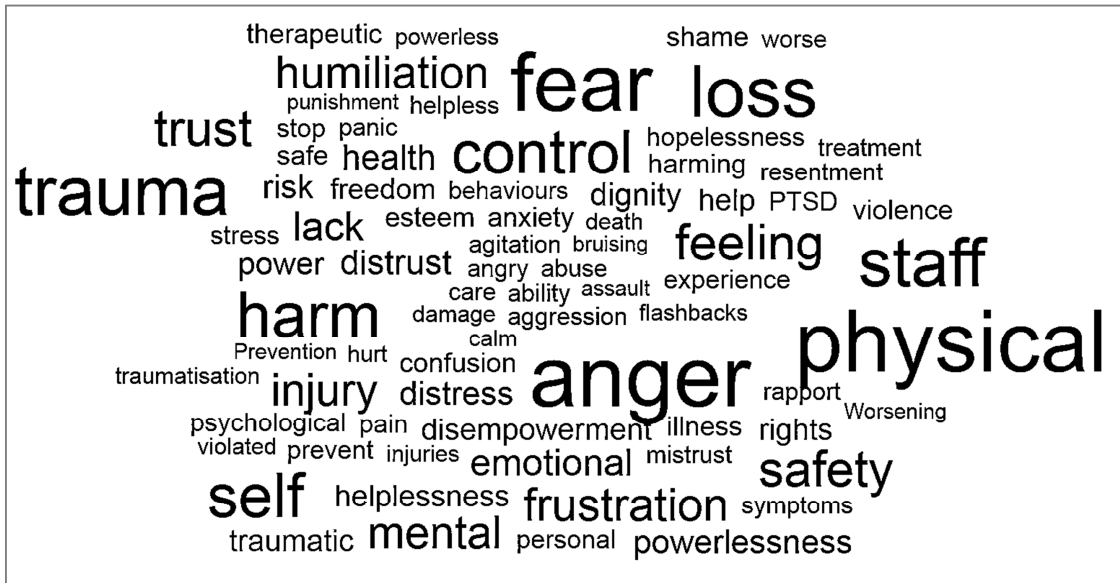
Figure 4.17: Word Cloud of the Main Effects of Restraint – Consumers Only

Figure 4.18: Word Cloud of the Main Effects of Restraint – Practitioners Only

4.4.16 Causes of Main Effects – Seclusion

Participants were asked to outline, in their own words, what they felt were the direct causes of the effects of seclusion. These responses allowed for the further exploration of the specific aspects of seclusion and restraint that the participants saw to be pivotal.

Thirty-seven per cent of responses noted the 'disempowerment of the consumer' as the main cause of the negative effects of seclusion, stating that these effects occurred:

> '*Because people are generally sent to seclusion not offered it and they have no control or say in the matter*' (Practitioner)

> '*Because the person has no control or support while isolated - the individual is dehumanized by having their freedom removed. It does not address mental health issue it puts it on hold, there is no therapeutic value to the individual*' (Consumer)

Eight per cent of responses specifically indicated that these negative effects were caused primarily by the mental health sector (in using seclusion), using the 'wrong focus'. It was thought that the focus should be redirected from managing aggression to caring for the consumer. Responses indicated that if such a focus-shift occurs, then practices will change as well, such as '*incompatible with recovery-oriented practice*'

(Practitioner) and *'it is anti-therapeutic. Stigmatising. Shows lack of humane care.'* (Carer)

A further 8% of responses specifically noted that the cause of the effects of seclusion stems from the staff implementing seclusion. That is, the attitude of staff members and their apparent lack of care for the consumer, were highlighted:

'Inappropriate untrained staff administering these methods and abuse their power. Lack of individuality of treatment for the person being treated. Lack of educated staff and staff with their own issues (also mental health) which are not acknowledged' (Consumer)

'Person is perceived by staff as being 'crazy' even though they are in a crazy environment' (Practitioner/Consumer)

The remaining responses noted a variety of causes including 'feeling isolated', 'patient causes', and 'flawed processes'. Participants stated:

'Anyone would lose it mentally if isolated from others for long enough. Humans are social beings and not meant to be alone. Seclusion is a punishment, not a treatment' (Consumer/Carer)

'Many patients are of the opinion that there is nothing wrong with them. Why lock me up? That is not going to help me' (Carer)

Other responses highlighted the *'power difference between staff and patient, agitated and aggressive patients are often seeking help and are not receiving it'* (Practitioner).

4.4.17 Causes of Main Effects – Restraint

In a similar way to the responses for seclusion, the majority of the responses noted that the main negative effects of restraint were due to 'disempowerment of the consumer'. One practitioner stated that '*being restrained means someone is taking control of your situation and no one likes to be out of control*', while one consumer argued that '*because physical restraint is often quite obvious to anyone in the area and not being able to freely move or cover can leave a person feeling exposed and undignified*'.

Eight per cent of responses noted that the main causes of the effects of restraint could be attributed to the mental health sector having the 'wrong focus' when caring for consumers. Participants noted this was '*because isolation and its attendant message of social rejection are all about punishment … our mental health system is stuck in this punitive culture*' (Practitioner/Carer) and *'there is a need to view mental health differently'* (Carer).

Another 8% of responses also noted that 'staff-related' issues are the main causes of the negative effects of restraint with participants referring to *'inappropriate use of procedures and poor staff training; Staff using these procedures as a response without having preventative plans in place to avoid occurrence in the first place or escalation'* (Practitioner), and *'staff are sometimes not skilled enough and do not have enough confidence to deal with some pts [patients]. Staff can be reactionary to situations, lack of resources can see seclusion and restraint utilised too quick'* (Practitioner).

The remaining responses noted a variety of causes including 'flawed processes', and 'patient-related' issues. This was thought to be *'because the intervention is an act of violence'* (Practitioner/Carer), and *'a physically risky procedure… an affront to a person's sense of agency'* (Practitioner/Carer).

4.4.18 Strategies to Prevent the Use of Seclusion and Restraint

The survey presented participants with a list of possible strategies that may be used to prevent the use of seclusion and restraint. Participants were asked to rate the effectiveness of each strategy on a four-point scale (not at all effective, slightly effective, effective, extremely effective). The strategies included:

- staff training in de-escalation strategies (staff de-escalation)

- staff training in recognising and appropriately responding to signs of distress (staff appropriate response)

- mandatory reporting of all episodes of seclusion and restraint within the service organisation (mandatory reporting within organisation)

- mandatory reporting of all episodes of seclusion and restraint to a commission or similar government body (mandatory reporting to commission)

- restricting the use of seclusion and restraint to only life-threatening situations (used only when life threatened)

- better access to medications that help when needed (access to medication)

- changes to the environment in which seclusion and restraint might occur (for example; having privacy when needed, sensory rooms, entertainment and distraction activities) (environmental change)

- having better access to counselling and other 'talking and listening' opportunities (access to counselling)

- increased access to peer workers or people who have lived experience of mental health issues, for consumers and staff (access to peer workers)

- increased access to people able to provide advocacy that would ensure people are aware of their rights and are supported in exercising their rights (access to advocacy)

- opportunities to express treatment choices and preferences through tools such as advance statement or joint crisis plans (advance statement/joint crisis plans)

- involvement of the person with a mental health issue, family supporters or an otherwise nominated person in decision-making (family involvement)

Participant ratings of the effectiveness of each strategy for reducing the use of seclusion and restraint are shown in Figure 4.19. Three strategies were endorsed as 'extremely effective' by the majority of participants: access to counselling, environmental change and staff training in de-escalation. However, the majority of participants suggested that all of the proposed strategies would be either effective or extremely effective.

Figure 4.19: Perceived Effectiveness of Strategies to Prevent the Use of Seclusion and Restraint

Access to counselling (n = 810): Extremely Effective 53%, Effective 31%, Slightly Effective 13%

Environmental change (n = 811): Extremely Effective 52%, Effective 32%, Slightly Effective 13%

Staff de-escalation (n = 781): Extremely Effective 51%, Effective 35%, Slightly Effective 11%

Family involvement (n = 806): Extremely Effective 42%, Effective 35%, Slightly Effective 18%

Mandatory reporting to Commission (n = 778): Extremely Effective 41%, Effective 34%, Slightly Effective 20%

Access to peer workers (n = 804): Extremely Effective 40%, Effective 33%, Slightly Effective 22%

Advance Statement/Joint Crisis Plans (n = 802): Extremely Effective 36%, Effective 37%, Slightly Effective 20%

Access to advocacy (n = 806): Extremely Effective 36%, Effective 30%, Slightly Effective 26%

Mandatory reporting within organisation (n = 773): Extremely Effective 34%, Effective 40%, Slightly Effective 22%

Used only when life threatened (n = 800): Extremely Effective 31%, Effective 30%, Slightly Effective 23%, Not at all Effective 16%

Staff appropriate response (n = 766): Extremely Effective 30%, Effective 30%, Slightly Effective 26%, Not at all Effective 14%

Access to medication (n = 805): Extremely Effective 28%, Effective 44%, Slightly Effective 22%

Legend: ■ Extremely Effective ■ Effective ■ Slightly Effective ■ Not at all Effective

Note: To improve presentation, values < 10% are not labelled in the figure.

Participants were then asked to give general comments on the effectiveness of these strategies. A number of general themes emerged from participants' statements concerning how best to prevent the use of seclusion and restraint.

A 36% 'other' theme emerged as 'empowering the consumer'. That is, some statements suggested that if a consumer is involved in his or her treatment and provides informed consent to it, there will be fewer instances meriting seclusion and restraint: As one participant stated:

> *'Any time where a person's autonomy is increased this 'failed practice' will be unnecessary'* (Consumer/Carer/Practitioner)

Twenty-two per cent of participants stated that a more effective strategy would be to focus initial efforts on 'professional development and increase resourcing', highlighting that without adequate training for mental health staff and better facilities of care, not much could be done to prevent seclusion and restraint. One carer noted:

> *'… there is a woeful shortage of access to talking therapies, sensory and coping spaces help to learn coping skills, group activities and other ways to manage ourselves.'*

The theme of 'organisational culture change' became evident through responses (16%) that stressed that positive ward culture, staff attitudes and support from the senior management of mental health institutions is imperative for any change to be seen, arguing that *'the culture of wards would undermine positive changes in policy'* (Practitioner).

Ten per cent of responses focused on the need for 'evaluation and monitoring' as a means of reducing inappropriate instances of seclusion and restraint practices. One carer explained:

> *'…all incidents need to be reviewed, with a meeting afterwards with the client and their family to debrief, discuss concerns and how it can be prevented plus to offer support.'*

While 10% of participants noted 'the need for strict processes', in which some of the responses indicated that the current implementation of seclusion and restraint needs to be more standardised, limited in its frequency and the number of staff who are permitted to implement these practices delineated. The remaining 7% listed the need to use a more 'holistic approach' to care, such as *'inclusion of all persons concerned in the care of the individual'* (Consumer/Carer).

4.4.19 Strategies to Reduce the Effects of Seclusion and Restraint

In addition to considering strategies for reducing seclusion and restraint, participants were asked to consider the effectiveness of strategies for reducing the negative effects of seclusion and restraint, where these practices occur. Again, participants were asked to rate the effectiveness of each strategy on a four-point scale (not at all effective, slightly effective, effective, extremely effective). The strategies included:

- staff training in appropriate counselling and/or debriefing (staff counselling training)

- staff training in the physical skills of restraint (physical restraint training)

- quality assurance activities focussed on monitoring and improving practice (quality assurance monitoring)

- increased role for peer workers or people who have a lived experience of mental health issues at all levels from direct work with consumers, through to policy development (involvement of peer workers)

- regular involvement of the individual with a mental health issue, family and supporters or other nominated persons in decision-making and debriefing (consumer involvement in incidents)

- involvement of persons who have been subject to seclusion and/or restraint in planning future prevention strategies (consumer involvement in planning)

- recognising and responding to the needs of others involved in the episode of seclusion or restraint (for example, through witnessing the event) (recognising others' needs)

- taking a person-centred approach to assessment and treatment (person-centred approach)

830 participants answered this question, the majority of whom indicated that taking a person-centred approach and training staff in counselling and debriefing would be extremely effective ways of reducing the negative effects of seclusion and restraint. Almost half also indicated that involving persons with lived experience of seclusion and restraint in planning future prevention strategies would be extremely effective. The majority of participants indicated that all eight of the proposed strategies would be either effective or extremely effective in reducing the negative effects of seclusion and restraint.

Figure 4.20: Perceived Effectiveness of Strategies to Reduce the Negative Effects of Seclusion and Restraint

Strategy	Extremely Effective	Effective	Slightly Effective	Not at all Effective
Person-centred approach (n = 773)	60%	30%		
Staff counselling training (n = 783)	51%	35%	11%	
Consumer involvement in planning (n = 776)	48%	34%	14%	
Consumer involvement in decisions (n = 777)	43%	39%	15%	
Involvement of peer workers (n= 779)	41%	34%	20%	
Quality assurance monitoring (n = 774)	34%	40%	22%	
Recognising other's needs (n = 770)	33%	42%	22%	
Physical restraint training (n = 768)	30%	30%	26%	14%

Legend: ■ Extremely Effective ■ Effective ■ Slightly Effective ■ Not at all Effective

Note: To improve presentation, values < 10% are not labelled in the figure.

Participants were asked to provide general comments on the effectiveness of the strategies in reducing the negative effects of seclusion and restraint. The themes that emerged were similar to those relating to strategies preventing the use of seclusion and restraint.

The majority of responses (27%) indicated that there needs to be an investment in 'professional development and resourcing', with *'increased staff development resources at unit level'* (Practitioner)

Twenty-four per cent of responses noted that there needs to be some 'organisational culture change' if any of the staff practices are to be changed, as the system was *'dominated by the medical model of care in which psychiatrists and psychologists and nurses are only able to intervene'* (Carer/Consumer/Practitioner).

Seventeen per cent of responses noted the importance of focussing on the care of the patient by applying 'client/consumer empowerment' practices, outlining that

care was '*person driven not person centred*' (Practitioner/Carer). Similarly, 11% of responses noted that there needs to be a shift to more 'holistic' approaches 'rather than a medical model' in mental health care.

Nine per cent of responses indicated the there is a need for 'evaluation' in mental health care, such as '*multi-disciplinary reviews of all restraints and seclusion with peer workers*' (Consumer). A further 8% of responses noted that 'strict processes' would be beneficial to reducing the harmful effects of seclusion and restraint:

> '*…the negative effects can be minimized by more stringent criteria for authorizing such measures to be used, or threatened to be used*' (Consumer)

Finally, 5% of responses listed 'other' important themes such as the need for an increase in 'counselling and debriefing' practices. One practitioner elucidated this as including '*adequate debriefing of staff and patients following seclusion may be more effective - ensuring patients are aware of the behaviours that result in seclusion - ensuring staff work more closely with patients to meet patient needs*'.

4.4.20 Barriers to Reducing the Use of Seclusion and Restraint

Informed by a review of the literature and guided by the project Advisory Groups, participants were presented with a list of 17 possible barriers to the reduction of seclusion and restraint. They were asked to indicate whether, in their opinion, each item in the list was *not at all a barrier*; *somewhat of a barrier*; *a considerable barrier*; or *very much a barrier*. The list of possible barriers included:

- lack of information on current best practices (lack of information)

- organisational values that do not support reducing coercion (organisational values)

- organisational culture that does not prioritise reducing coercion (organisational culture)

- insufficient leadership within the organisation (leadership)

- insufficient involvement of people with lived experience of mental health issues (consumers not involved)

- inadequate staff training (staff training)

- lack of staff awareness of trauma responses (staff awareness)

- lack of compassion on the part of staff (staff compassion)

- lack of political will and support at the state and/or federal level (political will)

- inadequate involvement of relevant professional bodies in advocating for change (professional advocacy)

- lack of alternative ways of responding (alternatives)

- poor continuity of care within a service – for example, across shift changes (continuity of care)

- poor continuity of care between services – for example, from ambulance to hospital (continuity between services)

- poor continuity of care between inpatient and outpatient settings (continuity to outpatient)

- insufficient staffing levels to permit implementation of best practice (insufficient staffing)

- reluctance on the part of staff to invest in long-term change (staff reluctance)

- lack of accountability of services for decision-making or poor practice (service accountability)

Participant responses to these items are shown in Figure 4.21. The items endorsed as 'very much a barrier' by the largest proportion of participants were 'lack of information on best practice' (47%) and 'lack of staff awareness of trauma responses' (46%). However, more than half of those who responded considered every item to be either 'very much a barrier' or 'a considerable barrier' to the reduction of seclusion and restraint. These responses indicate a view that much could be done to reduce seclusion and restraint by addressing these barriers.

Figure 4.21: Participant Perceptions of Barriers to Reducing Seclusion and Restraint

Barrier	Very much a barrier	Considerable barrier	Somewhat of a barrier	Not at all a barrier
Insufficient staffing (n = 736)	47%	28%	20%	
Staff awareness (n = 732)	46%	31%	18%	
Alternatives (n = 739)	45%	27%	19%	10%
Staff training (n = 733)	45%	28%	22%	
Organisational culture (n = 729)	44%	28%	17%	12%
Service accountability (n = 709)	43%	24%	21%	11%
Political will (n = 733)	42%	26%	20%	11%
Leadership (n = 719)	39%	28%	23%	10%
Organisational values (n = 727)	37%	30%	20%	14%
Staff compassion (n = 730)	35%	22%	28%	15%
Staff reluctance (n = 727)	35%	27%	27%	11%
Consumers not involved (n = 728)	33%	26%	29%	13%
Continuity to outpatient (n = 724)	31%	30%	31%	
Professional advocacy (n = 726)	29%	28%	32%	12%
Continuity of care (n = 726)	28%	30%	35%	
Continuity between services (n = 721)	24%	30%	35%	11%
Lack of information (n = 737)	23%	31%	32%	14%

■ Very much a barrier ■ Considerable barrier
■ Somewhat of a barrier ■ Not at all a barrier

Note: To improve presentation, values < 10% are not labelled in the figure.

The qualitative analysis of the general comments given by participants for the possible barriers resulted in themes similar to those of the comments made in response to the 'strategies' questions. This indicates that there is some consensus as to what can be done to reduce/eliminate seclusion and restraint, the effects of these practices and barriers to their elimination/reduction.

For example, the lack of 'strict processes' in current mental health practice was noted as a barrier to reducing seclusion and restraint.

> '*Lack of accountability is very much an issue*' (Carer)

Secondly, the current 'organisational culture' was noted to be not conducive to mental health *care* and as such is thus a significant barrier. Participants also indicated that efforts are needed to make the reduction of seclusion and restraint a priority.

> '*There are some great caring staff, and some not so. In many cases it is the organisation that needs to prioritise the change*'
> (Consumer/Carer/Practitioner)

The current state of 'professional development and resourcing' was highlighted as a barrier. Responses indicated that more is needed when it comes to training staff on the alternatives to seclusion and restraint.

> '*Lack of education and practices and policies seem to be a major issue. Also treatment often comes down to the individual practitioner*'
> (Consumer/Practitioner)

Interestingly, two themes emerged providing solutions to the barrier, in other words, enablers of reducing seclusion and restraint. The first being the need for 'evaluation, research and monitoring'.

> '*The main driver of change with regard to seclusion and restraint should be science. Evidence based research is available from around the world*'
> (Practitioner)

The second was the need to use 'multidisciplinary approaches' in mental health care.

> '*There needs to be investment in multidisciplinary teams (not just psychiatry, nursing and peer workers) and investment in staff having a toolkit of interventions that can be drawn upon to support an individual during a time of change*' (Practitioner)

4.4.21 Eliminating Seclusion and Restraint

Two questions addressing the complete elimination of seclusion and restraint were posed in the survey with one pertaining to the feasibility of elimination and the other

regarding the importance of elimination. There were quantitative and qualitative aspects to both questions.

The quantitative questions were presented in multiple drop-down options. Here, the opportunity to provide comments and elaborating on response choices was also offered to the participants. These comments were scanned and thematically coded. However, a limitation of the qualitative data in this section is that the content was derived from an elaborative, open-ended text field. Therefore, there was not always a visible link between the comment and each choice participants made to answer the question.

Across the qualitative responses, there was a trend of great concern for safety should seclusion and restraint be completely eliminated. Additionally, a number of responses from mental health practitioners urged alternatives to be found based on lessons from other countries, research and evaluation. Additionally, there were a number of responses that also acknowledged that if staff safety was to be compromised, the result may be the departure of high quality staff, leaving the mental health sector with staff '*of lower calibre*' (Practitioner).

Some participants suggested that alternatives to complete elimination as well as alternatives to current practice could be made until complete elimination is feasible. Some participants suggested changes to the physical environments in which seclusion and restraint tend to occur, for example the addition of bathroom facilities within seclusion areas. Others suggested improvements to the current implementation of seclusion and restraint practices including limiting the number of staff who are allowed to implement these practices, as well as facilitating high levels of training.

There were also a number of responses that viewed seclusion and restraint as not only traumatic for the consumer, but also for the restrainers and any witnesses that may be involved. Participants recommended employing respectful and comforting language in order to inform the consumer as to what is happening and why. This was acknowledged as important because, although a consumer's mental state may not allow for total comprehension of the restrainer's words, appropriate use of language could assist witnesses to the incident.

The open-ended responses were coded according to two themes: *Approach* and *Rationale/Concern*.

Approach encompasses any action suggested by the participants as to how best to eliminate seclusion and restraint and for some, what to do instead of elimination. *Rationale/Concern* relates to those statements that argued that complete elimination is not feasible. Here, a rationale for the response was noted within the open-ended comment. Once the responses were thematically coded, they were further analysed and placed into categories within each of the themes.

The following table outlines the categories of responses that fall under the theme of *Approach*.

Table 4.7: 'Approach' Theme Categories

'Approach' Themes	Explanation	Quotation Example
Change Focus	The Focus of Mental Health Practices needs to change	It's about choice not coercion. Freeing things up, rather than imposing limitations. Allowing informed decision-making to occur and respecting the judgement of consumers
Excluded	No answer provided	
Not applicable	No 'approach' theme was identified from response	Academics and people not having the responsibility of patient care dream of such things
Organisational Culture Change	Mental health organisations need to change their culture of practice	There needs to be willingness to change culture around seclusion and restraint and have it as a last resort response to…life in danger
Professional Development and Increase Resources	Training for staff, increase in staffing, workforce development, more funding etc.	I would like to think that better staff numbers who have the time to spend with Consumers in a therapeutic relationship and the increased use of modalities such as sensory modulation could contribute to the elimination of these practices
Reduce	Reduce instead of eliminate	I strongly believe they can be reduced but not completely eliminated. The safety of staff involved needs to be taken in to consideration. If you enforce elimination at the expense of the safety of the staff, we will have no one willing to work
Research and Evaluation	More evidence basis is needed to inform practice. Evaluation of current practices is needed	There needs to be a complete review of the practices
Strict Processes	More restriction on practices, standardisation of how they are implemented, restricting the number/type of staff allowed to seclude or restrain	The criteria under which seclusion and restraint can be used needs to be tightened, and consequences for inappropriate use needs to be introduced

The following table outlines the categories of responses that fall under the theme of *Rationale/Concern*:

Table 4.8: 'Rationale/Concern' Theme Categories

'Rationale/ Concern' Themes	Explanation	Quote Example
Excluded	No understandable response provided	Please see previous
Not applicable	No 'rationale' theme was identified from response	All forms of seclusion and restraint are a failure in care
Patient related	Patient mental state/behaviour or mental illness are a barrier to elimination	People with a mental illness in an acute episode are not always able to comprehend the situation, to be talked down etc.
Safety	Safety of staff, the consumer, others around needs to be ensured before elimination	There are times when people will need to be restrained and secluded for their own safety and the safety of others
Situation dependent	Some situations will require seclusion and restraint, others may not	As I have stated before you can't generalise. It depends on the situation

### 4.4.22 Quantitative Results – Eliminating Seclusion and Restraint

Participants were asked whether or not they believed that various forms of restraint or seclusion could be completely removed from practice. Three possible response options were provided – yes, no, and unsure. Participants were then asked to indicate whether they believed that each form of seclusion and restraint should be completely eliminated from current practice. Again, for each question, participants were given three response options – yes, no and unsure.

In order to examine whether responses to these questions differed for those with and without lived experience, responses were compared between four mutually exclusive groups of participants: Consumers (those who reported personal experience of receiving treatment for a mental health issue), Carers (those who reported personal experience of caring for, supporting or being a family member of someone with a mental health issue, but no personal experience as a consumer), Mental Health Practitioners (those who reported being a mental health practitioner,

but no personal experience as a consumer or carer) and Other Staff (those who reported exposure to mental health issues in some other work capacity, but no personal experience as a consumer or carer). Responses to this series of questions are summarised below in Figures 4.18 to 4.22.

With respect to physical restraint, an equal proportion of Consumers indicated that this practice should (38%) and should not (38%) be completely eliminated; smaller proportions of Carers (28%), Mental Health Practitioners (25%) and Other Staff (26%) believed that physical restraint should be completely eliminated. Perhaps reflecting perceived barriers to the reduction of these practices, only about one in four Consumers (26%) indicated that physical restraint could be completely eliminated. Again, smaller proportions of Carers (16%), Mental Health Practitioners (13%) and Other Staff (18%) believed that physical restraint could be completely eliminated. The majority of participants in all categories did not believe that physical restraint could be completely eliminated.

Figure 4.22: Participant Views Regarding Whether Physical Restraint Should and Could Be Completely Eliminated
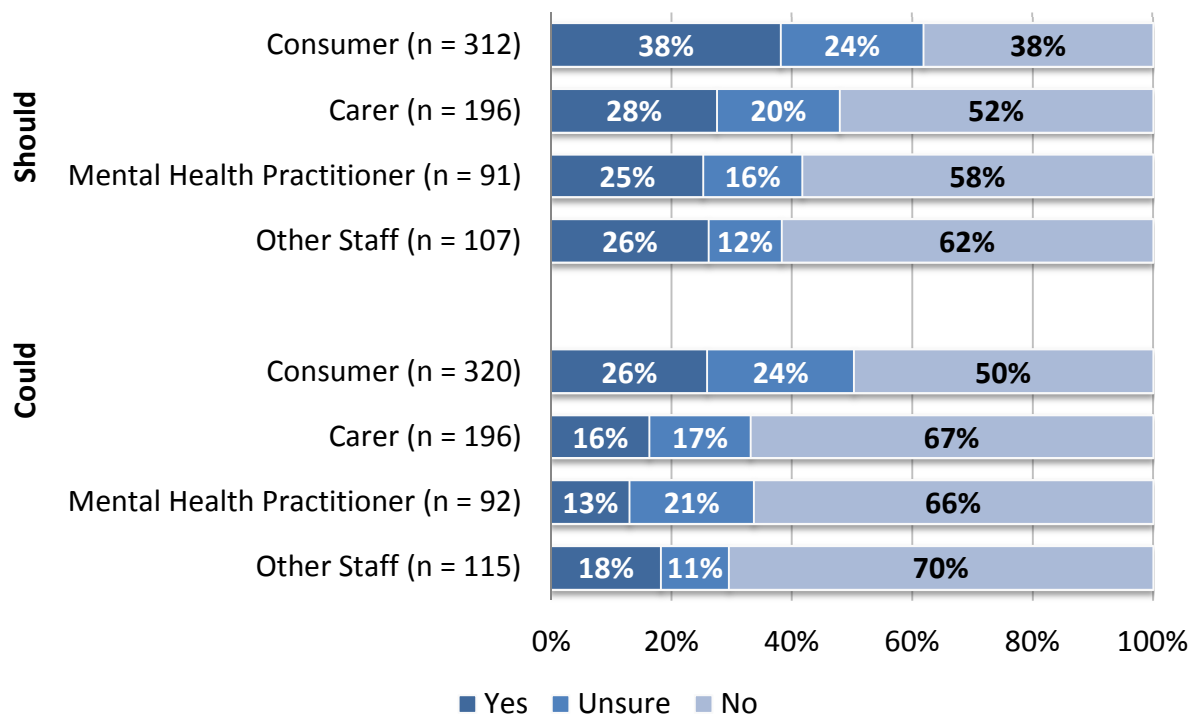
Responses with respect to mechanical restraint are shown in Figure 4.23. As for physical restraint, Consumers (38%) were more likely than other groups of participants to indicate that this practice should be completely eliminated, although the same proportion of Consumers (38%) and the majority of other participants indicated that they were unsure whether physical restraint should be eliminated. By contrast, the majority of participants in all groups believed that mechanical restraint could be completely eliminated from current practice.

Figure 4.23: Participant Views Regarding Whether Mechanical Restraint Should and Could Be Completely Eliminated
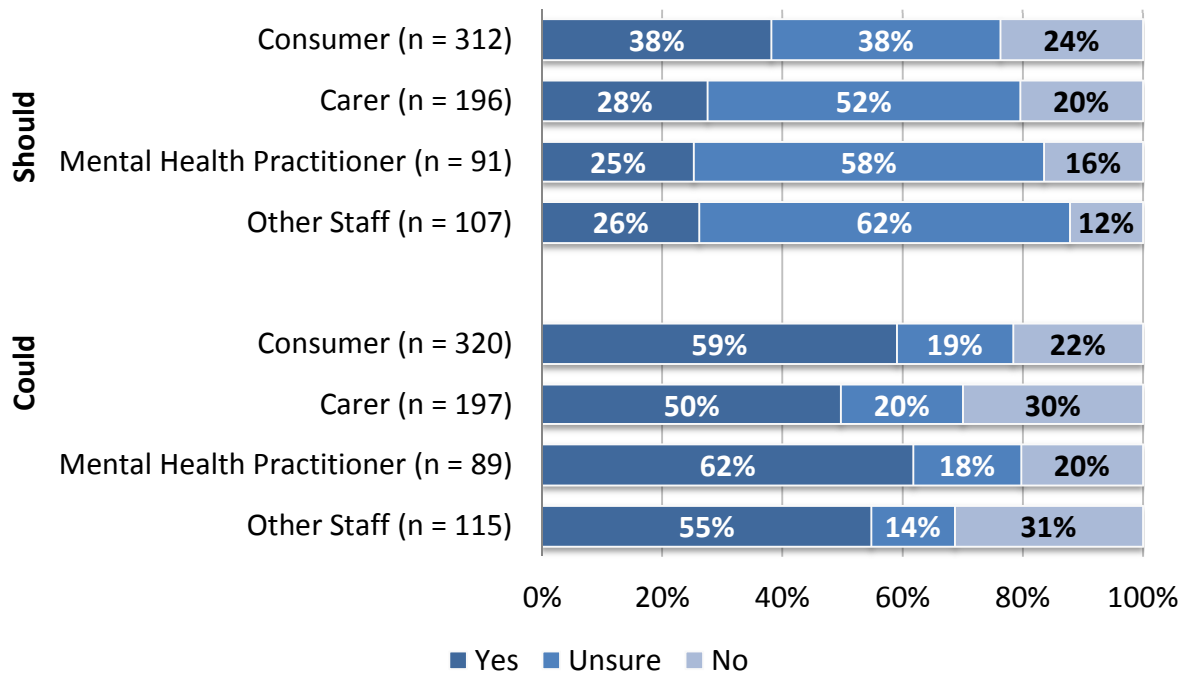
Responses with respect to chemical restraint are shown in Figure 4.24. More than a third of Consumers (36%) indicated that chemical restraint should be completely eliminated from current practice, although a larger proportion (41%) indicated that it should not. The majority of Carers (51%), Mental Health Practitioners (67%) and Other Staff (72%) believed that chemical restraint should not be completely eliminated from current practice. The majority of participants in all groups did not believe that chemical restraint could be completely eliminated from current practice, although a larger proportion of Consumers (28%) than of Carers (18%) or Mental Health Practitioners (12%) believed that this practice could be completely eliminated.

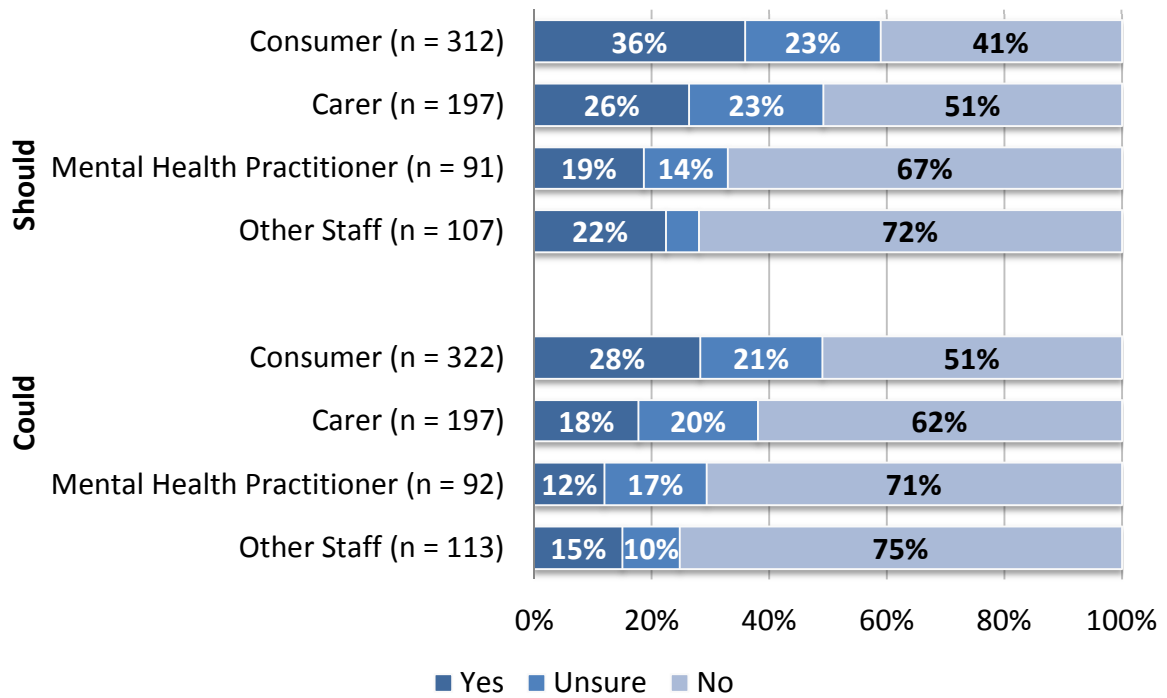**Figure 4.24: Participant Views Regarding Whether Chemical Restraint Should and Could Be Completely Eliminated**

Note: To improve presentation, values < 10% are not labelled in the figure.

Responses with respect to emotional restraint are shown in Figure 4.25. In contrast to other forms of restraint, the majority of participants in all groups indicated that emotional restraint both should and could be eliminated from current practice. However, around one in five Carers was unsure whether this practice could or should be eliminated, and around a third of Mental Health Practitioners were either unsure (20%) or believed that emotional restraint could not (14%) be eliminated entirely.
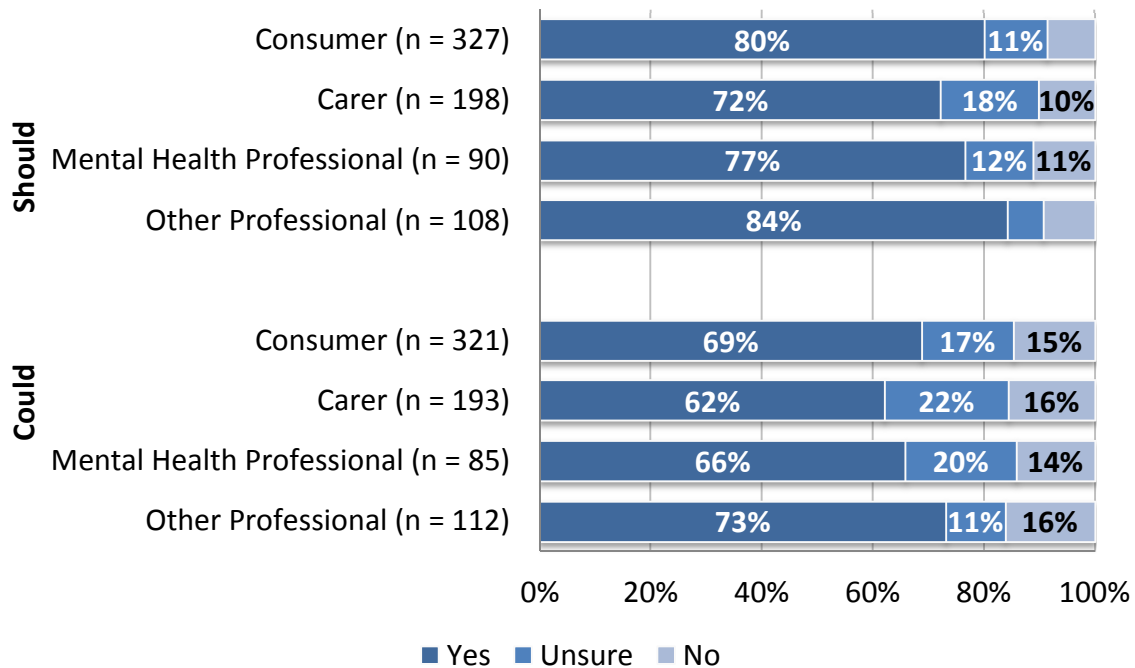
**Figure 4.25: Participant Views Regarding Whether Emotional Restraint
Should and Could Be Completely Eliminated**

Note: To improve presentation, values < 10% are not labelled in the figure.

Finally, responses with respect to seclusion are shown in Figure 4.26. In contrast to responses with respect to restraint, there was considerable disagreement between Consumers, Carers and staff with respect to the elimination of seclusion. The majority of Consumers (54%) and almost half of Carers (48%) believed that seclusion should be completely eliminated, compared with only 28% of Mental Health Practitioners and 30% of Other Staff. A large proportion of participants in all groups (26%-58%) were unsure and a substantial minority (for example, 20% of Consumers) did not believe that seclusion should be completely eliminated from current practice.

Some participants believed that seclusion could be completely eliminated from current practice, although again Consumers (46%) and Carers (36%) were more likely than Mental Health Practitioners (23%) or Other Staff (23%) to express this view. More than a third of Consumers (35%) and Carers (43%), and more than half of Mental Health Practitioners (58%) and Other Staff (62%), did not believe that seclusion could be completely eliminated from current practice.

**Figure 4.26: Participant Views Regarding Whether Seclusion
Should and Could Be Completely Eliminated**

Should			
Consumer (n = 316)	54%	26%	20%
Carer (n = 198)	48%	36%	16%
Mental Health Practitioner (n = 90)	28%	49%	23%
Other Staff (n = 107)	30%	58%	12%

Could			
Consumer (n = 321)	46%	19%	35%
Carer (n = 198)	36%	21%	43%
Mental Health Practitioner (n = 92)	23%	20%	58%
Other Staff (n =115)	23%	15%	62%

0%   20%   40%   60%   80%   100%

■ Yes   ■ Unsure   ■ No
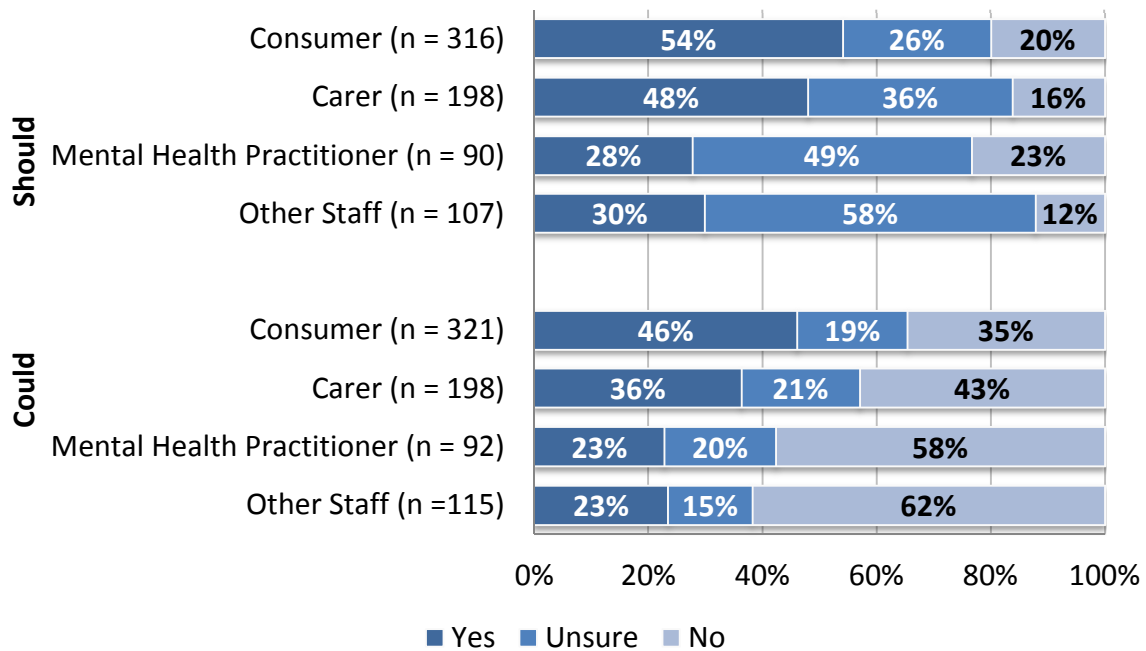
4.4.23 Qualitative Results – Eliminating Seclusion and Restraint

Feasibility of Elimination

A total of 505 participants offered comments when asked to elaborate on their previous selections (as reflected in the above quantitative data). Of these responses, 36 were excluded due to the fact that the comments were not useable or could not be understood. For example, one participant simply noted '*covered earlier*'. With consideration afforded to the exclusions, a total of 469 comments were qualitatively analysed.

Under the overarching theme of *Approach*, there were some coded responses that showed no identifiable approach. Examples such as '*all forms of seclusion and restraint are a failure in care*' (Consumer); '*I can only speak on the experience with my son who had a psychotic condition*' (Carer); and '*I'd like to see them all eradicated but I have picked unsure for all of the above*' (Practitioner) were all deemed to have no identifiable approach. However, from the responses that could be identified within the 'approach' theme category, analysis showed several interesting trends. The first was a call for more investment in the professional development of staff, prompting innovative, high quality practices in mental health care. This included a call for ways to reduce harmful effects of seclusion and restraint as well as alternatives to seclusion and restraint. Further, participants indicated the need for more funding to upgrade the physical environment of mental health settings so that they are conducive to the care of consumers, as the following responses outline:

'Current staffing levels and workload demand ill prevent any reduction strategy merely because of the absolute lack of resources. Services are not funded to manage the acuity levels'(Practitioner)

'I think that with peer workers more staff training and funding for sensory modulation rooms the restraining of consumers can be eliminated' (Consumer)

Some participants noted that it may be better to reduce seclusion and restraint rather than completely eliminate them. Upon examining their comments it became evident that many are hesitant to eliminate seclusion and restraint without having alternatives in place, as the following responses illustrate:

'I believe all of the above can be reduced but not eliminated. There are cases whereby mental state is seriously affected by the use of illicit drugs and/or severe mental illness that practitioners are left with no alternative' (Practitioner)

'*You do always need these things as a last resort except emotional restraint. People should always feel empowered to express what's going on. We just need to look at ways to minimise the use of the others'* (Consumer/Carer)

Meanwhile, other responses called for *Organisational Culture Change* and more *Strict Processes.* These categories are closely related in that they both call for systemic change to occur prior to the feasible elimination of seclusion and restraint. Upon examining the comments, it became evident that participants believed that although more staff need to focus on caring for, rather than managing the consumer, for such change to occur the organisation and the health system in which it sits need to support such changes, as the following responses indicate:

'I don't think there is enough will among politicians, governing bodies or professionals to eliminate these practices' (Practitioner)

'All of these could be eliminated, but there'd have to be major change to the entire mental health system. I don't see that as realistically occurring' (Consumer/Carer)

Importance of Elimination

A total of 387 participants provided text answers in elaboration upon their previous selections as to the importance of eliminating seclusion and restraint. Thirty-four of these responses were excluded due to the fact that the comments were not able to be understood or used. One consumer, for example noted *'I have nothing further to add'*. This left a total of 353 responses for qualitative analysis.

Of those responses from which an 'approach' theme category could be identified, analysis showed several trends similar to those noted when examining the feasibility of elimination. The most common category was that of *Reduction*. This encompasses

responses that suggested that it may be better to reduce seclusion and restraint rather than eliminate them completely. Upon examining their comments it became evident that many are hesitant to eliminate seclusion and restraint without having alternatives in place, as the following responses demonstrate:

'I wish it was different but every one of those is desperately needed at times. I am happy with trying to minimise the use but eliminating them is the most irresponsible thing I have ever heard - complete madness!' (Carer)

'Neither yes or no, rather 'less'' (Consumer/Carer/Practitioner)

'Physical restraint only for short term safety, as a strategy of last resort' (Practitioner)

The second category calls for an increase in the *professional development* of staff, and an increase in *financial investment* to increase staffing and improve the physical environment in mental health settings:

'Environmental factors (small in-patient units with limited space for people to have time away from others which causes conflict amongst patients) need addressing' (Practitioner)

'There's always a better solution to all of the above but it involves much better training of staff, and ensuring the staffs personalities are kind and compassionate etc.' (Consumer)

'Staff and services need to be up to speed on effectively addressing distress' (Consumer/Practitioner)

A further trend was the call for a *change of (organisational) culture* in mental health settings in which incidents of seclusion or restraint can occur. This includes changing the focus from managing consumers to caring for and including them in treatment options, as the following responses depict:

'These practices should be eliminated to reduce the effects of using these practices and alternatives found, but the current system does not allow such use of alternatives' (Practitioner/Carer)

'Treating Clients as Human Beings AND NOT Labelling AND Treating as a Bag of Symptoms' (Consumer/Carer/Practitioner)

'I don't believe that restraint or coercion should be a feature of the mental health system at all - we are all human beings, and [there needs to be] a greater focus on the human dimensions of mental distress (rather than addressing symptoms or 'inappropriate behaviours')' (Consumer/Carer)

Finally, responses noted the importance of having strict and standardised processes as well as evidence-based research into mental health practices. There was a clear consensus that *'not enough research seems to have been done to address issues of these types of restraints'* (Carer), and that *'Real alternatives need to be found… research is needed in this area'* (Practitioner/Carer).

The second overarching theme examined was that of 'Rationale/Concern' which covered any reasoning offered by participants on their quantitative answers. In a similar manner to the 'Approach' theme, some responses could not be assigned a category, such as one practitioner who noted *'I believe that mechanical restraint can cause more harm than seclusion. Freedom of speech is paramount.'*

Of those responses from which a 'Rationale/Concern' theme category could be identified, 'Safety' concerns and the importance of understanding that every situation is different were predominant trends among the responses. This is very similar to the trends noted when examining the feasibility of elimination. Some of these responses are listed below:

> *'If a person is in danger of hurting themselves or someone else, then I believe some form of restraint is acceptable'* (Consumer)

> *'There are times when all but emotional restraint are required and would be best practice. I have had clients attempt to stab themselves and or others and I have had to restrain them for their and others safety'* (Practitioner/Carer)

> *'I am unsure how we will deal with aggressive violent clients in EDs [emergency departments] and inpatient units without some sort of restraint for safety reasons'* (Practitioner)

> *'Where someone is endangering themselves or others, it may be necessary to restrain them. I am unsure that seclusion is ever necessary. However it is important that people suffering mental illness are able to express themselves'* (Carer)

4.4.24 General Statements

The survey ended by asking participants to indicate their agreement or disagreement with a series of statements regarding seclusion and restraint. Participants were invited to indicate whether they strongly agreed, agreed, disagreed or strongly disagreed with each statement. The statements were:

- the practice of restraint aids staff more than the person restrained

- the practice of restraint is an appropriate resort only in an emergency situation

- when used appropriately, seclusion can provide a safe environment where a person can gain control over his or her actions

- seclusion is almost always unjustified

- seclusion does more harm than good for the person secluded

- restraint practices in Australia are implemented better than seclusion practices

- there is a place for seclusion and restraint in some settings, when all other strategies have been exhausted

- having family present throughout treatment and planning mitigates the need for seclusion and restraint

- seclusion and restraint practices have a high risk of the person secluded or restrained developing deep anger towards staff

- interactions with staff during and after a seclusion period is the main source of dissatisfaction for persons secluded

- seclusion and restraint are important safety measures, but should be implemented more appropriately

Participant responses are summarised in Table 4.9. Almost all participants (92%) agreed or strongly agreed that restraint is appropriate only in an emergency situation, and the majority (85%) agreed or strongly agreed that seclusion and restraint practices have a high risk of the consumer developing deep anger towards staff. Almost three quarters of participants (73%) agreed or strongly agreed that restraint aids staff more than the person restrained. However, reflecting the complexity of views regarding seclusion and restraint, the majority of participants also agreed or strongly agreed that '*Seclusion and restraint are important safety measures, but should be implemented more appropriately*' (70%), that '*When used appropriately, seclusion can provide a safe environment where a person can gain control over his or her actions*' (65%) and that '*There is a place for seclusion and restraint in some settings, when all other strategies have been exhausted*' (78%).

Table 4.9: Responses to General Statements About Seclusion and Restraint

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Total (n)
Only Restrain In Emergency	54%	35%	6%	3%	740
Seclusion Develops Consumer Anger	39%	43%	12%	2%	720
Restraint Aids Staff	39%	31%	20%	6%	716
Seclusion More Harmful	26%	28%	26%	8%	649
Seclusion Provides Safety	26%	37%	20%	14%	717
Better Seclusion Implementation	26%	36%	17%	10%	660
Seclusion/Restraint Final Resort	25%	49%	13%	8%	690
Seclusion Unjustified	19%	24%	33%	19%	698
Staff Interaction Primary Dissatisfaction Source	19%	32%	22%	6%	575
Family Involvement Reduces Seclusion	11%	30%	34%	9%	613
Restraint Better Implemented	2%	13%	24%	11%	364

The themes that emerged in the closing comments were consistent with those of previous questions. For example, 'research and evidence-based practice' was seen as a way forward for mental health care.

> *'I believe there are too many aggression management training programmes within Victoria and not enough research on them. The Victorian government needs to research and give more explicit guidelines and direction, standardisation of aggression management training'* (Carer/Practitioner)

'Professional development' and 'organisational culture change' were also highlighted; and *'Trained and caring staff are a must'* (Carer/Practitioner).

Lastly there was a distinct call for 'multi-disciplinary and holistic approaches', with some participants stressing that these are necessary for preventing future incidents requiring seclusion and restraint.

'It should be mandatory to provide a report and briefing meeting after any use of restraint or seclusion. Families should be offered the chance to understand why, what happened, and whether there is a plan as to how to prevent or deal with next time' (Carer)

4.4.25 Final Comments

To close the survey, the participants were give a final text box in which they were encouraged to provide any final comments. Generally, the responses were split between optimistic and pessimistic views on this topic. Some participants expressed their gratitude for conducting research and the survey. To illustrate:

'I appreciate the work you are undertaking and hope your findings will be acted on' (Practitioner)

'Thank you for the opportunity to contribute and comment on a subject close to my heart' (Consumer)

'Thank you for doing this...hopefully we can improve awareness and accountability for the actions of staff and improve the care provided to clients in mental health facilities' (Carer)

Other comments included details of personal experiences of seclusion and restraint which are too sensitive to report on. However, it is noteworthy that despite letting participants know that the survey did not require them to recount their experiences for fear of causing trauma, many still took the opportunity to do so. This further illustrates the desire of many with lived experience of seclusion and restraint to be heard.

4.5   Summary

Reflecting the high level of community interest in seclusion and restraint, 1,451 people responded to the survey over a two-month period. The survey was circulated widely in order to capture a broad range of views from people with lived experience, carers, mental health practitioners and others with an interest in the issue. Almost half of the sample reported experience as a carer for a person with a mental health issue, and 40% reported personal experience of treatment for a mental health issue. Around one in three reported personally experiencing seclusion and/or restraint, and these experiences had occurred in not only mental health inpatient and outpatient settings, but also in other community settings such as emergency departments, primary care settings and prisons; and involved not only mental health practitioners, but also paramedics, police officers, correctional officers and security guards. These findings indicate that people experiencing mental health issues may be subjected to seclusion and restraint in a wide range of settings, not always involving mental health practitioners.

4.5.1 Defining Seclusion and Restraint

Definitions of the various types of seclusion and restraint were introduced to the participants, in the initial section of the survey and a link back to those definitions was also provided throughout the remaining pages to allow participants to refer to them at any time. Subsequently, survey participants were also given an opportunity to define physical restraint, mechanical restraint, chemical restraint, emotional restraint and seclusion in their own words. This afforded them the opportunity to express their understanding of these terms if they disagreed with the definition supplied. The definitions were thematically coded against three key areas:

- mode (method of implementation/enactment);
- purpose (of the seclusion or restraint type); and
- tone (of the definition/response).

Overall, two key trends emerged. While the majority of definitions with an unbiased tone pertained to mechanical restraint, emotional restraint was defined mostly with a negative tone. A group of participants was unsure about the nature of emotional restraint and suggested that they were informed of the definition by the actual survey. It is interesting to note that the analysis suggests the majority of the definitions were only 'somewhat similar' to the ones supplied within the survey. This indicates a lack of consensus about the nature of these interventions and how they can be defined.

4.5.2 Main Effects of Seclusion and Restraint

Participants were asked to share their own understanding of the effects of seclusion and restraint. In a similar finding to what Gerace and colleagues (2014) have reported, survey participants indicated that there are deleterious outcomes associated with seclusion and restraint.

There was a perception that seclusion and restraint are used more often as forms of punishment rather than for crisis management. The majority of participants who were identified as 'practitioners' in mental health care reported that seclusion and restraint were used to prevent harm to the consumer, others and property. Other participants who identified as consumers and/or carers indicated that some mental health staff merely used seclusion rather than deal with consumers and some suggested that they were ignored by staff whilst being secluded or restrained. It is important to note that most of these narratives are based on participants' perceptions of staff behaviours. Many practitioners also noted a number of negative effects of seclusion and restraint. Some suggested that negative effects are experienced by staff and others involved as well as consumers.

Participants were asked to outline, in their own words, what they felt were the direct causes of the effects of seclusion and restraint. Many cited the 'disempowerment of

the consumer' 'and the lack of holistic and proactive approaches' as the leading causes of negative effects.

4.5.3 Strategies

The survey provided participants with a list of possible strategies aimed at two goals:

- preventing the use of seclusion and restraint for mental health issues; and
- reducing the harmful effects of seclusion and restraint.

Narrative comments for both of these goals illustrated similar trends.

The 'empowerment of the consumer' was a predominant theme within the responses. It was considered that if consumers and members of their social support system were involved in the decisions pertaining to their care, this could lower the incidence rates of seclusion and restraint. Additionally, when these incidents occur, the harmful effects such as 'lowered self-esteem', 'anger' and 'fear' could be significantly reduced.

Some participants stressed that before any changes can occur, there must be legislative changes and support from leadership teams in mental health settings. The list of strategies appeared appropriate to consumers and there was some suggestion that these strategies may have the potential to work. However, there was a commonly held doubt that any strategies could work in the system as it is today. It was interesting to note that practitioners, carers and consumers were in agreement on this. Participants cited the need for an increase of professional development for staff, support for multidisciplinary teams and more funding to improve the physical environments of mental health settings.

4.5.4 Elimination of Seclusion and Restraint

Two questions addressing the complete elimination of seclusion and restraint were posed in the survey. There were a number of aspects to both questions, with one pertaining to the feasibility of elimination and the other regarding the desirability of elimination. Although many participants believed that these practices should be completely eliminated, many, including a proportion of consumers and carers, did not. These findings indicate that some consumers and carers do not wish for seclusion and restraint to be eliminated entirely. The reasons for this are unclear, and require further exploration through targeted research. It may be that some participants considered these practices appropriate and desirable in some circumstances. Alternatively, it may be that seclusion and restraint were considered less harmful than other possible responses to challenging behaviour in mental health settings – that is, the 'lesser of two evils'. It is possible that further community education about the potential for more therapeutic, prevention-oriented responses to challenging behaviour in mental health settings may reduce support for these practices. Future research should seek to explore the reasons why some consumers,

carers and mental health practitioners support the use of seclusion and restraint; a richer understanding of these stakeholders' views is essential for reform.

The open-ended responses showed a trend of great concern for safety should seclusion and restraint be completely eliminated. Some mental health practitioners called for alternatives to be found based on lessons from other countries, research and evaluation. Additionally, there were those that stated that should staff safety be compromised, then this could lead to the departure of 'good' staff.

Some participants commented on a number of strategies relating to changes to the physical environments in which seclusion and restraint tend to occur. For example, it was considered that the addition of bathroom facilities within seclusion areas would make seclusion more humane. Others suggested improvements to the current implementation of seclusion and restraint such as limiting the number of staff who are allowed to implement these practices, as well as training them in the least harmful ways of restraint. Some participants recommended that interventions should be accompanied by respectful and comforting language to inform the consumer of what is happening and why this is happening.

4.5.5 Overall

The diversity of backgrounds, perspectives and experiences of the participants was reflected in the diverse beliefs and opinions about the practice of seclusion and restraint. Almost all participants believed that the practices of seclusion and restraint were an infringement upon human rights and had negative effects. There was evidence of a tension inherent in views about seclusion and restraint, with most participants citing a range of negative outcomes associated with these practices (for example, triggering trauma, compromised therapeutic relationships) but at the same time identifying a number of positive outcomes (increased consumer and/or staff safety).

Importantly it was suggested that much could be done to reduce the harms associated with these practices, while working towards elimination.

When faced with the question whether seclusion and restraint could be eliminated, people with lived experience were more likely to advocate for the elimination of seclusion and restraint. However, a significant proportion of participants either disagreed that these practices should be completely eliminated, or were unsure about whether they should be. The notable exception was emotional restraint, with the majority of participants stating that this practice should be completely eliminated. Perhaps reflecting perceived barriers to elimination, the proportion of participants who believed that seclusion and restraint could be completely eliminated was smaller than the proportion believing that these practices should be eliminated.

The majority of participants were tertiary educated, non-Indigenous females, typically aged 30-50 years and living in a capital city or regional centre. Despite considerable efforts to promote the survey to other groups, only a small proportion of participants were young people (aged < 25 years), Indigenous or residing in rural or remote locations. In order to capture the perspectives of these groups, more targeted research strategies will be required.

Overall the survey of over 1,400 participants reveals much depth of experience, knowledge and emotion in relation to the practices of seclusion and restraint. Further, it is clear that there is much variance amongst this diverse group, and while there was little doubt that not all groups saw total elimination as feasible, the call for change in current practice was unanimous.

5. RESULTS OF THE FOCUS GROUP DISCUSSIONS

5.1 Introduction

This chapter presents the results of a series of focus group discussions with people with lived experience (Consumers) and carers, family members and support persons (Carers). In total, five focus groups for consumers and five focus groups for carers were conducted in Melbourne, Shepparton, Perth, Brisbane and Sydney. The groups were held on the same day in each location. The focus groups all ran for the allocated two hour period and were co-facilitated by Cath Roper and Dr Lisa Brophy. All participants needed to be aged 18 years or older and able to participate in a group discussion.

The Plain Language Statement, Consent Form and Facilitation Guide for the focus groups are set out in **Appendix Five**.

5.1.1 Participants in the Focus Groups

The Consumer focus groups 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 Consumer focus groups included participants who:

- had direct experience of seclusion and restraint;

- had witnessed these practices first-hand as inpatients;

- were employed as consumer advocates, peer support workers or consultants in mental health services; and/or

- were involved in advisory committees and support groups for people with a lived experience of mental health issues.

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. Members included:

- parents, partners, children and siblings of consumers (including young carers) who have experienced restraint or seclusion;

- carers on advisory boards, forums, committees and working groups which involve lived experience of serious mental health issues;

- carers with lived experience as both consumers and care providers;

- carer representatives; and

- advocates experienced in supporting consumers.

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 over 70. No Indigenous Australians attended but people involved in supporting Indigenous people did attend.

Participants self-selected and opted into the groups after receiving information through peak bodies and support services (including Indigenous health organisations) in each state where the focus groups were held. The facilitators spoke to the majority of the participants by telephone before the focus groups to confirm their participation and arranged to send the Plain Language Statement in advance of the session. In some cases another person (such as a peer worker) made arrangements for people to attend and preliminary information was passed on via this person. A small number of people arrived on the day of the focus groups after seeing information about them. The facilitators had a brief discussion with each of these people to confirm their eligibility to take part prior to the focus groups commencing.

5.1.2   What Happened at the Focus Groups

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. The groups commenced with a thorough discussion of the Plain Language Statement and signing of consent forms. Each focus group was digitally recorded and the recordings checked to ensure the best audio quality for transcription.

Participants were asked to introduce themselves and an opportunity was provided in each session for participants to share why they were interested in attending the focus group. Seven potential questions to encourage discussion on seclusion and restraint were initially set out in a Facilitation Guide for the focus groups. These questions are set out in **Appendix Five**. However, during the early groups it became clear that the limited time allocated enabled a focus on just three key topics. These were participants':

- understanding of seclusion and restraint and their impact on the people involved;

- observations about poor practice and what contributes to it; and

- ideas and recommendations regarding strategies to reduce or eliminate seclusion and restraint.

The first topic enabled the development of a shared understanding of what was meant by seclusion and restraint. Many participants had attended the focus groups because they were concerned about poor practice and what they understood to be contributing to ongoing poor practice, so this tended to be an important topic to cover in some depth. The third topic provided participants with an opportunity to contribute to the discussion of examples of good practice and potential strategies to reduce and eliminate seclusion and restraint, informed by the knowledge they had gained from their lived experience. This also enabled discussion about the barriers to any change. There was considerable discussion in the focus groups about the impact of seclusion and restraint on people with lived experience. The same topics were covered in the Carer and Consumer groups. This chapter presents the analysis of these focus groups' discussions.

5.1.3   How the Focus Groups Were Analysed

The focus group recordings were transcribed, then analysed using the NVivo 10 qualitative data analysis software. NVivo is a useful tool for organising and making sense of large amounts of data. As with the online survey analysis, a general inductive approach was used to analyse the data (Thomas, 2006). This approach allows 'research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies' (Thomas, 2006, p. 238).

Each transcript was closely read and re-read multiple times in order to identify categories, which were coded for words, phrases and meanings in the text by one member of the research team who was independent of both facilitators. Categories were continually refined through the analysis with coding consistency checks performed by another team member to ensure trustworthiness of the data.

5.2   Definitions of Seclusion and Restraint

Participants were asked what seclusion and restraint meant to them. The responses have been divided according to type of group.

5.2.1   Carer Perspectives on What is Meant by Seclusion and Restraint

One Carer participant suggested that any behavioural intervention that was not therapeutic was by definition a form of seclusion or restraint.

> *'Anything that's not therapeutic, locking them in a locked unit, drugging them, threat of tying them down and injecting them, anything that's not therapeutic.' (Carer)*

An overarching theme of *control and risk management* underpinned many comments made by this group about how they understood seclusion and restraint. As one participant noted in general regarding restraint:

> *'It's sold as a safety and protection strategy, but it's a management strategy… every person who's been restrained or seen a person restrained behaves differently in the future, so it's a management strategy, not just for that moment, but it continues along in time, and that it holds a person in fear.' (Carer)*

Seclusion and restraint were identified as being used as a way to control the behaviour of consumers during a crisis by ambulance staff and in psychiatric hospitals. Participants identified multiple forms of restraint including chemical restraint. This was described in the Carer focus groups as a common response to crisis in an acute setting:

> *'As soon as somebody's like that the first thing they do is sedate and that may or may not be appropriate and that's the first thing everybody seems to do.' (Carer)*

Participants identified chemical restraint as being consistent with the overarching theme of control and managing risk in two ways. The first is to manage an acute scenario as the quote above suggests, incapacitating a patient from a period of a few hours to days. The second way is when medication is prescribed and given without the person's consent while they are in the community.

Another participant equated 'chemical restraint' with over-medication.

> *'There's chemical restraint, that's huge you know, and I think that we don't pay as much attention to chemical restraint as we should, I think often people are over-medicated.' (Carer)*

One participant described psychotropic medications as '*chemical straightjackets'*, referring to medication as an agent of behaviour control rather than a recovery-based treatment.

Emotional restraint was also identified as a method of behavioural control. It featured frequently in the Carer focus group discussion and was considered by one participant to be *'where a lot of the [change] work needs to be done'*. As described by another participant:

> *'A coercive type of action or behaviour, and it's using something that is close to that person, withdrawing it, saying they can't have it unless they do x y z, you know it's utilising – and emotionally taking, it might be that your family can't come and visit you today unless you are doing x y z.' (Carer)*

Threatening to withdraw privileges from patients was seen by one participant as a taking away of rights, while another commented on an example of emotional restraint when her daughter '*didn't behave properly*' and mental health services

withheld activities which *'aggravated the situation'*. According to participants, the threat of seclusion was a form of emotional restraint:

> *'And people are threatened, do that again and you'll go into seclusion.' (Carer)*

Participants were concerned that emotional restraint was inconsistent with their ideas about good care:

> *'And I'd like to talk about an emotional restraint for voluntary patients is if you leave this facility you will be made involuntary…and that is one of the most powerful emotional restraints that is used in public and private facilities.' (Carer)*

Participants spoke about mechanical and physical restraint. Two carers had been exposed to extreme events including one person whose child had been shot and killed by police, another who had had her son's arm broken in the context of physical restraint. Another participant spoke of her husband being tied to a bed and her frustration about this happening over a prolonged period.

Seclusion was identified as the end result of behaviour modification and/or a risk management strategy for inpatients. Participants likened seclusion (and by extension involuntary admission) to putting people in isolation:

> *'Certainly some of them have been involuntary patients, and they didn't think they should've been, but they weren't restrained, they were like isolated, secluded...I know that the mental health system is a very complex one, and I know that carers need to be protected as well as staff, etc. But at the same time you've also got to consider the needs I believe of the patient too.' (Carer)*

5.2.2 Consumer Perspectives on What is Meant by Seclusion and Restraint

Participants from this group were able to clearly describe different types of seclusion and restraint and how they are used in conjunction with one another. One Consumer describes their experience of physical, mechanical and chemical restraint during a psychotic episode:

> *'I'm obviously unarmed, I'm obviously harmless, I'm obviously in deep distress and what do they do, they call in these hefty blokes who physically hold me down and push me onto the bed and strap me onto the bed and forcefully inject me with an IV. Like was that really necessary, really, really.' (Consumer)*

Physically being *'held down'*, *'wrestled'* and *'pushed down'* were phrases used by participants to describe physical restraint. Another participant describes their restraint experience as follows:

> *'A whole heap of people come around, I've got one on each arm, one behind here, one on this leg, get carried through the hall and then a big jam in the leg, and then when you wake up again suddenly all these people rush at you and it's another jab in the leg…some of these times I actually didn't even know who I was, I'd had this big amnesia of who, what my name was, where I was, what was going on, so I couldn't have any, it's like you're totally disassociated from everything, so you're quite confused, but no one said your name is so and so, this is where you are, this is what we're doing, there was no explanation.'* (Consumer)

The distress caused by mechanical restraint was emphasised by two separate participants:

> *'It's quite claustrophobic it's sort of like being in one of those MRI machines where you've got to sit in there straight for an hour…If you've got your hands tied and you can't move it's awful. It's very distressing.'* (Consumer)

> *'And we deal with a lot of people brought in by the police and the ambulance that are restrained, on the, in the ambulance it's a 6 point restraint across the chest, here, on your arms and on your legs, and you can't get out, once you're in there you can't get out. And I tell you what it's not very nice when you have that, when you're locked in with that locked mount, not very nice.'* (Consumer)

Chemical restraint is used to sedate inpatients as an adjunct to seclusion, as one participant describes:

> *'But they do give you injections in that seclusion room as well, if they think that…you're not going to take the medication and they want to sedate you.'* (Consumer)

The above quotation connects into the overarching theme of *control and risk management* discussed in the Carer focus groups. Also, one participant in the Consumer focus groups reiterated the notion that chemical restraint went beyond management of an immediate risk:

> *'I just wanted to say something about medication too, you were talking about that's a form of restraint too when you get hospitalised. I was put on, because I was going through a psychotic episode, I was put on antipsychotics and I've remained on those since I've been hospitalised, and I haven't been able to get off them because of the side effects of trying to come off, and they've been too difficult for me to deal with, so I now feel restrained in my lifestyle because I'm taking this medication which I don't need any more but I can't get off them.'* (Consumer)

Emotional restraint was discussed by Consumer participants as being a practice that enforces compliance through *'bullying'*:

'…so I think it is that, I think it's about a threat as well, I think it can be about just that threat, that knowledge, that you can have power taken from you. That's to me the essence of it, it's the power, the power differential that comes into play. It's something that you have no control over whatever it is and just the threat of it can screw you or it can coerce you to do things that you don't want or that…aren't going to be okay for you.' (Consumer)

'I was just going to say I think it's really sad that emotional restraint isn't currently recognised by psychiatric bodies because of the way that emotional restraint is used interactively with those other forms of restraint, so emotional restraint being forms of cohesive and manipulative practices that lead you to comply and if you don't comply then other forms of restraint and seclusion then kick in.' (Consumer)

Another participant recounts being threatened with seclusion:

'I found the nurses approach was at times very cold and intolerant, once I was told that if I didn't stop crying that I would be placed in a cell with no toilet and only a very tough mattress and a canvas sheet, with the bright lights left on for unknown hours.' (Consumer)

5.3 Perspectives on 'Poor Practice' and What Contributes to It

The following sections of this chapter combine the responses of all participants, since it was found that these themes emerged from the Consumer and Carer focus groups and they had more in common than any divergence. Many participants had attended the focus groups because they were concerned about ongoing poor practice. Participants discussed what they identified as contributing to poor practice and what they identified as potential barriers to eliminating the use of seclusion and restraint.

5.3.1 Views on Poor Practice

The use of excessive force to combat escalation and manage risk was a practice questioned by many participants in the context of their discussion about what they identified as poor practice.

A participant recounted an experience of restraint with use of excessive force:

'The last time it started with the police tackling me and putting me in a paddy wagon but putting me on my stomach and leaving the cuffs on that was about the worst part of it...I was saying I can do no harm and I still got tackled.' (Consumer)

One participant questioned education around escalation being connected with poor practice:

> *'Education, and everybody talks about doctors and nurses receiving education, that's great, but the volunteers at the hospitals and the security guards really need to be educated that because somebody's displaying agitated behaviour does not give you the right to come and restrain them physically.' (Consumer)*

Some participants who had participated in training because they were employed in services wondered whether the emphasis around de-escalation and physical restraint is too focused on physically restraining people:

> *'…but what do I do, I just don't know how to do it differently and also what they practice is what kicks in. You know the aggression management stuff it's all about…the emphasis on this physical takedown stuff so when you get stressed what are you gonna do, you're gonna do the stuff you've practiced. Why don't we keep practicing with the escalation stuff and all the other things.' (Consumer)*

> *'We put complaints about it, and so that's the statewide level, that's not just our area, there was a lot of complaints about it because, and I guess this is where when we're talking about…that undue use of power which is sometimes invoked with trying to seclude or restrain people, it comes right down to even when they start that aggressive behaviour management training.' (Consumer)*

> *'Somehow there's a sanction given to people to be horrible to other people because of the group that they're a member of. And I think that's something, if I don't say another thing, that's all I want to say.' (Carer)*

The culture and attitudes of mental health services staff were consistently discussed as an important contributing factor to poor practice. This quote from a participant paints a picture of an uncaring and threatening environment:

> *'Some of the things that went on in the past were just absolutely horrific, and there was no excuse for any of it, except perhaps laziness on the staff. You know I've seen staff go out and actually provoke patients, you know, I had one bloke say to me years ago that if I didn't shut my mouth I'd go in there too.' (Carer)*

Participants specifically pointed out the nursing staff in this respect, either they '*haven't got time and can't be bothered, or don't want to educate themselves*' about strategies that could assist to reduce incidences of seclusion and restraint. Lack of compassion and empathy were also other experiences noted by participants, which represented a lack of connection between staff and patients:

> *'I've seen people, patients…knocking on windows when nurses close them off…because they couldn't get heard, and therefore they'd start kicking the window and they'd be injected and taken off to seclusion.' (Carer)*

'There's no accountability in these places. The staff are overworked. If somebody's getting strung out over something it's just too easy. In fact if they want to actually get rid of them they've only got to aggravate him and then they've got an excuse to restrain. And that happens, I've seen that.' (Consumer)

'We're all human beings with our freedom taken away to certain degrees and I think why poor practice is still around is because, you know, despite the training and education that professionals that work in these units get, there's not the empathy, there's not the understanding.' (Consumer)

A Carer who also had experience as a Consumer described her frustration regarding poor practice as follows:

'See this is where the problem comes in for me, like I'll start from – yeah, I was an aged care nurse for ten years, so then I became mentally unwell, so to become mentally unwell, to sit there and look at the goldfish bowl, and the nurses just looking at you crying your heart out, wanting to kill yourself, and they don't spend time with us, they say even today, we've got paperwork, how can they have paperwork 'quote' when they do not talk to us consumers. Now because they don't talk to us consumers, we're going out of the hospital system still suicidal, we're back there in a week, if we're lucky we're back there.' (Carer)

There are three particular issues that emerge through this quote that were raised in many of the discussions with both consumers and carers:

- there was an issue with the 'fishbowl' ward design as a barrier which not only separates nursing staff from inpatients physically, but also appeared to reinforce separation on an interpersonal level;

- the inherent power imbalance between staff and inpatients is described whereby nurses have the power to choose whether or not to engage; and

- paperwork appears to be a barrier to staff having time to engage with consumers.

In the same Carer focus group, one participant commented:

'15 minutes talking, I said if you're lucky, because most of them just, the nurses who are in charge of the medications, that's their job for the day, they do the medications, and they don't have time to talk to anybody.' (Carer)

Participants shared their ideas about why staff did not appear to have the time to talk or interact with inpatients, particularly those who are distressed. Some participants thought some nursing staff were desensitised and uncaring. Others

wondered about a lack of appropriate training, or an inability or unwillingness to use recovery-based techniques:

> *'For those nurses in the ED, I mean they haven't got a clue many of them, you know, and never mind even the nurses in the mental health facilities.' (Carer)*

> *'We still have the issue with nurses like we want nurses to be involved in these [executive] meetings so they can hear what we're doing…to help the consumers, but none of the nurses want to give up their time or commit to any of the committees within the hospital.' (Consumer)*

One participant elaborates on their opinion regarding training in a psychiatric setting:

> *'The people, the nurses and the so called professionals I think within the wards are not trained well enough to be able to stay with people in their anger or in their frustration or their irritation, whatever it might be. These people are sick, and you need trained people to sit with that, in relative safety, know how to cope with that. Not that it triggers their own stuff and often the nurses are triggered, their own stuff is triggered. That's why they like to sedate everybody, it keeps everything under control'. (Carer)*

Participants were concerned about staff in an emergency department (ED) treating mentally unwell patients as a standard emergency, as one participant articulates:

> *'I guess if we want to start looking at the admission, someone comes in, it's a crisis, at the moment what happens is they come to emergency, the doctors are all running around dealing with triage patients, you get this person coming in who's traumatised, who's psychotic, they often, the doctors don't have time to look at them initially because they're too busy fighting other bushfires somewhere else. And consequently if the person's behaving in an unmanageable way then they're put into a room and then they're sedated to try and calm them down, because the doctors are too busy. So seems to me that the system is fundamentally flawed at the admission phase or stage, because the people with the mental health issue are coming into an emergency situation, which is already overloaded.' (Carer)*

In this situation, staff may have some training or experience in dealing with consumers who are in crisis. However, participants observed that the busy and over-stimulating ED setting often tends to aggravate symptoms.

> *'I've thought about it a lot. I think for me in my case the emergency department was really stretched, they were under staffed, I'm pretty sure my nurse was…like an emergency nurse without necessarily particular mental health training. The doctors were busy and yeah so I was threatening to kill everyone, I wanted to go home, I just wanted to leave but also part of me knew that I just needed to sleep and I was really wired and the undercurrent*

> *was my distress about my trauma and if someone had taken me into a quiet room, because I was in such a like a heightened altered state, I was really sensitive to everything that was going on around me so there were cardiac arrests and people having haemorrhages and people being taken to emergency surgery and people being resuscitated and it was just a really heightened environment.' (Consumer)*

> *'Emergency [department] is just the worst place for mental health issues.' (Consumer)*

The lack of de-escalation strategies being used from the initial point of crisis was linked by some participants to the use of restraint:

> *'So what they said is if we're concerned before they get in the ambulance we're going to physically restrain them, because that is their number one priority.' (Carer)*

> *'So I would talk to these guys across the road, and they'd know, like if I express pretty bizarre and not very good things going through my head, they wouldn't panic because they know me and they'd just talk through things, whereas you can talk to Lifeline or you can get that triage which is in [place name], and they don't know so they panic, and the next thing you've got police.' (Consumer)*

Emotional restraint was linked with poor practice. Participants were concerned that withholding privileges can create escalation of tension and agitation, justifying the management of risk through seclusion and restraint:

> *'So sometimes the removal of privileges where you can then withhold them, not even privileges, rights, you can withhold them, creates the circumstance of escalation that then allows them to feel justified.' (Carer)*

> *'The only time I've ever seen nurses engaged in any kind of de-escalation tactics other than seclusion and restraint, is when they're giving the patient the alternative that they take their sedative willingly or they're held down, that's it.' (Carer)*

Carer participants suggested that they often shared the sense of powerlessness that consumers feel. Poor communication from staff across the admission process, family members being prevented access to their loved ones by mental health services and a lack of follow-up from staff after release all contribute to their identification of poor practice:

> *'It's in the way that communication happens, so not just communication but really specific mutual type of communication, and I think that needs to be taught and explored with staff, it's not just something that you start saying*

well start communicating, because you still communicate sometimes with your own views, and you're not communicating taking on board that person's views as well, so they've got to be kind of taught I think that mutual understanding of the communication.' (Carer)

One Carer from a culturally and linguistically diverse background described their experience of poor communication from mental health services during a time when her husband was being restrained:

'I didn't know what's wrong when that happen, and just too much for me, and then next thing I call my sister-in-law and she came with her husband, and then the doctors and nurses start talking to her, and the whole night they didn't talk to me, I asked them what's wrong with my husband, and I think it's discrimination because I'm from overseas.' (Carer)

This participant thought she knew her husband better than anyone in this situation but that she was not consulted because English was not her first language and her cultural background:

'…and then she said he sick like this all his life, he's crazy, and I said no my husband he's a nice person, he never ever hurt anyone, and then just the way they treat me is horrible, and I think because I think that they didn't bother consult with me because oh she's just from overseas.' (Carer)

Paternalism and the importance of achieving compliance were also identified as poor practice and inappropriately contributing to the overuse of seclusion and restraint:

'I think that the restraint, whatever it is, the seclusion, the chemical, the emotional, I think it's linked in with those values that you were talking about too. It's when there is a mismatch of those values it smacks with paternalism at times so there might be very well good intent behind it for people thinking that they're helping and trying to get you to come to that…understanding or have that, my pet hate word, insight…about it but it smacks with all of that and to me it's about a chemical restraint, any kind of restraint, there is absolutely an element of it in a lot of the time around bringing people around to doing things the way the organisation thinks it should be. So there's no place for having a different view to the organisation, or very little space, and it's very much reliant on the individual that you might come across a clinician who is much more open to that sort of stuff. To me the restraint is about bringing you into line with a way of thinking about doing what's best for you…Seclusion and restraint is about compliance.' (Consumer)

5.3.2   Views on What Contributes to Poor Practice

Many of the factors that contribute to seclusion and restraint are discussed above in relation to poor practice. However participants also identified drug use as a potentially important factor:

> *'The issue is when a person has psychiatric symptoms, but then has drugs as well, and becomes quite violent, how do you manage that. I mean I don't know. It's a question to ask.' (Carer)*

Participants were concerned that people who are drug affected may be seen as undeserving of compassionate attention and therefore unfairly subject to more seclusion and restraint:

> *'I used to always want to be stoned and I think well that's beyond panic attacks, that's like I want to be in a coma, that's how stressed out I am, I want to be like partially conscious…that's not like something that we should just reject these people, and say…they've got these drug problems…they brought it on themselves…that's the feeling I get when people talk about dual diagnosis.' (Consumer)*

Also the lack of a quiet, private space that offered an alternative to a seclusion room:

> *'But after about six or seven admissions the unpredictability of that, because that had never happened before, and my son had actually often, when he was admitted, asked to use seclusion as a way of getting away from people and getting some peace.' (Carer)*

Participants identified hospitals being under-resourced and staff being too busy as factors that explain poor practice. For example:

> *'But even the staff get frustrated with it too, like they get frustrated with it, you can see, you can tell and then…you'll go talk to them and they seem run off their feet and angry and stuff, and they take it, then their mood affects everyone else, because they're usually carrying on. Sometimes they're just as bad as people on the ward.' (Consumer)*

Stigma and fear were seen as common contributors to the use of seclusion and restraint:

> *'Staff are frightened, police officers are probably frightened too, like people don't necessarily have those connections, like staff in hospitals don't always have connections with people that are like deep enough to, or like genuine enough to talk to people when they're in really bad distress, and I think it's not necessarily that the staff are really bad, it's just that there's not the money for them to spend the time that they would need to spend…I think there's all that*

stuff, there's a culture of fear in Australia like fear of difference, I think that adds to it.' (Consumer)

'I think stigma permits this to continue, and I think that…permits the lack of kindness, kindness is the sweetest thing, we get a bit of kindness from a person on the street and we feel uplifted. And so I think stigma that's supported …You're absolutely right. And I think that stigma is perpetuated by psychiatrists as you've just said, and it feeds down to the public, and it's this cycle then, it makes it very easy to stigmatise people because…that's coming from the top, and the public remain ignorant, and therefore stigmatise our people. It's all this cycle…Those exact words you've just said I've heard every one of them from my son.' (Carer focus group participants)

5.4 Barriers to Reducing Seclusion and Restraint

All ten focus groups with consumers and carers discussed a variety of barriers that prevent the reduction of seclusion and restraint. Two specific themes that emerged were Environment and Drug and Alcohol Issues.

5.4.1 Environment

Participants commented that the physical environment is a barrier to the reduction of seclusion and restraint in two main areas; the emergency department and the inpatient setting.

One participant describes the inappropriate features of the lighting and waiting area of the emergency department:

> *'And I think the environment has to be changed, I mentioned fluorescent lights and…sitting on benches and so on as a lot of people do in emergency. It's the wrong emotional environment, therapeutic environment, for someone who's traumatised or what have you.' (Carer)*

Fluorescent lighting along with room design are mentioned by another participant in the context of seclusion:

> *'It occurs to me quite obviously that when people are locked up in rooms with fluorescent lights and very bare walls, it is the least conducive environment to put somebody who is traumatised, it's like a cell.' (Carer)*

The bare environment of the inpatient setting was explicitly identified by one set of participants as a contributing factor to seclusion and restraint:

> *'Because it's so cold when you walk in, just everything is just cold about it.' (Consumer)*

In the same focus group, one Consumer participant elaborates as to why an environment that restricts their freedom would increase the use of seclusion and restraint:

> *'Yeah, they get worked up and angry, and they direct their anger at staff and then when they do that they end up…being restrained.' (Consumer)*

5.4.2 Drug and Alcohol Issues

Participants across the Carer and to a lesser extent the Consumer groups discussed how drugs and alcohol contribute to the use of seclusion and restraint.

> *'I think that's very real, anyone who's been into an ED knows that methamphetamine produces a violent outcome, and…there are definitely cases where people have to be restrained to keep them from other people, in a hospital environment, where there's other public around.' (Carer)*

> *'…this person may have also [had] a history of mental illness, but it's the amphetamine induced psychosis that has caused the need, or has led to anyway, whether it caused it or not I don't know, but it led to some form of restraint.' (Carer)*

The Carer in the above quote links drug-induced psychosis to restraint and describes how people with mental health issues often present with drug and/or alcohol problems. The comment below raises questions about whether or not practitioners make distinctions between behaviours that are a result of mental health issues and those that are a result of drug and alcohol problems:

> *'I mean how much do people distinguish between what's drug induced and what's actually contributing from the mental illness itself?' (Carer)*

Participants expressed concern about the potential lack of care for people who are drug affected, even though this may be a result of their attempts to deal with their mental health issues or the side effects of medication:

> *'Well I just think why is there a difference, like whether or not you're intoxicated or not, why is there this moral judgement put into it, like they're intoxicated so like, well all we can do really is restrain them, like most people that become, like a lot of people that use Ice and go into psychosis, if they go into a persistent psychosis, have underlying mental health issues, and often people who are on like quite heavy mental health drugs will take amphetamines and stuff because they're so sedated and they want to feel – and I've heard them say like I want to feel like I'm alive, I want to feel like I've got energy, you know.' (Consumer)*

Drug and alcohol issues can also disproportionately affect members of rural and Indigenous communities who have contact with mental health services:

> 'We've certainly had people who have come in from rural communities and the alcohol issues and the drug issues are huge and that's because again for various reasons they've lost their background heritage and all those sorts of things.' (Carer)

The process of admission of an intoxicated person in the emergency department may also be a barrier to reducing seclusion and restraint in cases of acute mental health issues:

> 'But the reality is in the public mental health system in NSW if someone actually is brought into the emergency department either intoxicated or under the influence of drugs, they can't actually start to have a mental health assessment until they're actually sober, and that can take anywhere from 12 to 16 hours, so people can actually be held for 16 hours before the mental health assessment process starts.' (Consumer)

In one youth ward, a Carer participant observed high rates of seclusion in relation to drug-induced psychosis:

> 'We have gone to a particular youth ward, so 18 to 25, I think we're the only service that's done that in Victoria, and that was where high seclusion rates are, and most of them are drug-induced psychosis events.' (Carer)

After discharge, one participant reported that consumers with drug or alcohol issues may have to wait a considerable time for rehabilitation services:

> 'Guys that have to wait 3 months when they get out of the mental health to go into rehab, because they really, really want to go to rehab but there's no placement.' (Carer)

5.5 The Experience and Impact of Coercive Interventions

In nine of the ten focus groups with both consumers and carers there was discussion about the experience and impact of coercive interventions. The six themes that emerged from the analysis are: Human Rights, Trauma, Control, Isolation, Dehumanisation and 'Othering' and Anti-Recovery.

5.5.1 Human Rights

In nine groups there was considerable discussion about the impact of coercive interventions on consumers and their carers. In the main, participants identified these interventions as a breach of human rights, even when it may have seemed necessary to manage risk. For example:

'Unfortunately, I think there is a place for it that you do need it but on the other hand it really does take away people's rights and it's a pretty harsh thing to do to somebody. It's kind of a bit of a necessary evil I suppose. My mother really did need that time away in a secluded area by herself and things like that.' (Carer)

Many participants were concerned that there was a lack of accountability for human rights breaches that may have occurred in the context of coercive interventions. This linked to participants being aware that many consumers seemed powerless in the situation and also, because they had mental health issues, may not be believed when they complained of abuse.

'We've had people who have come in and said this happened and I don't know why. I don't know why they dealt with me this way and why was I thrown on the floor and injected when all I said was please don't give me any more of that medication it makes me really, really unwell.' (Carer)

'Can I say that I think one of the things about it is that the state, the state constrains one of its citizens, at one level it's either the cops or mental health nurses under the Mental Health Act, something, restrains or limits the freedom of movement of one of its citizens. And I think it's a massive human rights question, and I think sometimes we don't put it in a human rights framework when these sorts of things are done to people, because it hurts them as a human rights abuse, it feels like a human rights abuse, and then when everybody just goes, oh well you know, it's for your own good, or they minimise it, they're minimising the impact of this state coming down on one of its citizens and saying we categorise you in this way and we think we can do this to you. And so I would want a high order context put around this, that this is a human, these are potentially human rights abuses that are happening in an affluent, beautiful blue sky environment, by otherwise nice people who go home and are nice to their kids – but somehow there's a sanction given to people to be horrible to other people because of the group that they're a member of. And I think that's something, if I don't say another thing, that's all I want to say.' (Carer)

One participant was aware that this may also have cultural significance:

'I think ethnic communities in particular, the Europeans, they see seclusion and restraint as an unlawful activity…They see it, it's like they've committed a crime, the families, that's how they see it.' (Consumer)

5.5.2 Trauma

Many participants discussed how coercive interventions resulted in trauma and also how past trauma was sometimes revisited or resonated with the experience of being coerced.

> *'And I can say that my son is so traumatised by these events, that he lives in fear of being picked up at any stage. He's marked.' (Carer)*

> *'You know they could've been sexually abused, drugs, everything like that throughout their life, and they're innocent, they want to go get help. But the thing is if they're getting locked up like they're in prison, it's coming back on their post-traumatic stress and that, and they then believe that they are being punished all over again, and that they're unworthy human beings.' (Carer)*

> *'Sweeping them all under the carpet, it's easier to not deal with you and your problems, even though that's the only reason you're here, is to have somebody help you deal with yourself and your problems, so instead of doing that for you we're just going to sweep you under the rug and put you in a cell that has no toilet and no air and leave you there for ten hours and then you'll be cured, and it's not – you go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless.' (Consumer)*

Participants made a link between the trauma experienced as a result of seclusion and restraint, and the subsequent impact this had on the person's recovery and relationship to service providers.

> *'So what I've seen with people who've felt, when they've had even a single 24 hour experience of seclusion and restraint under the mental health system, which is the door, the police, the medication, down into the whatever, the taking of the clothes, the whole lot – that person's changed forever in their feeling and their relationship to the society around them. To every other state agency they're changed, and that allows, that's again that learned helplessness.' (Consumer)*

5.5.3 Control

Participants discussed how seclusion and restraint were used by staff to gain control over consumers and also to manage the environments they found themselves in. The quote below captures the discussion about how control relates to both behaviour control and maintaining the ward routines in order to contain the environment.

> *'Well I was thinking about it, yeah the notion of control though is a sort of core sort of feature of – my experience inside units with clients really, because I worked at a [service] for many years so I used to visit people from that*

perspective as well as family members' reports of it, and then control for me became a sort of key feature of how – the result of control was isolation in a sense, so people, one way you control the situation, because I guess the feeling of the medical staff was that it was out of control…so isolation was obviously a way, the other way was sort of punishment, which is what you're talking about isn't it. The other thing that I thought was interesting, and the feedback I get and being on a unit, is that the idea of medical routine, so if people are not behaving accordingly to the routine…that they need to have their obs taken, they need to have their medication done, and that's just routine, doesn't matter what the individual's state of mind is, so then they have to be kind of contained within that routine. And I think that for me always was really obvious when you wanted to talk to the nurse about it, no I'm sorry I'm in the middle of my – there was no room for…the family members, but particularly for the consumer'. (Carer)

Again there were concerns about people from different ethnic and cultural communities and the impact of the use of control and its link to further stigmatising mental health issues.

'So there's a massive control attitude out there. The other thing is that we are a multicultural society. I'm from a CALD background and believe me the CALD community is suffering 100 fold, because often they don't understand what's happening to them, certainly the families aren't involved. I do lots of presentations on de-stigmatising mental health issues amongst the CALD community, because there's a lot of, depending on what culture people are coming from,(and) the Indigenous community. So we've got a very, very big job. But I'm just grateful that we are, I think we're starting and we can make a change.' (Consumer)

5.5.4   Isolation

Many participants commented on their concerns about people being isolated and its impact on their mental health, self-esteem and relationship with the service.

'People only went near them I think to put the food tray out there with the paper plates and paper cups and things like that, they weren't even treated properly like they couldn't be trusted with proper cutlery and plates and things, it was just awful.' (Carer)

'Deny people their freedom, for example if it's restraint of freedom of movement, or the freedom to ask questions, the freedom to be able to interact with other people, I mean isolation basically is almost another form of punishment, you've been bad, you've done something wrong. I mean that's how I see somebody being isolated. And takes that confidence away, because you must be bad so you are in isolation.' (Consumer)

'…if I'm isolated from the community or if I'm isolated for a set period of time, I start getting triggers and symptoms of my illness and many others have told me they do the same. When they get isolated it just exacerbates the illness further.' (Consumer)

Isolation was raised by participants as presenting a particularly negative impact for Indigenous people in their experience:

'And then you become more isolated and then the whole problem just gets worse. That's not peculiar to aboriginal people it's perhaps more common.' (Carer)

'Could I put another perspective on – another form of restraint and isolation is …when traditional aboriginal people are brought down out of their country, and placed in an environment that's totally alien to them, so on top of their mental illness issue they're out of context, they're out of country, they could be in the middle of an exercise yard, but they're still restrained, they're still totally isolated because they can't connect, and that's one of the ones I think it's more a prison issue, but also it folds over into the mental health issue as well.' (Carer)

5.5.5 Dehumanisation and 'Othering'

Participants identified dehumanisation as one of the contributing factors to what they identified as poor practice, why seclusion and restraint continued as an everyday practice in mental health contexts and also it emerged as a theme in relation to the experience or impact of seclusion and restraint. This could also be described as 'othering' in that people had to cope with times in their life when people treated them as though they were 'sub-human'.

'It's a social justice issue, because powerlessness is an injustice, it's actually dehumanising…and it's not just the consumer that's in the hospital, it's the actual carers.' (Carer)

'There was an incident where I went to the hospital, let's just say against my better judgment, and against my will for that matter, they decided that I had a weapon on me, where I would have got it I have no idea, so they made me literally strip down to nothing and wait in a room while they searched my clothes which apparently had bomb residue. I have no idea, basically I had to stand there naked and it was a room literally it was just like a standard hospital room…with the doors with the glass windows and people were just walking past. Who cares, he's only a psych patient, who gives a crap. And that's the way it felt. You literally just get de-humanised and it's sort of that once you have become part of that system you do become almost, well not completely, but treated in a sub-human way. You can do things that you would

not normally do. If you had a cancer patient in that same situation the furore would be terrible with the treatment they receive.' (Consumer)

'I think people are just so busy and under-resourced, there's complacency and desensitisation…we see it so often...Desensitisation like forgetting that we're actually people.' (Consumer focus group participants)

5.5.6 Anti-Recovery

Finally participants also discussed the impact of seclusion and restraint as being inconsistent with the personal recovery paradigm. Many were aware that recovery was otherwise having a significant influence on policy and practice in mental health services.

'But the other thing I wanted to raise while I was just thinking about, just seclusion and restraint, the very practices themselves, are sort of very anti-recovery…[Recovery is] all about self-responsibility, self-direction, and then seclusion and restraint is all about someone else's control, so it doesn't actually sit with recovery at all. And apart from the human rights abuses of it and the trauma that you carry for the rest of your life, when you're actually already at a point when you're severely traumatised when you go to a hospital and then you get extra trauma from it, it doesn't sit at all with recovery.' (Consumer)

The negative effects on mental health in the long-term of being secluded were recounted by participants:

'So then I was put in seclusion with the padded cells and the bed on the floor. For me personally being in that situation triggered me off more because I've had a lifetime mental health problem.' (Consumer)

'So it's not the best, because by the time you do actually get a chance to settle, after what's happened, they come and wake you up again. So then you're sort of going through that cycle and you're having to go through it over and over, because then you're back to being worked up and everything, so yeah. So it's not the best, it's not the nicest, yeah it's pretty horrible…you start to lose your mind.' (Consumer)

The challenge of trying to maintain a sense of balance during crisis and seclusion was articulated by another participant:

'It's pretty hard because you can't even use like some of your strategies you'd use at home because you're just in these four walls.' (Consumer)

5.6 Strategies to Prevent Seclusion and Restraint

In both the Consumer and Carer groups, strategies for prevention of seclusion and restraint were discussed. The seven main themes that emerged are discussed below.

5.6.1 Education in De-escalation Strategies and Improved Communication

This was one of the most frequently suggested strategies for reduction or elimination of seclusion and restraint. It was mentioned in nine of the ten focus groups.

> *'I became better at not panicking and being able to then actually call on those, this is how I de-escalate this, this is how I do, this is how I manage that. So when you come in from a different area, it's basically just got to be drummed into you, when somebody is distressed, step one, step two, step three.' (Consumer)*

> *'Follow the procedure.' (Carer)*

There was confidence among participants that de-escalation can work. For example:

> *'I saw a male nurse de-escalate what could've been a very volatile situation, and I was astounded.*

> *WHAT DID HE DO? (Facilitator)*

> *He spoke, quietly, calmly, and just like that the whole situation was turned around. I was just an innocent bystander, and later on I spoke to him and I said I was very impressed with what you just did, that was fantastic. I saw it once.*

> *I've seen it too, it's brilliant.*

> *It was so fantastic, why over the millions, hundreds of hundreds of times when I've been there, in the hospital, haven't I seen it before?' (Carer participants)*

Some participants were critical of the type of education currently offered to staff, particularly when it focused on physical intervention and 'takedowns':

> *'But even the amount of time that's dedicated to de-escalation techniques to take down, if you look at the amount of time that was spent physically doing it, you can obviously see there's a lot more time spent on oh let's practice these take downs…also the language that was used…the examples that they used of 'oh this person was saying this', like they were making fun of people that were in the hospital, ridiculing them about oh how their word was not to be taken.' (Consumer)*

Communication from a patient-centred perspective places the consumer (and by extension carers, family members and support persons) at the heart of an

interaction. For mental health services, developing personal skills and awareness of how one person can affect another was one suggestion made by a participant, particularly as patients are vulnerable. Another recommended more sensitive care in crisis situations:

> *'So there could have been some communication there to expect her in and the resident who examined her physically in the A&E department could have communicated a bit better that, you know, she's quite psychotic and she said she doesn't want to be here and could we just fast track the next one and perhaps get some medication in a bit quicker.' (Carer)*

5.6.2 Accountability

Again in nine out of ten focus groups, accountability was referred to. As an elimination or reduction strategy it was suggested that:

> *'There's no responsibility, no accountability. That's another thing that I'd like to mention with regards to the constraint, seclusion, and I'm not sure whether it fits into this thing, but what we find is that there is no consistency with the nursing staff. It is a different face every day, I think that is so wrong, because how can anybody relate to somebody new every day and try and recover.' (Carer)*

Participants suggested there needed to be more opportunities to obtain advocacy, to complain and to have staff who are asked to account for their actions:

> *'Yeah that's what I was getting at, that's basically what I was getting at the accountability. Also to say what they've actually done before they've actually restrained or secluded. The reasons for it. Yeah, and what they did to stop it happening. What was their intervention?' (Consumer)*

It was suggested that transparency and public accountability can be an effective mechanism for reducing seclusion:

> *'I was going to say that I just wanted to again bring up in terms of best practice for reducing seclusion and restraint, [service], I think I mentioned it before I can't remember but just how they had their graphs publically for how they're tracking, I just think that's a level of accountability that you don't often see.' (Carer)*

5.6.3 Peer Support and Advocacy

In seven of the ten focus groups, peer support and advocacy was suggested as an elimination or reduction strategy. This was relevant to both consumers and carers. Carers valued support from other carers and valued their loved ones having support from peers.

'I have a strong belief that the peer support workers for carers and consumers is what's needed in the frontline. People that have had lived experience, and I think this will be threefold, it will help with their healing of what's happened to them in the past, they're obviously going to help the consumer and then the carer. We won't get anywhere until we have people who treat people with compassion and understanding, and give them that peer support.' (Carer)

'It definitely changes the dynamics when you have peer workers there who do have advocacy and cultural change as part of their job description, and that definitely makes consumers and carers say they feel a lot more secure to have people there, but we're not there all the time and the night duty is always being raised as the big problem, because no one's there at night, we're not there all the time, it's [a] very small workforce currently, and we'd certainly like to see a bigger workforce.' (Consumer)

Participants described how peer support workers can assist in de-escalation through listening to and interacting with the Consumer, helping to create a space of safety and understanding in a highly stressful environment.

'And it's that interaction that's big, and the early intervention takes their mind off the other things, and therefore they're calmer, I find they're calmer when we're around.' (Consumer)

Having peers involved at the level of family meetings and debriefings may achieve both an increased confidence on the part of the person to advocate for themselves and also improve accountability in processes around the use of coercive interventions:

'…it does definitely change the effect of it going, we're asked all the time can you, I have a family meeting can you come in, because they just, even if I go there and I just say nothing, they want you there I guess as a support, but it's also a witness to what's being said, and so that you're actually there and later on, if they say we want to write something, they've got someone else who was there and witnessed exactly what was said.' (Consumer)

5.6.4 Family Members' Involvement

In half the focus groups, it was suggested that more family involvement could help reduce or eliminate seclusion and restraint. This was suggested and supported by both consumers and carers.

'So I think carers play a really important role in making sure that you're safe. Just because you've got that level of trust with someone who can actually, you can actually sort of feel like they can carry that burden for you.' (Consumer)

> *'We put it down to my wife and I's involvement, if we hadn't been involved at the level we have my daughter would've been on a slab years ago. We like to feel that we've had some sort of influence in the changes that have come about.' (Carer)*

Family involvement was identified as particularly important for Indigenous people:

> *'The family relationships within aboriginal communities is a lot different than it is in the city – in the extended family. And the extended family relationships, I mean most of us have got immediate family and then whatever, but even extended family they don't have that concept of extended family like we do. It's all family and…you might be the fourth uncle removed but you're still regarded as close family.' (Carer)*

One participant suggested that when he was restrained having his family close by had helped because:

> *'Yeah I think it does, I think it encourages the people doing the restraining or taking action to be careful, because this person is loved by somebody.' (Consumer)*

Participants were aware of situations when family members had not been listened to, leading to extremely distressing situations. For example:

> *'…so the dad was yelling at the police officer just don't spray him, don't spray him and the next minute he sprayed him and put him in the back of the police van and off they went. The parents were just besides themselves, apart from all the mental health issues going on…the policeman just didn't listen to what the dad was saying about the capsicum spray…and the parents were there, they could have utilised the parents to intervene a bit or…be a bit more involved or something, not just sort of telling them to go away.' (Carer)*

It was suggested that family members may need support and guidance in their caring role so that the opportunity to be supportive is maximised and there isn't the potential to inadvertently contribute to an escalation of behaviour that may lead to seclusion and restraint:

> *'I think there's a much better role that families can play in reducing seclusion and restraint as well, because sometimes we go and visit our loved ones in hospital and of course we also have our own anxieties and unaddressed fears and all the rest of it, and if we've not been appropriately engaged, we can set off triggers as well that can upset people…so then we get frantic and all the rest of it, and then okay so we might actually have to leave because they've suddenly found their visiting hours are ended.' (Carer)*

5.6.5 Environment

In over half the focus groups strategies to improve the environment in the inpatient unit were linked to strategies to reduce or eliminate seclusion and restraint. There were many criticisms of the environments people in mental distress or crisis were finding themselves in and how difficult it was to respond appropriately in these environments. One Carer participant commented as follows:

> *'You can do things with a room to make them cosy, relaxing, comfortable, music, different lights which don't intensify the experience.' (Carer)*

A Consumer described how attending to the environment may have helped her avoid an incident of restraint based on her previous experience:

> *'In the sensory room at [service] they had this ladybird pillow, it was like this really big pillow that was really, really heavy, it was stuffed full of some really heavy weights and if they had given me that ladybird pillow in emergency I would have happily cuddled it and rested. Because when I wanted to kill everyone I knew that I didn't want to actually kill everyone but I knew that that would get a code call and I knew that I wanted the attention because I was in so much distress I just wanted human contact and attention. And it was a way of getting attention, it was, it was a way of getting attention.' (Consumer)*

5.6.6 Improving Staff Culture

In half the focus groups improving staff culture was suggested as a useful strategy to support the reduction or elimination of seclusion and restraint. This was explained as:

> *'I think the culture has to change. At the moment it's all about...controlling and defusing the situation by just dominating, whereas if there was some sense of trying to calm the situation rather than contain it, it would be quite different. I realise that sometimes it's really hard to do that, but I'm just saying that the culture has to change.' (Carer)*

And:

> *'With dignity and care, like and professionalism, everyone should be treated like that, whether or not they're under the influence of Ice or not, like treated as a human who's made a decision that's got them into a compromising situation, and now your role as a professional is to hold that situation, no matter how difficult it is, and that's what your training's about.' (Consumer)*

Improving staff culture was strongly linked to education and training but also to steps such as 'weeding out' staff that appeared to lack skills and compassion and introducing more consumer feedback and involvement in services.

5.6.7 Cultural Sensitivity

Many participants were aware of the problems staff, consumers and carers encountered due to lack of cultural sensitivity, interpreters not being available and people not being able to communicate directly with care providers in their first language:

> *'I think because now Australia is [a] multicultural country really, and the carers of today they have no idea what is the mental issues, what's going on, and if some people that they got the ability to explain from their own language, it would be great. Because myself I speak many languages, and I'm going to different carers groups, and it's really fantastic when someone comes and talks to me and I talk to them in their own language.' (Carer)*

5.7 Elimination of Seclusion and Restraint

Participants in both groups discussed ways through which the elimination of seclusion and restraint could be realised. However, in the opinion of some participants, most often in the Carer groups, seclusion and restraint may be necessary if someone is a serious risk to themselves or to others:

> *'If a person is a severe and significant risk to either themselves or to another then I think that there is a duty on society to protect them, to protect them from committing offences against others or from doing those things to themselves. I think the issue is more the manner in which that protection is afforded to them.' (Carer)*

However, this may not always be the case, as one participant observed:

> *'I've seen people in hospitals who were secluded because they were loud and noisy. Not because they were doing anything, they're loud and noisy so it's just easier to seclude them. It's crazy stuff.' (Carer)*

And:

> *'For instance if my son thinks that something is going to come and kill him, something's going to kill him, he is so terrified and they put him in a straightjacket and lock him in a room on his own, how can we be doing that, who are these faceless people at the top, even if you don't have the lived experience within your family, you know, and let's face it we're all guilty of that, with problems in the world, we think oh isn't it terrible and then you get on with your life, until you experience it. But we're talking about psychiatry, that are dealing with people's thoughts, feelings, emotions, disconnection, they're taught, they use these phrases when they describe schizophrenia, and yet they just do this as, to get them out of the way. I'm, it's so appalling as somebody said...in this bright smart beautiful environment, what is going on*

at the highest level of management, and the people with the power, what is going on. This should be absolutely banned.' (Carer)

Five themes emerged from the data around the elimination of seclusion and restraint.

5.7.1   Prevention of Involuntary Admission in the First Instance

One participant believed improved monitoring in the community would prevent involuntary admission and therefore result in less chance of seclusion and restraint being used:

> *'Better monitoring in the community would have eliminated my mother going into the inpatient unit. If she was closer managed by the case manager…I feel that would have prevented it…her medication could have been changed at home, she may not have become as psychotic as what she had.' (Carer)*

Managing mental health issues in the community is seen as preferable to inpatient admission by another Carer:

> *'So we've experienced I guess during that period of hospitalisation an increase in anxiety and trauma that arose, and in fact we're at a point now where we try the best we can to keep her out of any hospital, because all of the hospital admissions have actually generally intensified the problem rather than been a way of addressing and helping. I guess in terms of looking at the restraint and seclusion, we experienced that first hand.' (Carer)*

5.7.2   Provision of Peer Support in Inpatient Settings

Across Carer and Consumer groups, there was strong consensus that peer support is vital to ensuring that understanding, empathy and patient-centred care occur in the inpatient setting and provides an opportunity to achieve elimination of the need for seclusion and restraint:

> *'We won't get anywhere until we have people who treat people with compassion and understanding, and give them that peer support. We need people…peer support workers from every walk of life really…' (Carer)*

Lived experience of seclusion and restraint gives peer support workers an important understanding of the traumatic effects of coercive interventions and ways to minimise these effects for all involved:

> *'…having peer workers available and on the spot definitely does I guess make people feel a bit more secure, that number one they're being listened to, and obviously if the consumer consultant is sitting there, you know, the nurses are*

not going to come up and start saying something really terrible to that person at that point right then and there…' (Consumer)

5.7.3 Changes to the Physical Environment

As outlined in section 5.4.1, participants clearly articulated barriers to reducing seclusion and restraint in the physical environment. Reduction leading to elimination requires reconsideration in existing and future building design. Changes such as non-fluorescent lighting; creating warmth by adding colour, pictures and quotes to walls; and sensory modulation were suggestions that can be implemented within existing inpatient buildings. Unlocking the doors to the main ward was also suggested.

Constructing a therapeutic environment connected to, yet separate from the emergency department, was suggested by participants.

> *'But having some kind of separate unit that's away from the emergency department that's more structured around people in a psychiatric crisis rather than a physical crisis.' (Consumer)*

> *'I do believe that most hospitals if they offer a mental health service they should have an area where you can at least go and be in a more sort of quiet area. I mean you're never gonna be able to isolate them or isolate yourself completely because there's just too much happening but almost a sub-lounge kind of area.' (Consumer)*

One participant suggested a more radical approach:

> *'If you took away involuntary wards altogether I think you'd find seclusion would disappear obviously…' (Carer)*

5.7.4 Enhancing Leadership

Carer and Consumer participants identified the importance of leadership influencing staff culture at the ward level and how this has the potential to change attitudes towards the use of seclusion and restraint:

> *'SO DO YOU THINK A LOT OF IT DOES COME DOWN TO ATTITUDE? (Facilitator)*

> *Yeah and it starts at the top too, who's managing the unit. Their values and things certainly filter through the rest of the staff.' (Carer)*

One Carer participant describes an environment where leadership has been driving the change necessary to achieve a recovery-based service through integrated peer support and engagement with staff:

'…the peer workers are involved in developing groups, community days out, they've kind of been involved in all of that, so they've also taken on a care coordination role, so they're like equals within the team…

the model is actually [a] recovery model so if someone's working, a staff member's working not within that model then…the managers are sitting down with them and having the conversations about how that fits, and is this place really right for you if you're not able to work in that environment then, those conversations are happening.' (Carer)

When asked about the kind of leadership required to help staff manage their own fear in the face of crisis, a Consumer participant answered:

'I think just morale, education amongst staff and staff feeling supported…as a team.' (Consumer)

Participants suggested that state and federal governments had an important role in leading change:

'Hopefully with the new Act and hopefully with the education that the government is putting in place to re-educate the mental health [workforce], things will change. It will take time, it won't take 5 seconds.' (Consumer)

Improving complaint systems and ensuring action is taken in relation to complaints was identified as an important role for government:

'Well I've had that experience where I've made complaints to the Health Minister, to the Director of Mental Health Nursing, and it's taken me 20 years to make a complaint, and the backlash that my daughter and I received from the staff on that ward was nothing short of disgraceful, and I'm talking only a few months ago. Absolutely disgraceful.' (Carer)

5.7.5   Changing Terminology around Seclusion and Restraint

Participants suggested that changing the language around seclusion and restraint may also change practice.

'And it's become this humdrum rhetoric that's been batted around for years… Yeah…How many times have we heard about, everyone knows it off by heart now, reduction of seclusion, elimination, over and over again you know, but if you change the terminology to something like…said, it's actually kidnapping, something a bit more real to what it actually is…Abduction.' (Carer)

Across Carer and Consumer groups, participants commented that terminology could have the effect of disguising the 'violence' of seclusion and restraint. For example:

'…seclusion and restraint, why aren't we calling it kidnap and assault…' (Carer)

Some participants further suggested that changing the terminology in this way could result in better understanding how the practices surrounding seclusion and restraint may not equate with care.

> *'I call it violence simply because I would be charged, criminally charged, if I conducted the care in the same way so.' (Carer)*

> *'Kidnapping and incarceration and if we called it kidnapping and incarceration we wouldn't want it to be part of our vernacular, the kind of things we talked about…we'd be embarrassed about it but in fact we kind of use this kind of terminology but then what you're saying is take another step and say that should be shocking us, the fact that we line these things up with providing treatment and care.' (Consumer)*

5.8   Discussion

When asked about how they defined seclusion and restraint, Consumers and Carers gave rich and varied responses. Participants described a continuum of coercion of which seclusion and restraint are examples. These included emotional, physical, mechanical and chemical restraint. Seclusion included not only seclusion rooms in hospitals but any situation when someone was forcibly isolated from others.

The use of seclusion and restraint was discussed as being a response to the need to manage risk and control the person's behaviour. This discussion is the only part of the chapter that deliberately separated the views of consumers and carers and it establishes how much consensus there was between the two 'types' of participants about the issues discussed. Therefore, the remaining sections of the chapter combined the perspectives of carers and consumers.

The themes presented in this chapter are based on the questions used in the focus groups to guide discussion and also themes that emerged in the data analysis, consistent with the general inductive approach that was taken in the analysis (Thomas, 2006). The responses suggest that many participants attended the focus groups in response to their concerns about poor practice and there are passionate and clear descriptions that provide the context and illustrate these concerns. The traumatic impact of seclusion and restraint represents one of the emerging themes that were apparent across the focus group discussions.

There was a confluence of contributing factors with a strong connection to staff training and education, staff culture and decreased accountability or poor communication. Also, participants suggested that staff resourcing issues may contribute to the negative aspects of staff culture and poor communication. Paternalism was identified as encouraging stigmatisation of people with mental health issues, leading to further fear and risk aversion.

Participants identified seclusion and restraint as not therapeutic, anti-recovery and an abuse of human rights. The traumatic effects of these practices are long-standing and not limited to an acute or inpatient setting. Participants also recognised specific challenges for people in rural and remote areas of Australia and also for Indigenous and culturally and linguistically diverse populations. The findings indicate the need for further, specific investigation into the use of seclusion and restraint involving minority and marginalised groups.

Discussion of these themes provided a rationale for how participants responded to the primary question of the focus groups – that of how seclusion and restraint could be reduced and/or eliminated.

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 in ways ranging 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;

- lessening the number of rules and restrictions in inpatient units;

- the need to ensure accountability; and

- 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; and

- the concurrent use of different forms of seclusion and restraint.

These are all areas that need further exploration.

The strategies proposed by participants that would create the necessary conditions for change included increased accountability and the need for leadership in services. This included ensuring the acknowledgement of every seclusion and restraint event beyond the immediate people involved, and also having mechanisms such as complaint processes and reporting requirements.

Participants also referred to the need for a change in the discourse surrounding seclusion and restraint, suggesting the current language appeared to support these practices as a legitimate use of power. Alternatively, describing them as assault, kidnapping or imprisonment would be the language that connects with what many consumers and carers see and experience, which might also challenge this legitimacy.

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 development of, and investment in, a range of peer roles inclusive of direct support, staff development, governance and organisational change.

6. DISCUSSION OF MAJOR THEMES

6.1 Introduction

During this 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, family members 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.

Duxbury and Whittington (2005) have previously pointed out that the perspectives of nurses and patients can differ markedly in relation to what occurs in mental health services. In their study, patients identified a lack of communication whereas nurses identified mental illness as the main cause of patient aggression. Differences in perspectives can make it challenging to identify how best to reduce, if not eliminate, the use of seclusion and restraint.

There is a considerable amount of *anecdotal* evidence as to drivers of change and barriers to the reduction and elimination of seclusion and restraint in mental health facilities, but little high quality empirical evidence in this regard. There is a dearth of material relating to factors which may reduce the use of seclusion and restraint in forensic and community settings and very little academic material about strategies as to how to reduce or eliminate the use of physical, mechanical and chemical restraint in community settings that require an inter-agency and/or emergency response. The most work in this area has been on policies and guidelines, rather than on evaluating specific factors that may serve to reduce the use of seclusion and restraint.

Of the empirical research that has been conducted in relation to mental health facilities, there have been few randomised controlled trials. Multi-interventional studies generally only report an overall effect, rather than an effect specifically for a particular intervention. There are also varying study lengths and follow up periods. On the evidence from the available literature, it is impossible to point with confidence to a single form of 'best practice' in reducing and eliminating seclusion and restraint.

It should also be noted that 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 certain cultural groups. These perceptions need further exploration, but were beyond the scope of this project to address.

With those riders, there are common themes that have emerged throughout the project. This chapter discusses some of the major themes with a view to

recommending the next steps that should be taken. It also sets out some of the research project's limitations and its significant contributions to the field.

6.2 Major Themes

6.2.1 Defining and Regulating Seclusion and Restraint

One major theme was the lack of uniform definitions and regulation of seclusion and restraint across Australia. While seclusion and mechanical restraint are defined and regulated in mental health legislation across Australia (although definitions differ), physical and chemical restraint are only defined and regulated in a few jurisdictions. This makes it difficult to gather data relating to the use of the different forms of restraint in particular.

While there is enormous variation in regulation across jurisdictions, recent reforms to mental health laws in states such as Tasmania and Victoria indicate the expectation that the use of seclusion and restraint are practices of last resort.

There was a lack of consensus as to the meaning of seclusion and restraint amongst survey participants, although many responses echoed the definitions supplied which were derived from the Tasmania's *Mental Health Act 2013* in relation to physical, chemical and mechanical restraint. Fifty-eight per cent of definitions of emotional restraint differed to the one developed by the National Consumer and Carer Forum. The main discrepancy related to the purpose of seclusion and restraint, with some participants highlighting safety issues, while others highlighted elements of control, containment and convenience for staff.

Many members of the focus groups spoke about seclusion and all forms of restraint as being about control, coercion and risk management. They tended to emphasise the practices of chemical and emotional restraint and a lack of recognition of them.

A further theme which emerged from the focus groups was the concurrent use of different forms of seclusion and restraint. This needs further exploration as there is a tendency to regulate seclusion and some forms of restraint separately.

6.2.2 The Effects of the Use of Seclusion and Restraint

One clear theme in the focus groups and in the surveys was that the practices of seclusion and restraint made things worse by (re)traumatising the individual concerned and often led to long-term negative effects. 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. These findings provide added impetus for investing resources into reducing and eliminating them.

6.2.3   Strategies to Reduce the Use of Seclusion and Restraint

The little empirical evidence there is points to certain multi-intervention strategies being effective. While evidence from the literature must be taken with caution, it is currently encouraging with recent studies in particular demonstrating reductions in seclusion and/or restraint through multiple interventions.

Of the strategies suggested to survey participants, the three strategies thought to be extremely effective, were:

- having better access to counselling and other 'talking and listening' opportunities;

- changes to the environment in which seclusion and restraint might occur; and

- staff training in de-escalation strategies.

Other themes from the literature, survey and focus group discussions concerned leadership, support for multidisciplinary teams and the involvement of consumers at all levels, as well as the involvement of carers, family members and support persons.

6.2.4   Opportunities to Communicate

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 limited opportunity for consumers to be able to talk with practitioners about how they were feeling and to receive a compassionate response.

A lack of communication between staff and consumers and their carers, family members and support persons was a major theme in the focus groups. There was a perception that staff members were too caught up in paperwork or too pressured to be able to spend the time needed with consumers.

6.2.5   Changes to the Environment

Throughout the project, participants stressed that emergency departments and mental health inpatients units were poorly designed and unpleasant environments. Participants also reported that there were insufficient staff and physical spaces available which contributed to feelings of distress and agitation, rather than feelings of security and calmness. Perhaps as a result, changes to the environment rated highly in the survey as a strategy that would reduce the practices of seclusion and restraint. There was a perception that the use of seclusion and restraint would be low if there was a 'therapeutic milieu' and high quality care.

Borckardt and colleagues (2011) have observed that physical changes to the environment are some of the easiest changes to implement and there is thus a need to explore further what works in this regard.

6.2.6 Ongoing Staff Training

Staff training was one of the most frequently suggested strategies for the reduction or elimination of seclusion and restraint by members of the focus groups. Focus group participants emphasised that any training should not be just about risk management, but take a recovery-oriented and trauma-informed approach to preventing conflicts which might lead to the use of seclusion and restraint occurring.

The need for staff training in de-escalation techniques and in recognising and appropriately responding to signs of distress were seen as extremely effective and effective responses respectively by survey respondents.

It is noted that some State governments are taking steps in relation to recovery and trauma-informed training and the Safewards model in England (Bowers et al., 2014) may provide a positive approach in this regard. 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.

6.2.7 Leadership

A clear theme arising from the literature is the importance of 'top-down' organisational leadership *in conjunction with* 'bottom-up' 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.

The survey results also pointed to insufficient leadership, insufficient political will and an organisational culture that does not prioritise reducing coercion as very much barriers to reducing seclusion and restraint. It would seem from this that leadership is a clear factor that needs more focus as a strategy to reduce and eliminate seclusion and restraint.

6.2.8 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.

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 or eliminating seclusion and restraint. The Canberra Hospital seclusion reduction intervention project (Foxlewin, 2012) provides one example of a consumer-led strategy, but there is a need for further strategies and evaluation in this regard.

6.2.9 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 listened to and involvement would help avoid stressful situations that led to the use of seclusion and restraint.

Seventy-seven per cent of survey participants answering the question on the effectiveness of strategies to reduce seclusion and restraint thought that family involvement in particular was an effective or extremely effective strategy.

6.2.10 Barriers to Reducing the Use of Seclusion and Restraint

A major theme in relation to barriers to reducing the use of seclusion and restraint revolved around organisational factors such as poor leadership, inadequate staff training, lack of staff and staff time and a lack of information about alternative approaches.

Members of the focus groups also brought up the issue of a lack of accountability when seclusion and restraint were used, as well as a lack of resources for mental health care in general and an apparent lack of concern about the ongoing, often traumatic, impact of seclusion and restraint on consumers and carers.

6.2.11 Eliminating Seclusion and Restraint

One theme that emerged from the survey results was that despite the consensus on the negative effects of seclusion and restraint, some participants believed that these practices can never be completely eliminated because some people may not respond to de-escalation techniques and that it is important to recognise safety issues.

However, there was a clear consensus amongst the survey participants that the negative effects of seclusion and restraint can be reduced and some suggestions proffered as to how to do this. There was also concern amongst participants that in working towards elimination, all forms of coercive practice need to be addressed so that one form does not become a substitute for another. This concern was also echoed during informal conversations with several stakeholders.

6.3 Research Project's Limitations

6.3.1 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 emphasises 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.

6.3.2   *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. Although information was lacking from settings outside of mental health and emergency departments, informal discussions with stakeholders suggested that these settings warranted greater attention, not least because their seclusion and restraint practices could influence practice in the mental health sector.

In addition, the National Mental Health Commission 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, the Netherlands, Germany, 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.

6.4   Significant Contributions of the Research Project

6.4.1   *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.

6.4.2   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 were 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.

6.4.3   Gaining Perspectives on How Best to Reduce Seclusion and Restraint

While there may not be enough solid evidence as to what is 'best practice' in reducing 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.

7. OPTIONS FOR REFORM

7.1 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.

7.2 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; and

- 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

- 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.

7.3 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; and
- 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 of the Mental Health Drug and Alcohol Principal 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 National Mental Health Commission 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.

7.4   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; and

  - taking into account the specific needs of Indigenous peoples and culturally and linguistically diverse groups;

- strategies suggested from literature in languages other than English; and

- the effect of multi-intervention strategies including those outlined in the next section.

7.5 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.

7.5.1 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.

7.5.2 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; and
- 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; and
- 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.

7.5.3 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.

7.5.4 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; and

- rewards and celebrate successes in reduction with staff'.

7.5.5 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.

7.5.6   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.

8. CONCLUSION

People with lived experience of mental health issues are often marginalised and their views discredited or ignored. Their voices as well as those of carers, family members and support persons were heard throughout this research project via membership of two project Advisory Groups, targeted focus groups and through responses to an online survey. The findings of this interdisciplinary project are therefore significant in providing a new evidence base for future research that is driven by consumer expertise.

This project makes a significant contribution to research 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, 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; and
- can be reduced.

There was overwhelming agreement amongst focus group and survey participants for change in current practice.

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

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.

BIBLIOGRAPHY

Allan, J. and Hanson, G. (2012) 'Monitoring Use of Seclusion', paper presented to the *National Forum on Seclusion and Restraint*, Cairns, 29-30 October 2012. Available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543928 (Accessed: 28 May 2014).

Anonymous (2007) 'CMS Eases One-Hour Evaluation Mandate in Final Rule on Restraint and Seclusion: Flurry of Written Comments Illustrates Emotion of Issue', *Mental Health Weekly,* 8 January 2007, 17(2), pp. 1-4.

Australian and New Zealand Society for Geriatric Medicine (2012) *Position Statement 2: Physical Restraint Use in Older People*. Available at: http://www.anzsgm.org/documents/PositionStatementNo2RevisedSept2012.pdf (Accessed: 10 June 2014).

Australian Capital Territory Health Directorate (2011a) *Policy - Restraint of Patients.* Canberra: ACT Government. Available at: http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=2757 (Accessed: 28 May 2014).

Australian Capital Territory Health Directorate (2011b) *Standard Operating Procedure - Code Black and Physical Restraint of Patients Process at the Canberra Hospital.* Canberra: ACT Government. Available at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=2759 (Accessed: 28 May 2014).

Australian Capital Territory Health Directorate (2011c) *Standard Operating Procedure - Restraint of Patients.* Canberra: ACT Government. Available at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=2758 (Accessed: 28 May 2014).

Australian Department of Health (2010) *National Standards for Mental Health Services.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf (Accessed: 10 June 2014).

Australian Department of Health and Ageing (2012a) *Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/215C090C7AD8E881CA257BF0001AFF06/$File/COMMUNITY%20Aged%20Care_internals_FA3-web.pdf (Accessed: 10 June 2014).

Australian Department of Health and Ageing (2012b) *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/F97925A7FE1F7CBECA257BF0001AFDED/$File/RESIDENTIAL%20Aged%20Care_internals_FA3-web.pdf (Accessed: 10 June 2014).

Australian Department of Social Services (2014) *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector (the 'National Framework').* Canberra: Commonwealth of Australia. Available at: http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-

national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector (Accessed: 28 May 2014).

Australian Health Ministers' Advisory Council (2013a) *A National Framework for Recovery-Oriented Mental Health Services - Guide for Practitioners and Providers.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf (Accessed: 17 June 2014).

Australian Health Ministers' Advisory Council (2013b) *A National Framework for Recovery-Oriented Mental Health Services - Policy and Theory.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/B2CA4C28D59C74EBCA257C1D0004A79D/$File/recovpol.pdf (Accessed: 17 June 2014).

Australian Health Ministers (2009a) *Fourth National Mental Health Plan - An Agenda for Collaborative Government Action in Mental Health 2009-2014.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf (Accessed: 17 June 2014).

Australian Health Ministers (2009b) *National Mental Health Policy 2008.* Canberra: Commonwealth of Australia. Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/B4A903FB48158BAECA257BF0001D3AEA/$File/finpol08.pdf (Accessed: 17 June 2014).

Australian Human Rights and Equal Opportunities Commission (1993) *Human Rights and Mental Illness : Report of the National Inquiry into the Human Rights of People with Mental Illness.* Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2012) *Use of Restricted Practices During Admitted Patient Care*. Canberra: Commonwealth of Australia. Available at: http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices (Accessed: 21 August 2014).

Australian Institute of Health and Welfare (2013) *Mental Health Services in Australia: Admitted Patient Mental Health-Related Care.* Canberra: Commonwealth of Australia. Available at: http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=27917288164 (Accessed: 28 May 2014).

Australian Institute of Health and Welfare (2014) *Mental Health Services in Australia: Admitted Patient Mental Health-Related Care.* Canberra: Commonwealth of Australia. Available at: http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=38654705915 (Accessed: 28 August 2014).

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G. and Jones, R. B. (2011) 'Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital', *Journal of Child and Adolescent Psychiatric Nursing,* 24(1), pp. 11-15.

Bak, J., Brandt-Christensen, M., Sestoft, D. M. and Zoffmann, V. (2012) 'Mechanical Restraint - Which Interventions Prevent Episodes of Mechanical Restraint? A Systematic Review', *Perspectives in Psychiatric Care,* 48(2), pp. 83-94.

Bartlett, p. and Sandland, R. (2007) *Mental Health Law : Policy and Practice.* 3rd edn. Oxford, New York: Oxford University Press.

Barton, S. A., Johnson, M. R. and Price, L. V. (2009) 'Achieving Restraint-Free on an Inpatient Behavioral Health unit', *Journal of Psychosocial Nursing and Mental Health Services,* 47(1), pp. 34-40.

Boardman, J. and Shepherd, G. (2012) 'Implementing Recovery in Mental Health Services', *International Psychiatry,* 9(1), pp. 6-8.

Bonner, G., Lowe, T., Rawcliffe, D. and Wellman, N. (2002) 'Trauma for All: A Pilot Study of the Subjective Experience of Physical Restraint for Mental Health Inpatients and Staff in the UK', *Journal of Psychiatric and Mental Health Nursing,* 9(4), pp. 465-473.

Borckardt, J. J., Madan, A., Grubaugh, A. L., Danielson, C. K., Pelic, C. G., Hardesty, S. J., Hanson, R., Herbert, J., Cooney, H., Benson, A. and Frueh, B. C. (2011) 'Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital', *Psychiatric Services,* 62(5), pp. 477-483.

Bowers, L. (2000) 'The Expression and Comparison of Ward Incident Rates', *Issues in Mental Health Nursing,* 21(4), pp. 365-374.

Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., Jarrett, M., Jeffery, D., Nijman, H., Owiti, J. A., Papadopoulos, C., Ross, J., Wright, S. and Stewart, D. (2014) 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards', *Journal of Psychiatric and Mental Health Nursing,* 21(4), pp. 354-364.

Bowers, L., Van Der Merwe, M., Nijman, H., Hamilton, B., Noorthorn, E., Stewart, D. and Muir-Cochrane, E. (2010) 'The Practice of Seclusion and Time-out on English Acute Psychiatric Wards: The City-128 Study', *Archives of Psychiatric Nursing,* 24(4), pp. 275-286.

Brookbanks, W. (2005) 'Seclusion and Restraint', in Bell, S. and Brookbanks, W. (eds.) *Mental Health Law in New Zealand*. Wellington: Thomson Brookers, pp. 199-222.

Centers for Disease Control and Prevention (1999) *Framework for Program Evaluation in Public Health.* Atlanta, Georgia: US Department of Health and Human Services. Available at: ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf (Accessed: 12 June 2014).

Centers for Medicare and Medicaid Services (2008) *Medicare State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.* Baltimore: Maryland Department of Health and Human Services. Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf (Accessed: 28 May 2014).

Chalmers, A., Harrison, S., Mollison, K., Molloy, N. and Gray, K. (2012) 'Establishing Sensory-based Approaches in Mental Health Inpatient Care: A Multidisciplinary Approach', *Australasian Psychiatry,* 20(1), pp. 35-39.

Champagne, T. and Sayer, E. (2003) *The Effects of the Use of the Sensory Room in Psychiatry*. Available at: http://www.ot-innovations.com/images/stories/PDF_Files/qi_study_sensory_room.pdf (Accessed: 28 May 2014).

Champagne, T. and Stromberg, N. (2004) 'Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion & Restraint', *Journal of Psychosocial Nursing and Mental Health Services,* 42(9), pp. 34-44.

Chandler, G. E. (2012) 'Reducing Use of Restraints and Seclusion to Create a Culture of Safety', *Journal of Psychosocial Nursing and Mental Health Services,* 50(10), pp. 29-36.

Chedekel, L. (2014) 'Connecticut Hospitals Restrain Psychiatric Patients at Double National Average', *The New Haven Register.* 31 May 2014. Available at: http://www.nhregister.com/general-

news/20140601/connecticut-hospitals-restrain-psychiatric-patients-at-double-national-average (Accessed: 12 June 2014).

Chief Civil Psychiatrist (Tas) (2013a) *Clinical Guideline 9: Seclusion.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148242/9_CCP_Clinical_Guideline_9_-_Seclusion.pdf (Accessed: 19 June 2014).

Chief Civil Psychiatrist (Tas) (2013b) *Clinical Guideline 10: Chemical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/148243/10_CCP_Clinical_Guideline_10_-_Chemical_restraint.pdf (Accessed: 19 June 2014).

Chief Civil Psychiatrist (Tas) (2013c) *Clinical Guideline 10A: Mechanical and Physical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/148244/11_CCP_Clinical_Guideline_10A_-_Mechanical_and_Physical_restraint.pdf (Accessed: 19 June 2014).

Chief Civil Psychiatrist (Tas) (2013d) *Standing Order 9: Seclusion.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/148235/CCP_Standing_Order_9_-_Seclusion.pdf (Accessed: 19 June 2014).

Chief Civil Psychiatrist (Tas) (2013e) *Standing Order 10: Chemical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0006/148236/3_CCP_Standing_Order_10_-_Chemical_Restraint.pdf (Accessed: 19 June 2014).

Chief Civil Psychiatrist (Tas) (2013f) *Standing Order 10A: Mechanical and Physical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/148237/4_CCP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013a) *Clinical Guideline 9: Seclusion.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148260/23_CFP_Clinical_Guideline_9_-_Seclusion.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013b) *Clinical Guideline 10: Chemical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/148261/24_CFP_Clinical_Guideline_10_-_Chemical_Restraint.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013c) *Clinical Guideline 10A: Mechanical and Physical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148251/15_CFP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013d) *Standing Order 9: Seclusion.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/148249/CFP_Standing_Order_9_-_Seclusion.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013e) *Standing Order 10: Chemical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/148250/14_CFP_Standing_Order_10_-_Chemical_Restraint.pdf (Accessed: 19 June 2014).

Chief Forensic Psychiatrist (Tas) (2013f) *Standing Order 10A: Mechanical and Physical Restraint.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148251/15_CFP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf (Accessed: 19 June 2014).

Ching, H., Daffern, M., Martin, T. and Thomas, S. (2010) 'Reducing the Use of Seclusion in a Forensic Psychiatric Hospital: Assessing the Iimpact on Aggression, Therapeutic Climate and Staff Confidence', *Journal of Forensic Psychiatry and Psychology,* 21(5), pp. 737-760.

Committee on the Rights of Persons with Disabilities (2013) *Concluding Observations on the Initial Report of Australia, adopted by the Committee at its Tenth Session (2–13 September 2013).* Geneva: United Nations. Available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUS%2fCO%2f1&Lang=en (Accessed: 28 May 2014).

Committee on the Rights of Persons with Disabilities (2014) *General Comment No 1 on Article 12 - Equal Recognition before the Law.* U.N. Doc. CRPD/C/GC/1. Available at: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx (Accessed: 28 May 2014).

Creswell, J. W. and Clark, V. L. p. (2011) *Designing and Conducting Mixed Methods Research.* 2nd edn. Thousand Oaks, California: Sage Publications.

Department of Health (UK) (2008) *Code of Practice: Mental Health Act 1983.* London: The Stationary Office. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf (Accessed: 6 June 2014).

Department of Health (UK) (2014) *Positive and Proactive Care: Reducing the Need for Restrictive Interventions*. London: Department of Health (UK). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf (Accessed: 25 August 2014).

Department of Health (WA) (2005) *Guidelines: The Management of Disturbed/Violent Behaviour in Inpatient Psychiatric Settings.* Brisbane: Department of Health, Government of Western Australia. Available at: http://www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/HP8973_The_management_of_disturbed_violent_behaviour.pdf (Accessed: 10 June 2014).

Department of Health (WA) (2006) *Operational Directive: Seclusion, Restraint and 'Time Out'.* Brisbane: Department of Health, Government of Western Australia. Available at: http://www.health.wa.gov.au/circularsnew/pdfs/12592.pdf (Accessed: 10 June 2014).

Department of Health and Victoria Police (Vic) (2010) *Protocol for Mental Health.* Melbourne: Department of Health, Victorian Government. Available at: http://www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf (Accessed: 10 June 2014).

Duxbury, J. and Whittington, R. (2005) 'Causes and Management of Patient Aggression and Violence: Staff and Patient Perspectives', *Journal of Advanced Nursing,* 50(5), pp. 469-478.

El-Badri, S. and Mellsop, G. (2008) 'Patient and Staff Perspectives on the Use of Seclusion', *Australasian Psychiatry,* 16(4), pp. 248-252.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment (2013) *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment (CPT) Standards.* Document No CPT/Inf/E (2002) 1 Rev. 2013: Council of Europe. Available at: http://www.cpt.coe.int/en/documents/eng-standards.pdf (Accessed: 28 May 2014).

Fisher, W. A. (1994) 'Restraint and Seclusion: A Review of the Literature', *The American Journal of Psychiatry,* 151(11), pp. 1584-1591.

Foxlewin, B. (2012) *What is Happening at the Seclusion Review that Makes a Difference? A Consumer Led Research Study*. Available at: http://www.actmhcn.org.au/images/documents/Research/2012-06_REPORT_SRRM_RESEARCH_incl_Executive_Summary.pdf (Accessed: 28 August 2014).

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., Yim, E., Robins, C. S., Monnier, J. and Hiers, T. G. (2005) 'Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting', *Psychiatric Services,* 56(9), pp. 1123-1133.

Gaskin, C. J. (2013) *Reducing Restrictive Interventions: Literature Review and Document Analysis*. Melbourne: Department of Health, Victorian Government. Available at: http://docs.health.vic.gov.au/docs/doc/DC1E1694E5493238CA257C38000E1824/$FILE/Reducing%20restrictive%20interventions%20literature%20review.pdf (Accessed: 3 August 2014).

Gaskin, C. J., Elsom, S. J. and Happell, B. (2007) 'Interventions for Reducing the Use of Seclusion in Psychiatric Facilities', *The British Journal of Psychiatry,* 191(4), pp. 298-303.

Gaskin, C. J., McVilly, K. R. and McGillivray, J. A. (2013) 'Initiatives to Reduce the Use of Seclusion and Restraints on People with Developmental Disabilities: A Systematic Review and Quantitative Synthesis', *Research in Developmental Disabilities,* 34(11), pp. 3946-3961.

Georgieva, I., de Haan, G., Smith, W. and Mulder, C. L. (2010) 'Successful Reduction of Seclusion in a Newly Developed Psychiatric Intensive Care Unit', *Journal of Psychiatric Intensive Care,* 6(1), pp. 31-38.

Gerace, A., Pamungkas, D. R., Oster, C., Thomson, D. and Muir-Cochrane, E. (2014) 'The Use of Restraint in Four General Hospital Emergency Departments' Australasian Psychiatry', *Australasian Psychiatry,* 22(4), pp. 366-369.

Greene, J. C. (2007) *Mixed Methods in Social Inquiry.* San Francisco: Jossey-Bass; an Imprint of Wiley.

Gupta, U. and Kharawala, S. (2012) 'Informed Consent in Psychiatry Clinical Research: A Conceptual Review of Issues, Challenges, and Recommendations', *Perspectives in Clinical Research,* 3(1), pp. 8-15.

Hamilton, B. and Castle, D. (2008) 'Seclusion Reduction: Policy Drive, Gaps in the Science and Results of a 3-Point Intervention in a Victorian Inpatient Unit', *Australian and New Zealand Journal of Psychiatry,* 42(1), Supplement, A72.

Happell, B. and Koehn, S. (2010) 'Attitudes to the Use of Seclusion: Has Contemporary Mental Health Policy Made a Difference?', *Journal of Clinical Nursing,* 19(21-22), pp. 3208-3217.

Hassan, I. (2012) 'Coercive Measures and Secondary Prevention', *Australasian Psychiatry,* 20(3), pp. 256-257.

Haw, C., Stubbs, J., Bickle, A. and Stewart, I. (2011) 'Coercive Treatments in Forensic Psychiatry: A Study of Patients' Experiences and Preferences', *Journal of Forensic Psychiatry and Psychology,* 22(4), pp. 564-585.

Holmes, C., Walton, J. A. and Muir-Cochrane, E. (2002) 'Law and Policy in Relation to the Use of Seclusion in Psychiatric Hospitals in Australia and New Zealand', *Contemporary Nurse,* 13(2-3), pp. 136-145.

Huckshorn, K. A. (2004) 'Reducing Seclusion & Restraint Use in Mental Health Settings: Core Strategies for Prevention', *Journal of Psychosocial Nursing and Mental Health Services,* 42(9), pp. 22-33.

Hyde, S., Fulbrook, P., Fenton, K. and Kilshaw, M. (2009) 'A Clinical Improvement Project to Develop and Implement a Decision-Making Framework for the Use of Seclusion', *International Journal of Mental Health Nursing,* 18(6), pp. 398-408.

Katsakou, C. and Priebe, S. (2006) 'Outcomes of Involuntary Hospital Admission: A Review', *Acta Psychiatrica Scandinavica,* 114(4), pp. 232-241.

Katsakou, C., Rose, D., Amos, T., Bowers, L., McCabe, R., Oliver, D., Wykes, T. and Priebe, S. (2012) 'Psychiatric Patients' Views on Why their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study', *Social Psychiatry and Psychiatric Epidemiology,* 47(7), pp. 1169-1179.

Khadivi, A. N., Patel, R. C., Atkinson, A. R. and Levine, J. M. (2004) 'Association between Seclusion and Restraint and Patient-Related Violence', *Psychiatric Services,* 55(11), pp. 1311-1312.

Klassen, A. C., Creswell, J., Plano Clark, V. L., Smith, K. C. and Meissner, H. I. (2012) 'Best Practices in Mixed Methods for Quality of Life Research', *Quality of Life Research,* 21(3), pp. 377-380.

Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M. and Valimaki, M. (2012) 'Seclusion and Restraint in Psychiatry: Patients' Experiences and Practical Suggestions on How to Improve Practices and Use Alternatives', *Perspectives in Psychiatric Care,* 48(1), pp. 16-24.

Kumble, S. and McSherry, B. (2010) 'Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective', *Psychiatry, Psychology and Law,* 17(4), pp. 551-561.

Larue, C., Dumais, A., Boyer, R., Goulet, H., Bonin, J.-P. and Baba, N. (2013) 'The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients', *Issues in Mental Health Nursing,* 34(5), pp. 317-324.

Lazarus, A. (2001) 'Physical Restraints, Thromboembolism, and Death in 2 Patients', *The Journal of Clinical Psychiatry,* 62(3), pp. 207-208.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011) 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry,* 199(6), pp. 445-452.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L. and Sudders, M. (2004) 'Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-Based Care', *Journal of the American Academy of Child and Adolescent Psychiatry,* 43(1), pp. 37-45.

Lee, S. J., Cox, A., Whitecross, F., Williams, p. and Hollander, Y. (2010) 'Sensory Assessment and Therapy to Help Reduce Seclusion Use with Service Users Needing Psychiatric Intensive Care', *Journal of Psychiatric Intensive Care,* 6(2), pp. 83-90.

Legislative Reference Bureau (US) (1996) *The Pennsylvania Code - Title 55, Chapter 13: Use of Restraints in Treating Patients/Residents.* Mechanicsburg: Commonwealth of Pennsylvania. Available at: http://www.pacode.com/secure/data/055/chapter13/055_0013.pdf (Accessed: 10 June 2014).

Legris, J., Walters, M. and Browne, G. (1999) 'The Impact of Seclusion on the Treatment Outcomes of Psychotic In-Patients', *Journal of Advanced Nursing,* 30(2), pp. 448-459.

Lewis, M., Taylor, K. and Parks, J. (2009) 'Crisis Prevention Management: A Program to Reduce the Use of Seclusion and Restraint in an Inpatient Mental Health Setting', *Issues in Mental Health Nursing,* 30(3), pp. 159-164.

Livingstone, A. (2007) *Seclusion Practice: A Literature Review.* Melbourne: Victorian Quality Council & Chief Psychiatrist's Quality Assurance Committee, Department of Human Services, Victorian Government.

Mason, T. (1993) 'Seclusion as a Cultural Practice in a Special Hospital', *Educational Action Research,* 1(3), pp. 411-423.

McSherry, B. (2012) 'Legal Capacity under the Convention on the Rights of Persons with Disabilities', *Journal of Law and Medicine,* 20(1), pp. 22-27.

McSherry, B. and Freckelton, I. (eds.) (2013) *Coercive Care: Rights, Law and Policy*. London: Routledge.

McSherry, B. and Weller, p. (eds.) (2010) *Rethinking Rights-Based Mental Health Laws*. Oxford: Hart Publishing.

Méndez, J. E. (2013) *Statement by Mr Juan E Méndez - Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (4 March 2013).* 22nd session of the Human Rights Council, Agenda Item 3: Geneva.

Mental Health, Alcohol and Other Drugs Branch (Qld) (2014) *Mental Health Act 2000 Resources Guide.* Brisbane: Queensland Health. Available at: http://www.health.qld.gov.au/mha2000/documents/resource_guide_all.pdf (Accessed: 28 May 2014).

Mental Health and Drug and Alcohol Office (NSW) (2006) *Aged Care - Working with People with Challenging Behaviour in Residential Aged Care Facilities: Using Appropriate Interventions and Minimising Restraint.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf (Accessed: 28 May 2014).

Mental Health and Drug and Alcohol Office (NSW) (2009) *Mental Health for Emergency Departments: A Reference Guide.* Sydney: New South Wales Department of Health. Available at: http://www.health.nsw.gov.au/mhdao/publications/Publications/pub-emergency.pdf (Accessed: 28 May 2014).

Mental Health and Drug and Alcohol Office (NSW) (2012a) *Aggression, Seclusion and Restraint in Mental Health Facilities - Guideline Focus upon Older People.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/gl/2012/pdf/GL2012_005.pdf (Accessed: 28 May 2014).

Mental Health and Drug and Alcohol Office (NSW) (2012b) *Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_035.pdf (Accessed: 28 May 2014).

Mental Health Branch (Qld) (2013) *Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services.* Brisbane: Queensland Health. Available at: http://www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf (Accessed: 28 May 2014).

Mental Health Commission of Ireland (2009a) *Code of Practice on the Use of Physical Restraint in Approved Centres - Version 2.* Dublin: Mental Health Commission of Ireland. Available at: http://www.mhcirl.ie/File/Revised_COP_PR.pdf (Accessed: 28 May 2014).

Mental Health Commission of Ireland (2009b) *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Version 2.* Dublin: Mental Health Commission of Ireland. Available at: http://www.mhcirl.ie/File/Revised_Rules_SecMR.pdf (Accessed: 28 May 2014).

Mental Health Commission of Ireland (2011) *Addendum to the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Version 2.* Dublin: Mental Health Commission of

Ireland. Available at: http://www.mhcirl.ie/File/Addendum_to_Rules.pdf (Accessed: 28 May 2014).

Mental Health Coordinating Council (2013) *Trauma Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia: A National Strategic Direction.* Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J. and Henderson, C. (MHCC), Kezelman, C. (Adults Surviving Child Abuse, ASCA). Lilyfield, MA: Mental Health Coordinating Council. Available at: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf (Accessed: 25 August 2014).

Mental Welfare Commission for Scotland (2007) *Good Practice Guide: The Use of Seclusion.* Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/51894/The%20use%20of%20seclusion.pdf (Accessed: 28 May 2014).

Mental Welfare Commission for Scotland (2013a) *Good Practice Guide: Deprivation of Liberty.* Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/124856/mwc_deprivation_of_libertyanalysis-2.pdf (Accessed: 28 May 2014).

Mental Welfare Commission for Scotland (2013b) *Good Practice Guide: Rights, Risks and Limits to Freedom.* Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf (Accessed: 28 May 2014).

Mental Welfare Commission for Scotland (2014) *Good Practice Guide: The Use of Seclusion.* Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf (Accessed: 28 May 2014).

Murphy, T. and Bennington-Davis, M. (2005) *Restraint and Seclusion: The Model for Eliminating Their Use in Healthcare*. Marblehead: HCPro, Inc. Available at: http://www.sanctuaryweb.com/PDFs_new/Murphy%20&%20Bennington-Davis%20Restraint%20and%20Seclusion.pdf (Accessed: 25 August 2014).

National Association of State Mental Health Program Directors (2006) *Training Curriculum for the Reduction of Seclusion and Restraint*. Alexandria, VA: National Association of State Mental Health Program Directors. Available at: http://www.nasmhpd.org/index.aspx (Accessed: 25 August 2014).

National Health Service (NHS) Protect (2013) *Meeting Needs and Reducing Distress: Guidance on the Prevention and Management of Clinically Related Challenging Behaviour in NHS Settings*. Available at: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Meeting_needs_and_reducing_distress.pdf (Accessed: 28 May 2014).

National Institute for Clinical Excellence (NICE) (2005) *Clinical Practice Guidelines: Violence - The Short-Term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Settings and Emergency Departments.* London: Royal College of Nursing. Available at: http://www.nice.org.uk/nicemedia/pdf/cg025fullguideline.pdf (Accessed: 28 May 2014).

National Mental Health Commission (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* Sydney: National Mental Health Commission. Available at: http://www.mentalhealthcommission.gov.au/our-report-card.aspx (Accessed: 28 May 2014).

National Mental Health Consumer and Carer Forum (2009) *Ending Seclusion and Restraint in Australian Mental Health Services.* Deakin West: National Mental Health Consumer and Carer Forum. Available at: http://www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf (Accessed: 28 May 2014).

National Mental Health Working Group (2005) *National Safety Priorities in Mental Health: A National Plan for Reducing Harm.* Canberra: Department of Health and Ageing, Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/DB6FC7B04519D195CA257 BF000217B28/$File/safety.pdf (Accessed: 28 May 2014).

National Technical Assistance Center (2005) *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool.* Alexandria, VA: National Association of State Mental Health Program Directors. Available at: http://www.ot-innovations.com/images/stories/PDF_Files/2._six_core_sr20plan20template20with20cover2 07-05.pdf (Accessed: 28 May 2014).

National Technical Assistance Center (2006) *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool (Revised Version).* Alexandria, VA: National Association of State Mental Health Program Directors. Available at: http://www.nasmhpd.org/docs/NCTIC/Consolidated_Six_Core_Strategies_Document.pdf (Accessed: 28 May 2014).

New Zealand Standards Council (2008) *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Wellington: New Zealand Ministry of Health. Available at: http://www.health.govt.nz/system/files/documents/pages/81342-2008-nzs-health-and-disability-services-restraint-minimisation.pdf (Accessed: 28 May 2014).

O'Hagan, M., Divis, M. and Long, J. (2008) *Best Practice in the Reduction and Elimination of Seclusion and Restraint: Seclusion - Time for Change.* Auckland: Te Pou o Te Whakaaro Nui - the National Centre of Mental Health Research, Information and Workforce Development.

O'Donoghue, B., Lyne, J., Hill, M., Larkin, C., Feeney, L. and O'Callaghan, E. (2011) 'Physical Coercion, Perceived Pressures and Procedural Justice in the Involuntary Admission and Future Engagement with Mental Health Services', *European Psychiatry,* 26(4), pp. 208-214.

Office of the Chief Psychiatrist (Vic) (2006) *Mechanical Restraint.* Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://health.vic.gov.au/mentalhealth/cpg/restraint.pdf (Accessed: 28 May 2014).

Office of the Chief Psychiatrist (Vic) (2011a) *Safe Transport of People with a Mental Illness.* Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://health.vic.gov.au/mentalhealth/cpg/safetransport.pdf (Accessed: 28 May 2014).

Office of the Chief Psychiatrist (Vic) (2011b) *Seclusion in Approved Mental Health Services.* Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://www.health.vic.gov.au/mentalhealth/cpg/seclusion-cpg-1103001.pdf (Accessed: 28 May 2014).

Office of the Chief Psychiatrist (Vic) (2013) *Practice of Prone Restraint.* Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://docs.health.vic.gov.au/docs/doc/A3D7E24D93C07554CA257C0F0008A0B7/$FILE/Prac tice%20of%20Prone%20Restraint.pdf (Accessed: 28 May 2014).

Pollard, R., Yanasak, E., Rogers, S. and Tapp, A. (2007) 'Organizational and Unit Factors Contributing to Reduction in the Use of Seclusion and Restraint Procedures on an Acute Psychiatric Inpatient Unit ', *Psychiatric Quarterly,* 78(1), pp. 73-81.

Premier of Victoria (2014) '$2 Million Funding Package to Drive Down Seclusion and Restraint at Mental Health Services', Media Release, 28 April. Available at: http://www.premier.vic.gov.au/media-centre/media-releases/9723-2-million-funding-package-to-drive-down-seclusion-and-restraint-at-mental-health-services.html (Accessed: 2 August 2014).

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O.-P. and Kautiainen, H. (2013) 'Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men with Schizophrenia', *Psychiatric Services,* 64(9), pp. 850-855.

Qurashi, I., Johnson, D., Shaw, J. and Johnson, B. (2010) 'Reduction in the use of seclusion in a high secure hospital: A retrospective analysis', *Journal of Psychiatric Intensive Care,* 6(2), pp. 109-115.

Recupero, p. R., Price, M., Garvey, K. A., Daly, B. and Xavier, S. L. (2011) 'Restraint and Seclusion in Psychiatric Treatment Settings: Regulation, Case Law, and Risk Management', *Journal of the American Academy of Psychiatry and the Law,* 39(4), pp. 465-476.

Riahi, S. (2014) 'A Recovery Oriented Approach in the Prevention of Restraints and Seclusion in a Canadian Mental Health Hospital', paper presented to the *Refocus on Recovery Conference*, Guy's Hospital, London, England, 2 June 2014.

Riahi, S., Dawe, I. C. and Klassen, p. E. (2012) 'A Multidimensional Approach in Restraint Minimization: The Journey of a Specialized Mental Health Organization', paper presented to the *International Conference on Workplace Violence in the Health Sector*, Vancouver, Canada, 24-26 October 2012.

Roberts, L. W. (2002) 'Informed Consent and the Capacity for Voluntarism', *The American Journal of Psychiatry,* 159(5), pp. 705-712.

Robins, C. S., Sauvageot, J. A., Cusack, K. J., Suffoletta-Maierle, S. and Frueh, B. C. (2005) 'Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and "Sanctuary Harm" in Psychiatric Settings', *Psychiatric Services,* 56(9), pp. 1134-1138.

Royal Australian and New Zealand College of Psychiatrists (2010) *Position Statement 61: Minimising the Use of Seclusion and Restraint in People with Mental Illness*. Available at: https://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx (Accessed: 28 May 2014).

Sailas, E. E. S. and Fenton, M. (2000) 'Seclusion and Restraint for People with Serious Mental Illnesses (Cochrane Review)', *The Cochrane Database of Systematic Reviews*. Oxford: Update Software.

Scanlan, J. N. (2010) 'Interventions to Reduce the Use of Seclusion and Restraint in Inpatient Psychiatric Settings: What We Know so Far a Review of the Literature', *The International Journal of Social Psychiatry,* 56(4), pp. 412-423.

Sclafani, M. J., Humphrey II, F. J., Repko, S., Ko, H. S., Wallen, M. C. and DiGiacomo, A. (2008) 'Reducing Patient Restraints: A Pilot Approach Using Clinical Case Review', *Perspectives in Psychiatric Care,* 44(1), pp. 32-39.

Senate Select Committee on Mental Health (2006) *A National Approach to Mental Health – From Crisis to Community (Final Report).* Canberra: Australian Parliament. Available at: http://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/report02/report_pdf.ashx (Accessed: 28 May 2014).

Sivakumaran, H., George, K. and Pfukwa, K. (2011) 'Reducing Restraint and Seclusion in an Acute Aged Person's Mental Health Unit', *Australasian Psychiatry,* 19(6), pp. 498-501.

Skuse, D. (2012) 'Recovery', *International Psychiatry,* 9(1), pp. 3-4.

Smith, G. M., Davis, R. H., Bixler, E. O., Lin, H.-M., Altenor, A., Altenor, R. J., Hardentstine, B. D. and Kopchick, G. A. (2005) 'Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program', *Psychiatric Services,* 56(9), pp. 1115-1122.

South Australia Health - Safety and Quality Unit (2013) *A Framework for Recognition and Management of Challenging Behaviour (Draft for Consultation).* Adelaide: Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/8966f000414a7549a7c4af6e3bdc556a/2_RMCB_Framework_PHCS_SQ_20130930.pdf?MOD=AJPERES&CACHEID=8966f000414a7549a7c4af6e3bdc556a (Accessed: 28 May 2014).

South Australia Health, Mental Health and Substance Abuse (2014a) *Mental Health Services Pathways to Care Policy Guideline.* Adelaide: Department for Health and Ageing, Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/010ec8004428c517aa1fffb3ef7a0fe8/Guideline_Mental+Health+Services+Pathways+to+Care.pdf?MOD=AJPERES&CACHEID=010ec8004428c517aa1fffb3ef7a0fe8 (Accessed: 6 June 2014).

South Australia Health, Mental Health and Substance Abuse (2014b) *Policy Directive: Compliance is Mandatory - Mental Health Services Pathways to Care.* Adelaide: Department for Health and Ageing, Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/1223b4804428c24ba9d9ffb3ef7a0fe8/Directive_Mental+Health+Services+Pathways+to+care.pdf?MOD=AJPERES&CACHEID=1223b4804428c24ba9d9ffb3ef7a0fe8 (Accessed: 6 June 2014).

Standing Council on Health (2012) *Mental Health Statement of Rights and Responsibilities.* Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/8F44E16A905D0537CA257B330073084D/$File/rights.pd (Accessed: 29 May 2014).

Steinert, T., Birk, M., Flammer, E. and Bergk, J. (2013) 'Subjective Distress After Seclusion or Mechanical Restraint: One-Year Follow-Up of a Randomized Controlled Study', *Psychiatric Services,* 64(10), pp. 1012-1017.

Stewart, D., Van Der Merwe, M., Bowers, L., Simpson, A. and Jones, J. (2010) 'A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients', *Issues in Mental Health Nursing,* 31(6), pp. 413-424.

Substance Abuse and Mental Health Services Administration (2005) *Roadmap to Seclusion and Restraint Free Mental Health Services*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: http://store.samhsa.gov/shin/content/SMA06-4055/SMA06-4055-A.pdf (Accessed: 3 August 2014).

Substance Abuse and Mental Health Services Administration (2014) *Trauma-Informed Care in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf (Accessed: 25 August 2014).

Sullivan, A. M., Bezmen, J., Barron, C. T., Rivera, J., Curley-Casey, L. and Marino, D. (2005) 'Reducing Restraints: Alternatives to Restraints on an Inpatient Psychiatric Service - Utilizing Safe and Effective Methods to Evaluate and Treat the Violent Patient', *Psychiatric Quarterly,* 76(1), pp. 51-65.

Swadi, H. and Bobier, C. (2012) 'Lessons from an Investigation of Seclusion at an Older Adolescent Inpatient Unit', *Australasian Psychiatry,* 20(2), pp. 98-101.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Wagner, H. R., Moser, L. A., Wilder, C. and Gilbert, A. R. (2008) 'Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions', *Journal of Mental Health,* 17(3), pp. 255-267.

Swartz, M. S., Swanson, J. W., Hannon, M. J., Petrila, J. and Monahan, J. (2003) 'Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals', *Behavioral Sciences and the Law,* 21(4), pp. 459-472.

Te Pou (2010) *Impact of Sensory Modulation in Mental Health Acute Wards on Reducing the Use of Seclusion*. Auckland: Te Pou o te Whakaaro Nui - the National Centre of Mental Health Research, Information and Workforce Development. Available at: http://www.tepou.co.nz/download/asset/159 (Accessed: 25 August 2014).

Te Pou (2013) *Six Core Strategies for Reducing Seclusion and Restraint Checklist*. Auckland: Te Pou o Te Whakaaro Nui - the National Centre of Mental Health Research, Information and Workforce Development. Available at: http://www.tepou.co.nz/library/tepou/six-core-strategies-for-reducing-seclusion-and-restraint-checklist?utm_source=MailingList&utm_medium=email&utm_campaign=Te+Pou+e-bulletin+l+Planning+for+the+future (Accessed: 28 May 2014).

Thomas, D. R. (2006) 'A General Inductive Approach for Analyzing Qualitative Evaluation Data', *American Journal of Evaluation,* 27(2), pp. 237-246.

Tunde-Ayinmode, M. and Little, J. (2004) 'Use of Seclusion in a Psychiatric Acute Inpatient Unit', *Australasian Psychiatry,* 12(4), pp. 347-351.

van de Sande, R., Nijman, H. L., Noorthoorn, E. O., Wierdsma, A. I., Hellendoorn, E., van der Staak, C. and Mulder, C. L. (2011) 'Aggression and Seclusion on Acute Psychiatric Wards: Effect of Short-Term Risk Assessment', *The British Journal of Psychiatry,* 199(6), pp. 473-478.

van der Schaaf, p. S., Dusseldorp, E., Keuning, F. M., Janssen, W. A. and Noorthoorn, E. O. (2013) 'Impact of the Physical Environment of Psychiatric Wards on the Use of Seclusion', *The British Journal of Psychiatry,* 202(2), pp. 142-149.

van der Zwan, R., Davies, L., Andrews, D. and Brooks, A. (2011) 'Aggression and Violence in the ED: Issues Associated with the Implementation of Restraint and Seclusion', *Health Promotion Journal of Australia,* 22(2), pp. 124-127.

Victorian Department of Health - Mental Health, Drugs and Regions Division (2010) *Ambulance Transport of People with a Mental Illness Protocol 2010.* Melbourne: Department of Health, Victorian Government. Available at: http://www.health.vic.gov.au/mentalhealth/publications/amb-transport0910.pdf (Accessed: 10 June 2014).

Victorian Department of Health - Mental Health, Drugs and Regions Division (2013a) *Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions.* Melbourne: Victorian Government. Available at: http://docs.health.vic.gov.au/docs/doc/1020E7C38806095DCA257C380011BA55/$FILE/Framework%20for%20reducing%20restrictive%20interventions%20FINAL.pdf (Accessed: 28 May 2014).

Victorian Department of Health - Mental Health, Drugs and Regions Division (2013b) *Reducing Restrictive Interventions: Literature Review and Document Analysis.* Melbourne: Victorian Government. Available at: http://docs.health.vic.gov.au/docs/doc/DC1E1694E5493238CA257C38000E1824/$FILE/Reducing%20restrictive%20interventions%20literature%20review.pdf (Accessed: 28 May 2014).

Victorian Department of Health (2009) *Creating Safety: Addressing Restraint and Seclusion Practices Project Report.* Melbourne: Victorian Government. Available at: http://health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/creating_safety_project _report.pdf (Accessed: 28 May 2014).

Vruwink, F. J., Mulder, C. L., Noorthoorn, E. O., Uitenbroek, D. and Nijman, H. L. (2012) 'The Effects of a Nationwide Program to Reduce Seclusion in the Netherlands', *BMC Psychiatry,* 12(1), pp. 231-235.

APPENDIX ONE

Regulatory Framework for Seclusion and Restraint in Australia and Certain Other Countries

Policies, Procedures and Guidelines: AUSTRALIA
ACT
Mental Health (Treatment and Care) Act 1994 (ACT), ss 35, 36, 36G, 38, 44.
- Australian Capital Territory Health Directorate (2011) ***Policy - Restraint of Patients***. Canberra: ACT Government. Available at: http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=2757   - Australian Capital Territory Health Directorate (2011) ***Standard Operating Procedure - Restraint of Patients****.* Canberra: ACT Government. Available at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=2758   - Australian Capital Territory Health Directorate (2011) ***Standard Operating Procedure - Code Black and Physical Restraint of Patients Process at the Canberra Hospital****.* Canberra: ACT Government. Available at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=2759
NSW
Mental Health Act 2007 (NSW), ss 85, 86.
- Mental Health and Drug and Alcohol Office (NSW) (2006) ***Aged Care - Working with People with Challenging Behaviour in Residential Aged Care Facilities: Using Appropriate Interventions and Minimising Restraint****.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf   - Mental Health and Drug and Alcohol Office (NSW) (2009) ***Mental Health for Emergency Departments: A Reference Guide****.* Sydney: New South Wales Department of Health. Available at: http://www.health.nsw.gov.au/mhdao/publications/Publications/pub-emergency.pdf   - Mental Health and Drug and Alcohol Office (NSW) (2012) ***Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales****.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_035.pdf   - Mental Health and Drug and Alcohol Office (NSW) (2012) ***Aggression, Seclusion and Restraint in Mental Health Facilities - Guideline Focus upon Older People****.* Sydney: New South Wales Department of Health. Available at: http://www0.health.nsw.gov.au/policies/gl/2012/pdf/GL2012_005.pdf

Policies, Procedures and Guidelines: AUSTRALIA
NT
Northern Territory Mental Health and Related Services Act 1998 (NT), ss 61, 62.
None.
Qld
Mental Health Act 2000 (Qld), ss 26, 162A-W; *Mental Health Regulation 2002*, cl 5.
• Mental Health Branch (2013) ***Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services****.* Brisbane: Queensland Health. Available at: http://www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf • Mental Health, Alcohol and Other Drugs Branch (Qld) (2014) ***Mental Health Act 2000 Resources Guide****.* Brisbane: Queensland Health. Available at: http://www.health.qld.gov.au/mha2000/documents/resource_guide_all.pdf
SA
Mental Health Act 2009 (SA), ss 7, 90, 98.
• South Australia Health - Safety and Quality Unit (2013) ***A Framework for Recognition and Management of Challenging Behaviour*** (Draft for **Consultation**). Adelaide: Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/8966f000414a7549a7c4af6e3bdc556a/2_RMCB_Framework_PHCS_SQ_20130930.pdf?MOD=AJPERES&CACHEID=8966f000414a7549a7c4af6e3bdc556a • South Australia Health, Mental Health and Substance Abuse (2014) ***Mental Health Services Pathways to Care Policy Guidelines***. Adelaide: Department for Health and Ageing, Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/010ec8004428c517aa1fffb3ef7a0fe8/Guideline_Mental+Health+Services+Pathways+to+Care.pdf?MOD=AJPERES&CACHEID=010ec8004428c517aa1fffb3ef7a0fe8 • South Australia Health, Mental Health and Substance Abuse (2014) ***Policy Directive: Compliance is Mandatory - Mental Health Services Pathways to Care***. Adelaide: Department for Health and Ageing, Government of South Australia. Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/1223b4804428c24ba9d9ffb3ef7a0fe8/Directive_Mental+Health+Services+Pathways+to+care.pdf?MOD=AJPERES&CACHEID=1223b4804428c24ba9d9ffb3ef7a0fe8

Policies, Procedures and Guidelines: AUSTRALIA
Tas
Mental Health Act 2013 (Tas), ss 3, 56-58, 92-94, 179, 147.

Chief Civil Psychiatrist

- Chief Civil Psychiatrist (Tas) (2013) ***Standing Order 9: Seclusion**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/148235/CCP_Standing_Order_9_-_Seclusion.pdf
- Chief Civil Psychiatrist (Tas) (2013) ***Clinical Guideline 9: Seclusion**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148242/9_CCP_Clinical_Guideline_9_-_Seclusion.pdf
- Chief Civil Psychiatrist (Tas) (2013) ***Standing Order 10: Chemical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0006/148236/3_CCP_Standing_Order_10_-_Chemical_Restraint.pdf
- Chief Civil Psychiatrist (Tas) (2013) ***Clinical Guideline 10: Chemical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/148243/10_CCP_Clinical_Guideline_10_-_Chemical_restraint.pdf
- Chief Civil Psychiatrist (Tas) (2013) ***Standing Order 10A: Mechanical and Physical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/148237/4_CCP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf
- Chief Civil Psychiatrist (Tas) (2013) ***Clinical Guideline 10A: Mechanical and Physical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/148244/11_CCP_Clinical_Guideline_10A_-_Mechanical_and_Physical_restraint.pdf

Chief Forensic Psychiatrist

- Chief Forensic Psychiatrist (Tas) (2013) ***Standing Order 9: Seclusion**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/148249/CFP_Standing_Order_9_-_Seclusion.pdf
- Chief Forensic Psychiatrist (Tas) (2013) ***Clinical Guideline 9: Seclusion**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148260/23_CFP_Clinical_Guideline_9_-_Seclusion.pdf
- Chief Forensic Psychiatrist (Tas) (2013) ***Standing Order 10: Chemical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/148250/14_CFP_Standing_Order_10_-_Chemical_Restraint.pdf
- Chief Forensic Psychiatrist (Tas) (2013) ***Clinical Guideline 10: Chemical Restraint**.* Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/148261/24_CFP_Clinical_Guideline_10_-_Chemical_Restraint.pdf

Policies, Procedures and Guidelines: AUSTRALIA
Tas (continued)
• Chief Forensic Psychiatrist (Tas) (2013) ***Standing Order 10A: Mechanical and Physical Restraint***. Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148251/15_CFP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf • Chief Forensic Psychiatrist (Tas) (2013) ***Clinical Guideline 10A: Mechanical and Physical Restraint***. Hobart: Department of Health and Human Services. Available at: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/148251/15_CFP_Standing_Order_10A_-_Mechanical_and_Physical_Restraint.pdf
Vic
Mental Health Act 2014 (Vic), ss 110-112, 113-116.
Victorian Department of Health • Victorian Department of Health (2009) ***Creating Safety: Addressing Restraint and Seclusion Practices Project Report***. Melbourne: Victorian Government. Available at: http://health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/creating_safety_project_report.pdf • Victorian Department of Health – Mental Health, Drugs and Regions Division (Vic) (2010) ***Ambulance Transport of People with a Mental Illness Protocol 2010***. Melbourne: Department of Health, Victorian Government. Available at: http://www.health.vic.gov.au/mentalhealth/publications/amb-transport0910.pdf • Department of Health and Victoria Police (2010) ***Protocol for Mental Health***. Melbourne: Department of Health, Victorian Government. Available at: http://www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf • Victorian Department of Health - Mental Health, Drugs and Regions Division (2013) ***Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions***. Melbourne: Victorian Government. Available at: http://docs.health.vic.gov.au/docs/doc/1020E7C38806095DCA257C380011BA55/$FILE/Framework%20for%20reducing%20restrictive%20interventions%20FINAL.pdf • Victorian Department of Health - Mental Health, Drugs and Regions Division (2013) ***Reducing Restrictive Interventions: Literature Review and Document Analysis***. Melbourne: Victorian Government. Available at: http://docs.health.vic.gov.au/docs/doc/DC1E1694E5493238CA257C38000E1824/$FILE/Reducing%20restrictive%20interventions%20literature%20review.pdf

Policies, Procedures and Guidelines: AUSTRALIA
Vic (continued)
Chief Psychiatrist • Office of the Chief Psychiatrist (Vic) (2006) **Mechanical Restraint**. Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://health.vic.gov.au/mentalhealth/cpg/restraint.pdf • Office of the Chief Psychiatrist (Vic) (2011) **Safe Transport of People with a Mental Illness**. Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://health.vic.gov.au/mentalhealth/cpg/safetransport.pdf • Office of the Chief Psychiatrist (Vic) (2011) **Seclusion in Approved Mental Health Services**. Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://www.health.vic.gov.au/mentalhealth/cpg/seclusion-cpg-1103001.pdf • Office of the Chief Psychiatrist (Vic) (2013) **Practice of Prone Restraint**. Melbourne: Mental Health, Drugs and Regions Division, Victorian Government Department of Health. Available at: http://docs.health.vic.gov.au/docs/doc/A3D7E24D93C07554CA257C0F0008A0B7/$FILE/Practice%20of%20Prone%20Restraint.pdf
WA
Mental Health Act 1996 (WA), ss 116-124; *Mental Health Regulations 1997; Mental Health Bill 2013* (WA), cls 211-240.
• Department of Health (WA) (2005) **Guidelines: The Management of Disturbed/Violent Behaviour in Inpatient Psychiatric Settings**. Brisbane: Department of Health, Government of Western Australia. Available at: http://www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/HP8973_The_management_of_disturbed_violent_behaviour.pdf • Department of Health (WA) (2006) **Operational Directive: Seclusion, Restraint and 'Time Out'**. Brisbane: Department of Health, Government of Western Australia. Available at: http://www.health.wa.gov.au/circularsnew/pdfs/12592.pdf

Policies, Procedures and Guidelines: AUSTRALIA
National

- National Mental Health Working Group (2005) *National Safety Priorities in Mental Health: A National Plan for Reducing Harm*. Canberra: Department of Health and Ageing, Commonwealth of Australia. Available at: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-safety-toc
- Australian Institute of Health and Welfare (2012) *Use of Restricted Practices During Admitted Patient Care*. Canberra: Commonwealth of Australia. Available at: http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices
- Australian Department of Health and Ageing (2012) *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care*. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/F97925A7FE1F7CBECA257BF0001AFDED/$File/RESIDENTIAL%20Aged%20Care_internals_FA3-web.pdf
- Australian Department of Health and Ageing (2012) *Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care*. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/215C090C7AD8E881CA257BF0001AFF06/$File/COMMUNITY%20Aged%20Care_internals_FA3-web.pdf
- Australian Institute of Health and Welfare (2013) *Mental Health Services in Australia: Admitted Patient Mental Health-Related Care*. Canberra: Commonwealth of Australia. Available at: http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=27917288164
- Australian Department of Social Services (2014) *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector* (the 'National Framework'). Canberra: Commonwealth of Australia. Available at: http://www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector

Broader Framework

- Senate Select Committee on Mental Health (2006) *A National Approach to Mental Health – From Crisis to Community (Final Report)*. Canberra: Australian Parliament. Available at: http://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/report02/report_pdf.ashx
- Australian Department of Health (2010) *National Standards for Mental Health Services*. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

Policies, Procedures and Guidelines: AUSTRALIA
National (continued)
• Standing Council on Health (2012) ***Mental Health Statement of Rights and Responsibilities***. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/8F44E16A905D0537CA257B330073084D/$File/rights.pdf • Australian Health Ministers' Advisory Council (2013) ***A National Framework for Recovery-Oriented Mental Health Services - Policy and*** • ***Theory***. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/B2CA4C28D59C74EBCA257C1D0004A79D/$File/recovpol.pdf • Australian Health Ministers' Advisory Council (2013) ***A National Framework for Recovery-Oriented Mental Health Services - Guide for Practitioners and Providers***. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf
Professional Bodies
• **National Mental Health Consumer and Carer Forum** (2009) *Ending Seclusion and Restraint in Australian Mental Health Services*. Deakin West: National Mental Health Consumer and Carer Forum. Available at: http://www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf • **Royal Australian and New Zealand College of Psychiatrists** (2010) *Position Statement 61: Minimising the Use of Seclusion and Restraint in People with Mental Illness*. Available at: https://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx • **Australian and New Zealand Society for Geriatric Medicine** (2012) *Position Statement 2: Physical Restraint Use in Older People*. Available at: http://www.anzsgm.org/documents/PositionStatementNo2RevisedSept2012.pdf

Policies, Procedures and Guidelines: INTERNATIONAL
England/Wales
• National Institute for Clinical Excellence (NICE) (2005) ***Clinical Practice Guidelines: Violence - The Short-Term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Settings and Emergency Departments***. London: Royal College of Nursing. Available at: http://www.nice.org.uk/nicemedia/pdf/cg025fullguideline.pdf • Department of Health (UK) (2008) ***Code of Practice: Mental Health Act 1983***. London: The Stationary Office. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf • National Health Service (NHS) Protect (2013) ***Meeting Needs and Reducing Distress: Guidance on the Prevention and Management of Clinically Related Challenging Behaviour in NHS Settings***. Available at: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Meeting_needs_and_reducing_distress.pdf • Department of Health (UK) (2014) ***Positive and Proactive Care: Reducing the Need for Restrictive Interventions***. London: Department of Health (UK). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf
Scotland
• Mental Welfare Commission for Scotland (2013) ***Good Practice Guide: Rights, Risks and Limits to Freedom***. Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf • Mental Welfare Commission for Scotland (2013) ***Good Practice Guide: Deprivation of Liberty***. Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/124856/mwc_deprivation_of_libertyanalysis-2.pdf • Mental Welfare Commission for Scotland (2014) ***Good Practice Guide: The Use of Seclusion***. Edinburgh: Mental Welfare Commission for Scotland. Available at: http://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf

Policies, Procedures and Guidelines: INTERNATIONAL
Ireland
• Mental Health Commission of Ireland (2009) ***Code of Practice on the Use of Physical Restraint in Approved Centres - Version 2***. Dublin: Mental Health Commission of Ireland. Available at: http://www.mhcirl.ie/File/Revised_COP_PR.pdf • Mental Health Commission of Ireland (2009) ***Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Version 2***. Dublin: Mental Health Commission of Ireland. Available at: http://www.mhcirl.ie/File/Revised_Rules_SecMR.pdf • Mental Health Commission of Ireland (2011) ***Addendum to the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Version 2***. Dublin: Mental Health Commission of Ireland. Available at: http://www.mhcirl.ie/File/Addendum_to_Rules.pdf
New Zealand
• Ministry of Health (NZ) (2000) ***Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992***. Wellington: Ministry of Health (New Zealand). Available at: http://www.health.govt.nz/system/files/documents/publications/gmpmha.pdf • New Zealand Standards Council (2008) ***Health and Disability Services (Restraint Minimisation and Safe Practice) Standards***. Wellington: New Zealand Ministry of Health. Available at: http://www.health.govt.nz/system/files/documents/pages/81342-2008-nzs-health-and-disability-services-restraint-minimisation.pdf • Ministry of Health (NZ) (2010) ***Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992***. Wellington: Ministry of Health (New Zealand). Available at: http://www.moh.govt.nz/notebook/nbbooks.nsf/0/2b272ce3aef58622cc2576d90001ca17/$FILE/seclusion-guidelines-feb10.pdf

Policies, Procedures and Guidelines: INTERNATIONAL
United States of America

- Legislative Reference Bureau (US) (1996) ***The Pennsylvania Code - Title 55, Chapter 13: Use of Restraints in Treating Patients/Residents***. Mechanicsburg: Commonwealth of Pennsylvania. Available at: http://www.pacode.com/secure/data/055/chapter13/055_0013.pdf
- National Technical Assistance Center (2005) ***Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool***. Alexandria, VA: National Association of State Mental Health Program Directors. Available at: http://www.ot-innovations.com/images/stories/PDF_Files/2._six_core_sr20plan20template20with20cover207-05.pdf
- Substance Abuse and Mental Health Services Administration (2005) ***Roadmap to Seclusion and Restraint Free Mental Health Services***. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: http://store.samhsa.gov/shin/content/SMA06-4055/SMA06-4055-A.pdf
- Substance Abuse and Mental Health Services Administration (2014) ***Trauma-Informed Care in Behavioral Health Services***. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf
- Centers for Medicare and Medicaid Services (2008) ***Medicare State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals***. Baltimore: Maryland Department of Health and Human Services. Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

(All links in Appendix One were accessed on 29 August 2014.)

APPENDIX TWO

Scope of Application and Coverage of the Mental Health Acts

State or Territory	Who does it apply to?
Australian Capital Territory	The *Mental Health (Treatment and Care) Act 1994* (ACT) applies to: • Patients with a psychiatric treatment order: s35(1) • Patients subject to a Community Care Order: s36(2)(c) • Voluntary patients who are detained: s38(2) The ACT (2011) ***Policy - Restraint of Patients*** policy applies to 'provide information relating to mechanical devices, environmental, chemical and physical restraint (that is required outside of a clinical treatment program) for use in acute and community environments where patients are under the care of Health Directorate. It does not address use of physical restraint for non-patients on Health Directorate premises….. does not address use of restraint by other agencies, e.g. ACT Corrective Services' (p. 2) and does not cover seclusion.
New South Wales	The NSW Policy (2012) ***Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales*** provides that it applies to: • Mental health intensive care (p.1) • High dependency, acute and non-acute inpatient units that service all age groups of mental health consumers (p.1) • Emergency Departments that are declared mental health facilities (p.1) In non-declared mental health units, such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) units, consent for the use of restraint must be obtained under the Guardianship Act 1987 (NSW) (p.1) • Seclusion and restraint should not apply to voluntary patients. If it is applied, their status needs to be reviewed as soon as

State or Territory	Who does it apply to?
	possible after the event (p.11).
	• A child under the age of 14 may be reasonably restrained for uncomfortable medical procedures, such as taking blood or dressing a wound, with parent's consent or if it is urgently required to save the child's life or to prevent serious damage to the child's health provided that the use of restraint is ancilliary to the provision of treatment. A child will need to have an involuntary status if they are being restrained to prevent harm to themselves or others (p.12).
	• All seclusion for children under 14 must be under the *Mental Health Act 2007* (NSW) (parents cannot consent) (p12).
	The NSW Policy (2012) ***Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales*** also notes that 'it is recognised that there may be rare occasions when it is necessary to deviate from this procedure. In these instances, reasons for the deviation must be noted in the consumer's health care record and included in a post-incident review' (p.5).
Northern Territory	The *Northern Territory Mental Health and Related Services Act 1998* (NT) applies to:
	• Patients being assessed or receiving treatment under the Act: s61(1)
Queensland	According to the Qld (2014) ***Mental Health Act 2000 Resources Guide*** seclusion and mechanical restraint can only be authorised for an involuntary patient in an authorised mental health service. This includes:
	• A patient detained for assessment
	• A patient subject to an involuntary treatment order
	• A classified patient
	• A patient subject to a forensic order or a disability forensic order (p. 13-5)
South Australia	The SA (2014) ***Mental Health Services Pathways to Care Policy Guidelines*** apply to all SA Health staff who may be required to care for a person experiencing mental distress.
	The SA (2013) ***A Framework for Recognition and Management of Challenging Behaviour*** guideline applies to all challenging behaviours across SA Health.

State or Territory	Who does it apply to?
Tasmania	According to the *Mental Health Act 2013* (Tas), seclusion can apply to involuntary civil patients in an approved hospital (s56). Restraint can apply to involuntary patients in an approved hospital or assessment centre (s57). According to section 140(7), an approved hospital is also taken to be an approved assessment centre, unless it is stated otherwise. The Act also applies to forensic patients.
Victoria	According to the *Mental Health Act 2014* (Vic) seclusion and bodily restraint can be applied to a person receiving mental health services in a designated mental health service (ss110, 113). A desgnated health service includes the Victorian Institute of Forensic Mental Health (s3). Seclusion and bodily restraint may only be used afterall reasonable and less restrictive options have been tried or considered and have been found to be unsuitable (s105).
Western Australia	The *Mental Health Act 1996* (WA) applies to patients in an authorised hospital (s117). The *Mental Health Bill 2013* (WA) applies to patients in an authorised hospital and people referred for an examination by a psychiatrist at an authorised hospital (cls 214, 230).

Country	Who does it apply to?
England and Wales	The *Mental Capacity Act 2005* (Eng and Wales) applies to adults who lack mental capacity, but excludes people detained under the *Mental Health Act 1983* (Eng and Wales) in relation to their psychiatric treatment. The use of seclusion and restraint under the *Mental Health Act 1983* (Eng and Wales) is limited to involuntary patients as the Act contains no provisions on seclusion and restraint and the power to seclude and restrain comes from the fact of detention. The (2008) **Code of Practice: Mental Health Act 1983** applies to people detained under the Act, but 'should also be beneficial to the police and ambulance services and others in health and social services (including the independent and voluntary sectors)

Country	Who does it apply to?
	involved in providing services to people who are, or may become, subject to compulsory measures under the Act ' (para v). The Code is not legally binding and it may be departed from where there are 'good and cogent reasons.' (See the European Court of Human Rights Decision in *Munjaz v United Kingdom* and para iv.) The Code provides that 'nationally recognised guidelines, such as those of the National Institute for Health and Clinical Excellence (NICE), complement the guidance provided in this chapter' (para 15.2). The NICE Guidelines apply to psychiatric in-patients and emergency departments. The (2013) ***Meeting Needs and Reducing Distress: Guidance on the Prevention and Management of Clinically Related Challenging Behaviour in NHS Settings*** applies to 'any adult patient and service user in any NHS healthcare setting.' (p i). It is limited to clinically-related challenging behaviour that arises as part of their condition. This includes individuals with 'some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder' (p.10).
Scotland	The Scottish (2014) ***Good Practice Guide: The Use of Seclusion*** and the (2013) ***Good Practice Guide: Deprivation of Liberty*** apply to people with mental illness, learning disability and related conditions who are in hospital and are involuntarily detained.
Ireland	The *Mental Health Act 2001* (Ire) and the (2009) ***Code of Practice on the Use of Physical Restraint in Approved Centres - Version 2*** and the (2009) ***Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint - Version 2*** apply to all approved centres that means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that are registered pursuant to the Act. The Act applies to voluntary and involuntary patients.
New Zealand	The (2010) ***Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*** guidelines apply to those under the *Mental Health (Compulsory Assessment and Treatment Act) 1992*. The NZ (2000) ***Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992*** apply to those who have been assessed by a medical practitioner to possibly mentally disordered and as requiring urgent assessment. The (2008) ***Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*** apply to all services that use seclusion and restraint.

Country	Who does it apply to?
United States	The (2008) *Medicare State Operations Manual: Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals* apply to all hospitals that participate in the Medicare and Medicaid programs. The TJC Accreditation is a voluntary accreditation code that certifies more than 20,000 health care organisations and programs in the United States. The (1996) *The Pennsylvania Code - Title 55, Chapter 13: Use of Restraints in Treating Patients/Residents* applies to institutions operated by the Department, regardless of the type of facility, patient/resident composition, or services covered. Facilities covered include Youth Development Centers, Youth Forestry Camps, Restoration Centers, State general hospitals and State-operated institutions for the mentally ill or mentally retarded. The APA (2003) *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health* report is highly regarded and referred to in the CMS Rules Operations Manual. It is based on information from behavioral healthcare facilities.

APPENDIX THREE

Summary of Literature on Seclusion and Restraint Reduction Strategies/Interventions and their Effects

Author/Date/State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Azeem, et al. (2011) Minnesota, USA	• Setting = one large CAMHS hospital • Sample of 458 young people admitted over 3 years • Data gathered from file review • Patient length of stay (LOS) in study period was approx. 70 days	*Aim:* **'To determine the effectiveness of six core strategies with trauma informed care, in reducing the use of seclusion and restraints with hospitalized youth'** *Method:* • **Case study**, **pre and post** retrospective analysis of routine data regarding patients and events • Comparing two time-points pre and post intervention, i.e. baseline data first 6 months in 2004, compared with last 6 months in 2007 • No statistical tests for significance	• 2005: Hospital **staff training in trauma informed care** and 6 core strategies (as per NASMHPD) • Training was provided at orientation and ongoing sessions, major element of program • Also describe 6 core strategies: Leadership, data use, trauma-oriented care tools, consumer and carer inclusion, debriefing	• 'downward trend in seclusions/restraints' • …from 93 events with 33 young people at T1 to … • 31 events with 11 young people at T2

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Bak, et al. (2012) Review in Denmark, international papers	• Review of findings from 59 empirical papers (11 qual. and 48 quant.) from 1998-2009. • Focus on reduction of mechanical restraint alone or seclusion/ restraint combined. • Included languages: English and all Scandinavian	*Aim:* To identify **which conditions in nursing** and **which nursing interventions** have been **shown to reduce the frequency** of mechanical restraint episodes. *Method:* • Systematic review • Systematic search, critical review matrix, evidence ranking and synthesis of findings from 59 empirical papers	Diverse interventions, clustered into 27 descriptors and ranked from 1-27	*Two conclusions:* • 'Implementation of **cognitive milieu therapy, combined /program interventions and patient-centered care** were the three interventions most likely to reduce the number of mechanical restraints.'… • 'There is a **lack of high-quality** and effective intervention **studies'**
Barton, et al. (2009) Pennsylvania, USA	• Setting = **one adolescent 'behavioral health unit** of 26 beds within a private, non-profit community hospital' • Length of Stay (LOS) = 5-7 days	*Aim:* To report on seclusion and restraint reduction project and outcomes *Method:* **Case study** of **restraint reduction project**, reporting on process of change -implementation and select endpoints	Hospital staff training, practice and organisational changes referencing the 6 core strategies (as per NASMHPD)	• Baseline of 9 events in 2004-5, 0 in 2007-8. • Reports restraint free for 2 years at 2009, accompanied by decrease (-20%) in medication use

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Borckardt, et al. (2011) South Carolina, USA	• Setting = **one large state hospital in southeastern USA,** included 5 units: acute adult-, geriatric-, general adult-, substance abuse-, and child and adolescent units • Participants = patients and staff, for a total of 89,783 patient-days over a 3.5-years from 2005 to mid 2008 • Av LOS = 7 days • Primary measure = events per pt-day, secondary = staff and patient ratings of care	*Aim:* 'examine the effect of systematic implementation of behavioral interventions on the rate of seclusion and restraint in an inpatient psychiatric hospital.' *Method:* **Non controlled multiple-baseline design**; • 'five inpatient units were randomly assigned to implement the intervention components in a different order; each unit served as its own control' • In analysis compared pre-post measures for each unit and controlled for time, order and other organisational impacts	Adapted version of 6 core strategies called 'engagement model', includes 'trauma-informed care training, changes to unit rules and language, changes to the physical characteristics of the therapeutic environment, and involvement of patients in treatment planning' staggered physical changes in the units.	*Primary results:* • Rate of seclusion and restraint events reduced by of 82.3% (p = 0.008) between the **baseline phase** (January 2005 through February 2006) and the follow-up, post-**intervention phase** (April 2008 through June 2008) • (oddly inequitable time period sampling?) *Secondary results:* No significant change in staff ratings of care; patients' ratings showed some significant improvement in care re two elements of the program: improved environment and involvement in own care plans
Bowers et al. (2008) London region, England	• Setting = **8 NHS service acute adult wards**: three for intervention, five for control comparison • Data = validated measured of conflict, staff documentation of containment	*Aim:* Apply theoretical model re changes to staff attitudes, behaviours and organisational structure, related to conflict *Method:* **Non-experimental study, pre-post** design. Replication of an earlier pilot study with bigger sample, using matched ward/patient controls	'City Nurse' intervention of 3 elements: • positive appreciation • emotional regulation and • effective structure	No significant change when results controlled for occupancy, results clustered by ward.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Bowers et al. (2012) England	Setting = **84 wards in 31 English hospitals** Analysis of clinical documentation re 522 acute admissions over 10 months from June 2009.	*Aim:* To describe and investigate seclusion and timeout practices – i.e. what preceded and followed time out and seclusion episodes in a large sample of hospitals *Method:* **Observational study** • Retrospective analysis of a continuous sequence of documented seclusion and timeout interventions. • Develop hypotheses about change in seclusion practice	Nil	*Key points:* • Some seclusion appeared to follow less serious disturbed behaviour. • An important variation in rates of seclusion between hospitals, room for change. *Conclusion:* • Proposing replacement of seclusion with timeout as a viable option, in units with higher rates of seclusion and apparently lower thresholds for seclusion. • Presents UK healthcare organisations with epidemiological evidence for potential to use timeout strategy before/instead of seclusion
Bowers (2014) England	• Setting = **15 regional NHS services, 31 adult psychiatry wards** randomised, involved through: 8 weeks baseline data collection, 8 weeks implementation, 8 weeks outcome data collection • LOS not stated • 564 staff consented and provided data, survey tools	*Aim:* Test a psychosocial intervention to reduce conflict, seclusion and restraint in acute wards *Method:* • **Cluster RCT** with in NHS services. Trial of 10 point therapeutic intervention, control = 10 point staff self-care intervention. • Measures were staff ratings of conflict events & rate of containment measures: seclusion & restraint per 1000 occ.bed days • Fidelity checklist, 2ndary measures e.g. ward atmosphere, economic eval.– results still to come	• 10 defined elements to Safewards, derived from earlier CityNurse studies- shows some influence of 6 core strategies: • 'clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, discharge messages + handbook' • Each element has a champion assigned	• 15% decrease in the rate of conflict 24% decrease in the rate of 'containment measures', i.e. seclusion and restraint combined • Complex intervention - fidelity was modest, potential for better outcomes if longer, higher fidelity *N.B.:* • results so far presented at conferences, abstracts; major finding papers not yet peer-review published • secondary measures results still to come

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Ching, et al. (2010) Victoria, Australia	• Setting = **one** statewide adult **forensic inpatient service** of 118 beds with acute, sub-acute, continuing care and rehabilitation units, seclusion areas on 5/7 units • LOS = days to years • Participants were staff and patients on the 5 units with seclusion spaces • Project period was 28 months from late 2006-2008 ***Primary measures:*** • frequency and • duration of seclusion episodes • frequency of aggression ***Secondary standard measures***: • therapeutic climate, • staff attitudes towards seclusion, • staff confidence to manage aggression • Staff questionnaires = 60 pre, 61 post • Patient questionnaire = 13 pre, 7 post	***Aims:*** • to determine whether it was possible to reduce use of seclusion • to examine impact of this initiative on frequency of aggressive behaviour • to evaluate impact on staff and patients perceptions of the unit culture, staff attitudes towards seclusion, staff confidence to manage aggression. ***Method:*** Evaluated via **pre- post** measurements, using 14 months of data pre-intervention and the following 14 months as post intervention period ***Limitations***: Survey data was: • unpaired/unmatched, with Time 1 on the pre period, Time 2 at end of 14 months intervention • Non-parametric tests used w survey data	Intervention was implemented over 14 months. Elements included: • 'review of existing seclusion practices, staff training in the management of aggression, the implementation of evidence based alternatives'	***Primary effects:*** Significant reduction in the use of seclusion, (from 36 to 13 events per month) and duration of seclusion (from 844.24hrs to 371.17hrs per month). NB. These seclusions are long duration ***Secondary***: • Although staff used seclusion less frequently to manage a similar number of aggressive incidents (15 to 16.5 per month), staff perceptions of personal safety and staff confidence to manage aggressive patients remained steady. • There was also no change to therapeutic climate or staff attitudes towards seclusion – perhaps suggesting no culture change accompanied the reduction.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Gaskin, et al. (2007)	Narrative **review of studies of interventions to reduce use of seclusion** in psychiatry (English language only), following a 2004 Cochrane review of evidence to support seclusion (there was nil evidence)	*Aim:* To report on empirically supported interventions 'that allow' reduction in the use of seclusion *Method:* **Narrative review** of peer-reviewed and published studies (lit search up to 2006)	16 papers reviewed, mainly from USA, 3 from UK reporting on diverse strategies implemented in adult and adolescent settings, mainly single sites. Interventions included: senior managers active in units, training in trauma care, use of sensory interventions, individual prevention plans, special teams, increased visitors, increased monitoring of events, change of ward architecture	• Reported decreases in range of 75-26%. One CAMHS ceased use of seclusion. • Strategies were mainly complex combinations of: increased staffing/skill mix, staff training, new models of interaction, organisational and environmental changes.
Georgieva, et al. (2010) Netherlands	• Setting = **one new 4 bed Psychiatric Intensive Care Unit (PICU)**; population was 8 patients (7 with diagnosis of borderline personality disorder) admitted to PICU; all patients had previously been admitted in an adult acute unit • Data was patient records. • Av. LOS unclear, but referred to admissions up to 3 years duration. *N.B.:* Baseline seclusion periods of extreme durations, ranging from shortest of 7 days to 517 days for one person.	*Aim:* To determine 'whether coercive measures were used less often with admitted participants at the PICU than had been used with the same patients in their earlier stays in psychiatric units'. *Method:* • **Case study**, comparing use of seclusion with small cohort of patient in two different settings, adult psychiatric unit V PICU • Retrospective audit of patient records re seclusion. Study period was 28months of PICU operation, seclusion data for individuals in PICU were compared with seclusion data for previous admissions. • No statistical analysis on small sample	New environment with small number of beds = 4, high staff ratio (1+staff :2 patients), different model of care, with multidisciplinary members, negotiation and choices, crisis prevention plans, comprehensive group therapy including mentalisation therapy	Seclusion almost eliminated in the PICU: • Combined seclusion episodes of 1200 days for the 8 people when in previous ward, 4 seclusion days total in PICU *Conclusion:* PICU approach may be non-coercive approach suited to other patient groups *N.B.:* No description of previous/ alternative acute unit model of care in operation

Author/Date/State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Georgieva, et al. (2013) Netherlands	• Setting = acute units (number of units not provided, more than one) in one psychiatric hospital over 33 months, from Nov 2007 to 2010. • 520 patients were allocated to groups, at the beginning of 659 admissions. • Av LOS was 13 days. • Data analysed was seclusion and coerced medication events. • Incidence rates and risk ratios(RRs) used to examine differences in number and duration of coercive incidents between groups.	*Aim:* 'The study evaluated whether seclusion and coercive incidents would be reduced in extent and number if involuntary medication was the first choice of intervention.' *Method:* • **Quasi-experimental design**, random allocation of admitted patients to 2 groups, with plan for managing agitation /aggression either with seclusion first or medication first. • Analysis showed no between-group characteristic differences.	• In Group 1, involuntary medication was the intervention of first choice for dealing with agitation/ risk of violence. In Group 2, seclusion was the intervention of first choice. This was in effect treatment as usual. • Group 1 intervention was 'rapid tranquillization' which involved the **oral or intramuscular administration** of a combination of haloperidol and promethazine, to achieve rapid, short-term behavioural control of any extreme • agitation, aggression or potentially violent behaviour that placed the individual and those around them at risk. • No other practice change was implemented/ detailed.	• 177 individual coercive measures recorded overall, involving approx. 12% of patients. Considerable intervention cross-over, patients receiving new protocol medications in group 2. • Overall rates of coercive events were the same between groups, durations of seclusion events were also the same in both groups. *Conclusion:* • Alternative interventions are needed to reduce the overall number and duration of coercive incidents. • This paper provides useful warning against replacement of one coercive measure with another. **N.B.:** the two studies by this author illustrate that seclusion specifically can be reduced while instituting other coercive measures, such as forced medication and lengthy involuntary admission.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Hamilton and Castle (2008) Victoria, Australia (abstract only)	• Setting = a 42 bed public acute unit of 2 wards within a tertiary hospital • LOS =9 days • Used a standard event measure (events/occupied bed days) allows comparison between units of different sizes and demand	*Aim:* To determine if seclusion reduction strategies reported as effective in USA are transferrable to an Australian acute MH setting *Method:* **Pre – post design**, also reporting differences in populations	Focus on 3 elements of the 6 core strategies: • **Management roles** = executive support, senior leaders setting goal of major reduction • **Data** review = informing all levels of the organisation about events and performance • **Staff training** = regarding harms of seclusion, trauma, de-escalation Also established an Emergency Response Team, to assist when patients at risk of seclusion	• Seclusion was reduced by 49%, from 32.7 events per occ. bed days per quarter in 2006 to 16.7 events per occ. bed days in 2007 (p=0.007) • No significant differences between patient groups (gender, age, diagnosis) in T1 compared to T2
Hyde, et al. (2009) Queensland, Australia	• Setting = two acute inpatient wards with 30 beds each • 6 month intervention in 2008	*Aim:* To develop and implement a clinical decision-making framework around the use of seclusion. *Method:* **Practice development/action research.** • Information from workshops over several months were used to development of a decision tool, including change to earlier team-based review of patient seclusion (from 4 to 3 hours). • Recorded seclusion rates	*Project goal:* To reduce the incidence of seclusion and the length of time of seclusion events to below 4 hours' duration *Project objectives:* Focusing on nurses in the mental health unit, the objectives were to: • identify the cues nurses use to recognize a patient at risk of seclusion • distinguish the factors nurses consider when making a decision to seclude a patient and to release a patient from seclusion • restrictive practices like seclusion	No reported seclusion data; outcome was decision model to represent and inform seclusion decisions

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Hyde, et al. (2009) Queensland, Australia (continued)			*Project objectives:* • develop a step-by-step decision-making framework for nurses to use to direct their clinical practice • enhance awareness & knowledge of factors that positively influence quality patient care if using restrictive practices like seclusion	
Jayaram, et al. (2012) USA	• Settings = John Hopkins Meyer 3 service, short stay acute unit. Admissions are 'not elective'. • Prospective screening of **229 consecutive admissions** in 2007-2008, using a new screening tool and determined its inter-rater reliability and predictive validity. A variety of interventions, were systematically recorded. This paper briefly reports **seclusion hours**.	*Aim:* To improve assessment and reporting of aggression and interventions used. *Method:* • Analysis of newly developed assessment instrument, the Phipps Aggression Screening Tool. • Measured inter-rater reliability, • tested predictive utility of the tool via odds ratios. • No statistical analysis of seclusion events/hours.	Centred on an aggression management tool. It was aimed to systematically identify potential aggressors among admitted patients within 24 to 48 hours of admission. Though its use, staff were simultaneously trained to use less restrictive interventions and to collect data on its use.	• Mainly reports on patient characteristics associated with the tool and aggressive behaviour. • Use of seclusion decreased from 32 in 2004 to 22.4% in 2007. Use of seclusion was 0.1/1000 patient hours in 2011, reportedly in keeping with US-wide trend.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Johnson (2010)	Review of 46 studies (pre 2009) reporting projects for **reduction of seclusion** in **inpatient psychiatric units**	*Aims:* • To compare and contrast the design, content and outcomes of programs aimed at reducing seclusion/restraint or aggression/violence. • To identify trends in design, content, and outcomes of seclusion/restraint and aggression/violence reduction efforts. *Method:* • Integrative review • Limitations of reviewed studies • Most studies were pre-post design with no comparison group, only one with randomisation. • Most studies included small sample sizes, were conducted in one institution, the lacked • statistical analyses and lacked comparison groups	Most interventions featured education of nurses. Multifaceted interventions were used more for reduction of seclusion/restraint than for reduction in aggression/violence.	**Characteristics of two streams of research:** • Outcome measures tended to be **either** restraint/seclusion reduction or aggression/reduction. The extent to which reduction in restrictive measures impacts rate of aggression/violence is not clear. • When reducing aggression is aim of several studies, but incongruent • objectives are to evaluate impacted on staff variables such as attitudes, knowledge, confidence, or satisfaction with the program; not a simple relationship with aim. • Only four studies measured impact of an educational intervention on both restraint/seclusion and aggression/violence. • Only 5 studies replicated an intervention. • Studies in which staff were the unit of analysis have larger sample sizes than those in which the hospital, unit, or patient was the unit of analysis.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Lee, et al., (2010) Victoria, Australia	• Setting = a 30-bed acute psychiatric unit, one of 2 acute adult units on the site of a tertiary medical hospital, with a PICU within the unit. Patients for the pilot were in PICU at some point during admission. • Data was analysed from audit of 43 psychiatric intensive care service users over 6 months in 2008. These patients had significantly longer hospital stays (Av 39.4 days) than unit Av (19.0 days).	*Aim:* To see if a new assessment tool and sensory resources in an acute unit would be used by staff and impact on use of seclusions *Method:* • **Six-month pilot** of a sensory intervention in a single unit, using pre-post measures. • There was no statistical analysis of results	• Implemented a brief sensory and risk assessment tool (**Safety Tool**) accompanied with **sensory modulation resources**, with furnishings and a sensory cart of equipment, including: • Optic lamps, digital music players, musical instruments, herbal teas, glider chairs, exercise bike, • weighted blankets, stress balls and exercise putty, added to existing art and music therapy resources. • This pilot intervention was based on approaches within one of the 6 core strategies.	• Whereas 65% PICU patients had been previously secluded, only 26% were secluded after completing a Safety Tool. • Most staff had completed or read a Safety Tool; 76% considered it should become part of standard care. *Conclusion:* Findings support the significant role that sensory assessment and engagement can play in improving service user care and reducing seclusion use

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Lewis, et al. (2009) Maryland USA	• 88 acute inpatient beds located on five units (including substance use and geriatric units) within the large tertiary teaching hospital, Johns Hopkins. • 20% of patients had been secluded, restrained, or required constant observation during past hospitalizations. • Annual chart audit of hours of seclusion and restraint over four years, 2004 as baseline	*Aim:* To describe an evidenced-based Crisis Prevention Management (CPM) program. *Method:* • Detailed **case-study,** description of program elements. • Time series/annual data recorded, pre-post data reporting.	• Program focused on changing the culture of patient care, using public health prevention model as a framework. The multi-faceted program - using NASMHPD six core strategies - built from the initial training of senior staff, focus groups with all staff, one day training, with piloting of main interventions in different units. • Specific interventions included: using Phipps Aggression Screening Tool and personal Safety Plans, Daily Safety Focused Community Meeting, Initiative to improve patient comfort, via family style meals, music and art materials, 'comfort cart', increased staff presence, non-offensive de-escalation training, monitoring seclusion and restraint data, review of all seclusions as a critical event, post seclusion support and planning with each patient.	• Decrease in the use of restraint ranging from 20–97% across the 5 units; decreased in seclusion use between 30–63% across 3 of 4 units. • State that a small number of patients account for large proportion of hours (no detail analysis). *N.B.:* This report is a clear example of major organisational change project directed at reducing seclusion and restraint: • Provides a detailed description of project/interventions, but uses basic data measures not standardised for ready comparison with other settings, no statistical analysis, no demographic details or other data to explain between unit variations.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Martin, et al. (2008) Connecticut, USA	• Setting = 15-bed psychiatric inpatient unit for school-age children. • 755 children (median age=11 years; 64% boys) in 998 admissions from years 2003/4 to 2007/8. • Length of stay decreased in study period (due to increase demand/pressure to admit). • Defined mechanical restraints as leather or Velcro straps attached from a person's limbs to bed railings.	*Aim:* To prevent and manage aggression through non-coercive means. *Method:* **Prospective study** of admission and seclusion/restraint data	• Collaborative problem solving (CPS), a manualised therapeutic program for working with aggressive children and adolescents. • The CPS model conceptualizes aggressive behavior as the by-product of lagging cognitive skills in the domains of flexibility, frustration tolerance, and problem solving. • It provides a framework to understand • children's aggressive behaviour as stemming from impairments in one of five non–mutually exclusive pathways: • executive functioning, language processing, emotion regulation, cognitive flexibility and social skills. • CPS seeks to identify impairments and precipitating antecedent events; it models alternative means of de-escalation through • social problem-solving, conflict resolution, and anger management strategies. • Through these means, CPS seeks to ultimately prevent further aggressive outbursts.	• Reduction in the use of restraints from 263 events to seven events per year = **37.6-fold reduction** (slope [beta]=–0.696) • Reduction in seclusion from 432 to 133 events per year, representing a **3.2-fold reduction**, beta=–0.423). • The mean duration of restraints decreased from 41±8 to 18±20 minutes per episode, so cumulative unitwide restraint use dropped from 16±10 hours to 0.3±0.5 hours per month, **a 45.5-fold reduction**, (beta=–0.674). • The mean duration of seclusion decreased from 27±5 minutes to 21±5 minutes per episode, so unitwide seclusion use dropped from 15±6 to 7±6 hours • per month, a 2.2-fold reduction • During the early phases of implementation, there was a transient increase in staff injuries through patient assaults.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Möhler, et al. (2012)	• Lit. search in 2009 for studies to include. • Setting for the studies: • Of the six, five studies were with nursing home residents and one study with residents in group dwelling units. • Definitions of physical restraints varied. **All studies included belts or chairs with fixed tables**, but only some included bedrails, restrictive clothes (e.g. sleeping • suits) and electronic measures, which could restrict a person's • movement (e.g. sensor mats or motion alarm systems)	*Aim:* To evaluate the effectiveness of interventions to **prevent and reduce the use of physical restraints** in older people requiring long-term nursing care. *Method:* **Cochrane review** • Systematic review of six cluster randomised controlled trials, ranging in size from only 1-2 sites in the 'cluster'. • Follow-up ranged from 3-12 months. • Limitations in the reviewed studies included between group differences in gender, dependency, agitation ratings, baseline use of restraint and medication use, non-blinded assessors	• All studies included **educational approaches** targeting nursing staff. In addition, two studies offered consultation, two guidance and one support and free access to technical aids. • Best study was by Huizing 2009	• Methodological quality of studies was low. • Their results were inconsistent. • Restraint methods differ in aged care services than adolescent or adult MHSs. • One study with good method quality in the nursing home setting showed increase in physical restraints use in both groups. • The four lower quality studies showed reduced use of physical restraints in the intervention group. • The single study in group dwelling units found no change in use of physical restraints in the intervention group, but significant increase in control group. *Conclusion*: Educational programs with nurses might not be effective in reducing use of physical restraints in geriatric long-term care.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Noorthoorn, et al. (2008) Netherlands	Two wards (one experimental, one control) followed for 29 months in a prospective cohort study. Data collected on daily basis. Both wards had two seclusion rooms and each department could rely on a psychiatrist, a resident, a psychologist and a social worker.	*Aim:* To explore the effects of different ward cultures on two wards on the use of seclusion *Method:* Prospective cohort study. Ward populations compared with demographic variables and diagnosis. Seclusion use analysed between 1 Jan 2003 and 1 June 2005.	Project accompanied by process evaluation by project leader and researcher to experimental ward introducing interventions including staff training, family participation, proactive approach to detecting aggressive behaviour and project feedback from researcher to experimental team	• Study shows a powerful difference between an experimental ward and a comparable control ward in the number of seclusion incidents. The results further show that the experimental ward was especially successful in preventing seclusion. • Once a patient was secluded, the seclusion duration was only somewhat shorter in the second and third year in the experimental ward than in the control ward.
Pollard, et al. (2007) Washington, USA	The study examined unit characteristics and the use of seclusion and restraint in a Veterans Affairs facility with a secured, acute mental health unit before and after (46 month period) the promulgation of the JCAHO 2000 standards for utilization of seclusion and restraint for behavioural health reasons.	*Aim:* The study examined the effect of policy changes on the use of seclusion and restraint and attempted to clarify the relationships between the use of seclusion and restraint and a variety of environmental variables. *Method:* Variables examined by statistical tests looking at **pre and post** policy implementation.	Data collected for a 46 month period. The JCAHO standards were introduced at week 28. Involved a series of formal and informal interventions implemented by the senior unit leadership and facility leadership, including discussions regarding alternatives to the use of seclusion and restraint, exploration of staff concerns about the new standards.	These results suggest that the introduction of the JCAHO 2000 standards had a significant impact on the hours of seclusion or restraint use on an inpatient mental health unit. The hours of seclusion and restraint use showed a notable decline post policy implementation.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Putkonen, et al. (2013) Finland	Over the course of a year (Jan-Dec 2009), 13 wards of a secured national psychiatric hospital in Finland received information about seclusion and restraint prevention. Four high-security wards (N=88 beds) for men with psychotic illness were then stratified by coercion rates and randomly assigned to two equal groups. Incidence rates with 95% confidence intervals (CIs) were calculated by assuming a Poisson distribution.	*Aim:* To determine if seclusion and restraint could be prevented in the psychiatric care of people with schizophrenia without an increase of violence. *Method:* **Cluster RCT** The study was designed according to the CONSORT statement and its extension to cluster-randomized trials (19) (www.consort statement.org/extensions/ designs/cluster-trials). Allocation of the participants was based on treatment ward (place-based allocation).	Between January and June 2009 the researchers assisted staff of the intervention wards to initiate the new practices consisting of six core strategies.	• Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behaviour. • The proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% for intervention wards and 25% to 19% for control wards. Seclusion-restraint time decreased from 110 to 56 hours per 100 patient days for intervention wards but increased from 133 to 150 hours for control wards. Incidence of violence decreased from 1.1% to 0.4% for the intervention wards and from 0.1% to 0% for control wards.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Qurashi, et al.(2010) England, UK	Data on all episodes of seclusion and restraint at Ashworth Hospital between Jan 2002 – Jan 2005 were analysed.	*Aim:* To determine if measures implemented to existing governance structures were associated with a reduction in the number of seclusion episodes and their duration in a high secure hospital. *Method:* Statistical analysis of seclusion episodes and associated records.	Introduced measures included: Information use and transparency; effective use of audit and peer reviews; positive risk management; patient involvement; education and training; and enhanced clinical leadership	• The results demonstrate a progressive and sustained reduction in seclusion use (over 60% reduction in the number of seclusion episodes). The authors found no increase in adverse incidents in conjunction with the reduction in seclusion use. • The authors suggest 'reductions in seclusion use and improvements in clinical practice are achievable when it is identified as both a managerial and clinical priority, supplemented by robust performance monitoring and effective clinical governance arrangements' (p. 114)
Scanlan (2010)	• Article analyses evidence from 29 papers (from an initial total of 144) on **single restraint and/or seclusion reduction** programs. • No detail of search dates	*Aim:* Article aims to analyse the evidence which looks at programmes based within inpatient psychiatric settings. *Method:* Narrative literature review, mapping all the interventions against (5 of the) 6 core strategies (NAMHPD) and noted additional strategy details, with reported rates of reduction. No ranking or rating of study quality	Key strategies emerged from analysis which influence reduction of restraint and seclusion largely reflect the **6 core strategies**: • policy change/leadership; • external review/debriefing; • data use; • training; • consumer/family involvement; • programme elements/changes with addition of: • increase in staff ratio/crisis response teams	*Conclusions*: • 'Overall, the most effective programme elements appear to be strong executive support at a local level coupled with engagement of frontline staff and changes in programs at a unit level' (p. 421). • Notable when reviewing the tabled papers that greatest level of reduction (> 50%) were achieved in CAMHS projects, also in large state hospitals with long LOS • In all cases, greater reductions were achieved in mechanical restraint than in seclusion, and in duration of seclusions than events

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Sclafani, et al. (2008) New Jersey, USA	Non-traditional consultation process between university research team and the New Jersey State Division of Mental Health Services over a 16 month period. The unit assessed had a 35-bed capacity.	**Aim:** To reduce incidence of restraints by focusing on patient consultations to collect data on interventions, milieu approaches/conditions and staff interactions. **Method:** Simple pre-post data presented	• Consultations and a variety of intervention points operationalized to meet patients' specific needs. • The consultation team's interventions took two directions: one focused on working with the two patients who were the subject of the consultation, and the other focused on working with the unit staff to develop modified ward structures and routines. Both initial consults were for female patients. The work with the patients began with rapport building and history discovery. Unit staff were encouraged to accompany the members of the consultation team during interviews or when a team member spent time with either patient on the unit' (p. 35).	The efforts resulted in restraint reduction from 36 episodes per month at its peak to 0 episodes for the final two months, as well as precipitating a change in unit climate and care approaches on a specialized unit for patients with developmental disabilities and mental illness (p. 32).
Sivak (2012) Delaware USA	• In Jan 2012, a small, tertiary, rural mental health hospital introduced comfort room as a pilot project in each of the male and female inpatient admission units. • Client ratings of intervention. • No data regarding seclusion rates.	**Aim:** Zero use of seclusion and restraint within four months of instating the rooms. 50% reduction of assaults and self-injurious behaviours also within four months. **Method:** Comfort room usage recorded (e.g. incident rates) and 14 voluntary feedback forms received from clients who used the rooms during the four month period.	Comfort rooms.	A reduction of restraint, seclusion and assaultive behaviours since introduction of comfort rooms noted. 92.9% of clients found comfort rooms helpful when they experienced increased distress.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Sivakumaran, et al. (2011) Victoria, Australia	• Setting = one acute aged care facility. • Seclusion and restraint data provided to Chief Psychiatrist's Office analysed from ward records of South Ward, Peter James Centre, Eastern Health from 2005-2010	***Aim:*** To describe how an aged acute mental health unit in Victoria achieved a marked reduction in restraint and seclusion practices ***Method:*** Data analysed via ward records, random audit of patient files to understand context of seclusion/restraint, and nursing staff survey on restraint/seclusion practices on the South Ward	Data analysed by research team.	Four major factors contributed to reduction of seclusion and restraint: a) leadership/support from management; b) increased multidisciplinary team input; c) inpatient setting renovations; and d) changes in treatment-related factors
Stewart, et al. (2010)	• Searched papers reporting interventions in adult psychiatric settings. • 36 empirical studies were identified from 1960 – 2009	***Aim:*** To examine the effectiveness and nature of interventions that reduces the use of **mechanical restraint and seclusion** among adult psychiatric inpatients ***Method:*** Narrative literature review of 36 papers: 32 from USA, 2 from UK, one Finnish, one Australian	• N/A • 'The interventions were diverse, but commonly included new restraint or seclusion policies, staffing changes, staff training, case review procedures, or crisis management initiatives' (p. 413)	• Evidence suggests various interventions can reduce restraint/seclusion practices, however studies reviewed had weak designs and looked at packages of interventions, rather than assessing which intervention was the most effective • Data on patient and staff perspectives were absent from intervention studies.

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Swanson, et al. (2008) North Carolina, USA	Random samples from de-identified client files from two county-based health systems in North Carolina. 'Study participants were required to be age 18–65; have a chart diagnosis of schizophrenia, schizoaffective disorder, other psychotic disorder, or major mood disorder with psychotic features; be currently receiving mental health treatment services from one of the two designated county programs; and be able to provide informed consent to participate in the study' (p. 257).	*Aim:* To examine if completion of a facilitated psychiatric advance directive (PAD) helped to reduce coercive interventions. *Method:* 'The study prospectively compared a sample of PAD completers (n=147) to non-completers (n=92) on the frequency of any coercive interventions, with follow-up assessments at 6, 12, and 24 months. Repeated-measures multiple regression analysis was used to estimate the effect of PADs' (p.257).	Facilitate completion of Psychiatric Advance Directive. This provides a means for a competent individual to refuse or consent to certain treatment, during a period of future incapacity.	Completion of a psychiatric advance directive was associated with lower odds of coercive intervention usage.
Trauer et al. (2010) Victoria, Australia	Setting = high dependency units of two adult acute psychiatry wards in a tertiary hospital.	*Aim:* To evaluate impact of new behaviour management program on use of seclusion. *Method:* • Quasi-experimental design using one unit as intervention, second unit as control. • Poisson regression	Staff trained in using Management of Acute Arousal Progam (MAAP), a five level protocol for staging early response to patient arousal and agitation, with (escalating) elements of distraction, verbal de-escalation, timeout, offer of prn medication, seclusion as last resort.	Statistically non-significant difference in use of seclusion between two units. *Limitations*: Relate to patients moving between units/study conditions, resulting in data excluded

Author/Date/ State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
van de Sande, et al. (2011) Netherlands	• Study undertaken on four acute psychiatric wards. 'All patients admitted during the study • Period (n = 597) were included in the trial. The average length of stay in the wards was approximately 3 weeks, mostly involuntarily (62%). Most patients were diagnosed with a psychotic disorder (58%)' (p. 473).	*Aim:* Evaluate the effect of risk assessment on number of aggression incidents and time in seclusion. *Method:* **Cluster randomised controlled trial**, randomisation of 2 units each to intervention and control condition. Period of time – 40 weeks. N=597 patients.	Crisis monitoring versus 'care as usual'.	'The numbers of aggressive incidents (relative risk reduction 768%, P50.001) and of patients engaging in aggression (relative risk reduction RRR =750%, P50.05) and the **time spent in seclusion** (RRR =745%, P50.05) were significantly lower in the experimental wards than in the control wards. Neither the number of seclusions nor the number of patients exposed to seclusion decreased.' (p. 473).
van der Schaaf, et al. (2013) Netherlands	Data collected from multicentre study on building safety/quality of 77 psychiatric hospitals and a benchmark study of coercive measure usage in 16 psychiatric hospitals.	*Aim:* To explore the effect of design features on the risk of being secluded, the number of seclusion incidents and the time in seclusion, for patients admitted to locked wards for intensive psychiatric care. *Method:* Data combined over 12 month period and statistical analyses performed (nonlinear principal components analysis; multilevel regression analyses) to explore relationship between seclusion and principal design components on the studied psychiatric wards.	Building/Ward design features, including number of patients accommodated in the unit, indoor and outdoor space, security features.	Notable design features that **increased potential for seclusion** included: presence of large outdoor space, large number of patients in the building and special safety measures (e.g. warning systems).' Design features such as more 'total private space per patient', a higher 'level of comfort' and greater 'visibility on the ward', decreased the risk of being secluded' (p. 142).

Author/Date/State/Country	Populations, Sampling Procedure and Respondents, Data Sources	Study Aim and Method	Reduction Intervention	Effects, Event Reduction
Vruwink. et al. (2012) Netherlands	From 2006-09, the Dutch government instigated a program to reduce seclusion in psychiatric hospitals by 10% every year.	*Aim:* To establish if numbers of seclusion and involuntary medication changed as a result of a national program to reduce seclusion *Method:* Using Poisson regression analysis, data from 1998-2009 were analysed to examine national numbers of seclusion and involuntary medication before and after the program's inception.	Government funding to hospitals required them to have 'a specific target for reducing seclusion, developing psychiatric intensive care, gathering reliable data on coercive measures, and enhancing expertise of staff' (p. 1-2). Strategies at levels of institution, ward and patient levels.	Seclusions fell after start of national program and did not meet 10% target. The number of involuntary medications did not change, and actually increased when corrected for an increasing number of involuntary hospitalizations. The researchers recommend the use of more extensive national guidelines to aid in the implementation and monitoring of evidence-based programs to reduce seclusion.

APPENDIX FOUR

Preamble to the Survey

Reduction of Seclusion and Restraint in Mental Health Care Project

Invitation to Respond to an Online Survey

The National Mental Health Commission is funding a project being conducted by a team of researchers from across the University of Melbourne led by Professor Bernadette McSherry.

The project aims to enable the full and effective participation of people with lived experience, their families, friends and supporters in guiding research directions. The project aims to:

(1) identify and assess the drivers behind current practice in Australia;

(2) provide examples of how the use of seclusion and restraint practices has been reduced or eliminated; and

(3) discuss options for reducing and eliminating the use of seclusion and restraint in mental health care settings in Australia.

The results of this research will have important implications for policy development and will better inform the debate surrounding this important issue.

This survey aims to gather information about how best to reduce or eliminate seclusion and restraint in mental health services and other settings and to identify barriers to their reduction or elimination.

We are encouraging in particular people who are over 18 years old with a lived experience of mental health issues, their families and support people as well as practitioners and other service providers working in a range of mental health, general health, custodial and community settings to complete the survey.

Before proceeding, we need you to read the Plain Language Statement.

Plain Language Statement for Survey Participants

Reduction of Seclusion and Restraint in Mental Health Care Project

BACKGROUND

This survey aims to gather information about how best to reduce or eliminate seclusion and restraint in mental health services and other settings and to identify barriers to their reduction or elimination.

We are encouraging in particular people who are over 18 years old with a lived experience of mental health issues, their families and support people as well as practitioners and service providers working in a range of mental health, general health, custodial and community settings to complete the survey.

ARE THERE ANY RISKS INVOLVED?

It might be distressing to reflect about the use of restraint and seclusion if you have experienced it, yourself, observed it or applied it to someone else. However, the survey is **anonymous** and it does **not** seek detailed information about experiences of seclusion and restraint. Some of the questions ask for basic information about you for descriptive purposes and to permit comparison of responses from individuals with different perspectives. The other questions focus on definitions of seclusion and restraint, what you think are the consequences of these practices and strategies for reducing and eliminating seclusion and restraint.

If we reach a small sample size there is the chance of your responses being identifiable to us. However, we will not publish any information that may identify the circumstances of particular individuals and we will make every effort to ensure your confidentiality.

HELPLINES

If you experience any distress in responding to this survey, please contact:

Lifeline

13 11 14 - www.lifeline.org.au or ring one of the following state crisis numbers:

NSW   1800 011 511- Mental Health Line http://www.cclhd.health.nsw.gov.au/mhLine.html

VIC   1300 651 251 - Suicide Help Line http://suicideline.org.au/

QLD   13 43 25 84 - 13 HEALTH http://www.health.qld.gov.au/13health/

TAS   1800 332 388 - Mental Health Services Helpline
http://www.dhhs.tas.gov.au/service_information/services_files/mental_health_services/mental_health_service_helpline

SA   13 14 65 - Mental Health Assessment and Crisis Intervention Service

---

	www.sahealth.sa.gov.au/wps/wcm/connect/public+content/SA+Health+Internet/Health+services/Mental+health+services/
WA	1800 676 822 - Mental Health Emergency Response Line http://www.mentalhealth.wa.gov.au/getting_help/Emergency_help/emergency_mherl.aspx
NT	08 8999 4988 - Top End Mental Health Service http://www.teamhealth.asn.au/
ACT	1800 629 354 - Mental Health Triage Service http://health.act.gov.au/c/health?a=sp&pid=1316133581&site=51109&servicecategory=37

TIME COMMITMENTS

You will be able to complete the survey over as many sittings as you wish or require but it is estimated to take 20-30 minutes.

BEFORE YOU START THE SURVEY, PLEASE ENSURE YOU READ THESE STATEMENTS

- The information and opinions you provide are anonymous.

- There are no right or wrong answers to the questions and we appreciate and welcome your views and ideas.

- You can choose to stop the online survey at any point, you can always come back later and you can decide whether or not you wish to send the responses that you have completed.

- If there is anything that you would prefer not to answer, just skip that question and move to the next question.

- You do not need to finish the survey all at once; you can come back as many times as you like and your responses can be saved for when you choose to return to the survey at a later time.

CONFIDENTIALITY AND STORAGE OF DATA

Only the researchers will have access to the data you provide. Any information that may identify the circumstances of particular individuals who have experienced or used seclusion or restraint will be de-identified.

Storage of the data collected will adhere to the regulations the University set and will be kept on University premises in a locked cupboard or filing cabinet for 5 years and then shredded. Any data that is stored electronically will be in a password protected computer and it will be destroyed after 5 years too.

WHAT IF I HAVE A COMPLAINT?

Should you have any complaint concerning this survey for the research project *Reduction of Seclusion and Restraint in Mental Health Care Project*, project no 1340647, please contact the University of Melbourne Office for Research Ethics and Integrity at the following address:

Manager, Human Research Ethics
Office for Research Ethics and Integrity
Level 1, 780 Elizabeth Street (near cnr Grattan Street), (University Building No. 220)
Melbourne VIC 3010

Ph: 8344 2073; Fax 9347 6739   E-mail: research-integrity@unimelb.edu.au

CONTACT DETAILS

If you have any queries about the project or its progress, please contact:

- the **Principal Researcher** Professor McSherry on (03) 9035 7434 or via e-mail at

  bernadette.mcsherry@unimelb.edu.au or

- the Project Co-ordinator Dr Annegret Kämpf at annegret.kaempf@unimelb.edu.au.

The other researchers involved in this project are all staff of the University of Melbourne and can be contacted via phone on 13 MELB (136352) or via web address (www.unimelb.edu.au):

– Associate Professor Janet Clinton	– Ms Cath Roper
– Associate Professor Carol Harvey	– Mr Piers Gooding
– Associate Professor Stuart Kinner	– Ms Kay Wilson
– Dr Bridget Hamilton	– Ms Dee Al-Nawab
– Dr Lisa Brophy	– Mr Juan Jose Tellez

THANK YOU FOR EXPRESSING INTEREST IN PARTICIPATING IN THIS RESEARCH.

Before you start completing the survey, please let us know that you have read and understood the information provided above by answering the following questions:

☐ I am over the age of 18 years.

☐ I understand that my participation is voluntary.

☐ I understand that I can withdraw consent to participate in the survey at any time. I understand that I can either leave the survey at any time without submitting data previously supplied or I can withdraw any unprocessed data previously supplied by contacting the researchers.

☐ I understand that I can choose to answer as many or as few of the survey questions as I like.

☐ I understand that the survey is anonymous and that all information I provide in the survey will be kept confidential and that my privacy is assured.

☐ I understand that the survey may take 20-30 minutes to complete.

☐ I understand that I can leave the survey at any time.

☐ I understand that I can choose to complete the survey in multiple sittings and that I can return to the survey as often as I wish until the closing date of 17 May 2014.

☐ I understand that if I have a complaint about the survey, I can direct my concerns to Human Research Ethics at the University of Melbourne.

☐ I give my consent to responding to this survey.

At the end of the survey and at any time when you leave the survey, you will be reminded about telephone support and referral lines.

APPENDIX FIVE

Focus Groups Plain Language Statement, Consent Form and Facilitation Guide

Reduction of Seclusion and Restraint in Mental Health Care Project

Plain Language Statement for Focus Groups

for Families, Friends and Supporters/People with Lived Experience

Thank you for expressing interest in participating in this research.

We would like to invite you to participate in a focus group meeting to discuss the ways in which the use of seclusion and restraint can be reduced or eliminated in practice. We are holding focus group meetings in Perth/Sydney/Melbourne/Shepparton.

This project has received ethics approval from the University of Melbourne Human Research Ethics Committee (project no: 1340647).

BACKGROUND

The National Mental Health Commission aims to provide best practice guidelines on the reduction or elimination of the use of seclusion and restraint in mental health care. The Commission is funding this project to inform the development of these best practice guidelines. Professor Bernadette McSherry is leading this project and conducting the research with a team of multidisciplinary researchers from across the University of Melbourne**.**

We aim to enable the full and effective participation of people with lived experience, their families, friends and supporters in guiding research directions. We aim to:

(1) identify and assess the drivers behind current practice in Australia;

(2) provide examples of how the use of seclusion and restraint practices has been reduced or eliminated; and

(3) discuss options for reducing or eliminating the use of seclusion and restraint in mental health care settings in Australia.

The results of this research will have important implications for policy development and will better inform the debate surrounding this important issue.

At the focus groups [, the questions will not be aimed at eliciting your experience of seclusion and restraint.] W/we will ask you about your understanding of why restraint and seclusion are used in the context of mental health treatment and care, about the impact it has on the people involved and what ideas you have about how to reduce or eliminate seclusion and restraint.

REIMBURSEMENT AND TIME COMMITMENTS

Participants will receive a $25 shopping voucher in appreciation of their efforts to attend. Participants will be offered lunch during the meeting.

The time commitment will be approximately 1 - 2 hours.

CONFIDENTIALITY

All aspects of the focus groups will be strictly confidential (within legal limitations) and only the researchers will have access to information about participants. While the focus groups will be taped, comments about options for reducing seclusion and restraint in mental health care will not be attributed to particular individuals in the final report. Any information that may identify the circumstances of particular individuals [, including the person you care for] who have experienced or used seclusion or restraint will not be reported. We would like to use quotes in our papers and reports that illustrate particular issues. If a comment you make is used you will be referred to by a pseudonym or alias and we will make every effort not to use any quotes that could be traced back to someone.

Being part of the focus group is completely voluntary - you are under no obligation to consent to participation or to say anything you are uncomfortable with saying in a group environment. You may withdraw your consent at any stage, or avoid answering questions which you feel are too personal or intrusive. We will also encourage group members to be respectful of the other group members' privacy.

ARE THERE ANY RISKS INVOLVED?

It might be distressing to talk about [experiences of/a person you care about being subject to] restraint and seclusion, so we will provide you with a list of services that you can access to talk over any distress you may experience following the focus group meeting. We also encourage you to contact your regular support network if you are in distress in any way and please let the group facilitators know if you are distressed during or immediately after the focus group. They will support you to get any assistance you might require. We hope that the contribution you will be making to future service improvement will be worth having to talk about this potentially difficult subject. If you agree, we will also follow up with you by telephone or email after the meeting just to check whether you are OK with how the meeting went. The focus groups will involve relatively small numbers of people, so this increases the chance of your responses being identifiable. However, as described above, we will make every effort to ensure your confidentiality.

STORAGE OF DATA

Storage of the data collected will adhere to the regulations the University has set and will be kept on University premises in a locked cupboard or filing cabinet for 5 years and then shredded. Any data that is stored electronically will be in a password protected computer and it will be destroyed after 5 years too.

RESULTS

The results will form the basis for a Final Report to the National Mental Health Commission which will then disseminate the findings. If you wish to receive a copy of the Commission's findings from us, please contact the Project Co-ordinator Dr Annegret Kämpf at annegret.kaempf@unimelb.edu.au. The Commission will also publish its findings on http://www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project.aspx

The research team will also do seminar and conference presentations to tell the community about the findings. We will ensure details about presentations and any reports and papers we produce will be on the project website:

http://www.socialequity.unimelb.edu.au/seclusion-and-restraint/

CONTACT DETAILS

If you have any queries about the project or its progress, please contact:

- the **Principal Researcher** Professor McSherry on (03) 9035 7434 or via e-mail at bernadette.mcsherry@unimelb.edu.au;

- the conductor of your focus group meeting Dr Lisa Brophy at lbrophy@unimelb.edu.au or Ms Cath Roper at croper@unimelb.edu.au; or

- the Project Co-ordinator Dr Annegret Kämpf at annegret.kaempf@unimelb.edu.au.

The other researchers involved in this project are all staff of the University of Melbourne and can be contacted via phone on 13 MELB (136352) or via web address (www.unimelb.edu.au):

- Associate Professor Janet Clinton

- Associate Professor Carol Harvey

- Associate Professor Stuart Kinner

  Dr Bridget Hamilton

- Mr Piers Gooding

- Ms Kay Wilson

- Ms Dee Al-Nawab

WHAT IF I HAVE A COMPLAINT?

Should you have any complaint concerning the manner in which this research *Reduction of Seclusion and Restraint in Mental Health Care Project,* project no 1340647 is conducted, please do not hesitate to contact the University of Melbourne Office for Research Ethics and Integrity at the following address:

Manager
Human Research Ethics
Office for Research Ethics and Integrity
Level 1, 780 Elizabeth Street (near cnr Grattan Street), (University Building No. 220)
Melbourne VIC 3010

Tel: 8344 2073; Fax 9347 6739   E-mail: research-integrity@unimelb.edu.au

Reducing and Eliminating the Use of Seclusion and Restraint in Mental Health Care Project

Ethics application no: 1340647

Participation in Focus Group – Consent Form

If you wish to participate in the focus group, please indicate by signing this form that you have read and understood the following information:

1. The focus group meeting will take up to two hours and will be audio taped.

2. My involvement in this project is voluntary.

3. I can choose not to answer any question.

4. I can withdraw my consent to participate in the focus group at any time and request that my details and any information that I have provided will not be used.

5. The information that I provide is confidential.

6. The focus groups will involve relatively small numbers of people. This increases the chance of my responses being identifiable but the researchers will make every effort to ensure my confidentiality.

7. The information that I provide will be kept in a securely locked cabinet at the University of Melbourne that only the researcher can access. Any electronic data will be saved on secured devices or data storage of the University of Melbourne that can be accessed only by the researchers.

8. I am aware that the results from the focus group meetings will be published.

9. I am satisfied that all my questions about the research have been answered to my satisfaction.

10. I understand that if I have any further questions I can contact the focus group facilitator or the project coordinator (Annegret Kaempf, annegret.kaempf@unimelb.edu.au).

11. I have received a copy of this consent form.

12. I understand that my signed and returned consent form will be retained by the researchers in a securely locked cabinet at the University of Melbourne that only the researcher can access.

13. I understand that my data will be stored for 5 years and then be destroyed.

Name: _____

Date: dd / mm / yyyy

Signature: _____

Facilitation Guide for Focus Groups Discussion:

The same structure will be used for both group types.

Dr Lisa Brophy and Ms Cath Roper

- Introductions – facilitators and participants.

- Ensure everyone understands issues already covered in the Plain Language Statement, including protections and limitations to confidentiality, participants can leave/withdraw anytime, ensure everyone has support information in case of distress etc.

- Establishing safe environment for discussion – agree on how to ensure everyone is heard and that the conversation moves forward so all the topics are covered.

- Ensure shared understanding of the aims of the focus groups.

- Introduce how focus groups relate to other parts of the project – participants may also want to complete the survey on line.

- Ask why participants wanted to attend the focus group and what they hoped to contribute – confirm that people are not required or expected to talk about their individual experiences of S&E (or the person they support in the case of families, friends and other supporters).

- What do participants understand seclusion and restraint to be (range of actual actions/types and locations etc.)?

- What do participants understand about why seclusion and restraint is used?

- What impact does the use of seclusion and restraint have on consumers and others?

- What impression do participants have about current rates of the use of seclusion and restraint – is it going up or down?

- How can this be explained?

- If rates of seclusion and restraint were to go down what might need to happen?

- What are examples of poor practice or poor service delivery that contribute to the use of seclusion and restraint?

- What are examples of good practice or good service delivery that contribute to reducing seclusion and restraint? (Think about this at all kinds of levels including "one to one" all the way through to how services are organised.)

- If you had only one thing you could change what would the most important thing be to reduce the use of seclusion and restraint?

This is a guide only. The facilitators will have an opportunity to clarify and expand on points raised. There will also be opportunities to draw participants' attention to key findings from the literature review, consultations and, if possible, preliminary data from the surveys, to enable them to make comment on these findings from their perspective (for example when asking about what is going on with rates of seclusion and restraint and good practice).