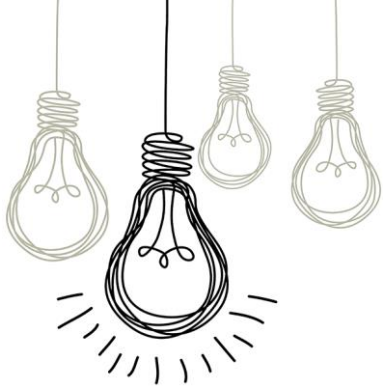

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INSIGHTS FROM LIVED EXPERIENCE TO END SECLUSION AND RESTRAINT IN VICTORIA

Interim findings from engagement with consumers who have experienced, feared, or witnessed seclusion or restraint in Victoria's public mental health system

June 2023

research@vmiac.org.au

Overview

- Consumer Engagement
  - Aims & methods
  - Who participated
  - Scope & focus
- Context for consumer recommendations
- Key Recommendations from Lived Experience
- Prevention & Alternatives – across settings, for in-patient wards
- Translating recommendations into actions – hold consumers at the centre

Acknowledgement of Country

VMIAC works across Victoria and acknowledges the Traditional Custodians of the lands. We pay our respect to Elders past, present and future. We acknowledge that Aboriginal and Torres Strait Islanders are the Traditional Owners of the lands we call Australia. We acknowledge and respect Aboriginal and Torres Strait Islanders' cultural, spiritual, physical and emotional connection with their land, waters and community. We acknowledge that this land was never ceded. VMIAC supports the Uluru Statement from the Heart and the Yes campaign.

Acknowledgement of Lived Experience

VMIAC acknowledges people with lived and living experience of mental health challenges in all their diversity and strength. We acknowledge that many people with mental health challenges have been marginalised and harmed within our institutions and communities. May they be seen, heard, believed, and their experiences never forgotten.

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Aims & Methods

Aim to collect a range of consumer perspectives for the Department of Health's strategy for the elimination of seclusion and restraint.

Method Interviews, small group discussion, written survey, written statements
Co-designed by VMIAC and VACCHO project team with input from the Department of Health.

Participating consumers who have experienced, feared, or witnessed restrictive practices in Victoria's mental health system (N=82, to date).

Reports and knowledge sharing
Presented to EWG & Leadership Forum; preliminary summary; brief written report
Shared through VMIAC and VACCHO communications, networks, and advocacy

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Who participated?

84 registrations of interest
42 interviews
40 survey responses

Age

18-25	**15%**
26-35	**38%**
36-45	**20%**
46-55	**11%**
56-65	**13%**
66+	**3%**

Diversity

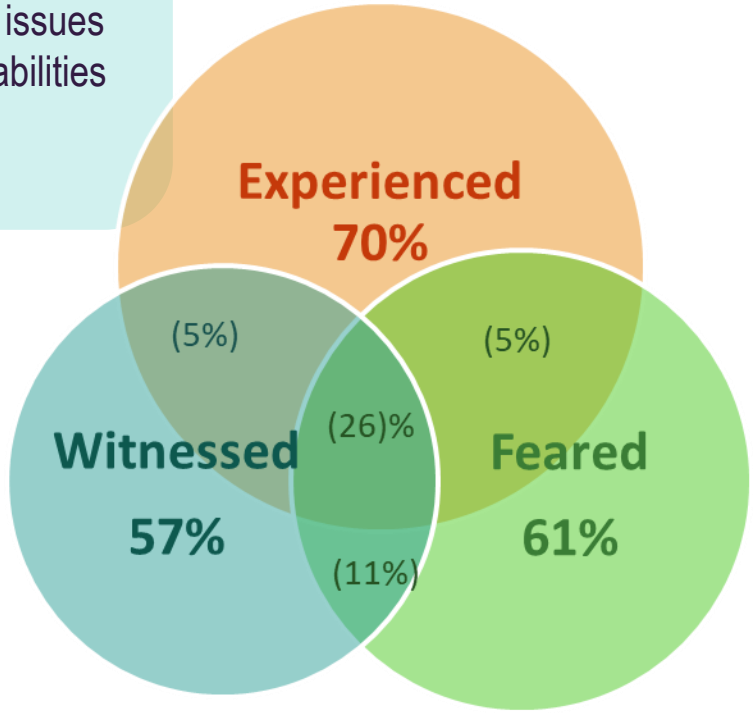
2 First Nations people
15 from culturally and linguistically diverse communities

34 LGBTQIA+
2 Transgender
13 non-binary
3 men
54 women

31 neurodiverse
5 with AOD issues
34 with disabilities

7 in 10 had experienced restrictive practices
More than half had feared
More than half had witnessed

1 in 3 consumers who had experienced seclusion and/or restraint had also feared and witnessed their use.



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Scope & focus – What about consumers' experiences?

While the focus was on the Strategy, not on consumers' experiences, truth-telling, or acknowledgement of harms, it was not possible to discuss the strategy adequately without drawing directly on consumers' experiences, harms, trauma, and lack of trust in their mental health care. Participating consumers shared experiences and insights drawn from the worst and most challenging times of their lives.

We owe it to the participants to acknowledge and value their experiences.

Every shared insight is based on traumatic experiences of legal and illegal seclusion or restraint, a failure of care, and loss of trust in the mental health system.

Consumer power, agency, & choice

Consumer voices are marginalised in system and service design and regulation, staffing guidelines and training, monitoring of public health service data

Underlying this gap

- compulsory treatment policies breach consumer rights
- a lack of consumer choice
- limited access to non-clinical and/or independent support, advocacy, and agency

Acknowledge and address consumers' lack of trust

Consumers have a profound desire to prevent others from experiencing similar trauma

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Context
Traumatic for all and shapes experiences of care

7461
Total number of recorded restrictive practices in Victorian mental health services 2020–2021

There is no place for restrictive practices in a safe, rights-based, health system
VMIAC, peak body for mental health service consumers in Victoria.

- Violent, scary, traumatic - like nothing ever experienced, not expected from seeking help
- Breach human rights, cause injury, even death
- Open to abuse
- Most in-patient consumers witness restrictive practices
- Fear and threats are used to control behaviour and gain compliance, often when there is no risk

"It was like a nightmare, like I imagined being in jail was like. I couldn't believe what they were doing to me. I couldn't understand why they thought it was necessary and why they didn't care about me."

Unconsidered impact on:
- healing, recovery, the experience of care.
- future help-seeking
- Clinicians, nurses, peer workers, supporters, the community

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Consumer recommendations 8 Key points

1. Immediate action can and should be taken to prevent further trauma

Seclusion and restraint are violent, dehumanizing, alienating and scary.

- Risk injury, even death
- Cause lasting trauma
- Often used illegally – clinicians do not follow existing legislation and many breaches are not investigated.
- Too many documented cases of poor and illegal practice

Immediate change to bad practice is possible:

- **Close all seclusion rooms and ban seclusion**
- increase the threshold for restraint to match other settings and citizens.

Leadership is needed to guide and reform decision-making and practices

- compulsory external review and investigation for any use of restrictive practices.
- Consumers who have been secluded or restrained should not have to continue to be cared for by those who have administered it.

If fail to change – reasons must be provided and oversight imposed – consumers' human rights must be prioritised.

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Consumer recommendations 8 Key points

2. Trauma-informed care

Workforce responses to psychological distress and trauma are poor at all levels and settings of the system.

- The narrow biomedical model does not respond appropriately to psychological distress and human behaviour.
- Standard clinical approaches are not consumer-centred and fail consumers, supporters, communities, and clinical and allied workforces.
- Separation of in-patient mental health care from consumers' ongoing mental health care is damaging and produces repeated trauma

"The use of restrictive interventions has been linked to retraumatisation of past experiences, serious injuries and even death."

…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.

Chief Psychiatrist. (2014). *Guideline: Restrictive interventions in designated mental health services.* Victoria, Department of Health

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Consumer recommendations 8 Key points

3. Limit the power of clinicians to order seclusion or restraint – enforce and review use only as a last resort until all use is eliminated

Clinicians in Victoria over-use their legislated powers to make compulsory treatment orders, make decisions for consumers, and over-ride consumers' preferences.

- seclusion and restraint have become accepted routine practice not a last resort
- Clinical training leads to seclusion and restraint frequently being the first and only response to psychological distress (including paramedics, policing, ED, Inpatient).

Limit power to direct police & security to act differently than with other citizens.

- Prevent restraint and seclusion in response to psychological distress without threat of violence, 'in case'
- Train specialist mental health security staff to increase understanding, reduce stigma and abuse

Over-emphasizing risk is a barrier to evidence-based alternatives and re-examining clinical practices, education, and complaints processes

- Extreme, unrepresentative anecdotes of consumer violence are used to justify use
- Clinicians and services have not widely reduced restrictive practices or implemented known alternatives or prevention. Consumers are the experts on their needs and experiences and reform must be co-designed.

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Consumer recommendations 8 Key points

4. Trigger consumer advocacy and independent oversight with every use of seclusion or restraint

The closed system of clinical governance is not working:

- Those who administer seclusion and restraint also control recording and reporting it – consumer voices are not included, there is no independent review unless a complaint is made
- Many complaints are dismissed as clinicians have the legal power to seclude and restrain and control the written records of incidents, behaviour, medical history
- Many complaints reveal inaccurate, incomplete, and biased patient records. Consumers have no right to have their records revised on review.

Supported consumer decision-making and automatic consultation of consumer advocates is needed to prevent abuses of clinicians' power to impose seclusion and restraint and to challenge clinical control of patient records.

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Consumer recommendations 8 Key points

5. Tighter regulation at service level.

- Use increasingly lower KPIs for use of seclusion and restraint until elimination
    - apply special measures for service-level failure to meet KPIs
- Ban restraints known to be potentially fatal.
- Train security and police to minimise restraint until eliminated.

6. Prioritise accountability and transparency

Independent oversight and review.

Extend data collection and compulsory reporting, including for priority groups.

- Independent data collection for all uses of seclusion and restraint to acknowledge consumers' lack of trust in clinical and service-level record-keeping and reporting.

Public and transparent data collection and reporting

- Co-design data collection with people with lived experience and independent advocacy.
- Tie reporting to evaluation of implemented reforms related to the strategy and identification of gaps and opportunities to improve
- Every action in the strategy must be monitored and evaluated at service level

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Consumer recommendations 8 Key points

7. Truth and trust.

The trauma and ongoing impact of seclusion and restraint in current and historic experiences must be acknowledged and redressed for consumers to trust in and contribute safely to systemic and service-level change.

- The Royal Commission did not focus on truth-telling and acknowledgment of harm.
- Many consumers have not been heard, believed, or acknowledged.
  - Consumer accounts are frequently doubted, gaslit, undermined, or dragged through lengthy, traumatic complaints processes that do not lead to a resolution or reparations.
- There is no guarantee that these experiences will not be repeated.
- Many consumers have a genuine fear that complaint will lead to them receiving poor treatment in future mental health care.

Katterl, Simon et al. (2023). *Not Before Time: Lived experience-led justice and repair.* Advice to the Minister for Mental Health on Acknowledging Harm in the Mental Health System. Melbourne.

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Consumer recommendations 8 Key points

8. Service re-design and change must be rights-based, consumer-led, inclusive, and culturally safe.

Expand the biomedical model and narrow psychiatric focus on medication to include more therapeutic options, better communication, cultural access and safety, supported decision-making and consumer choice.

This recommendation is not broad, non-specific, or indirectly related to the use of seclusion & restraint. It is a specific targeted action:

Current poor practice based on the biomedical model:

- involves routine seclusion and restraint, including scheduled restraint.
- fails to prevent or respond to psychological distress and agitation
- increases the likelihood of restrictive practices being used.

Many Aboriginal people have complex trauma…. A model of care that is focused on healing, social and emotional wellbeing and cultural safety is what works for Aboriginal people."

VACCHO, the Victorian Aboriginal Community Controlled Health Organisation

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Prevention & alternatives from lived experience
Simple, accessible, effective, proven

1. Trauma and psychological-distress training

Many mental health consumers have a history of trauma

- This may include the trauma of past seclusion or restraint
- Past trauma has known, predictable effects on current responses to triggering and traumatic settings and experiences including seclusion and restraint
- Much staff training in behaviour management is limited to how to restrain patients.

Train and/or employ mental health workforce to respond appropriately to psychological distress, be knowledgeable about trauma responses and trauma-informed care:

- Clinical staff, including psychiatrists and ED teams
- Allied health and peer workers
- Police and security
- Ambulance services and CAT teams.

"Seclusion and restraint were incredibly counterproductive and damaging for me. I think they could have been prevented if the environment had been calming, if I had not been left alone, and if a compassionate practitioner had built rapport with me."

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Prevention & alternatives from lived experience
Simple, accessible, effective, proven

2. Close all dedicated seclusion rooms

- Ban seclusion.
- Prohibit the design and building of seclusion rooms in new builds.
- Stop ordering de facto seclusion.
- Stop threatening seclusion to gain compliance.
- Consumers have a right to continuous care and company when suicidal or highly distressed.

"Seclusion is creating more detriment to a person's recovery... I was put in there because I attempted suicide but I shouldn't be punished for that."

"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"

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Prevention & alternatives from lived experience
Simple, accessible, effective, proven

3. **Stop using restraint as standard** for specific settings and/or diagnostic categories, regardless of current behaviour and circumstances.

Ban routine use of restraint:

- in police responses to mental health calls
- in transport
- as first resort in EDs
- as planned treatment for eating disorders
- for presentations of agitation or distress, especially for First Nations people, people from CALD communities with interpreter needs, people with disabilities affecting communication (including the Deaf community)
- Ban induced coma and intubation in response to agitation and distress
- Planned and routine restraint leads to stigmatisation of consumers by the workforce

Increase use of patient records to meet consumer preferences, past reactions to medication etc, including advanced and current care directives – not to pre-empt use of seclusion or restraint.

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4. De-escalation

Require training and routine use of tested de-escalation and distress-prevention techniques across roles, including clinicians, allied health, police, paramedics, and security forces.

Stop "restrain first-treat later" models in EDs and elsewhere

"I am quite passive and if you just talk to me that would be great. But if I see five burly security guards running at me, I'm ready to run. When I run, that's when restraints are put on me."

5. Mental health Emergency Departments

Consumer-led design of emergency responses to mental health crisis

- Access to pre-crisis & crisis care
- non-medical therapeutic and support options; peer support

Consumers highlighted:

- Mental health EDs should be co-located with standard EDs to reduce stigma and maximise access
- Important to minimise waiting time for mental health crises, which are often triaged as being of lower risk/need than immediate physical injuries.
- EDs often treat mental health consumers as time-wasters and attention-seekers and do not provide appropriate or sensitive care, which leads to agitation and distress and increased risk of restraint in ED and seclusion on admission.
- Over-use of compulsory treatment orders if consumers are not compliant on presentation to EDs (voluntary or involuntary presentation).

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Simple, accessible, effective, proven

6. Culturally specific and safe care models and options.

- Access to First Nations support and advocacy, and prioritising Aboriginal controlled health services
- Access to translators, interpreters, and cultural support for people from CALD communities
- Higher levels of matched peer support for priority groups including for
    - Deaf and hard of hearing people, Deaf-blind people.
    - People with communication disabilities

7. Respectful, trustworthy communication

Require clinicians to fully inform consumers about their care and options, and respect consumer questions and preferences

- make supported-decision-making standard for compulsory and voluntary treatment
- increase and enforce use of advanced and current co-designed care statements.
- In training and case review, address bias to interpret consumer questions and preferences as ‘non-compliance’ or ‘attention-seeking’ - this increases the likelihood of being secluded or restrained and forcibly treated.

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8. Limit clinician/nursing power

- Address over-use of compulsory orders when consumers disagree with treatment plans as this directly leads to agitation and distress and increases the likelihood of seclusion and restraint
- Provide service delivery guidelines and external review for all use of restrictive practices
- prevent clinical staff from directing police and security staff to apply looser criteria for restraint for people with mental health challenges than in the criminal justice system and other settings
- Infringing a human right by secluding or restraining does not mean all other rights to dignity, respect, to be informed, to be involved in decision-making, should also be breached

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Prevention & alternatives: in-patient settings
Simple, accessible, effective, proven

1. Consumer expectations

Orient consumers to care settings – in person, and by providing information about the setting and procedures

- Including ready access to matched advocacy and support for priority groups
- Peer workers are ideal for this role – combining orientation with support and advocacy that is empowering for recovery and healing.
- Providing information packs to consumers' friends, family, and carers would help them to provide and seek support, during and following admission

"I realised there were two extra security guards standing behind her. Next thing I knew they had come over and forced the injection on me. I was an older lady who had difficulties moving. This was unnecessary. I felt like I had been assaulted and I sat there crying afterwards."

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Prevention & alternatives: in-patient settings
Simple, accessible, effective, proven

2. **Provide independent and/or consumer advocates** as standard across health settings

Consumers report that being connected to advocacy:

- shortens admission times, shortens compulsory orders, increases consumer consultation and communication, increases consumer choice
- Can lead to being 'punished' and treated as oppositional and non-compliant.

Independent advocacy should be triggered with any use of seclusion or restraint in EDs and wards, at minimum. This would help to:

- destigmatise consumers seeking advocacy and support
- Normalise importance of human rights in settings where consumer rights are commonly breached
- Diversify the professional balance in hospital settings – reduce clinical dominance and control
- Encourage a holistic approach to mental health care.

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Prevention & alternatives: in-patient settings
Simple, accessible, effective, proven

3. Reform mental health nursing models and role descriptions and/or diversity of in-patient care roles

In-patient wards and standard mental health nursing models are experienced as:

- Non-therapeutic
- Distressing
- Unsupportive and uncommunicative, isolating
- Compliance and medication-centred, focused on observation and checklists

Acknowledging consumer experiences is:

- vital for clinicians to understand consumers' responses to them in these settings
- vital for clinical reform at the service and system level, including service design, clinical education and training, workforce models and balance
- reveals the personal and professional support that should be available to clinicians.

Re-train mental health nurses and create additional non-nursing roles to provide consumer support, communication, advocacy, therapeutic care, and continuity of care.

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Prevention & alternatives: in-patient settings
Simple, accessible, effective, proven

4. In-patient daily life

Address key factors to prevent agitation and distress that lead to seclusion or restraint:

- in-patient boredom
- lack of communication with staff and supporters
- lack of access to therapeutic care
- over-control of consumer choice and autonomy in the practices of daily life (e.g., phone use, access to supporters, access to food, smoking and/or nicotine replacement)

Implement best practice in management of co-occurring AOD issues and/or provide separate services for AOD-related crises and consumers experiencing addiction and withdrawal.

5. Less medicalised environments

To prevent and respond to distress and help consumers to manage their own experience off ill-health and recovery, humanise clinical settings with access to:

- Quiet spaces
- Outdoors; Exercise; Activities
- Comfortable shared spaces with support and attention to gender and sexual power imbalances
- Not 'hospital colours' and design
- Maintained facilities
- Access to safe rooms and wards, secure from gender-based and sexual violence

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Prevention & alternatives: in-patient settings
Simple, accessible, effective, proven

6. Implement non-clinical and/or multi-disciplinary models of inpatient mental health care including

- peer workers and advocates
- allied health
- non-clinical case managers and supported decision-making

7. Independent debrief and addressing trauma of past and current seclusion and restraint

- Acknowledge immediate and longer-term impact on healing, trust, health care, and future help-seeking

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Consumer concerns about the strategy

Consumer-led strategy?

- Will consumer voices genuinely inform the strategy?
- Will clinician and workforce concerns continue to dominate and limit system reforms?
- The strategy must guide the workforce to accept and listen to consumers' experiences and respect consumer rights to have a say in their care
- Will there be an ongoing forum for consumers to share experiences and insights?

Funding commitment?

- Will funding limitations limit the success of the strategy?
- Will access to pre-crisis mental health services be improved?

Power and control in the changing system?

- Will psychiatrists' control over consumers' rights have appropriate oversight?
- What consequences will there be for services that don't improve?

Acknowledging trauma – truth and trust

- Will the misuse of seclusion and restraint, and its effects, be acknowledged? Will consumers have improved access to advocacy, independent complaints mechanisms, and compensation?

Definite actions

- Over-general strategies are ineffective. Include specific recommended actions for services to implement, evaluate and report progress

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Hold the perspectives of people with lived experience at the centre

Ask yourself:

HUMAN RIGHTS

CONSUMER AUTONOMY

COMMUNICATION

TRUST

TRAUMA-INFORMED

INDEPENDENT OVERSIGHT

POWER

- Are these actions trauma-informed?
- Do these actions maximise consumers' rights?
- Will these actions increase consumers' trust in the system?
- Do these actions recognise and address the harm and trauma experienced by consumers?
- Do these actions address gendered and sexual violence?
- Do these actions address discrimination and cultural safety?
- Do these actions address the experiences of First Nations peoples, people from culturally and linguistically diverse backgrounds, refugees, people with a disability, LGBTQIA+ people, gender diverse people, neurodivergent people, people without access to housing and social and economic supports?
- Will these actions have an immediate impact on poor practice and the use of seclusion and restraint?
- Will these actions prevent unjustified and inappropriate use of seclusion and restraint in the short, medium, and longer term?
- Will these actions ensure minimum standards?
- Do these actions support consumer preferences and decision-making in mental health care?
- Do these actions embed genuine co-design of services, practices, and reform?
- Do these actions address consumers' key concerns and experiences?
- Do these actions ensure adequate independent oversight from a consumer perspective?
- Will these actions support clinicians and mental health nursing to reform practice, including providing clear practice guidelines, training, and trauma –informed workforce support?
- Do these actions address change at all levels of leadership and the workforce?

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Translating recommendations from lived experience into actions

Leadership & Culture

- Mandatory staff training for de-escalation, safety drills, alternatives to restraint, minimising restraint.
- Mandatory staff training with peer support workers with a range of lived experience to share lived experience. and re-humanise people with mental health challenges
- Consumer advocacy involvement across all settings.
- Facilitate independent oversight and reporting.
- Develop and implement service-level guidelines for multi-disciplinary care, working toward elimination, and acknowledging trauma.
- No-one turned away - prevent services meeting KPIs for seclusion and restraint by refusing to treat.

Environment & Infrastructure

- Immediately close seclusion spaces, no new seclusion spaces, including de facto seclusion (e.g., in own room).
- Minimum seclusion standards before seclusion eliminated.
- Create calming physical, therapeutic, and living environment, including access to secure outside areas, activity and exercise, sensory modulation, appropriate shared spaces, voluntary retreat and privacy.
- Prevent over-crowding.
- Manage social power imbalances in space use including gendered violence and control of facilities, and sexual violence (e.g., secure spaces for vulnerable people and/or those that feel at risk).

Best Practice

- Trauma-informed practice, use of de-escalation and effectively respond to psychological distress across roles and settings.
- Ban psychological restraint (i.e., threats) immediately.
- Ban physical restraints known to be potentially fatal.
- Minimum standards for restraint prior to elimination, including banning punishment or control. Enforce last resort principle.
- Change risk assessment approach, safeguard choice, safety, trust.
- Improve communication with consumers, continuity of care, supported decision-making, enforcing advanced directives.
- Provide continuous support and compassionate relationship-building– no consumer left alone when support is needed.
- Use evidence-based exemplars for elimination.
- Acknowledge and address the traumatic impact of seclusion and restraint in practice.
- Implement mental health EDs.

Cohort-specific responses

- Improve systems and culture to be culturally safe, including people who are: from First Nations communities; CALD communities; the Deaf, Deaf-blind and hard of hearing community; neurodiverse; have disabilities; LGBTQIA+; and/or gender diverse.
- Improve systems to counter discrimination, including based on racism, culture, sex, gender, sexuality, or disability. Co-design services and anti-discrimination policies.
- Fund advocacy and outcome monitoring for priority cohorts.
- Provide matched peer and community supports, including translators and supporter liaison.
- Follow-up care and services for people without housing and social supports.
- Specific approaches for people with AOD needs.

Data & Accountability

- Monitored KPIs for all forms of seclusion and restraint, increasingly lower maximum rates until elimination.
- Mandatory notification of independent advocate with seclusion or restraint.
- Mandatory reporting of restraints and diversionary actions in EDs - particularly with priority cohorts (including threat of restraints, non-medical induced comas, and forced use of medication).
- Random independent inspections.
- Mandatory detailed public reporting at service level.
- Special measures for services with high rates of use or failing KPIs.
- Acknowledge and compensate for trauma and injury.
- Capture information on priority cohorts.

Workforce

- Minimum consumer:staff ratios.
- Consumer-led alternative service design.
- Training and practice guidelines for trauma-informed care, responses to psychological distress, maximising human rights, minimising seclusion and restraint, preventing dehumanisation and stigmatisation of consumers, minimising use of restraint and types of restraint until elimination.
- Matched peer workers, greater peer presence and integrated roles.

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Translating recommendations from lived experience into actions

Leadership & Culture

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Translating recommendations from lived experience into actions

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- Minimum consumer:staff ratios.
- Consumer-led alternative service design.
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- Matched peer workers, greater peer presence and integrated roles.
- Expand access to therapeutic options, allied health.

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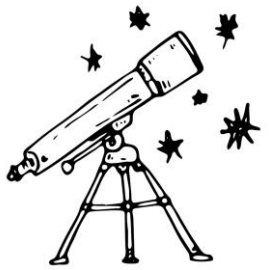
Consumer recommendations

Overview of what matters to consumers: vision, principles & actions

Vision

- Safety for everyone, all consumers
- Fairness, equity and anti-discrimination
- Adequate funding to support best practice
- Consumer autonomy
- Therapeutic services for healing and recovery



Principles

- Change must be consumer-led and consumer-centred
- All consumers have human rights, consumers are diverse
- Consumers are the experts about their own lives and can make decisions and choices about care
- Mental health services must be amply funded
- Mental health services must be accountable
- Practice must be based on non-selective evidence and consumer-led preferences

Actions

- Take immediate, evidence-based action to end seclusion and progressively limit restraint
- Improve access to culturally safe, adequate clinical and non-clinical services to prevent mental health crises
- Implement minimum standards for facilities, staffing levels, training, follow-up, trauma care
- Increase monitoring, regulation and independent oversight of restrictive practices – for elimination
- Change at all levels of leadership and the workforce

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Selected references

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