VMIAC Submission in response to the Victorian Department of Health's Discussion Paper on the draft Strategy towards the elimination of seclusion and restraint

24th July 2023

Acknowledgement

VMIAC works across Victoria and acknowledges the Traditional Custodians of the lands.

We acknowledge Victoria's First Nations communities and cultures pay our respects 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 communities.

We acknowledge that First Nations sovereignty over this land was never ceded.

VMIAC supports the Uluru Statement from the Heart.

About VMIAC

The Victorian Mental Illness Awareness Council (VMIAC) is the peak body run by and for Victorian mental health consumers. By *mental health consumers* VMIAC means people with lived experience of mental health challenges, trauma, or emotional distress, who may have accessed mental health or related services to support their wellbeing.

Our vision is a world where all consumers stand proud, live a life with their choices honoured and their rights upheld, and where these principles are embedded in all aspects of society.

VMIAC support extends state-wide across metro, rural and regional communities. We provide individual and systemic advocacy to consumers with psychosocial disabilities, using a rights-based approach, to ensure their rights and freedoms are exercised.

VMIAC's program of work includes leading:

- systemic policy advocacy and campaigning
- consumer lived experience-led individual advocacy support
- consumer lived experience-led NDIS-related information and support
- training and consumer lived experience capacity development
- a Lived and Living Experience Workforce (LLEW) program
- consumer lived experience community engagement events and opportunities
- consumer lived experience-led research and research project support
- consumer lived experience secondary consultations
- operation of a state-wide consumer register

Contents

Our submission

This VMIAC submission to the draft strategy is informed by:

- consumer engagement on the Victorian Department of Health's draft Strategy Towards the Elimination of Seclusion and Restraint, including 42 interviews and 40 survey responses.
- a rapid review of literature related to the elimination of seclusion and restraint in public mental health systems, including consumer perspectives and recommendations for effective implementation of strategies to eliminate seclusion and restraint.
- VMIAC's Seclusion Reports and their critical evaluation of available data and key gaps in data collection about the use of restrictive practices in Victoria.

VMIAC partnered with Victorian Aboriginal Controlled Community Health Organisations (VACCHO) in the consumer engagement, and we also acknowledge the contribution of Deaf Victoria who supported this engagement process.

We also thank the consumers with lived experience of seclusion and restraint who participated in the engagement and those who are contributing to the Department's External Working Group on the Strategy. Only through the determination of those willing to share their stories can we truly learn how to improve mental health systems and processes to be supportive rather than harmful.

What are seclusion and restraint? Defining terms.

People with lived experience do not often describe their experience in the same terms as those used by legislators, policy makers, researchers, clinicians, and service providers. For Victorian policy makers and others, seclusion and restraint are the kinds of restrictive practices defined in legislation that empowers clinicians to breach mental health service consumers' human rights by restricting their freedoms.

For people with lived experience, seclusion means being left alone in a room against their will. Often, it means having all their belongings removed and taken away. Clothing might be forcibly removed, people may have no sheets or blankets on a mattress, and people may have no ready access to a toilet, food, or water. People with lived experience describe this as being like they imagine solitary confinement in prison to be. It is traumatic and not experienced as health care.

Restraint can be physical, mechanical, chemical, or psychological. For people with lived experience, this means being held against their will, shackled, or strapped to a bed or being given medication to manage behaviour. It also means feeling threatened or scared, so they comply with others' decisions.

Overview – the foundations of reform

The use of seclusion and restraint in mental health care is a breach of people's fundamental human rights and must face the utmost scrutiny. VMIAC does not condone the use of restrictive practices and we maintain that 2031 is too long to wait to eliminate them. However, we acknowledge significant reform is needed for this to occur. We argue a reformed system must be built on four foundations: human rights, holistic, safe, health-led, and person-centred care, supported decision-making, and valuing the voice of consumer lived experience. These four foundations are interdependent – the strength of each relies on the others to be effectively implemented.

Human rights and legislative change

Restrictive practices, including seclusion and all forms of restraint (physical, mechanical, chemical, and psychological) violate consumers' human rights to liberty, autonomy, equality before the law, bodily and mental integrity, and, at times, the right to protection from torture and other cruel, inhumane, or degrading treatment.[1] These fundamental rights should only be limited in exceptional circumstances and for the shortest possible time.

VMIAC believes that changes must be implemented in Victorian mental health services immediately to steadily reduce and ultimately eliminate the use of restrictive practices by 2031. Victoria has the highest rate of restrictive practices in Australia, with 2,472 reported instances of seclusion in 2020-2021 in Victorian mental health services and 4,889 episodes of bodily restraint.[2] These figures do not include the use of restrictive practices in other mental health system settings including policing, ambulance transport services, and hospital emergency departments, where there is no requirement to record instances of restrictive practices.

Holistic, safe, and person-centred care

VMIAC have heard from consumers that treatments they received while on a compulsory order or receiving voluntary acute mental health care frequently caused further harm and have an ongoing impact on healing, recovery, experience of care, and future help-seeking. Consumers rarely receive any form of debriefing or follow-up after experiencing seclusion or restraint.[3]

Treatment should be safe in the broadest sense, including psychological and emotional safety, as well as physical safety. Seclusion and restraint are violent, scary, and traumatic.[4] Consumers describe their experiences as outside the realm of anything else they have experienced and not what they expected when seeking help and support. Furthermore, consumers tell us fear and threats related to seclusion and restraint are commonly used to control consumer behaviour across mental health system settings and to gain compliance, often when there is no risk of harm to the consumer or others.[5]

Our system is currently premised on risk aversion and concern about the 'harm' consumers might do either to themselves or another. This leads to treatments often singularly focused on preventing risks of harm, rather than seeing people as whole with varied, unique needs and values. It also leads to practices open to misuse and which are inadequately monitored.

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[1] *Victorian Charter of Human Rights and Responsibilities 2006* (Vic) ss 21, 8 & 10; *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, A/RES/61/106 (entered into force 3 May 2008) arts 12, 14, 15, 17 & 18.
[2] VMIAC, *Seclusion Report 3* (Report, 2022) 54.
[3] Hannah Butterworth, Lisa Wood and Sarah Rowe, 'Patients and staff members' experiences of restrictive practices in acute mental health inpatient settings: systematic review and thematic synthesis' (2022) 8(178) *BJPsych Open* 1, 4.
[4] Ibid, 3.
[5] Lisa M. Brophy et al, 'Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups' (2016) 10(6) *International Journal of Mental Health Systems*, 1061 – 1062.

Supported decision-making.

Supported decision-making requires that clinicians take the time to speak with consumers and understand what they want and need, what they are concerned about, and their treatment preferences. Consumers have noted health-led, consumer-centred, trauma-informed responses to the experience and expression of psychological distress is a more hopeful response to situations where seclusion and restraint are currently used. Consumers say that many experiences of seclusion and restraint are related to them being subjected to compulsory treatment that is against their will and preferences. Therefore, reducing the use of compulsory treatment is an important step to eliminate the use of restrictive practices. An approach that puts supported decision-making at the centre of clinical practice would reduce the likelihood of consumers' decision-making and autonomy being unduly restricted and would help to uphold their human rights.

Valuing the voice of lived experience

VMIAC believes including lived experience voices in all reform planning and implementation will help create a system that consumers can trust.[6] System reform, including the elimination of seclusion and restraint, must be driven by those most affected by the changes.

This should include lived experience, co-design, and co-production of alternatives to seclusion and restraint, as well as other improvements in service design. Consumers are still largely excluded from reform processes that drive substantive system and service design, regulation, workforce planning, training, practice guidelines, and monitoring of public health service data. Underlying this is the continuing dominance of the biomedical model and a greater resort to compulsory treatment in Victoria than in other jurisdictions.[7]

This clinical culture works against consumer choice and involvement in mental health care, limits access to non-clinical and independent support, advocacy, agency, and under-values consumer preferences in system reform, including the role of peer workers. Most consumers specifically identified the presence of peer workers in inpatient services as essential for reducing the likelihood of seclusion and restraint being used. This was due to peer workers facilitating better communication with consumers, involvement of consumers in their own care, support for consumers beyond pharmacological treatment, and broadening the type of and approach to support provided for an acute mental health crisis.[8]

Mental health system reform must also incorporate acknowledgement and redress for past and current harms to consumers. Seclusion and restraint are associated with trauma, physical injury, and even death. Every insight shared in our consumer engagement was based on traumatic experiences of lawful or unlawful seclusion or restraint, a failure of care, and loss of trust in the mental health system. Consumers consistently raised the importance of acknowledgement and apology for harms, and genuine commitment by Government to them not being repeated.

For many consumers with a lived experience of seclusion and restraint, or who have witnessed, or feared seclusion or restraint, rebuilding trust in the system is essential for them to seek mental health support into the future before, or when it becomes acute. Only through taking immediate steps toward building a responsive and trustworthy mental health system can we reduce the likelihood of acute situations when seclusion and restraint are likely to be used.

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[6] Sophie Isobel et al, 'What would a trauma-informed mental health services look like? Perspectives of people who access services' (2021) 30 International Journal of Mental Health Nursing 495, 498 – 499.
[7] VMIAC, above n 2, 55.
[8] Lisa Brophy et al, 'Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings' (2016) 40 Australian Health Review 599, 602.

VMIAC Response to Department of Health Consultation Paper

Draft vision for the strategy

Please see our feedback on the following statements (see pages 23 to 24 of our submission for context):

- 'why' statement - the vision: 'Committed to human rights and centred on lived experience, Victoria's mental health and wellbeing system promotes healing and strives toward eliminating seclusion and restraint by 2031'.
- 'how' statement - how the vision will be realised: '…through a system that is safe for all, has clear accountabilities, and is properly resourced to provide compassionate, equitable, culturally safe, evidence-informed therapeutic care, in partnership with consumers, carers, and all those who work in it.'

Does the 'why' statement reflect everything you feel it should?

No

VMIAC recommends using the following wording in this statement to better reflect the intention of the Royal Commission to eliminate restrictive practices by 2031:

> '*Committed to human rights and centred on lived experience, Victoria's mental health and wellbeing system promotes healing and* ***pledges to*** *eliminate all seclusion and restraint by 2031'*.

Does the 'how' statement reflect everything you feel it should?

No

VMIAC recommends adding 'trauma informed' to this sentence so it reads as:

'…through a system that is safe for all, has clear accountabilities, and is properly resourced to provide compassionate, equitable, ***trauma informed****, culturally safe, evidence-informed therapeutic care, in partnership with consumers, carers, and all those who work in it.'*

Draft principles for the strategy

How important are each of the principles described in the discussion paper?
Why have you nominated these as important or less important?

1. Lived experience-led: people with lived experience of mental illness or psychological distress, family members, carers, and supporters, as well as local communities, drive the planning and delivery of mental health treatment, care, and support services.

(1) VMIAC believes this is very important. However, we recommend people with lived experience of restrictive practices (including being threatened with them or witnessing their use) are the focus of this principle and are the drivers of planning and delivering mental health treatment, care, and support services.

We are the only stakeholder who is subjected to or threatened with restrictive practices and breaches of our human rights. People with lived experience as carers or supporters (or local communities) do not have the same experience and do not have as much at stake in this issue.

An amendment could be:

"Lived experience-led: people with lived experience of mental illness or psychological distress, ***will drive*** *the planning and delivery of mental health treatment, care, and support services.* ***This should be done in consultation with family members, carers, and supporters, as well as local communities."***

2. Appropriately resourced system: services and the workforce are well-resourced to provide responsive, high-quality treatment, care, support, and opportunities for healing.

(1) VMIAC believes this is very important. However, we would like to see the Lived Experience workforce included in this principle alongside mainstream clinical workforces, as well as a focus on advocacy.

"Appropriately resourced system: services and the ***workforce (including Lived Experience workforces)*** *are well-resourced to provide responsive, high-quality treatment, care, support, and opportunities for healing and* ***advocacy****."*

3. Collaboration and communication: in all parts of the system, there is a commitment to listen and learn from and with others, and an openness to change and adapt to new opportunities and understandings.

(1) VMIAC believes this is very important. We would like to see consumers as system stakeholders recognised here in the wording. An amendment might be:

"Collaboration and communication: in all parts of the system, there is a commitment to listen and learn from and with others ***(including consumer service users****), and an openness to change and adapt to new opportunities and understandings."*

4. Embracing First Nations wisdom: Aboriginal and Torres Strait Islander communities have thrived for 80,000+ years and have a deep understanding of Social and Emotional Wellbeing. The mental health and wellbeing system values Aboriginal and Torres Strait Islander ways of knowing, being and doing.

(1) VMIAC believes this is very important.

However, it is not enough to 'embrace' the wisdom from Aboriginal and Torres Strait Islander people. The Strategy must include clear steps to ensure this wisdom is truly valued and is incorporated throughout the Strategy, otherwise this principle is simply tokenistic. This might include requirements for Reconciliation Action Plans in every service within the scope of the Strategy over its duration. We suggest an amendment to the Principle as per below:

"Embracing First Nations wisdom: Aboriginal and Torres Strait Islander communities have thrived for 80,000+ years and have a deep understanding of Social and Emotional Wellbeing. The mental health and wellbeing system values ***and will integrate these understandings of ways of knowing, being and doing guided by and in partnership with Aboriginal and Torres Strait Islander communities****."*

5. Equity and responsiveness to diversity: persons receiving mental health services have their individual needs – such as their gender, family circumstances, culture, language, religion, sexual and gender identity, age, and disability - recognised and responded to in a safe and sensitive way. Intersectionality is acknowledged and addressed.

(1) VMIAC believes this is very important. Similarly, as above we believe this Principle should not be tokenised in practice – but rather integrated into service provision in partnership with communities.

"Equity and responsiveness to diversity: persons receiving mental health services have their individual needs – such as their gender, family circumstances, culture, language, religion, sexual and gender identity, age, and disability - recognised and responded to in a safe and sensitive way. Intersectionality is acknowledged and ***systematically addressed within services guided by and in partnership with priority communities****."*

6. Evidence-based practice: mental health and wellbeing services use data and continuing research, evaluation, and innovation – including lived experience-led research and evidence – to provide therapeutic, recovery-oriented, trauma informed and relational care, using alternatives to seclusion and restraint.

(1) VMIAC believes this is very important, but we must be careful to ensure the evidence base is both relevant and current. There should be specific criteria for evaluating quality of evidence and a means to define and prioritise 'lived experience-led' research and approaches within the Strategy.

7. Family inclusive: family members, carers and supporters of people living with mental illness or psychological distress have their contributions recognised, respected, and supported.

(4) Somewhat unimportant

Family and supporters contribute to the mental health system in many important ways. However, family-inclusivity is not essential to all elements of reform, including the elimination of restrictive practices. What is essential is consumer choice about family inclusion. While family and supporters may be able to provide insights into the use of restrictive practices, these insights are secondary to those of people with lived experience of restrictive practices. We recommend family is only included in line with consumer will and preferences, and otherwise that family/carer/supporter needs are secondary to considerations of consumers' human rights.

8. Human rights: the inherent dignity of people living with mental illness or psychological distress is respected, and with the least possible restriction of rights and autonomy. People are free to be themselves and heal without fear of consequence or coercion.

(1) VMIAC believe this is very important. This principle should be reflected in the legislation and in the Strategy, by ensuring that all decisions which restrict a consumer's rights comply with the test for limiting rights that is set out in the *Victorian Charter of Human Rights and Responsibilities 2006.*

9. Safety for all: all Victorians – including people living with mental illness or psychological distress, their families, carers and supporters, the workforce, and the broader community – experience safety in their interactions with the mental health and wellbeing system.

(3) VMIAC believe this is neutral. As stated above, only consumers' human rights are systematically breached. This principle seems to assume that all people experience a lack of safety in the mental health system on an equal basis, which is not the case. While it is true everyone should be safe in their interactions with the mental health system, there is no need to emphasise safety for all any more than in any other health or community setting. The same

conditions and responses should apply for mental health consumers as for everyone else in any setting.

10. Transparency: at both the service and system level, data about the use of seclusion and restraint and decision-making processes that lead to restrictive practices is reported and accessible.

(1) VMIAC believe this is very important. We note there is no specificity as to where or how the data is reported. While it may not be appropriate to specify in this principle, we believe it is important to emphasise accountability and oversight of service data and decision-making processes. An amendment of the wording might be:

"Transparency: at both the service and system level, data about the use of seclusion and restraint and decision-making processes that lead to restrictive practices is reported and ***publicly*** *accessible".*

Are there any additional principles that should guide the design, implementation and monitoring of this strategy?

As mentioned under principle 10 'Transparency', accountability and oversight are key to ensuring data reporting is meaningful and are critical to monitoring the implementation of the strategy, which is listed as one of the purposes of the principles.

VMIAC recommends either including an additional principle relating to accountability and oversight or that this be incorporated explicitly under the 'Transparency' Principle.

Additionally, we believe the role of the Mental Health and Wellbeing Commission in the oversight of the system (as outlined under its objectives and functions) should be highlighted to clarify responsibility for data collection and reporting.

Finally, VMIAC also recommend including a principle related to supported decision-making. It is critical that supported decision-making underpins the reformed system. We believe this is crucial to reducing both compulsory treatment and restrictive practices and will help enable many of the recommended changes.

Draft pillars for the strategy

The discussion paper proposes six pillars (or priority areas) for the strategy. The proposed pillars are:

- leadership and culture
- data and accountability
- best practice
- workforce
- environment and infrastructure
- cohort-specific responses.

Questions for feedback:

1. Are the pillars proposed above the right priority areas for the strategy?

VMIAC agrees the pillars are the right priority for the Strategy but recommend amending some of them.

Workforce Pillar: We recommend retaining the Workforce pillar, but with some amendments. The description states:

"The mental health and wellbeing workforce has the right skills, is of the right mix, and is supported to safely use alternatives to seclusion and restraint in each setting."

We recommend including a reference to ensuring adequate resourcing due to the impact that resourcing has on the use of restrictive practices. Additionally, as well as supporting the workforce to use alternatives, we must ensure they can implement them. This will require education, training, and review of staff failures to use alternatives. Therefore, we recommend the description be amended as follows:

"The mental health and wellbeing workforce ***receives sufficient training, education and oversight to ensure they have*** *the right skills, are of the right mix,* ***and are both supported to and capable of safely using alternatives to seclusion and restraint in every setting."***

Environment and infrastructure pillar. The description of this pillar states:

"The environment and infrastructure are fit for purpose and enable therapeutic, safe and supportive care."

This description is vague and open to interpretation. It presumedly refers to the environment and infrastructure of mental health services, but this should be made specific. Additionally, 'fit for purpose' is not sufficiently clear. VMIAC recommends amending this pillar as follows:

"The environment and infrastructure ***of mental health and wellbeing services*** *enables and encourages care that is therapeutic, safe and supportive,* ***and does not support, promote or enable the use of restrictive practices."***

2. Should the strategy identify any additional priority areas to create the greatest impact and help us achieve our vision?

Yes, VMIAC believe the following pillars should be added:

Lived Experience

We believe a pillar requiring *consumer* lived experience, engagement and leadership should be added and be foundational across all pillars and actions. This would be in line with the 'Full Inclusion of Lived Experience' strategy that is set out in the six core strategies.[9]

Evaluation

We also recommend including one additional pillar, that relates to the evaluation of the Strategy. This is separate from the evaluation and monitoring at service level. This pillar should provide a timeframe within which the efficacy of the whole Strategy will be assessed, and a guarantee that the Strategy will be amended as needed if it is found to be ineffective in any of the identified priority areas, particularly if it fails to result in a meaningful decrease in the use of restrictive

[9] 'The Six Core Strategies Service Review Tool' *Te Pou* (Web page, 17 January 2021) https://www.tepou.co.nz/initiatives/least-restrictive-practice/the-six-core-strategies-service-review-tool

practices. We recommend a timeframe of 2 years to conduct the evaluation, and that evaluations are ongoing until restrictive practices have been effectively eliminated.

Which priority areas are needed to create the greatest impact and help us achieve our vision?

Potential actions

"The strategy will include actions under each pillar that will help us work towards the elimination of seclusion and restraint. These may be:

- *short, medium, or long-term actions*
- *actions at the system or at the service level*
- *actions that build on work already underway in Victoria to reduce restrictive interventions, or new ideas*

POTENTIAL ACTIONS

Thinking about what is needed to reduce and work towards elimination of seclusion and restraint, what three actions would you prioritise? Why have you nominated these? In providing your response, you may wish to include links to any literature, evidence, or examples that you think can support the development of the strategy.

ACTION ONE: Eliminate enabling factors.

In this context, we refer to practical enabling factors that, if eliminated, would materially help to reduce the use of restrictive practices. VMIAC believes physical factors, legal factors and compulsory treatment all need to be considered here.

Physical factors

VMIAC recommends taking steps to eliminate physical enablers, including seclusion rooms and mechanical restraints. In relation to seclusion rooms, we recommend the closure and repurposing of all existing seclusion rooms. While our position is that this should be done immediately, we recognise the strategy aims to eliminate the use of restrictive practices by 2031. Therefore, we recommend a staged closure of all existing seclusion rooms to coincide with target reductions, so there are fewer rooms available to seclude people in. In line with this, we also recommend that government prohibit the establishment or building of any new seclusion rooms in services.

The use of mechanical restraint has been identified as particularly problematic by consumers, and has been noted to cause physical harm, including death, on multiple occasions.[10] Given the already relatively low rate of mechanical restraint in Victorian psychiatric hospitals,[11] we recommend immediately prohibiting the use of mechanical restraint.

In addition to this, there are certain types of physical restraint that are particularly dangerous, including chokeholds and restraining a person by being positioned on top of them. VMIAC strongly recommends reviewing these practices, the research around them and relevant protocols and procedures in relation to prohibited types of physical restraint. We recommend specifically prohibiting chokeholds or holding someone down by being on top of them, and consulting consumers and people with lived experience as well as other

[10] Yvette Maker & Bernadette McSherry, 'Regulating restraint use in mental health and aged care settings: Lessons from the Oakden scandal' (2019) 41(1) *Alternative Law Journal* 29, 31.
[11] VMIAC, above n 2, 26.

experts in relation to other forms of physical restraint that are potentially dangerous or fatal in the course of designing the restraint KPIs for services.

Legal factors

Under the *Mental Health and Wellbeing Act 2022* (Vic), restrictive practices are permitted for two reasons: firstly, to prevent imminent and serious harm to the person or another; and secondly, bodily restraint is permitted in order to administer mental health treatment to a person.[12] In both instances, all other reasonable and less restrictive options must be tried and failed prior to resorting to the use of restrictive practices.[13] However, we know from the research and speaking to consumers that restrictive practices are rarely used as a last resort, and are often used to gain consumer compliance rather than to prevent harm.[14]

Therefore, VMIAC recommend amending the criteria for using restrictive practices and codesigning new criteria with consumers to ensure there is no room for clinical staff to interpret (or misinterpret) the criteria. As well as being more stringent, the new criteria must ensure any use of restrictive practices causes less harm than the harm being prevented. This is in line with the 'balancing of harm' principle in the Act.[15]

We also recommend prohibiting the use of bodily restraint to administer treatment, as is currently permitted under s 127(b) of the Act. Given the work currently underway to reduce the use of compulsory treatment, we do not believe it is necessary to continue to permit the use of bodily restraint to administer treatment. In a reformed system based on supported decision-making and, at worst, treating consumers in line with their will and preferences where supported decision-making has failed, there is no place for the use of bodily restraint in administering treatment - unless it has been expressly consented to in an advance statement.

Compulsory treatment

Consumers have identified a strong link between the use of compulsory treatment and restrictive practices. This point was also acknowledged by the Royal Commission in its Final Report, where it noted compulsory treatment can cause agitation and frustration for patients, which staff may respond to by using seclusion and restraint.[16] This can particularly be the case when the consumer had not agreed or complied with recommended treatment in the order.

That is, when consumers question a treatment plan, their autonomy and preferences are interpreted as a lack of compliance and/or a lack of capacity and met with forced seclusion or restraint and compulsory admission or treatment. Many consumers told us they learned to 'comply' in inpatient settings, rather than receiving therapeutic support for their recovery.

The Royal Commission recommended reducing the use of compulsory treatment, and we note work is currently underway to do that. Change does not happen in a vacuum and therefore when considering steps to reduce and eliminate restrictive practices, we must also consider how compulsory treatment is used.

VMIAC recommend working with services to assist them in reducing the use of compulsory treatment, and when the work to reform the compulsory treatment laws has been completed, we recommend ensuring that the Strategy operates in tandem with the reforms

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[12] *Mental Health and Wellbeing Act 2022* (Vic) s 127.
[13] Ibid, s 128.
[14] Lisa M. Brophy et al, above n 5, 1061 – 1062.
[15] *Mental Health and Wellbeing Act 2022* (Vic) s 82.
[16] *Royal Commission into Victoria's Mental Health System* (Final Report, 2021) vol, 4, 321.

to reduce the use of compulsory treatment. In addition to this, reforms VMIAC recommended to the *"Independent Review into the Compulsory Treatment Criteria and Alignment with other Decision-making Laws"* are also relevant when considering reducing restrictive practices. These reforms include using supported decision-making as a foundation for providing treatment in the system, and aligning the use of compulsory treatment with other substitute decision-making regimes that require decisions to be made in line with the consumer's will and preferences.[17]

Using supported decision-making as a foundational practice in the mental health system will empower consumers to make/communicate their own decisions, ensure they are respected in relation to their treatment preferences, and help foster their relationships with clinicians. This will help mitigate consumer frustration, which in turn should reduce distress borne out of feelings of disempowerment and confinement.

Many consumers told us their experience was that seclusion and restraint are used routinely by clinicians and even planned. They noted seclusion and restraint is often used with no regard for individual circumstances, or any reference to advanced statements. By ensuring compulsory treatment is only given in line with consumer will and preferences, clinical staff will be required to consider consumer preferences and advanced statements whenever they are treating people – including when using restrictive practices.

Recommendations:

1. *Close and re-purpose all dedicated seclusion rooms*
2. *Prohibit the inclusion of seclusion rooms in new service builds and cease their use in existing services.*
3. *Prohibit the use of mechanical restraints, which are known to be potentially fatal, in all settings (including policing, ambulance services, emergency departments, and in-patient services).*
4. *Amend the criteria for the use of restrictive practices as set out in the Mental Health and Wellbeing Act 2022 ('the new Act'), and co-design a new purpose and criteria for using restrictive practices with consumers and people with lived experience to limit clinical interpretation of the criteria, ensure that the harm being prevented is both immediate and serious, and change practice so when restrictive practices are used, they are used in the least traumatising way possible, as identified by consumers.*
5. *Implement a requirement that the use of restrictive practices must prevent more harm than it causes.*
6. *Remove s 127(b) from the new Act so that administering treatment is no longer a permitted reason for using bodily restraint.*
7. *Work with services to reduce the use of compulsory treatment, as this is strongly correlated with the use of restrictive practices.*
8. *Embed supported decision-making practices in clinical practice and mental health service provision across settings so supported decision-making and access to independent advocacy is the default. The following steps must be taken to strengthen supported decision-making, which will help to prevent the use of restrictive practices:*
    a. *Clinicians must discuss treatment options clearly with consumers, including exploring how different treatments might fit with the consumer's wants, needs and personal recovery goals. Clinicians should make every effort to collaborate with consumers, including when writing clinical records, and allow consumers to provide input or correct their records when necessary.*

[17] See, for example, *Guardianship and Administration Act 2019* (Vic) s 9.

b. *Clinicians must ensure conversations occur in circumstances where the consumer is most comfortable and permit them to have support persons present.*
c. *Ensure consumers remain active participants in the decision-making process, even if they are assessed as lacking capacity and have a substitute decision-maker appointed. This includes utilising supported decision-making wherever possible, including when substitute decision-making is permitted.*

ACTION TWO: Strengthen accountability and safeguarding.

Accountability and safeguarding must be key to the Strategy to reduce and eliminate restrictive practices. Without ensuring service accountability and creating strong safeguards and oversight of the use of restrictive practices, attempts to do so are unlikely to be successful.

Accountability

One way to ensure services accountability is by implementing service KPIs for both seclusion and restraint and to ensure these are reduced over time. The Royal Commission recommended "an immediate decrease from 15 episodes per 1,000 bed days to eight episodes for adult and forensic services, and five episodes for child, adolescent and aged services". This was to be followed by "a subsequent reduction of two episodes per 1,000 bed days every two years across all services".[18]

However, implementation of this recommended reduction quota has been slow since the release of the Royal Commission's Final Report. Despite over two years having passed, the Government only reduced the seclusion KPI to the recommended eight in October 2022, and there have been no further reductions made to service KPIs. Commitments to reduction targets must be enforced strictly by Government if we are to see change occur in services.

VMIAC recommend immediate steps are taken to reduce service KPIs so they are in line with the recommendations made by the Royal Commission. Based on the timeline that was given, this means seclusion KPIs should be reduced to six immediately. In addition, VMIAC recommend creating service KPIs for the use of restraint. Noting our recommendation above that mechanical restraint should be eliminated immediately, the targets should apply to physical restraint only. We also urge that targets and a reduction schedule for restraint are co-designed with consumers and people with lived experience.

Another mechanism for ensuring service accountability is the implementation of special measures for services that fail to meet their KPIs. We recommend establishing a Seclusion and Restraint Elimination Taskforce that includes lived experience representatives, workforce, and others with specific expertise. The core functions of this taskforce being to advise sector leaders and government on implementation of the strategy, provide a focused response and support services that fail to meet reduction targets. The Taskforce should begin with more supportive measures for services that have failed to meet KPIs and later move to stronger measures such as recommendations for funding cuts or referring services to the Mental Health and Wellbeing Commission (MHWC) to conduct an inquiry into repeated failures to meet KPIs.

Another accountability mechanism is already partly set out in the Act. Under s 133, the clinician responsible for authorising the use of a restrictive practice must document the reason it is necessary, alternatives tried or considered, and the reasons any alternatives

[18] *Royal Commission into Victoria's Mental Health System* (Final Report, January 2021) vol 4, 344.

failed.[19] While the intention of this requirement is admirable, it needs additional requirements to ensure service compliance. We recommend implementing a requirement that this documentation is sent to each of the entities that services are required to notify when a restrictive practice is used. This includes the Department of Health, the Office of the Chief Psychiatrist (OCP) and Independent Mental Health Advocacy (IMHA). We also believe the MHWC should be included in this list.

Safeguarding and Oversight

As restrictive practices are likely to continue to be a feature of the post-reform mental health system, VMIAC recommends implementing strong safeguards to ensure restrictive practices are not misused, or a straightforward option in an over-stressed system where clinicians lack knowledge and training in evidence-based alternatives.

Safeguarding

Consumers we have interviewed support a requirement of more than one clinician to authorise restrictive practices and many recommend the involvement of an independent advocate be triggered as soon as an episode of seclusion or restraint was authorised. VMIAC note the automatic involvement of independent advocates when restrictive practices are initiated is provided for in the legislation. We strongly support this and recommend the Strategy reference the opt-out non legal advocacy service.

We also recommend the role of advocates in relation to restrictive practices extend to assessing the circumstances of the consumer in relation to the criteria to determine whether, in their opinion, the restrictive practice is necessary or should be ceased. While advocates cannot force services to cease the restrictive practice, they are able to provide advice on consumer rights and remind services of their obligations to consumers – including ceasing restrictive practices when they are no longer necessary.

Additionally, the support provided by advocates to consumers when treatment decisions are being made can help self-advocacy and ensure a consumer's preferences are heard, making compulsion and coercion more unlikely, which in turn reduces the likelihood of consumers feeling overwhelmed by being forced into treatment and being secluded or restrained because of this.

Record-keeping too can play an important role in safeguarding by ensuring the use of restrictive practices is able to be accurately reported to the relevant entities. It can also give services a way to measure their own progress, thereby providing motivation to meet KPIs/targets. It is important all parts of the mental health system who may influence the use of restrictive practices are required to keep records, including first responders, ambulances, emergency departments and general health settings where consumers are being treated.

Embedding human rights in decisions related to seclusion and restraint is also important to safeguard consumer rights. The test for limiting rights set out under the Charter[20] should be embedded in the legislation, with a requirement that the test is met whenever a decision is made to seclude or restrain a consumer.

Furthermore, we recommend creating some additional rights for consumers. These include:

- the right to an immediate independent review of the decision to seclude or restrain someone.
- the right to have the restriction reviewed within a maximum, limited timeframe to ensure the criteria still apply and if not, the right to be released immediately.

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[19] *Mental Health and Wellbeing Act 2022* (Vic) s 133.
[20] *Victorian Charter of Human Rights and Responsibilities 2006* (Vic), *s 7.*

- an express prohibition on limiting other human rights such as rights to access food, water, adequate toilet facilities, or independent advocacy,
- the right to communicate while secluded or restrained,
- more generally the right to humane treatment when deprived of liberty,[21] and the right to protection from torture and cruel, inhuman or degrading treatment or punishment.[22]

Oversight

Consumers we spoke to expressed fear that without culture change, strong leadership, and coordinated requirements for monitoring and reporting restrictive practices, services will work around reporting requirements to find de facto ways to seclude and restrain them. For example, by diverting distressed people to ICU and intubating them following chemical restraint, rather than recording restraint in an emergency department and/or inpatient mental health service.

Other examples given by consumers were being secluded de facto in their own room through psychological threats, rather than secluded in a seclusion room with legal protections in terms of monitoring and reporting. Others feared they would be left to manage a mental health crisis alone, or with family, carers, or supporters, rather than being admitted and receiving support.

This suggests the need for comprehensive definitions of restrictive practices that do not allow for services to work around them. It also requires strong oversight of the use of all restrictive practices, including the willingness to take-action when needed.

The MHWC has the power to oversee and report on the use of restrictive practices under the new Act. Its objectives include:

- Ensuring the accountability of Government for the performance, quality, and safety of the system, including implementing recommendations made by the Royal Commission;[23] and
- Promoting, supporting and protecting the rights of consumers.[24]

Its functions include:

- Monitoring and reporting on the use of restrictive practices in mental health services,[25]
- Reporting on the use of restrictive practices in mental health services, including their use in comparison to the targets that are set,[26] and
- Monitoring and reporting on Government progress in implementing the recommendations of the Royal Commission.[27]

This will require regular reporting from services on the use of restrictive practices. We recommend, in addition to reporting on the rate of restrictive practices, services also be obligated to include the documentation required by s 133 including, the reason for using the restrictive practice, alternatives that were tried or considered, and why those alternatives failed. This will ensure additional accountability of services and provide greater detail to the MHWC on issues that relate to the use of restrictive practices, which will assist in the

[21] Ibid, s 22.
[22] Ibid, s 10.
[23] *Mental Health and Wellbeing Act 2022* (Vic) s 413(a)(i).
[24] Ibid, s 413(e).
[25] Ibid, s 415(h)(ii).
[26] Ibid, s 415(i).
[27] Ibid, s 415(j)(ii).

judicious use of its power to issue compliance notices to services that repeatedly breach their obligations.

Recommendations

9. *Prior to elimination, set and monitor targets to reduce the use of seclusion and restraint immediately and ensure these targets are decreased over time.*
10. *Impose special measures on clinicians and services who fail to meet targets.*
    a. *Establish a Seclusion and Restraint Elimination Taskforce that includes lived experience representatives, workforce, and others with specific expertise, to advise sector leaders and government on implementation of the strategy and provide a focused response and support to services that fail to meet reduction targets.*
11. *Include a requirement under s 133 that services send the documentation required by this section to the Department, the OCP, IMHA and the MHWC.*
12. *Implement safeguards for the use of restrictive practices, including by implementing:*
    a. *A safeguard that requires restrictive practices to be signed off by two independent clinicians.*
    b. *A review process for the use of restrictive practices by an independent advocate to help ensure restrictive practices are used for the shortest possible time until the emergency is addressed and the criteria for imposing them no longer apply.*
13. *Every instance of seclusion or restraint before elimination should trigger the involvement of an independent advocate to monitor, advise, and support the consumer and ensure the restrictive practices are administered lawfully and for the minimum possible time.*
14. *An independent advocate should be accessible when a person doesn't have anyone else to support them or where assistance with supported decision-making is needed, to prevent greater distress and increased likelihood of the use of restrictive practices following treatment decisions.*
15. *Require the test for limiting human rights as set out under the Charter is incorporated into the legislation and be met in any circumstances where a decision-maker is permitted to make decisions in relation to seclusion and restraint.*
16. *Create additional rights for consumers, including:*
    a. *The right to a second opinion on the use of restrictive practices, and for this opinion to be provided within a reasonable timeframe.*
    b. *More tightly limit the duration of restrictive practices, after which time they must be independently reviewed, and the consumer consulted.*
    c. *Explicitly prohibit the restriction of other human rights, even when secluded or restrained (e.g., access to food, water, toilet facilities, family, carers, or supporters, independent advocacy).*
17. *Ensure all forms of restrictive practices are recorded in all settings – including by first responders, ambulance services, and in emergency departments, and general health settings.*
18. *Ensure that all restrictive practices are comprehensively defined to ensure services cannot avoid reporting them.*
19. *Require any use of restrictive practices in any setting triggers a notification to the Mental Health and Wellbeing Commission ('the MHWC).*
    a. *Require clinicians to include reasons for using restrictive interventions, other less restrictive means that have been tried and the reasons those means failed as per s 133 of the new Act in any notification they send to the MHWC.*
    b. *Require clinicians to seek consumer endorsement of their written records of seclusion and restraint and alternatives to seclusion and restraint, with the support of independent advocacy as needed.*

c. *Implement independent data collection for all uses of seclusion and restraint, including for priority groups.*
d. *Co-design data collection with people with lived experience and independent advocates*
e. *Tie reporting to evaluation of Strategy implementation, identify gaps and improvement areas.*
f. *Monitor and evaluate every Strategy action at service level, with referral to the Independent Seclusion and Restraint Taskforce for failures to meet implementation milestones.*

ACTION THREE: Support workforce change

The mental health workforce must undergo critical changes if the goal of reducing and eliminating seclusion and restraint is to be realised. These changes outlined below are interdependent and must be implemented in tandem to be successful.

Culture

We know from our Seclusion Reports that the use of restrictive practices varies greatly from service to service. This demonstrates the importance of culture in influencing the use of restrictive practices. One critical ingredient is strong organisational and local service level leadership that can create and maintain cultural change.[28] In order to create this change within services, leaders must explicitly discourage the use of restrictive practices and take steps to ensure staff understand these are no longer acceptable responses to challenging behaviour. This can include, for example, motivating staff to reduce their use, by putting up posters that congratulate staff on achieving a certain number of days without the use of restrictive practices and recognising staff for their work in reducing the use of restrictive practices.[29]

Resourcing

The Royal Commission acknowledged in its Final Report that resourcing is a key contributor to the continuing use of restrictive practices.[30] In an over-stretched system, resorting to coercion and restrictive practices may seem an easier option than collaborating with someone experiencing a mental health crisis.

Several consumers told us during their experience of eating disorders that they were compulsorily fed. This involved daily, scheduled restraint, without any significant efforts from clinicians to involve them in treatment choices. When daily restraint became untenable due to limited staff resources, an alternative treatment plan that met their preferences and was effective was implemented, demonstrating that alternatives are often not explored before restraint is considered as a last resort. Importantly, many consumers who experienced restraint were traumatised by the behaviour of those administering the restraints, rather than the restraint itself. Several suffered physical injury and fear of death because of poorly administered and excessive restraint, while others experienced extended neglect of basic rights to water and toilet facilities.

Under-resourcing leads to situations where staff are unable to adequately respond to consumer needs or are more likely to respond negatively.[31] Poor communication, lack of empathy and failure to implement trauma informed practice are all factors that have been

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[28] Piers Gooding et al, 'Alternatives to Coercion in Mental Health Settings' (Literature Review, University of Melbourne, October 2018) 48.
[29] Charles C. Dike, 'Implementing a program to reduce restraint and seclusion utilization in a public sector hospital: clinical innovations, preliminary findings and lessons learned' (2020) 18(4) *Psychological Services* 663, 3.
[30] *Royal Commission into Victoria's Mental Health System* (Final Report, January 2021) vol 4, 320.
[31] Lisa M. Brophy et al, above n 5, 1063 – 1064.

identified as contributing to the use of restrictive practices[32] and can all be traced back to services that are under-funded and stretched to breaking point. Increased resourcing should include adequate nurse to patient ratios, as well as employing additional staff who can help to address challenging consumer behaviour in more positive ways and provide staff with support to implement alternatives to restrictive practices. Increased employment of psychologists, including psychologists specialising in behavioural issues, and occupational therapists have all been found to be helpful in reducing the use of restrictive practices.[33]

Education

Specialised training will be instrumental in reducing the use of restrictive practices. Recovery oriented, trauma informed practice, and positive communication (including empathy, compassion and appropriate use of language) have all been identified as contributing positively to reducing restrictive practices.[34] Many consumers we consulted with raised the importance of orienting people to inpatient services on admission to alleviate anxiety and manage expectations. This sort of communication was a key area of workforce training that was identified as needing urgent attention. Additionally, training on alternatives such as applying talk-down and other de-escalation strategies should be mandatory. This must include training of security staff in de-escalation and trauma informed practice so they are better equipped to manage and respond to mental health issues.

Alternatives to restrictive practices

Elimination of restrictive practices will not be possible without the use of carefully thought-out alternatives. These can exist along a continuum – from when someone is first admitted to an inpatient unit, to their daily interactions with staff and to the moment staff feel the need to use restrictive practices.

One study identified that it was beneficial when people were psychologically assessed on admission to develop a treatment plan, identify needs and what supports might be helpful.[35] The same study also implemented a 'behavioural intervention service' that worked with people expressing challenging behaviours such as aggression, self-injury, or problematic sexual behaviours. This service also provided behavioural consultation and worked with staff to identify alternatives to help reduce people's stress. Occupational therapists were also employed to work with consumers and they developed 'comfort rooms', equipped with sensory modulation tools and calming environments, which people were encouraged to use when they were distressed.[36] All these interventions, along with staff training and strong leadership, proved extremely effective in reducing the use of seclusion and restraint.

Supported decision-making, while not an alternative to restrictive practices, can play a role in mitigating restrictive practices by fostering relationships between consumers and staff and helping staff to better understand consumer needs.

The Safewards model has also demonstrated some success and takes a practical approach to reduce restrictive interventions but needs some further refinement.[37] VMIAC recommend a reformed version of Safewards be co-designed and co-produced with people with lived experience to address the issues with the current model.

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[32] Lisa Brophy et al, above n 8, 601; Lisa M. Brophy et al, above n 5, 1062; Hannah Butterworth, Lisa Wood and Sarah Rowe, above n 3, 4.
[33] Charles C. Dike, above n 29, 3.
[34] Lisa Brophy et al, above n 8, 602; Sophie Isobel et al, above n 6, 498; Hannah Butterworth, Lisa Wood and Sarah Rowe, above n 3, 4 – 7; Hamilton Kennedy et al, 'Consumer Recommendations for enhancing the Safewards model and interventions' (2019) 28 *International Journal of Mental Health Nursing* 616, 619 – 622.
[35] Charles C. Dike, above n 29, 3 – 4.
[36] Ibid, 3 – 4.
[37] See, for example, Hamilton Kennedy et al, 'Consumer Recommendations for enhancing the Safewards model and interventions' (2019) 28 *International Journal of Mental Health Nursing* 616.

Finally, services need a broader range of therapeutic support options available for consumers, especially priority groups, and to address environmental factors that lead to the use of restrictive practices. These include a lack of calm and therapeutic activity spaces for people to use, lack of exercise areas, and inadequate outdoor spaces.[38] Therapeutic quiet spaces could be an alternative to seclusion rooms, increasing access to calming activities that alleviate boredom[39] and implementing ways to offer consumers some control over their treatment and input into the environment.

Consumers we spoke to all advocated for access to a broader range of therapeutic options and greater respect for consumer choice in agreeing to a mental health treatment plan. Broader treatment options and understandings beyond the dominant, biomedical approach are essential for increasing consumer autonomy and decision-making, which can greatly impact the use of restrictive practices.

Recommendations

20. *Leading up to elimination, reduce and limit the use of seclusion or restraint to the most exceptional circumstances and ensure every instance is a last resort. Sector, training, and service leaders must explicitly discourage the use of any form of seclusion and restraint in service and practice guidelines and training (prior to further legislative change).*
21. *Ensure services are properly funded to provide adequate nurse to patient ratios so seclusion and restraint are not relied upon based purely on service pressure.*
22. *Leading up to and beyond elimination, sector, training, and service leaders must be provided with explicit and ongoing training in proven and evidence-based alternatives to the use of any form of seclusion or restraint (prior to further legislative change). This should include (but not limited to): trauma-informed practice, effective de-escalation techniques, responding to psychological distress, approaches to mental health emergency triage/admission, minimising police involvement in health-led responses in community, pre-qualification training for all health and allied health professionals in effective communication and supported decision-making approaches – especially psychiatrists with authority to make compulsory orders and authorise seclusion and restraint, and mental health nursing staff with authority to seek remote authorisation for these practices.*
    a. *Ensure consumer management training for all health and allied workforce, including psychiatrists focuses on proven alternatives to restrictive practices such as de-escalation, sensory modulation, supported decision-making, communication, and holistic support rather than exclusively focusing on how to restrain consumers in psychological distress.*
    b. *Train specialist mental health security staff to understand and respond to psychological distress and use de-escalation techniques.*
23. *Codesign and develop alternatives to the use of restrictive practices with people of lived experience. Ensure these alternatives are tested and evaluated with staff and continue to develop and refine them if necessary.*
24. *Review the Safewards model and amend it based on a co-design process led by consumers and people with lived experience.*
25. *Redefine and redesign clinical treatment and workforce models to include a broader range of therapeutic options and allied health services that include psychological or emotional support. This should include:*

[38] D. Rose et al, 'Life in acute mental health settings: experiences and perceptions of services users and nurses' (2015) 24 Epidemiology and Psychiatric Sciences 90, 93 – 94.
[39] Lisa Brophy et al, above n 8, 602.

a. *Immediately implementing and supporting strategies to fill quotas for integrated peer worker roles, as well as allied health and psychological services.*
b. *Providing culturally safe and appropriate services, with tailored services as identified by priority groups to support their specific needs and preferences (e.g., including First Nations community controlled mental health services, Deaf controlled mental health services, LGBTQIA+ controlled mental health services).*
c. *Ensuring services work with the newly established Statewide Trauma Service and communities with lived experience to implement trauma-informed mental health care and facilitate pathways for trauma referral and support.*
d. *Redesigning emergency departments, including practices and responses, with consumers and people with lived experience. Co-design specialist mental health emergency areas co-located within standard emergency departments that use supported decision-making and person-centred care practices.*
e. *Providing access to First Nations support and advocacy, prioritising Aboriginal community controlled mental health and wellbeing services.*
f. *Providing access to translators, interpreters, and cultural support*
g. *Higher levels of matched peer support for priority groups*
h. *Implement best practice for management of co-occurring AOD issues – including tailored service provision.*
i. *Address consumer daily life in inpatient settings, and factors leading to agitation, distress, and increased likelihood of seclusion or restraint – i.e., boredom, lack of communication with supporters and staff, sensory modulation, lack of access to therapeutic care activities, over-control of consumer agency and autonomy in daily life (e.g., access to food, smoking etc).*
j. *Less medicalised environments – provide spaces for quiet, exercise, outdoor access, community, safe areas for priority groups and enable more consumer input to the environment.*

Further comment

Is there anything further you would like to contribute to inform the future-focussed strategy? This could include other ideas you have, including those related to implementation of the strategy.

Consumer recommendations from VMIAC's consumer engagement on the Strategy

The following recommendations are exclusively drawn from consultations undertaken by VMIAC for the purpose of supporting consumers in the development of the strategy. These recommendations have been provided to the Department of Health and Working Groups supporting the development of the Strategy and will be published in a forthcoming report by VMIAC. Please note, not all recommendations made by consumers have been included here. We have included only the recommendations we believe are most relevant to this submission.

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

To do this, and prior to the elimination of restrictive practices, consult with consumers and people with lived experience in relation to how services can make people feel safe, even when restrictive practices are being used. Research describes consumers feeling safe and supported despite the use of restrictive practices when staff communicated clearly and gently, and explained everything they were doing as they were doing it. Consumers noted it was also important that staff provided debriefing, apologised, and talked through what had happened

with the consumer to help them to make sense of it.[40]

2. Trigger consumer advocacy and independent oversight with all cases of seclusion and restraint to prevent abuses of power.

We note there is already work underway to ensure the opt-out non legal mental health advocacy service is notified every time someone is secluded or restrained. We recommend referencing this work in the Strategy.

3. Tighten regulation at service level.
    a. Use increasingly lower KPIs for seclusion and restraint until eliminated.
    b. Apply special measures for clinician and service-level failure to meet KPIs.
    c. Ban restraints known to be potentially fatal.
    d. Train police and security staff to minimise restraint until eliminated.

4. Prioritise accountability and transparency.
    a. Independent oversight and review of restraint and seclusion use. The *Mental Health and Wellbeing Act 2022* (Vic) already provides for the Mental Health and Wellbeing Commission to perform this role. We recommend the Strategy make reference to this and ensures the role of the Commission is incorporated into the Strategy.
    b. Extend data collection and compulsory reporting, including for priority groups.
    c. Co-design data collection mechanisms with people with lived experience and independent advocacy.
    d. Tie reporting to evaluation of the strategy implementation, identify gaps and opportunities for improvements.
    e. Monitor and evaluate every Strategy action at service level.

5. Service re-design and reform must be rights-based, consumer-centred, and culturally safe.

6. Trauma, de-escalation and psychological distress training
    a. Across all system settings including clinical staff, psychiatrists, emergency department teams, allied health and peer workers, police and security staff, ambulance services and CAT teams.
    b. Mandated training
    c. Stop use of restrain-first treat-later models in emergency departments and other settings.

7. Stop use of restraint as standard for specific settings and/or diagnoses
    a. Prohibit routine use of restraint in police responses to mental health calls.
    b. Prohibit routine use of restraint in transport.
    c. Prohibit routine use as first resort in emergency departments due to inadequate triage policies and staffing.
    d. Prohibit routine use of restraint as planned treatment for eating disorders.
    e. Prohibit routine use of restraint for presentations of agitation or distress, especially for priority groups with a history of negative interactions with police, security, and health services, including First Nations peoples, people from CALD communities, people with a disability, and LGBTQIA+ and gender diverse people.
    f. Prohibit induced coma and intubation in response to agitation and distress in any setting.
    g. Stop restrain-first treat-later models in emergency departments and other settings.

[40] Hannah Butterworth, Lisa Wood and Sarah Rowe, above n 3, 4 – 7.

8. Mental Health Emergency Departments
    a. Implement consumer-led design of emergency responses to mental health, as this is essential to prevent over-use of compulsory orders and subsequent higher rates of restrictive practices.
    b. Co-located with standard emergency departments.

9. Culturally specific and safe care models and options
    a. Access to First Nations support and advocacy, prioritising Aboriginal community controlled mental health and wellbeing services.
    b. Access to translators, interpreters, cultural support
    c. Higher levels of matched peer support for priority groups

10. Limit the overuse of restrictive practices by clinicians
    a. Address over-use of compulsory orders, which increase the likelihood of restrictive practices being used.
    b. Provide service guidelines and external review for all uses of restrictive practices.
    c. Prevent clinical staff from directing police and security staff to apply restraint with looser criteria than for other citizens or than is set out under the Act.
    d. Ensure human rights are maximised, even during seclusion or restraint.

11. Inpatient daily life
    a. Address key factors to prevent agitation and distress that leads to seclusion and restraint – boredom, lack of communication with staff and supporters, lack of access to therapeutic care, over-control of consumer choice and autonomy in daily life.
    b. Implement best practice management of co-occurring AOD issues.

12. Less medicalised environments
    a. Prevent and respond to distress and help consumers manage their experience of ill-health and recovery.
    b. Quiet spaces, outdoors access, exercise, activities, comfortable shared spaces, management of sexual and gender power imbalances, maintained facilities, access to safe rooms and wards for priority groups.

13. Implement non-clinical and multidisciplinary models of in-patient mental healthcare.
    a. Peer workers and advocates
    b. Allied health
    c. Non-clinical case-managers and supported decision-making