VMIAC
by and for consumers

# INSIGHTS FROM LIVED EXPERIENCE TO END SECLUSION & RESTRAINT IN VICTORIA

## Findings from our engagement with people with lived experience of mental health challenges who have experienced, feared, or witnessed being secluded or restrained in Victoria's public mental health system.

*Content warning: This report discusses seclusion and restraint in Victoria's public mental health system. Seclusion means being put in a room alone against your will. Restraint means being physically held in any way against your will, threatened, or given medication to control your behaviour rather than for treatment.*

**June 2023**


**Project team**

**VMIAC**
Nicola Guerin
Alycia O'Keefe
Gabriel Aleksandrs
research@vmiac.org.au
vmiac.org.au

**VACCHO**
Robert Dettman
Janty Blair
Karen McAlear
vaccho.org.au



The project team also acknowledges the advice of Jasmine Shirrefs, Deaf Victoria


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.

VMIAC acknowledges people with lived and living experience of mental health challenges.


This work was commissioned and funded by the Victorian Department of Health, Mental Health Policy Unit, to inform their drafting of Victoria's Strategy for the Elimination of Seclusion and Restraint

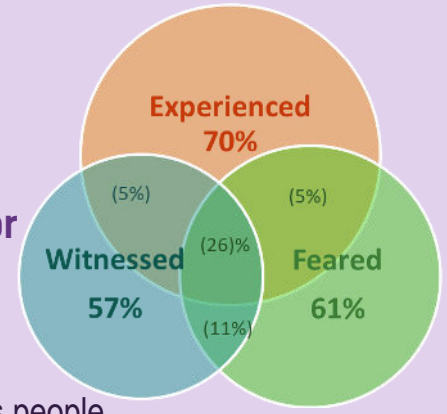
# What people with lived experience say about ending seclusion & restraint in Victoria

## Consumer engagement, April–June 2023

**42 interviews, 40 surveys**

Participants with lived experience of witnessing, fearing, or being secluded or restrained in Victoria's public mental health system

**70%**
**had been secluded or restrained**




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

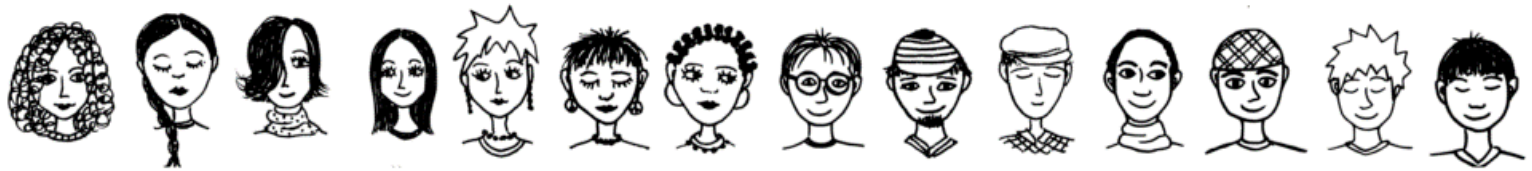
**2** First Nations people
**15** from culturally and linguistically diverse (CALD) communities

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

**31** neurodiverse
**5** with AOD issues
**34** with disabilities

## Key Recommendations

1. **Immediate action** can and should be taken. The need for change is urgent to prevent further trauma. Seclusion and restraint are violent, dehumanising, alienating, and scary. **Close all seclusion rooms and ban seclusion.**
2. **Trauma-informed care** is needed across the system, with urgent need for **training** clinicians and others in de-escalation, to respond to psychological distress, and prevent further distress.
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.
4. **Trigger consumer advocacy and independent oversight** with every use of seclusion or restraint
5. **Tighter regulation at service level.** Use increasingly lower KPIs for use of seclusion and restraint until elimination, with special measures for service-level failure to meet KPIs. Ban restraints known to be potentially fatal. Train security and police to use minimal restraint until eliminated.
6. **Prioritise accountability and transparency** with independent oversight and review.
7. **Truth and trust.** Acknowledge and redress the trauma and ongoing impact of seclusion and restraint in current and historic experiences.
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, supported decision-making and consumer choice.



vmiac.org.au
vaccho.org.au

VMIAC
by and for consumers

# Alternatives to seclusion & restraint suggested by people with lived experience in Victoria

## Alternatives to secluding & restraining people across the system – simple, effective, kind, safe

(Including with policing, crisis assessment teams, ambulance teams, hospital emergency departments, and in-patient settings).

1. **Trauma and psychological distress training** for psychiatrists and other clinical staff, allied health, peer workers, police and security.
2. **Close all seclusion rooms.** Ban seclusion.
3. **Stop using restraint as a standard response** for specific diagnostic categories, including scheduled use. All restraint must be a last resort until elimination.
4. **De-escalation** Require training and routine use of tested de-escalation and distress-prevention techniques across roles, including police, paramedics, and security forces. Stop "restrain first-treat later" models in EDs and elsewhere.
5. **Mental health Emergency Departments.** Consumer-led design of emergency responses to mental health crises.
6. **Culturally specific and safe care models.** Consumer-led and controlled service models for identified populations – including LGBTQIA+, the Deaf. Deaf-blind, and hard of hearing communities, First Nations Peoples, CALD communities.
7. **Respectful, trustworthy communication.** Require clinicians to share information, use supported decision-making including enforceable advanced statements, and respect consumer choice and autonomy.
8. **Limit clinician power.** Stop overuse of compulsory treatment, provide guidelines limiting restraint as in the criminal justice system.

## Alternatives approaches for in-patient settings

1. **Consumer expectations.** Orient consumers to care settings in person and with information (including real access to matched advocacy & support).
2. **Provide consumer advocates as standard** across health settings and as minimum, triggered with any use of seclusion or restraint
3. **Reform mental health nursing models** and/or diversity of in-patient care roles. In-patient wards are experienced as non-therapeutic, distressing, unsupportive, isolating, medication-centred, & compliance-centred. Re-train mental health nurses and/or implement multi-disciplinary models.
4. **In-patient daily life** Address in-patient boredom, lack of communication and therapeutic care, and over-control of consumer choice and autonomy in the practices of daily life. Implement best practice AOD issue management and/or provide separate services for AOD-related crises.
5. **Less medicalised environments.** Humanise clinical settings, access to quiet spaces, outdoors, exercise, activities, to prevent and respond to distress.
6. **Implement non-clinical and/or multi-disciplinary models of inpatient mental health care**, including peer workers, allied health, non-clinical case managers, and supported decision-making
7. **Independent debrief and address trauma from being secluded and restrained** – immediate and longer-term impact on healing, trust, health care, and future help-seeking,

vmiac.org.au
vaccho.org.au

VMIAC by and for consumers

# Strategy actions suggested by people with lived experience of seclusion & restraint in Victoria

## 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.

## 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.

## 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).

## 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.

## 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.

## 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.

vmiac.org.au
vaccho.org.au

VMIAC by and for consumers