Australian Government
National Mental Health Commission

A case for change:

Position Paper on seclusion, restraint and restrictive practices in mental health services

May 2015

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Introduction

In its 2012 National Report Card on Mental Health and Suicide Prevention the National Mental Health Commission recommended reducing the use of involuntary practices and working to eliminate seclusion and restraint and called for action whereby jurisdictions must contribute to a national data collection with public reporting on all involuntary treatment, seclusion and restraint each year from 2013[i].

The National Mental Health Commission also made a commitment to call for evidence of best practice in reducing and eliminating seclusion and restraint and identify alternative approaches.

This Position Paper has been developed following the completion of a seclusion and restraint project commissioned by the National Mental Health Commission and undertaken by the Melbourne Social Equity Institute of the University of Melbourne (the Seclusion and Restraint Project). The Seclusion and Restraint Project involved: an international literature review; consultations with people with lived experience of mental illness, their families and carers, mental health professionals and members of the police; analysis of legal and regulatory frameworks; and, an online survey and focus groups with people with lived experience of mental illness.

The project was steered by a project Core Reference Group, comprising representatives of people with a lived experience of mental illness, people who are carers/supporters, mental health clinicians, police, ambulance, academics and human rights experts. A list of the Core Reference Group members is at Appendix 1.

This Position Paper builds on the findings of the Seclusion and Restraint Project providing an overview of the evidence supporting best practice and presents options for reform. It describes definitions and outlines recommendations for driving action. In support of the recommendations background information is provided in relation to the incidence of seclusion and restraint, the complexity of the issue and findings from consultations with people with lived experience and families and carers.

It is important to note that the focus of the Seclusion and Restraint Project and also this Position Paper is on seclusion, restraint and restrictive practices in adult mental health services, though there is application of some strategies to other age groups and settings. The full final report from the research project is available on the Commission's website: http://www.mentalhealthcommission.gov.au/

1 What do we mean by seclusion and restraint?

Seclusion and restraint are interventions used in mental health facilities and other settings to control or manage a person's behaviour. In some Australian settings seclusion and restraint have been conceptualised as a 'failure in care'.

There are no consistent definitions of seclusion and restraint in the mental health acts across Australia. This Position Paper has adopted the definitions from the Tasmanian *Mental Health Act 2013*:

- *Seclusion*: the deliberate confinement of a person, alone, in a room or area that he or she cannot freely exit

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

The use of 'psychological restraint' is also raised as an issue by people with lived experience of a mental health difficulty and families and carers. There is no agreed definition of psychological restraint although the National Mental Health Consumer and Carer Forum's definition of emotional restraint provides some guidance:

> 'when the individual consumer is conditioned to such an extent that there is a loss of confidence in being able to express their views openly and honestly to clinical staff for fear of the consequences. …. (It) ….can also be coercive and threatening in nature (e.g. a consumer being told if they will not calm down they will be secluded)[ii]. Background to the issue

Since 2005, Australia has had a national performance target to reduce, and where possible, to eliminate the practices of seclusion and restraint. Reducing the use of, and where possible, eliminating restraint and seclusion became one of four national mental health safety priorities in 2005.[iii] This aim was more recently supported by the Report to the Council of Australian Governments (COAG) from its Expert Reference Group on Mental Health reform that recommended the following targets for mental health reform over the next 10 years:

- Restrictive practices are rare events:
  - Involuntary treatment orders are rare
  - Seclusion rates are reduced by 70% in four years and 90% in 10 years
  - Restraint: A meaningful baseline measure required for all forms of restraint in four years and then 90% reduction on baseline is achieved in 10 years.[iv]

Seclusion and restraint have consistently been raised as issues of great concern. People with lived experience of mental health issues and their families, service providers and policy makers all want change.

2 Evidence based practice

Australian and international literature, including 'grey' literature, was reviewed as part of the Seclusion and Restraint Project to gather evidence and identify best practice initiatives and models of care to reduce and/or eliminate seclusion and restraint[v]. Evidence over the past ten years was collated and evaluated to identify not only the currency of evidence but also its applicability.

Evidence

The literature identifies the following interventions as valuable in reducing the use of seclusion and restraint:

- Organisational culture change through an emphasis on recovery, trauma-informed care and human rights, consumer participation and interdisciplinary activity, including review of events of restrictive practice
- Independent advocacy directed at public opinion, politicians, policy makers and service providers
- Physical changes to the environment
- National reporting and oversight of the use of seclusion and restraint.

In the United States the Substance Abuse and Mental Health Services Administration (SAMSHSA) developed a 'Roadmap to Seclusion and Restraint Free Mental Health Services'[vi] in 2005 and in 2006 the National Association of State Mental Health Program Directors (NASMHPD) developed a 'Training Curriculum for the Reduction of Seclusion and Restraint' [vii] . These two documents have provided guidance in the area of seclusion and restraint since their development. In its training curriculum, NASMHPD describes six core strategies that have been used in sites around the world to reduce the use of seclusion and restraint. The six core strategies are:

- 'Leadership towards organisational change' – outlining a philosophy of care that targets seclusion and restraint reductions
- 'Consumer roles in inpatient settings' – having an inclusive approach which involves consumers, carers and other advocates in seclusion and restraint reduction initiatives
- 'Using data to inform practice' – using data in an empirical, non-punitive way to review, analyse and monitor patterns of seclusion and restraint
- 'Workforce' – developing procedures, practices and education that promote mental health recovery
- 'Use of seclusion and restraint reduction tools' – using assessments and other resources to develop individual aggression prevention approaches
- 'Debriefing techniques' – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.

While there are examples of the implementation of all six strategies, most of the evidence available to support these strategies relates to that of leadership. The literature identifies the importance of top-down organisational leadership supported by local leadership in order to create and maintain culture change. While many seclusion reduction projects use the strategies of staff training and the use of new assessment, review and debriefing tools, very few projects identified in the literature incorporate consumer and/or carer roles.

The Safewards model [viii] [ix], developed in the United Kingdom, identifies the factors influencing rates of conflict and containment, known as 'flashpoints', on mental health wards and describes 10 interventions aimed at helping staff manage these flashpoints.

The 10 interventions are:

- Clear mutual expectations
- Soft words
- Talk Down
- Positive words
- Bad News Mitigation
- Know each other
- Mutual Help meeting
- Calm Down Methods
- Reassurance
- Discharge messages

A summary of the model is shown below.

Domain/originating factors, such as:	Flashpoints, such as:	Staff modifiers, such as:
Staff team or internal structures and routines	Denial of request or limit setting	Staff anxiety and frustration; teamwork and consistency
Physical environment	Complexity of layout	Checking routines; caringly vigilant and inquisitive
Outside hospital issues including family relationships	Bad news; home crisis; loss of relationship or home	Family therapy; carer / relative involvement; active patient support
Patient – patient interaction	Crowding; queuing; bullying; stealing; staff / patient turnover	Role modelling; information and patient education; removal of means
Patient characteristics, symptoms and demographics	Exacerbations; identity; acuity	Pharmacotherapy; psychotherapy; nursing support and intervention
Regulatory framework and external structures; policy; prosecutions; complaints	Compulsory detention; enforced treatment	Justice; respect for rights; due process; support to appeal

The Victorian Government, in April 2014, announced trials of the Safewards model in seven Victorian metropolitan and regional health services[x].

3 Recommendations for driving action

The stakeholder consultations as part of the Seclusion and Restraint Project found general agreement on the need to change current practices and implement strategies to reduce and eliminate the use of seclusion, restraint and other restrictive practices. The drivers for change include human rights, the principles of recovery-oriented care and trauma-informed care and the person-centred approach.

We know that changing practice has been a goal of reform for ten years. We also know that seclusion rates have declined by 12.2% of the five years to 2013-14, but also that these improvements were inconsistently evident across Australia and between the different types of inpatient units.

The National Mental Health Commission instigated the Seclusion and Restraint Project to identify options to support reinvigorated action, based upon best practice and learnings from success elsewhere. The Commission recommends a set of actions, which taken together, can act to positively reduce and eliminate seclusion and restraint in mental health and related services in Australia.

Recommendation 1: Educate mental health practitioners about multi-intervention strategies

The research literature indicates that certain multi-intervention strategies are effective though there is no evidence for the efficacy of single intervention strategies. Implementation of the following strategies should be the focus of activity.

Improving Organisational Culture

The input from people with lived experience, their supporters and the literature identify that improved communication is important. The survey results and outcomes of the focus group discussions, undertaken as part of the Seclusion and Restraint Project, identified a strong perception that there was far too limited opportunity for people using a mental health service to be able to talk with practitioners about how they were feeling and to receive a compassionate response because of a lack of resources, in particular a shortage of staff. Focus group participants also reported that good communication, supported by other changes to practice as outlined below, helped prevent conflict and emphasis on the use of conflict preventative measures and de-escalation techniques was required.

Communication by health staff, based upon person-centred and recovery approaches, is also important to improving culture. As identified in the literature, senior health professionals, supported by organisational and local leaders, have an important role to play in cultural change by setting expectations for practice, revising policies and enabling internal data collection and reporting to assess ongoing performance improvement.

Ongoing training in recovery-oriented and trauma-informed models of mental health care promoting a person-centred approach may also assist in improving organisational culture. The Safewards model provides an approach for changing ward culture by implementing strategies to reduce conflict in inpatient settings.

Changes to the Environment

One of the key findings from the Seclusion and Restraint Project was that the physical environment in many health facilities does little to support feelings of security and safety. Implementing changes to the physical environment are some of the simplest changes that can be undertaken.

Some options for changes to the environment may seem relatively minor in nature yet can assist in people feeling safe and secure, including:

- Painting walls with warm colours
- Providing comfortable furniture
- Floor coverings and plants that promote a more informal, casual environment
- Allowing more natural light in and greater vision to the outside, as well as access to green space, sunshine and the natural environment.

Other changes that could be made to the environment include:

- The use of sensory modulation rooms and sensory modulation tools
- More space being made available in wards and greater openness for patient movement within and outside the ward
- Removing seclusion rooms or turning them into relaxation rooms
- Providing alternative spaces that are safe, where consumers and staff can work together to reduce distress or conflict such as, small lounge rooms, courtyards
- Providing quiet spaces, particularly in emergency departments, for use by people in crisis or distress
- Consideration of the use of music.

While there is a lack of research evaluation on changes to the physical environment it has been suggested that an *'inviting, calm environment may help set the tone for patients' and staff members' behaviour on psychiatric hospital units*[xi]. This is also supported by the Safewards model that emphasises the importance of wards being as welcoming as possible.

Similarly the way a person feels about the ward and what staff can do to make the experience more welcoming and less stressful are important. Changes in attitudes can often be achieved easily if people are aware of what needs to happen and can see its benefit. Again, this reinforces the need for a positive cultural environment alongside a positive physical environment.

The milieu or atmosphere of the ward is important and it can be fostered through considering the following:

- The openness of communication between staff and consumers with friendly, clear and non-coercive and non-judgemental language
- Activities, groups and programs which create involvement and a sense of trust
- Orientation to, and clear expectations about, what to do if upset and how to seek help
- Involvement of consumers in a consumer-oriented model of care that has a recovery focus aimed at identifying strengths and methods of solving problems.

Workforce Development

The importance of the mental health workforce in creating positive work environments and positive healthcare environments for patients is fundamental. This is affected by staff time and availability, capacity and skills in de-escalation and intervening early, and adopting models of care that take a recovery approach to how staff engage with and support patients.

Workforce barriers to the reduction of seclusion, restraint and other restrictive practices have been identified as a lack of staff and a lack of time. A commitment to the development of competencies among the workforce, including education, supervision and support, in addition to ensuring an adequate and appropriate ratio of staff to consumers will assist in the reduction in the use of seclusion and restraint.

Supporting staff is crucial, and a critical element in addressing the use of seclusion and restraint is workforce culture. Addressing the attitudes of staff to seclusion and restraint and offering staff a suite of clinical and non-clinical tools to assist in early identification of potential crises and interventions to reduce the reliance on seclusion and restraint or coercive interventions, will be essential. This is already occurring, but the evidence on variation in seclusion rates across Australia indicates that this needs to be embedded across the mental health system.

Often restrictive interventions are used because the clinical management of behavioural disturbance has not been addressed early enough or with appropriate pharmacological and non-pharmacological interventions. These early interventions are supported by evidence in relation to the management of acute behavioural disturbance in the acute setting.

Investigating the use of seclusion and restraint and restrictive practices from the workforce perspective is essential if there is to be sustained changes in practice. Unless the workforce can be supported to consider alternative options that will ensure the safety of all involved, the workforce will remain somewhat resistant.

Leadership and the development of workplaces that model good practice, underpinned by a human rights framework, will also be crucial in affecting change.

Leadership

The importance of leadership at a national, state and territory and local level in reducing seclusion and restraint is highlighted in the literature. 'Top-down' and 'bottom-up' leadership was identified as a priority by participants in the Seclusion and Restraint Project.

O'Hagan and colleagues identify the following elements required in the style of leadership:

- ‘Champion’ reduction and make it a clear priority
- Include all major stakeholders in the process: staff, service users, families and advocates
- Keep up constant dialogue with staff and other stakeholders
- Motivate staff with the reasons how reduction will benefit them, such as a more pleasant work environment and evidence of increased safety
- Create a supportive, respectful, non-coercive milieu for staff that models the milieu they need to create for service users
- Use language that models recovery values
- Reward and celebrate successes in reduction with staff’[xii].

Consumers’ involvement

There is a clear message in the Seclusion and Restraint Project that consumers need to be involved in policy development, research, and training as well as in incident review and evaluation and that peer support should be readily available in mental health services.

The participants in the Seclusion and Restraint Project focus groups emphasised the need for peer support and advocacy. However, there is little in the literature relating to the importance of consumer leadership as a factor in reducing and eliminating seclusion and restraint.

The Canberra Hospital seclusion reduction intervention project provides one example of a collaborative and consumer-led strategy that was successful in reducing the use of seclusion. It also paved the way for lasting consumer advocacy, support and other roles regarded as expert contribution by others'[xiii]. This project provides a model for implementation in other health facilities. Strategies developed in this project would benefit from further exploration and research.

The inclusion of consumer expertise is an element that has been under-utilised in projects identified using the six core strategies described by the NASMHPD. Throughout the Seclusion and Restraint Project consumers and carers expressed a clear and powerful commitment to change that should be utilised. Opportunities for consumer leadership in research, policy development and staff training should be developed in addition to consumer participation in organisational goal setting and post-event reviews.

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

Example of Good Practice: Pennsylvania Hospital System
Internationally the Pennsylvania Hospital System is noted for its initiatives to reduce the use of seclusion and restraint.

During 2009-10 seclusion was used only 11 times across the Pennsylvania hospital system. Five hospitals completely eliminated the use of seclusion and restraints and Pennsylvania's hospitals reported no increase in staff injuries. Changes to practice were implemented using only existing staff and resources with no additional funding.

The key components of Pennsylvania Hospital System's seclusion and restraints reduction policy are:

- Seclusion and restraints are exceptional and extreme practices for any consumers and must be the intervention of last resort
- A physician who has received training in the use of alternatives to restraint and how to reduce the physical and emotional harm caused by restraints must order seclusion and restraints
- Staff must work with the consumer to end seclusion and restraints as quickly as possible
- Orders are limited to one hour and require a physician to physically assess the consumer within 30 minutes
- Consumers being restrained may not be left alone
- Chemical restraints are prohibited
- The treatment plan must include specific interventions to avoid seclusion and restraint
- Consumers and staff must be debriefed after every incident and treatment plans must be revised
- Staff must be trained in de-escalation techniques.

Another component of the programme in Pennsylvania is the regulation of 'psychological restraints' which are defined in section 13.9 of the Pennsylvania Code as including 'those therapeutic regimes or programmes which involve the withholding of privileges and participation in activities'.
Source: Mental Health America Position Statement 24: Seclusion and Restraint Policy Position. Available at: http://www.mentalhealthamerica.net/go/position-statements/24

Family, carer and support persons' involvement

The focus groups undertaken as part of the Seclusion and Restraint Project identified the issue of a lack of communication with carers, family members and other support people in general as well as in relation to the use of seclusion, restraint and other restrictive practices. It was suggested that if carers, family members and support people were listened to or actively engaged, stressful situations that led to the use of seclusion and restraint could be avoided. To date it appears that the potential for involving carers, family members and support people in assisting to reduce the use of seclusion and restraint has not been utilised.

One approach is to ensure that carers, family members and support people have access to the consumer and are included in identifying reduction initiatives and throughout any crisis prevention planning process, while at the same time staff develop skills in family inclusion. There is also the possibility of including carers, family members and support persons in the development of discharge plans for individuals using inpatient and other services. Involvement by carers in other activities, such as interdisciplinary activity, reviews of seclusion and restraint and other critical incidents like absconding, also hold promise.

Recommendation 2: Agree uniform definitions, targets and reporting frameworks

There have been a number of national initiatives to reduce seclusion and restraint and data on seclusion rates is now being collected and publicly reported. However, it is difficult to find data on rates of physical, mechanical and chemical restraint across Australia.

The need for nationally agreed definitions of seclusion and restraint are critical to data collection, reporting and comparison. The definitions used in many of the mental health acts do not contain enough information to use them for nationally consistent data collection and reporting. The Mental Health Information Strategy Standing Committee (MHISSC), the Safety and Quality Partnership Standing Committee (SQPSC) and the Australian Institute of Health and Welfare (AIHW) have developed the draft Mental Health Seclusion and Restraint Data Set Specification (SECREST DSS) to enable consistent definitions on seclusion and restraint to be reported against. An ongoing challenge is the development of a practical definition of chemical restraint that is useful for monitoring or collecting data.

The Commission encourages national agreement between the key players in mental health such as the MHISSC, SQPSC, AIHW and the National Mental Health Consumer and Carer Forum, the Royal Australian and New Zealand College of Psychiatrists, the Australian College of Mental Health Nurses and the Australian and State and Territory governments to develop a process that would:

- Gather and receive data on coercive practices
- Establish targets to be met
- Provide reports on the use of coercive practices
- Have powers of inspection and powers to require compliance
- Coordinate training and education for workforce professional development
- Facilitate and support research, especially in the areas of interdisciplinary activities and cultural change.

The Dutch Health Care Inspectorate

The Seclusion and Restraint Project identified the work of the Dutch Health Care Inspectorate as one example of a national approach to monitor, inspect and collect data on the use of coercive practices in general, including the use of medication given without consent.

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

One option may be that an existing body, such as the Australian Institute for Health and Welfare or the Safety and Quality Partnership Standing Sub-Committee of the Mental Health, Drug and Alcohol Principal Committee of the Australian Health Ministers' Advisory Committee, in partnership with the relevant state and territory authorities, gathers and disseminates data on all restrictive practices. This national approach was used for the collection, analysis and public reporting of seclusion data in 2013 and 2014.

It is foreshadowed that a quality assurance and safety system will be implemented as part of the National Disability Insurance Scheme (NDIS) and that will include responsibilities for oversight of and reporting on the use of restrictive practices by disability services. This system may have the potential to carry over and apply to the mental health sector, particularly for those people with mental illness and associated psychosocial disability who become eligible for services under the NDIS.

Another option would involve an accreditation model, as in the United States, where facilities would lose accreditation or face financial penalties if there are breaches of the standards. While this option may not be entirely feasible given the differing State and Territory healthcare systems, the Australian Commission on Safety and Quality in Health Care may potentially have a role in this option.

The National Standards for Mental Health Services[xiv] include a criterion on safety which states that mental health services should reduce and where possible eliminate the use of seclusion and restraint. It is noted that the National Mental Health Commission is working with the Australian Commission on Safety and Quality in Health Care in relation to improving the uptake of these standards.

State health authorities across Australia are required to report on a set of nationally-agreed sentinel events which are generally 'events in which death or serious harm to a patient has occurred'. Suicide of a patient in an inpatient unit is currently reported. The inclusion of use of seclusion or restraint as a sentinel event could also be considered.

It is important that a national body facilitate standardised, effective reporting and data collection that allows for comparisons at local, state and national levels as well as intra-agency and inter-agency comparisons and in different settings in order to measure success in the reduction and elimination of seclusion and restraint. This should be a regular public report.

The Canberra Hospital

The Canberra Hospital has been noted as an exemplar of good practice in Australia. Their initiatives include a focus on consumer engagement and carer engagement, the establishment of a Seclusion and Restraint Working Party and participation in the Beacon Project which has resulted in a dramatic reduction in seclusion since 2007. Some of the strategies implemented include:

- A collaborative meeting between consumer and carer representatives and members of a multi-disciplinary team, including wardsmen, to review and examine all seclusion episodes
- An early support intervention team (ESIT) to develop further ways to respond to consumer distress in a positive manner
- A bottom to top, Consumer Representative to Director understanding and leadership around the idea "we don't do seclusion here anymore"
- Strategies to maximise engagement between staff and consumers e.g. captured engagement time (all staff on ward for 2 two hour periods per day, no excuses), staff and consumer barbeque each week.

The collaborative meeting between consumer representatives and members of a multi-disciplinary team to review and examine all seclusion episodes is an example of interdisciplinary activity which can be a catalyst for change. The Seclusion and Restraint Review Meeting enabled difficult situations to be discussed without blame. The meetings promoted discussion from all in attendance and every point of view was valued. Health professionals and consumer representatives were equal members in the meeting and rigorous debate of issues was encouraged. Attitudes were challenged and changed and this resulted in systemic and cultural change that allowed all stakeholders to better support consumers in their recovery.

The core aspects of interdisciplinary activity and practice are respect, relationship, awareness and the inclusion of differing perspectives. These aspects were evident in the workings of the Seclusion and Restraint Review Meeting that enabled questioning of current ways of working, valuing of the expertise of consumers and carers in clinical decision making and the development of trust. There were minimal resource implications for this way of working and the resulting significant reduction in seclusion rates and staff injury were rewards for the effort.

Research into the work of the Seclusion and Restraint Review Meeting found that the consumer voice and the lived experience of both consumers and health professionals was the central driver for cultural change leading to the reduction in seclusion. Seclusion is no longer viewed as a therapeutic option. The members of the Seclusion and Restraint Review Meeting identified other means to care for people in acute distress which gave rise to the Coping and Safety Tool, the Early Support and Intervention Team and staff training in Sensory Modulation, encouraging therapeutic alliance via a relational approach. Consumer/clinician collaboration was found to be a key strategy for the implementation of any work related to systems change.

Source: Foxlewin B, 2012, What is happening at the Seclusion Review that makes a difference? - a consumer led research study

Recommendation 3: Ensure seclusion and restraint practices and interventions are evaluated

There is a need to develop the evidence base for strategies that reduce seclusion and restraint. For example, when an intervention is used to reduce seclusion and restraint, there is often no publicly available data concerning what occurred or a rigorous evaluation of it. An analysis of the research literature indicated that there is little high quality empirical evidence relating to factors that may reduce the use of seclusion and restraint. This should also involve consumer led research and involvement in local evaluations and system research.

One approach is to ensure that, at a local level, every time an intervention is used to reduce the use of seclusion and restraint, a stakeholder review and evaluation is built into the process and the results of the evaluation are used to inform changes to practices and procedures.

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

The Canberra Hospital provides an example of consumer led research. Any research program should provide leadership opportunities for people with lived experience of mental health issues, families, carers and other support people.

The Seclusion and Restraint Project identified a number of possible research questions that could be progressed to further develop the research and policy surrounding the use and effectiveness of restrictive practices. These questions are listed in Appendix 2.

The Beacon Project

The National Mental Health Seclusion and Restraint Project 2007–2009, the Beacon Project, was part of the implementation of the National Safety Priorities for Mental Health. The Project comprised three parts:

- National Documentation Project - the establishment of a Community of Practice and Development and piloting data standards and performance indicators
- Beacon Demonstration Sites Project - eleven sites, with relevant jurisdiction support, developed and implemented best practice with the aim of becoming centres of excellence in relation to the reduction and, where possible, the elimination of seclusion and restraint.
- Scholarships to undertake a study tour of the United States of America - to identify evidence based best practice occurring in the USA and enable adaptation of this to Australian conditions.

A key component of the Beacon Project was the translation of international best practice to the Australian environment and the development and implementation of policies, guidelines and staff training based on good practice. The outcomes of the Beacon Project were positive, with several Beacon sites reporting significant reductions in the use, and/or duration of seclusion, which provided the foundation for further change.

The following strategies were identified as influencing positive outcomes to reduce seclusion:

- leadership to effect organisational change
- the use of data to inform practice
- investment in workforce development, and
- debriefing techniques involving people with lived experience, carers and staff.

To maintain the collaborative approach and momentum from the Beacon Project, states and territories agreed to host ongoing annual National Mental Health Seclusion and Restraint forums. These forums have provided opportunities to showcase initiatives, report on progress, share lessons with external stakeholders and identify areas for further focus. The first National Forum was held in Melbourne in 2008 and the forums have been held annually since, except in 2014.

Recommendation 4: Adopt a national approach to the regulation of seclusion and restraint

The development of standards and guidelines to be applied by each State and Territory would support uniformity in definitions of seclusion and restraint and monitoring and reporting. Standards and guidelines could:

- Establish rigorous interdisciplinary activity, including the consumer perspective, on reviewing critical incidents in all mental health settings.
- Define seclusion and all forms of restraint, including emergency sedation or rapid tranquilisation used to manage behaviour and/or facilitate transport to health services
- Provide clear limits to the use of these practices
- Clarify that seclusion and restraint must be a last resort and in what exceptional circumstances they may be applied as a matter of last resort
- Require that seclusion and restraint must end as soon as the intervention is no longer needed
- Require continuous monitoring to assess whether the seclusion or restraint should be continued
- Impose specific time limits and timeframes for assessment
- Require recording and reporting
- Clarify liability issues
- Establish effective complaints policies, procedures and practices.

Standards and guidelines could assist in clarifying the current situation by providing comprehensive practical advice. For example, the Department of Health in the United Kingdom has produced a 'guidance framework' on how to reduce seclusion and restraint[xv].

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

National standards and guidelines could:

- Set out key principles
- Clarify the involvement of people with lived experience of mental health issues and carers, family members and support persons in policy development, research, care planning, clinical decision making and training as well as during critical incident review and debriefing processes
- Clarify the employment of peer workers, supporters or advocates in settings where seclusion and restraint frequently, or are likely to, occur
- State the alternatives to using seclusion and restraint through outlining the use of prevention and de-escalation strategies
- State that only appropriately trained staff can use seclusion and restraint and only as a matter of last resort
- Set out who needs to be notified during and after the use of seclusion and restraint
- Set out requirements for continuous observation and reassessment by appropriately trained staff to ensure that interventions apply for the shortest time possible. This makes it more difficult to make a seclusion decision in the first place
- Describe practical protocols for critical incident debriefing

- Describe protocols for internal review processes with lines of reporting to external agencies such as the Public Advocate or Official Visitors
- Identify uniform and practical protocols for incident recording and reporting
- Clarify safety measures during instances of seclusion and restraint
- Provide guidance on changes to the physical environment.

The challenge for this recommendation is to provide standards and guidelines acceptable to all States and Territories.

4 Background to the Recommendations

4.1 The incidence of seclusion and restraint in mental health

Currently there is no formal, routine, nationally agreed data collection and reporting framework on the use of seclusion and restraint in Australia. However, since 2011 *ad hoc* seclusion data collections for specialised mental health public acute hospital services have been undertaken under the auspices of the Australian Health Ministers Advisory Council (AHMAC) through its Mental Health Drug and Alcohol Principal Committee's (MHDAPC) SQPSC in partnership with the relevant State and Territory authorities.

Seclusion data from 2012, for admitted patient care, were publicly released for the first time in June 2013 under special agreement with data custodians. The AHMAC has since agreed to the annual public release of the *ad hoc* national and state/territory seclusion data which is presented at the National Seclusion and Restraint Forum. The data is released on the Australian Institute of Health and Welfare website at: http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/

The MHISSC, the SQPSC and the AIHW has progressed activity to formalise the aggregate seclusion data and are seeking national endorsement for the recently expanded Mental Health Seclusion and Restraint Data Set Specification (SECREST DSS) for the 2015–16 collection period. The 2013-2014 ad hoc data (published in December 2014) already contains a number of these enhancements.

Use of restrictive practices during admitted patient care

The most recent data on the incidence of seclusion during admitted patient care episodes is from the period 2013-14[xvi]. Nationally there were 8.0 seclusion events per 1,000 bed days in public acute specialised mental health hospital services. There has been a reduction in the national seclusion rate since 2009-10, from 13.5 seclusion events per 1,000 bed days in 2008–09 to 8.0 in 2012–13. This equates to an average annual reduction of 12.2% over the five year period.

State and territory rates ranged from 1.1 seclusion events per 1,000 bed days (Australian Capital Territory) to 21.6 (Northern Territory) in 2012–13.

Seclusion data is also available by specific populations. Child and adolescent units had a higher rate of seclusion events (14.5 per 1,000 bed days) nationally, compared with general units (10.3) in 2012–13. It should be noted that many child and adolescent services are included in the mixed category, which can refer to any combination of older person, forensic, general, youth and child and adolescent services. Older person services had the lowest rate of seclusion events (0.5), a reduction of 34.4 per cent in five years.

To improve the data for the different inpatient populations, work is underway to improve the data collection methodology that will enable these services to be separately identified.

The collection and reporting of a broader range of data is necessary to identify opportunities to reduce and eliminate seclusion and restraint. AIHW and the AHMAC mental health committees are working together to collect data on restraint practices with the aim of developing and reporting of a national indicator on restraint. Some of this work includes the development of a seclusion and restraint Data Set Specification to standardise the national collection of seclusion and restraint data commencing from the 2015-16 collection period.

Data is not currently available for incidents of seclusion in other mental health settings or for incidents of restraint in any setting. Work is continuing to determine the capacity within jurisdictions to routinely supply seclusion and restraint data in line with agreed national definitions some of which are yet to be agreed.

Monitoring restrictive practices in other areas

In April 2014 the COAG Disability Reform Council endorsed a *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector*[xvii]. The framework encourages all jurisdictions to implement a data monitoring system by 2018 but will initially seek agreement on standardised data collection and reporting.

4.2 The complexity of seclusion and restraint

The use of seclusion and restraint in mental health services is a complex issue. The range of issues includes:

- Placing a service and cultural priority upon reducing use of seclusion and restraint
- Regulation of seclusion and restraint practices
- Human rights
- Evidence supporting the use of seclusion and restraint
- Drivers for change.

Placing a priority upon changing practice

From the work done for the Seclusion and Restraint Project, it can be said that there is existing good practice, evidence and models that identify the lack of therapeutic benefit and alternative approaches to seclusion. What is also apparent is that despite these existing evidence and good practice examples, system wide practice change is inconsistent. The interplay of human resource, environment, culture and staff/consumer engagement is the complex background against which change needs to occur. Priority for change therefore needs to be consistently reinforced and transparent across all levels of healthcare management.

Regulation of seclusion and restraint practices

Regulation of seclusion and restraint occurs through legislation, policy and accreditation. In Australia, legislation and policy are used to regulate seclusion and some forms of restraint. In addition there are numerous policies, procedures, guidelines and standards targeting the reduction of seclusion and restraint.

Regulation of seclusion and restraint – Current approaches across Australia

The Melbourne Social Equity Institute of the University of Melbourne found that the current regulation framework governing seclusion and restraint in Australia is a combination of laws and policies and recommended that greater uniformity in regulatory frameworks would be advantageous.

There are some advantages to regulation through legislation:

- Making the use of restrictive practices a matter of last resort
- Setting clear and consistent standards for practice
- Clarifying the circumstances in which a breach of standards occurs
- Providing policies with a legislative structure
- Making the regulatory framework easier to identify and locate.

Some of the advantages of policies, procedures, standards and guidelines are that they:

- Are more accessible and understandable for the community than legislation
- Promote uniformity between states and territories where national guidelines are developed
- Provide practical advice and useful examples
- Can be more flexible and adapted to local areas
- Are able to be updated more readily to take into account changes in the evidence.

In some countries the use of accreditation has the advantage of providing a financial incentive to comply with regulations.

The literature would support a combination of laws, policies and accreditation as 'best practice'. The recently endorsed National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector contains a number of high-level principles and core strategies for implementation across the disability services sector. This is a model which could be adapted and applied to the mental health sector.

Source: Melbourne Social Equity Institute, 2014, "Seclusion and Restraint Project Report' for the National Mental Health Commission, The University of Melbourne

In Australia seclusion and mechanical restraint are subject to the most regulation:

- Seclusion is regulated by mental health legislation, except in New South Wales which has a policy on its use.
- Mechanical restraint is regulated under policies and/or legislation across Australia.
- Physical restraint is regulated under policies and/or legislation in five states and the Australian Capital Territory but is not regulated in the Northern Territory or Western Australia.
- Chemical restraint is not regulated under legislation except in Tasmania. New South Wales has a policy on Chemical Restraint.
- Psychological restraint is not referred to in laws or policies in Australia.

Laws and policies, where they exist, differ in relation to:

- The criteria limiting when seclusion and restraint can be used
- Who has the authority to seclude and restrain
- Restrictions on the duration of seclusion and mechanical restraint
- Recording and reporting the use of seclusion and restraint

- Treatment of the person while in seclusion or under mechanical restraint
- Special provisions for certain groups perceived to be 'vulnerable'
- Concurrent use of seclusion and mechanical and/or chemical restraint.

Human Rights

Human rights are a significant factor in shaping Australia's commitment to the reduction and elimination of seclusion and restraint. In 2008 Australia ratified the United Nations *Convention on the Rights of Persons with Disabilities.* Article 17 of the Convention states that 'every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others' and Article 15 states that 'no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment'.[xviii]

The United Nations Committee on the Rights of Persons with a Disability has recommended that Australia take immediate steps to end the use of seclusion and restraint.

Some examples of how seclusion and restraint impacts on people's human rights

- Being confined in a space of which someone cannot freely exit
- Reduction of personal space and taking away freedom
- Humiliating and disempowering
- Punishment and abandonment
- Dehumanised by having your freedom taken away

The evidence supporting the use of seclusion and restraint

The evidence to support the practices of seclusion and restraint is difficult to find in the literature. A Cochrane Review, which reviewed 2,155 citations and 35 articles, found that no randomised studies exist that evaluate the value of seclusion or restraint in people with a serious mental illness. The review also found that there are reports of serious adverse effects for these techniques in qualitative reviews.[xix]

It should be noted that the literature that is available primarily focuses on the use of seclusion and restraint in inpatient units and emergency departments with lesser amounts of literature focusing on community, custodial and ambulatory settings.

Drivers for change in the use of restrictive practices

The drivers to reduce the use of restrictive practices are found in the increasing use of the 'recovery approach' to treatment and care in mental health services. The National Mental Health Policy, 2008, recommended that mental health services should adopt a recovery-oriented approach[xx]. In 2013 AHMAC endorsed the National Framework for Recovery-Oriented Mental Health Services that was developed as an action of the Fourth National Mental Health Plan 2009-2014[xxi].

Recovery approaches began as people with lived experience, carers and advocates sought greater influence and control over their experiences in mental health services. The recovery-oriented approach emphasises the importance of the people with lived experience of mental illness being active drivers of their own recovery and wellbeing, including defining their goals and aspirations.

Recovery-oriented mental health services have a responsibility to use evidence to inform their service delivery, for partnerships with consumer and community groups and support the development of peer-worker programs and services.

Another driver has been the increased emphasis on trauma-informed care and practice[xxii]. Trauma-informed care and practice involves acknowledging the high prevalence of traumatic experiences for people with mental health issues and responding to, and minimising, re-traumatisation in practice. The *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* developed by Adults Surviving Child Abuse provide guidance to support systemic changes in service provision and workplace culture to enable the principles and practice of the Trauma Informed framework to be implemented in mental health facilities[xxiii].

4.3 Contributions and views of people with lived experience and carers and families

The Seclusion and Restraint Project was designed from the beginning to involve the active contributions of people with lived experience and their supporters. To identify and understand the opinions of consumers and carers regarding the use of restrictive practices in mental health services, an online survey and focus groups were undertaken.

Results from the online survey, which received 1,240 eligible responses, identified some issues with strong agreement including:

- Between 80 and 90% of participants responded that seclusion and the four different forms of restraint would always or often infringe human rights
- A similar proportion (between 75-89%) believed that the use of seclusion and the four different forms of restraint would always or often compromise the therapeutic relationship/trust
- Ninety per cent of participants indicated that taking a person-centred approach to assessment and treatment would be an extremely effective or effective strategy to reduce the negative effects of seclusion and restraint
- Three strategies thought to be extremely effective or effective, were:
    - Staff training in de-escalation strategies (86%)
    - Having better access to counselling and other 'talking and listening' opportunities (84%)
- Changes to the environment in which seclusion and restraint might occur (84%)
- The majority of participants responded that eliminating psychological restraint was possible (72-84 % across all groups agreed) and should be achieved (62-73% across all groups agreed).

There were a number of areas where there was a difference of opinion among survey participants:

- There was a lack of agreement as to the meaning of seclusion and restraint; with 46% of responses given by those answering questions about definitions being only 'somewhat similar' to those supplied
- Carers and consumers were less likely to identify the purpose of seclusion and restraint as being 'the prevention of harm' compared with health providers
- There was variation between respondents as to whether seclusion and restraint practices should be eliminated, depending on their own experiences and the form of seclusion or restraint.

Consultations were also undertaken with mental health professionals and other service providers such as police and ambulance officers. People with lived experience, families and carers were less likely to express a concern for safety should seclusion and restraint be eliminated than other stakeholders.

While not all survey respondents saw the total elimination of seclusion and restraint as being feasible or desirable, there was overwhelming agreement for changes in current practice.

Focus groups were held for people with lived experience of mental health treatment and additional focus groups for carers, family members and support people. The aim of the focus groups was to give people an opportunity to share their perspectives on how seclusion and restraint could be reduced or eliminated.

Participants focused on three main topics: Understanding of seclusion and the different forms of restraint and their impact; Observations about poor practice and what contributes to it; and their ideas and recommendations regarding strategies to reduce or eliminate seclusion and restraint.

The findings in relation to each of the topics were:

I. Understanding of seclusion and the different forms of restraint and their impact:

- Seclusion and restraint were viewed as examples of coercion
- Emphasised a lack of recognition of the practices of chemical and emotional restraint
- Identified seclusion and restraint as not therapeutic, anti-recovery and an abuse of human rights
- Emphasised the traumatic impact of seclusion and restraint and how this can be long lasting.

II. Observations about poor practice and what contributes to it:

- Poor leadership
- Poor communication
- A lack of time for staff to talk with those with mental health issues
- Inadequate staff training
- A lack of accountability
- A general lack of resources
- Stressful environments.

III. Their ideas and recommendations regarding strategies to reduce or eliminate seclusion and restraint:

- The importance of services and treatments being person-centred, such that every effort is made to try to keep someone from being in crisis or involuntarily detained in hospital in the first instance
- The need to improve the quality of mental health services and staff through emphasising interpersonal skills to improve therapeutic relationships without resorting to the use of coercion

- The need to improve the environment in which services are offered to ensure people with mental health issues feel secure and safe. Suggestions ranged from having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed, to ensuring doors to the main wards are unlocked and the removal of seclusion rooms altogether
- The need to ensure accountability
- The value of peer workers and family members to support people in crisis and on inpatient units.

Other matters raised by participants included:

- The issue of drug and alcohol misuse complicating mental health treatment, particularly when seclusion and restraint is commonly used as an intervention while waiting for the intoxication or drug effects to dissipate
- The need to recognise the specific challenges for people in rural and remote areas of Australia and also for Indigenous and culturally and linguistically diverse populations
- The concurrent use of different forms of seclusion and restraint.

There was strong support for the development of, and investment in, a range of peer roles inclusive of direct support, staff development, governance and organisational change.

5 Contentious issues

While there appears to be general agreement from service providers, consumers, families and carers of the need to change practice to, at the least, reduce the use of seclusion and restraint, there are still some areas of controversy.

There are differences in opinions about whether or not seclusion and restraint can be eliminated. However there is strong agreement that the use of seclusion and restraint is not therapeutic, breaches human rights, compromises the therapeutic relationship/trust and that it can be reduced.

There is some debate about the issue of psychological restraint. There is no agreed definition and data is not collected. There is consensus among consumers and carers that psychological restraint both could and should be eliminated from current practice.

6 Conclusion

There is strong agreement from consumers, carers and health professionals that the use of seclusion and restraint is not therapeutic, breaches human rights, compromises the therapeutic relationship/trust and that it can be reduced. In the case of psychological restraint, there is consensus that it both could and should be eliminated from current practice.

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

A number of strategies as to how best to reduce the use of seclusion and restraint have been identified and the literature points to the implementation of multi-intervention strategies, and interdisciplinary activity, as the best ways forward.

The National Mental Health Commission believes that:

- Reinvigorated effort is required to introduce or continue the implementation of multi-intervention and interdisciplinary strategies, change reporting and oversight mechanisms, fill the gaps in the literature, evaluate the outcomes and provide uniformity in the regulatory framework in order to reduce, or eliminate, the use of seclusion and restraint in mental health.
- It is now timely for existing agencies and national committees to renew their commitment to implementing a multi intervention national approach, with a national coalition to drive public reporting and monitoring to support nationally consistent implementation.
- A higher priority must be accorded to research and evidence on effective strategies to reduce and eliminate seclusion, and this is undertaken alongside research on how to successfully introduce new models of care and cultural change to support practice change.
- It is essential to focus efforts on reducing rates of seclusion for more vulnerable groups, especially children and adolescents.

Appendix 1

Core Reference Group members

The National Mental Health Commission would like to thank the members for their expertise and dedicated contribution to this work.

MEMBER	AFFILIATION/EXPERIENCE
Mr Bradley Foxlewin (Co-Chair)	Community Educator, Consumer Researcher, NSW Mental Health Deputy Commissioner
Dr Christopher Ryan (Co-Chair)	Director of Consultation-Liaison Psychiatry, Westmead Hospital, Senior Clinical Lecturer, University of Sydney Centre for Values, Ethics and the Law in Medicine
Kath Thorburn (Co-Chair June 2013 – June 2014)	Director Inside Out and Associates
Dr John Allan	Chief Psychiatrist, Queensland Health Ministry, Chair Mental Health Information Steering Committee Safety & Quality Partnerships Sub-Committee of the Mental Health Information Strategy Standing Committee
Ms Jenna Bateman	CEO, Mental Health Coordinating Council
Mr David Bryce	Deputy Chief Police Officer (Crime), ACT Policing
Mr David Butt	CEO, Commissioner National Mental Health Commission
Ms Jackie Crowe	Commissioner, National Mental Health Commission
Mr Phillip French	Director, Australian Centre for Disability Law
Ms Georgie Harman (until April 2014)	(former) DCEO and CEO, National Mental Health Commission
Mr Graeme Innes	Disability Discrimination Commissioner, Australian Human Rights Commission
Ms Rosemary Kayess	Director, Disability and Human Rights Program, Faculty of Law, UNSW
Ms Kim Ryan	CEO, Australian College of Mental Health Nurses
Ms Margaret Springgay	Carer representative
Dr Lesley Van Schoubroeck	Queensland Mental Health Commissioner
Ms Fiona Whitecross	Quality and Risk Manager, Alfred Psychiatry
Mr Howard Wren	Council of Ambulance Authorities

Appendix 2

Possible research questions

There were a number of gaps in the literature in relation to the effectiveness of the use of restrictive practices in mental health identified in the Seclusion and Restraint Project[xxiv]. Any research in the area should involve people with lived experience, families and carers. Specific focus could be on the following areas:

- Evaluation of any interventions used to reduce the use of seclusion or restraint
- How consumer leadership and involvement in strategies may reduce the use of restrictive practices
- The impact of peer support roles on reduction of the use of restrictive practices
- How carers, family members and support persons' involvement may reduce the use of restrictive practices
- The attitudes, barriers and enablers of health professionals in relation to restrictive practices
- The incidence and effect of the concurrent use of varying forms of seclusion and restraint
- The impact of comorbid alcohol or other drug use and mental health issues on rates and experience of restrictive practices
- The impact of the physical environment in reducing the use of restrictive practices
- The effect of specific models of care, including interdisciplinary activity and multi-intervention strategies, in reducing the use of restrictive practices
- Similarities and differences in the use of restrictive practices in the criminal justice/forensic, disability, aged care and mental health sectors
- Specific strategies targeting the reduction in the use of restrictive practices in different settings and with different population groups such as:
    - In rural and remote areas
    - In community, custodial and ambulatory settings
    - The specific needs of Aboriginal and Torres Strait Islander people
- Strategies suggested from literature in languages other than English to meet the specific needs of people from culturally and linguistically diverse backgrounds.

References

[i] National Mental Health Commission, 2012, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* Sydney: National Mental Health Commission

[ii] National Mental Health Consumer and Carer Forum, 2010. Canberra, Ending Seclusion and Restraint in Australian Mental Health Services.

[iii] Commonwealth Department of Health and Ageing 2005, National safety priorities in mental health: a national plan for reducing harm (National Mental Health Plan 2003-2008)

[iv] Expert Reference Group on Mental Health Reform, National Targets and Indicators for mental health reform: Report to COAG Working Group on Mental Health Reform, 2013, Available at: http://www.mentalhealthcommission.gov.au/our-reports/expert-reference-group-on-mental-health-reform.aspx

[v] Melbourne Social Equity Institute, 2014, "Seclusion and Restraint Project Report' for the National Mental Health Commission, The University of Melbourne

[vi] Substance Abuse and Mental Health Services Administration, 2005, *Roadmap to Seclusion and Restraint Free Mental Health Services*. Rockville, MD. Substance Abuse and Mental Health Services Administration. Available at: http://www.samhas.gov/shin/content/SMA06-4055/SMA06-4055-A.pdf

[vii] National Association of State Mental Health Program Directors, 2006, *Training Curriculum for the Reduction of Seclusion and Restraint*. Alexandria, VA: National Association of State Mental Health Program Directors. Available at: http://www.nasmhpd.org/index.aspx

[viii] Safewards: Making psychiatric wards more peaceful places. Available at: http://www.safewards.net/

[ix] Bowers L, Alexander J, Bilgin H, Botha M, Dack C, James K, Jarrett M, Jeffery D, Nijman H, Owiti J.A, Papadopolous C, Ross J, Wright S and Stewart D, 2014, 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards', *Journal of Psychiatric and Mental Health Nursing,* 21 (4), pp354-364

[x] Premier of Victoria, 2014, '$2 Million Funding Package to Drive Down Seclusion and Restraint at Mental Health Services', Media release, 28 April. Available at: http://www.premier.vic.gov.au/media-releases/9723-2-million-funding-package-to-drive-down-seclusion-and-restraint-at-mental-health-services.html

[xi] Borckhardt J.J, Madan A, Grubaugh A.L, Danielson C.K, Pelic C.G, Hardesty S.J, Hanson R, Herbert J, Cooney H, Benson A, and Freuh B.C, 2011, 'Systemic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital', *Psychiatric Services,* 62 (5), pp477-483 and colleagues. (2011, pp.481-482)

[xii] O'Hagan M, Divis M and Long J, 2008, *Best practice in the reduction and elimination of seclusion and restraint: Seclusion – Time for change.* Auckland: Te Pou o Te Whakaaro Nui – the National Centre of Mental Health Research, Information and Workforce Development.

[xiii] Foxlewin B, 2012, *What is happening at the Seclusion Review that makes a difference? - a consumer led research study*

[xiv] Australian Department of Health, 2010, *National Mental Health Standards*, Canberra: Australian Government

[xv] Department of Health (UK), 2014, *Positive and Proactive Care: Reducing the Need for Restrictive Interventions*. London: Department of Health UK. Available at: https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

[xvi] Australian Institute of Health and Welfare, 'Use of restrictive practices during admitted patient care': http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/ accessed 20 November 2014

[xvii] Australian Government, 2014: *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector. Available at:* https://www.dss.gov.au/sites/default/files/documents/04_2014/national_framework_restrictive_practices_0.pdf

[xviii] *United Nations Convention on the Rights of Persons with Disabilities.* Opened for signature 13 December 2007 (entered into force May 2008)

[xix] Sailas E, Fenton M 2000, 'Seclusion and Restraint for people with serious mental illnesses', The Cochrane Database of Systematic Reviews 2000, Issue 1. Art. No.: CD001163

[xx] Australian Health Ministers, 2009, *National Mental Health Policy 2008*. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/B4A903FB48158BAECA257BF0001DeAEA/$file/finpol108.pdf

[xxi] Australia Health Ministers' Advisory Council, 2013, *A National Framework for Recovery-Oriented Mental Health Services – Guide for Practitioners and Providers*. Canberra: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

[xxii] Mental Health Coordinating Council, 2013; Substance Abuse and Mental Health Services Administration 2014

[xxiii] Kezelman C, and Stavropoulos P, 2012, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults surviving child abuse. Available at: http://www.asca.org.au/Portals/2/Practice%20Guidelines/ASCA%20Guidelines%202014_WEB_Final.pdf

[xxiv] Melbourne Social Equity Institute, 2014, "Seclusion and Restraint Project Report' for the National Mental Health Commission, The University of Melbourne