Australian Government
National Mental Health Commission

REVIEW OF SECLUSION, RESTRAINT AND OBSERVATION OF CONSUMERS WITH A MENTAL ILLNESS IN NSW HEALTH FACILITIES

Submission by the National Mental Health Commission

In Summary

The National Mental Health Commission (NMHC) recommends that the Review's final report and recommendations address the following:

- support for the implementation of a national approach to the regulation of seclusion and restraint with nationally consistent standards and guidelines;
- support for the implementation of a national approach to drive public consistent reporting and monitoring of restrictive practice across all jurisdictions;
- support for embedded human rights and the principles 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; and
- focus efforts on reducing rates of seclusion for more vulnerable groups, especially children and adolescents.

In the submission below, the NMHC will address in more detail the rationale for these recommendations. This submission will incorporate relevant findings and recommendations from the NMHC's document - *A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services* released in May 2015. Some findings will also be incorporated from the project *Supporting Mental Health Nurses towards cultural and clinical change: Facilitating ongoing reduction in the use of seclusion and restraint in mental health settings in Australia*, funded by the NMHC and conducted by the Australian College of Mental Health Nurses (ACMHN).

About the National Mental Health Commission

The NMHC's purpose is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

The NMHC seeks to engage with people with a lived experience of mental health issues, including carers and other support people, in all areas of our work. We affirm the right of all people to participate in decisions that affect their care and the conditions that enable them to live contributing lives. Diverse and genuine engagement with people with lived experience, their families and other support people adds value to decision-making by providing direct knowledge about the actual needs of the community, which results in better targeted and more responsive services and initiatives.

Overview

From its inception, the NMHC has promoted the basic human rights of those living with mental health issues, and targeted the use of restrictive practices such as seclusion and restraint. These interventions have no known therapeutic effect and in contrast, have been shown to be harmful to psychological and physical health of anyone involved in their use, including the consumers, their families and other support people and the mental health workforce. Of particular importance, anyone with a history of past trauma is likely to experience the use of restrictive practices as re-traumatising and counter-therapeutic. Aboriginal and Torres Strait Islander people have been subject to significant intergenerational trauma, and many others living with mental illness have significant experiences of past trauma.

While some improvements have been made from the initial focus on reducing, and where possible, eliminating the use of seclusion within mental health services, more needs to be done. Sustained attention is also required to reduce the use of all forms of restraint within mental health services, including physical, mechanical and chemical restraint. Other forms of restrictive practice such as involuntary detention also warrant continued attention, particularly given that Australia has signed and is in the process of ratifying the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Regulation of Seclusion and Restraint

Regulation of seclusion and restraint occurs through legislation, policy and accreditation. The NMHC supports a national approach to the regulation of seclusion and restraint with nationally consistent standards and guidelines. The challenge is to provide standards and guidelines acceptable to all States and Territories.

In Australia, legislation and policy are used to regulate seclusion and some forms of restraint. There needs to be jurisdictional agreement on definitions of seclusion, physical restraint, mechanical restraint and chemical restraint that is reflected in jurisdictional legislation. In addition there are numerous policies, procedures, guidelines and standards targeting the reduction of seclusion and restraint.

Consistency is required for the following elements as there is difference, where laws and policies exist, 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*; and
- concurrent use of seclusion and mechanical and/or chemical restraint.

THE NMHC position paper noted that 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; and
- provide guidance on changes to the physical environment.

The NMHC considers that this Review has the opportunity to provide leadership while recognising that shared ownership with clinicians and people with lived experience, their families and carers, and advocacy groups will be necessary to achieve positive change. It also needs to extend beyond mental health services to emergency departments and other health providers, schools, the justice sector and police and ambulance services.

Drivers for change in the use of restrictive practices

A fundamental principle underpinning safe and contemporary care of individuals with a mental illness is respect for human rights. Everyone in a mental health service has a right to expect not only safe and effective care, but also to be treated with dignity and respect, regardless of the circumstances. The system needs to be closely monitored and clinicians supported, so care can be delivered without using interventions that are experienced as adverse by consumers, carers and staff alike.

National and international research has revealed that the use of seclusion and restraint in mental health services has no evident therapeutic value. Perhaps even more concerning, it also reveals that the use of such practices has resulted in physical and emotional harm. In fact, their use is known to hinder recovery and traumatise or re-traumatise people – not only consumers but staff who are frequently distressed and injured by the process as well. Staff should also expect to work in an environment that is safe and supportive.

The Colleges representing psychiatrists and mental health nurses developed and issued position papers reflecting a clear commitment to provide leadership and to work with their respective members towards changing practices. A key message from these professional leaders is that the use of seclusion or restraint interventions is only ever a measure of last resort and must be used strictly in line with formal policies in a safe, dignified and respectful way. It should never be used as a method of punishment.

Principles to support a consistent best practice approach in all mental health services in Australia to eliminate the use of mechanical and physical restraint were launched at the 11th Towards Elimination of Restrictive Practices forum. The principles re-iterate that the use of restrictive practices is a last resort in managing behavioural emergencies, and the dignity and rights of people accessing mental health services should be respected and supported at all times.

The NMHC recognises that the prevention and safe management of behavioural emergencies involving people experiencing mental health difficulties can be challenging. Strategies are needed that are both safe and able to be used across all settings. Alternatives to hospitalisation need to be considered, such as, early intervention services, step-up and step-down facilities in residential settings and coordinated care programs to prevent re-hospitalisation.

There is a need for a cultural shift in reduction approaches from an aim focused primarily on de-escalation, to an approach in which the main priority is to prevent behavioural escalation from occurring in the first place.

The NMHC suggests that the Review needs to address the drivers for change to reduce the use of restrictive practices by increasing use of the 'recovery approach' to treatment and care in mental health services. 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 on care.

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. 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.

Monitoring and Reporting

Given the infringement on a person's liberty inherent in the use of seclusion and restraint and the potential for adverse consequences, there must be a national approach to monitoring and reporting on seclusion and restraint across jurisdictions and services, to provide transparency and accountability to the public about these practices.

To achieve real change, leadership is required at all levels from governments to each individual health services. Executives of health services need to embrace their responsibility for monitoring and reporting on their own service's data to ensure this process is being used as an essential tool for continuously improve their service's practice.

It should be noted however that a national approach to monitoring and reporting on seclusion and restraint across jurisdictions and services, is at an early stage. Comparative data on the use of seclusion in public mental health services was first made publicly available four years ago but data on restraint practices was published for the first time by the Australian Institute of Health and Welfare (AIHW) in May 2017. The recent AIHW report, noted that not all states reported under both categories of restraint – physical and mechanical. There is not yet jurisdictional agreement on definitions for seclusion, physical restraint, mechanical restraint and chemical restraint to ensure that data can be reported and compared reliably.

The NMHC recommends that the Review address the need for a national agreement between the key players in mental health to implement a process that would:

- gather and receive data on restrictive practices;

- establish targets to be met;
- provide reports on the use of restrictive practices;
- have powers of inspection and powers to require compliance; and
- coordinate training and education for workforce professional development.

The NMHC recommends the universal adoption of strategies and training guidelines that promote mental health recovery and support the goal of eliminating seclusion and mechanical and physical restraint in mental health services.

Placing a priority upon changing practice

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.

The ACMHN project funded by the NMHC identified that nurses do not believe containment methods can be eliminated under current conditions. The ACMHN notes the following findings in the research that identified these factors as negatively affecting a restraint free environment:

- insufficient resources (inadequate physical environment and equipment);
- inadequate staffing levels (high staff turnover, inadequate skill mix particularly on weekends, casualisation of nursing staff positions, and an ageing workforce);
- the changing role of the nurse, with nurses being time poor and having high workloads;
- concerns about safety and duty of care;
- inadequate skills/practice development opportunities for staff and limited to no education for families about alternatives;
- conflicts between staff approaches, specific approaches for individual consumers and policies;
- understanding and empathy with consumer, and communication difficulties.

Reported enablers to the elimination of seclusion and restraint included:

- strong clinical leadership;
- trained and experienced staff;
- adequate staffing levels;
- staff-consumer rapport and good therapeutic relationships with a focus on trauma-informed, empathic care;

- team collaboration and cohesion.

In conclusion

Leadership at all levels, by government to service level is required to effect meaningful reform to reduce and ultimately eliminate seclusion and restraint.

The NMHC urges the Review to address the recommendations:

- ensure the consumer and carer voice is central to all change strategies;
- promote the importance of clinical leadership in effecting change;
- adopt a national approach to the regulation of seclusion and restraint;
- agree to uniform definitions, targets and reporting frameworks;
- ensure seclusion and restraint practices and interventions are monitored and reported and prioritised by the Executive of health services;
- provide adequate resources to address staff ratios, physical environment and equipment; and
- invest in staff by training and educating mental health practitioners about multi-intervention strategies.