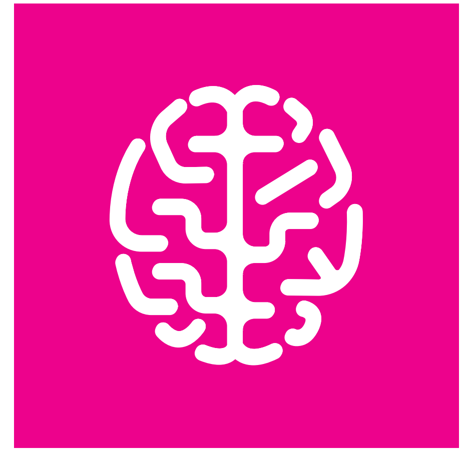

TOWARDS ELIMINATING SECLUSION AND RESTRAINT FROM MENTAL HEALTH SYSTEMS IN AUSTRALIA AND NEW ZEALAND

A Case Study of Alternatives to Coercion in Mental Health Care

May 2023

This case study is part of a three-part series commissioned by the World Psychiatric Association (WPA) and the Royal Australian and New Zealand College of Psychiatry (RANZCP) to examine how alternatives to coercion have been implemented in a variety of mental health care settings.

In 2019, the WPA initiated the Program on Supporting Alternatives to Coercion in Mental Health Care together with the RANZCP, and appointed a Taskforce to lead the work. The project has commissioned a literature review and discussion paper as well as the series of case studies. A WPA position statement that recommends action to promote changes in practice builds on this work.

This case study series is designed to share experiences and promote understanding of existing efforts to generate change in settings operating under varying social, cultural, and economic conditions. It aims to encourage and support mental health professionals around the world to work with people with lived experience, service providers and other partners to put alternatives to coercion into practice. It should be noted that the WPA has neither implemented nor evaluated the work described in the pages that follow.

The case study series has been produced by Community Works, an organization that specialises in participatory approaches to implementing community mental health initiatives.

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1. INTRODUCTION

Over the past twenty years, there have been concerted efforts in Australia and New Zealand to address coercion in mental health care. The use of seclusion and restraint in residential care facilities has been of particular concern. To learn about how this concern is being addressed, we spoke with nine people who are leading change and documented their stories here.

The World Psychiatric Association definitions of seclusion and restraint[1]

- **Seclusion** locking or confining a person to a space or room alone
- **Restraint** actions aimed at controlling a person's physical movement, including prolonged or unsafe holding by other person(s), the use of any physical devices ('mechanical restraint', chaining etc) and the use of psychotropic drugs for the primary purpose of controlling movement ('chemical restraint'). Note: chemical restraint does NOT include the judicious use of medication prescribed for treatment purposes.

Australia and New Zealand were chosen for this case study at a workshop held by the WPA Taskforce on Supporting Alternatives to Coercion in Mental Health Care. Participants in this workshop, who were mainly psychiatrists and social policy experts, were intrigued to hear about a shift in narrative that emerged as people in these two countries began making changes in their mental healthcare systems. Conversations about addressing seclusion and restraint had begun with the goal of reducing or minimising these practices. A decade later, the conversation had shifted to the more aspirational goal of eliminating seclusion and restraint.

Debate about which goal is most appropriate continues in the international arena, but there is widespread agreement amongst psychiatrists and human rights bodies that there is an urgent need to promote quality, human rights and alternatives to coercion in mental health services.[2] The pages that follow explain some ways in which this is being done in Australia and New Zealand in order to inform and inspire others who seek to improve mental health systems around the world.

1.1 Methods

Semi-structured interviews were conducted online with nine people. These participants were chosen through a 'snowball sampling' process beginning with John Allan (Co-Chair of the WPA Working Group on Implementing Alternatives to Coercion), who referred people he knew to be active leaders addressing seclusion and restraint in mental health care. Some of these interviewees then referred us to additional people with experiences to share. In some cases, interviewees also shared documents to support better understanding of the examples they shared.

Interviews focused on how use of coercion in mental health care has changed in Australia and New Zealand, and how that change has been achieved. Key discussion points were shared with interviewees before we spoke. They were:

- How alternatives to coercion have been implemented
- Challenges encountered along the way
- How things have changed, especially for service users and their families and carers
- What factors have been critical to success.

Interviews were then transcribed and summarised to form narrative accounts of the perspectives shared. The narratives focused on five key examples of change that interviewees spoke about. These narratives were then sent back to interviewees to give them an opportunity to verify or correct as needed to ensure their perspectives were accurately represented.

A thematic analysis was conducted across all five examples to understand key learning points that may be useful for people wishing to implement alternatives to coercion in Australia, New Zealand, and around the world.

1 World Psychiatric Association. Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care. Position Statment. 2020. Available from: https://www.wpanet.org/_files/ugd/e172f3_635a89af889c471683c29fcd981db0aa.pdf.

2 Gill, N & Drew, N et al. (in press) Bringing together the WHO QualityRights Initiative and the WPA position statement on implementing alternatives to coercion in mental health care – Working towards a common overarching goal. British Journal of Psychology Open.

1.2 Limitations

The pages that follow are by no means a definitive account of the use of seclusion and restraint in these two countries' mental health systems. We intentionally set out, rather, to provide concise narrative accounts of how changes in policy and practice have been achieved, including challenges experienced along the way.

One area of investigation that we were unable to pursue was the application of First Nations cultural knowledge to address the use of seclusion and restraint with Aboriginal and Torres Strait Islander people who use mental health services in Australia. This is important because, due to the devasting impacts of colonisation, Aboriginal and Torres Strait Islander people are more than twice as likely to be hospitalised for mental health conditions as non-Indigenous Australians and generally experience worse outcomes.[3] Efforts were made to identify and engage people with experience delivering culturally-located services to First Nations people in Australia. Unfortunately, limitations on time and resources eventually led us to conclude the study before such an interviewee could be engaged. We hope that future research will address this important gap.

1.3 Narrative accounts of change

Five narrative accounts of change are presented in the sections that follow.

These are:

- **Section 2: Using data on restrictive practices as a tool for change in Australia**, in which we gather an overview of policy changes to address seclusion and restraint from Associate Professor of Psychiatry, John Allan, and how public information about use of these practices can make a difference.
- **Section 3: A mental health practitioner's journey of advocacy**, in which we learn from Wendy Hoey's experiences as a psychiatric nurse manager who led whole-of-facility training programs with the aim of eliminating seclusion and restraint.
- **Section 4: Elevating lived experience perspectives to improve quality of care**, in which Bradley Foxlewin, Co-chair for the National Mental Health Commission's Expert Reference Group, explains why cooperative engagement with people who use mental health services is essential to implementing alternatives to coercion.
- **Section 5: The transformation of one of Australia's most coercive facilities**, in which we hear from Aaron Grove, Duncan McKellar and Del Thompson about how they made dramatic change at the Oakden Older Persons Mental Health Service in South Australia following its shutdown due to excessive use of seclusion and restraint.
- **Section 6: The Road to Zero Seclusion in New Zealand**, in which we share insights from Clive Bensemann, Dierdre Maxwell, and Kai Wairama about the consultative process of the Health Quality & Safety Commission to implement evidence-based interventions informed also by Māori cultural knowledge in New Zealand.

Section 7 then considers what we can learn from these examples by identifying four key mechanisms of change in Australia and New Zealand that emerge from the five narrative accounts.

3 Page I, Leitch E, Gossip K, Charlson F, Comben C, & Diminic S. (2022) Modelling mental health service needs of Aboriginal and Torres Strait Islander peoples: a review of existing evidence and expert consensus. *Australian and New Zealand Journal of Public Health*, https://doi.org/10.1111/1753-6405.13202.

2. USING DATA ON RESTRICTIVE PRACTICES AS A TOOL FOR CHANGE IN AUSTRALIA

Associate Professor John Allan has been thinking about the need to reduce coercive practices in Australia for a long time. Before being appointed co-chair of the World Psychiatric Association's Working Group on Alternatives to Coercion, he patiently championed the cause while developing a wide range of mental health services in Northern Queensland, holding the position of chief psychiatrist in two states and serving as president of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

"I'm still very enthusiastic about it. I guess what I've realised is that it takes time to embed change," he says.

Allan feels that the tide began to turn on restrictive practices in Australia in the mid-2000s. "Reducing seclusion and restraint became one of four new national focus areas in mental health safety," he recalls. "At the same time, consumer material was finally starting to get published, giving a voice to lived experiences. And the literature was starting to question the value of seclusion and restraint. It had always been an accepted part of practise – as a way of calming people down or dealing with dangerous situations – but people began to question whether it did more harm than good."

t was around this time that Allan joined the Beacon Site Project, a government-funded project that used the Six Core Strategies Planning Tool which entails 'Using data to inform practice'.[4] The project developed data through the work of eleven sites around Australia to demonstrate methods and outcomes for changing restrictive practices. From the Beacon Project, a national forum called the Seclusion and Restraint Reduction Forum emerged, explains Allan.

"People involved in the Beacon Project, and those advocating for reducing seclusion and restraint – from consumers, carers and clinicians to bureaucrats – got together and talked about their experiences and reported on projects they were doing. It was an important step that we were getting to the point of sharing strategies but it became clear that we needed more measurement; to use statistics as a tool to change people's opinions on how things currently stood and what could be achieved."

In 2009, Allan became chief psychiatrist in the state of New South Wales and joined the Safety and Quality Partnership Standing Committee. While on the committee Allan and colleagues launched a project to formally gather the much-needed data on restrictive practices in Australia.

The national data collection began to gather strong evidence but state governments were initially reluctant to allow publication of the results, recalls Allan. "It showed that the rates [of seclusion and restraint] were quite varied among the states and different services, which could lead to embarrassment at a service and state level. But it actually helps us understand that change is possible; that there is always an opportunity for change, rather than embarrassment. The key is to help the services and the politicians to be proud of the fact that they are publishing their data, owning up to the issues and taking steps to make change."

Allan and other champions of the cause pushed for this data to be made publicly accessible as a significant step towards improvements in mental health practice.

"It should be no different to publishing the rate of people who die from heart attack or stroke. You publish that to try to make improvements and it shouldn't be different in mental health. Ultimately the government will make hard decisions if you arm them with the evidence about why it's the right hard decision to make."

Eventually governments acquiesced to the data being publishing on the Australian Institute of Health and Welfare (AIHW) website[5] and in the literature, and the conversation of coercive practice increased across the country.

"We were always mindful that change was going to come from a whole-of-system change. So we worked on making the literature digestible to people who probably weren't academic, who were just hard workers. And we were trying to give people who were leaders tools that they could make change with," says Allan.

"You don't get change by going and telling people to change. You make sure they have the information and the right tools. So we worked on the first national framework for policy and guidelines around recovery-oriented services and there was a renewed focus on standards and professional education. We were just trying to give people the pathways to help them see a different future with a different culture."

In 2013, the National Mental Health Commission commissioned a 14-month project to investigate and identify instances of best practice in avoiding seclusion and restraint.

The same year, the name for the 'Seclusion and restraint reduction' forums changed to 'Towards eliminating restrictive practises'.

"We had actually had enough discussion with the participants that they were willing to work towards the idea of eliminate and not just reduction. The pendulum had shifted in terms of their attitudes towards this practise."

It was around this time that the shifts in practise really started coming through strongly in the data, says Allan. "There had always been individual successes but as a group that's when we started to see real change."

Since then, rates of seclusion in Australia have nearly halved, from 13.9 seclusion events per 1,000 bed days reported for acute specialised mental health hospital services in 2009–2010 to 7.3 per 1,000 bed days in 2020–2021.

4 National Technical Assistance Center. Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool [Internet]. Alexandria, VA: National Association of State Mental Health Program Directors; 2005. Available from: https://www.nasmhpd.org/content/six-core- strategies-reduce-seclusion-and-restraint-use

5 Australian Institute of Health and Welfare (2022). *Restrictive practices in mental health care, https://www.aihw.gov.au/mental-health/topic-areas/restrictive-practices*

The AIHW states that the collection and improvement of data on the use of restrictive practices in Australian mental health care is an ongoing initiative.[1] Annual reporting continues through cooperative efforts in the mental health data sector under national priority endeavours, particularly through coordinated work with state/territory mental health authorities.

To complement the data collection on seclusion, work was done to collect data on both physical and mechanical restraint data. It took time to get workable definitions of physical restraint and develop standardised collection tools and achieve data reliability. Although appearing to show some increase, especially in the states of Queensland, Tasmania and the Northern Territory, Allan explains that this more likely reflects better understanding by staff of the importance of recording all events than a compensatory increase for lower seclusion rates.

"The lesson is that it takes a long time to affect and make real change. But I think that reform always wins in the end," says Allan, ever passionate and patient about the long journey required for substantial change. "Incremental change is really happening and overall it's been sustained."

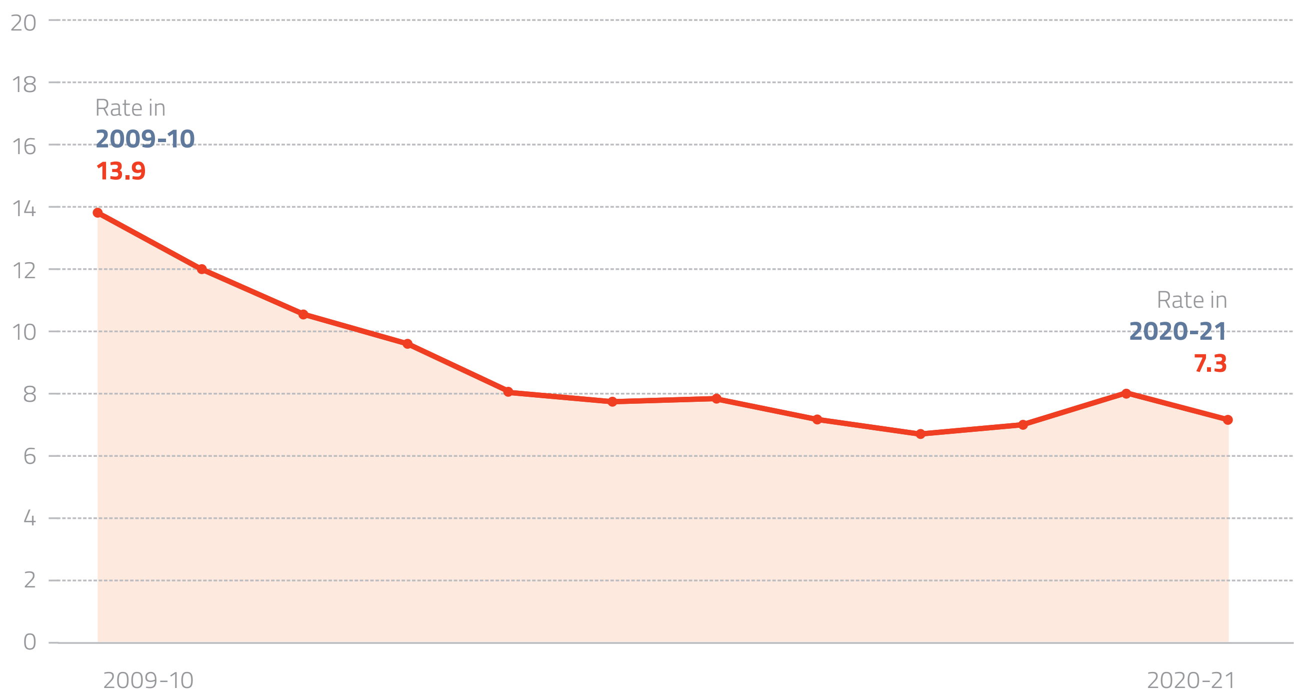
Further Reading:

Melbourne Social Equity Institute (2014). *Seclusion and Restraint Project: Overview.* Melbourne: University of Melbourne.

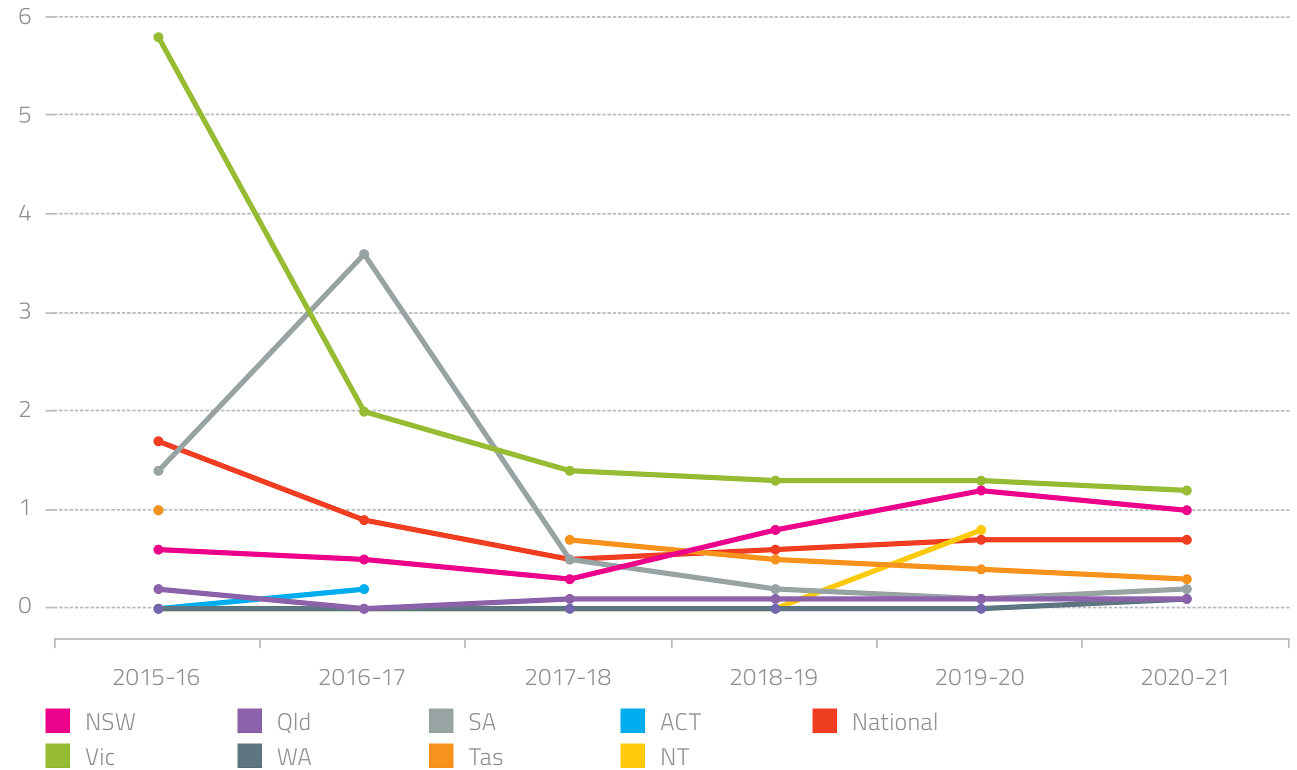
John A Allan, Gary D Hanson, Nicole L Schroder, Anna J O'Mahony, Australian Roxanne M P Foster, Grant E Sara, Six years of national mental health seclusion data: The Australian experience. Australasian Psychiatry, 2017 vol. 25, 3: pp. 277-281

Commonwealth of Australia (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Available on https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.

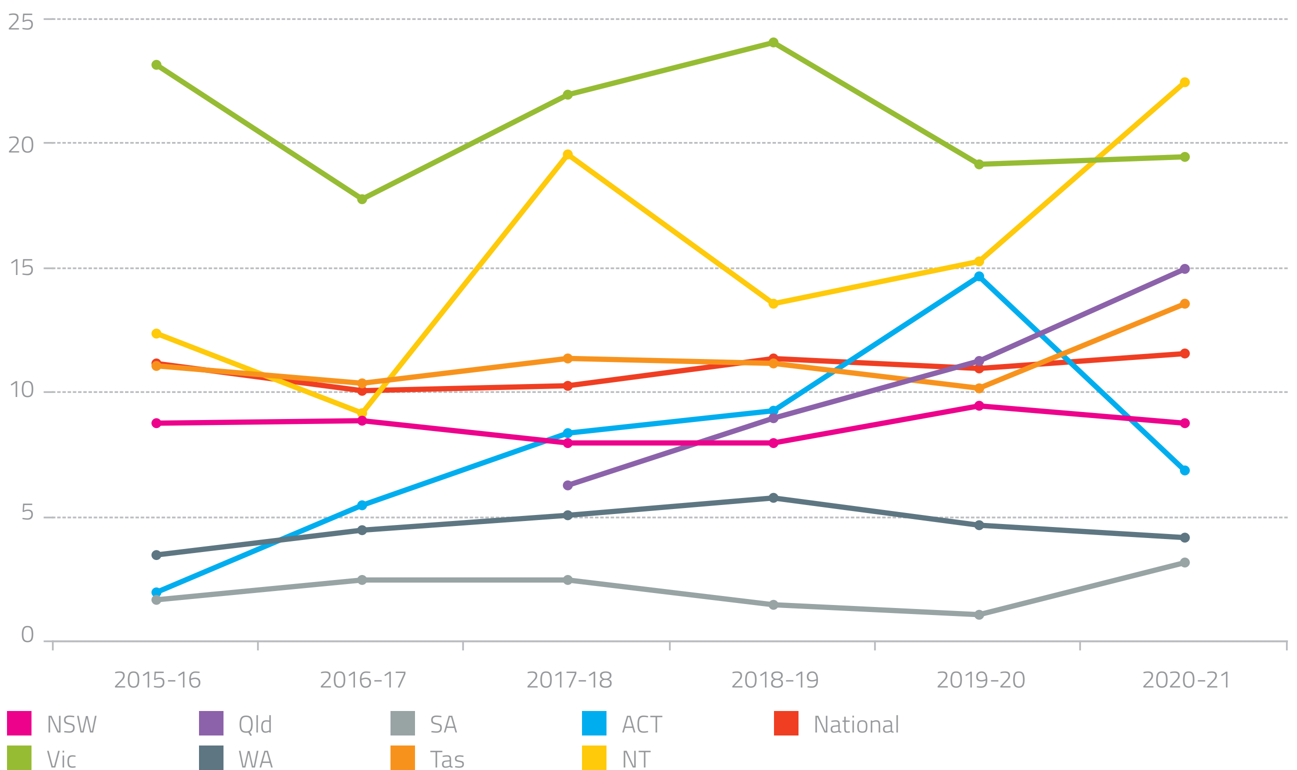
Use of seclusion in public sector acute mental health hospital services in Australia 2015-2021



Use of mechanical restraint in public sector acute mental health hospital services in Australia 2015-2021



Use of physical restraint in public sector acute mental health hospital services in Australia 2015-2021



3. A MENTAL HEALTH PRACTITIONER'S JOURNEY OF ADVOCACY

When Wendy Hoey moved from her native homeland of Scotland to Queensland, Australia in 1995, and found work in her trained field of mental health nursing, she was appalled by the use of seclusion and restraint.

In the three decades since, Hoey has been striving to reduce the use of coercion in Australia's mental healthcare system. She's known affectionately by colleagues as 'The Eliminator' recognising her passion to eliminate seclusion and restraint.

Now Acting Chief Executive of the NSW Justice Health & Forensic Mental Health Network, Hoey began her career as a frontline practitioner.

"I'd worked in mental health units as a mental health nurse in Scotland. I'd seen people chemically restrained but I'd never seen seclusion and I'd never seen physical restraints," recalls Hoey.

"By the time I actually realised people were put in shackles [in Australia] I had to get out, I couldn't handle it."

After taking a break, Hoey was invited to return to the mental health unit as a manager. She agreed on the proviso that staff underwent intensive training. Her request was approved and seven full days of training over three weeks was delivered to each staff member.

"In Australia you don't need specialist training to be a mental health practitioner," she says. "In the UK you have to study mental health nursing in addition to regular nursing. In Australia, you can do a post graduate qualification in mental health but you don't have to.

"Yet there's no one else in the world with the power of a psychiatric nurse. You can lock somebody in a room without asking them, without them committing a crime, because you think they're aggressive or because you've assessed them to be a worry. You can take their clothes off, strip them bare. You can inject them against their will because you think it's the right thing to do. And then you can put off the lights, walk out and leave them. That's the power we have."

Despite staff reluctance to undergo the training, by the time Hoey measured outcomes six months later, the unit was showing reduced staff harm, reduced use of seclusion, reduced use of medications, and had saved $300,000 in costs.

"When I presented the findings afterwards at a conference no one paid much attention – until I mentioned the savings."

Hoey was invited to join an informal national taskforce looking at alternatives to seclusion and restraint. She moved into policy for the Queensland Department of Health and established a reference group of people with lived experience of mental health problems and family carers.

"They were amazing. I remember sitting down and saying, 'You know, this policy would eliminate seclusion'. And they were saying to me, 'You can't stop nurses secluding people if you don't give them something else, what are you going to give them?' So it was actually the consumers that slowed me down and made me think 'I can't stop seclusion without giving them something else'."

Aware of the lack of tools practitioners have at hand to manage and defuse situations that may result in coercion, Hoey worked on training protocols. Like the training she'd done when managing a unit, she ensured training included mental health education, cognitive behavioural therapy, drivers of behaviour, how to design safety plans, and therapeutic intervention including the use of sensory interventions and other processes for identifying and de-escalating potentially aggressive situations.

"Clinicians need to understand how to gauge the environment before something escalates. 'Are they [the consumer] angry with me? Is anybody here at risk? No, he's just angry with the world. Ok, what can we do to support you through your anger?'

"One of the proudest moments I ever had was in a unit I was managing – we were just 12 months seclusion free at this point – and this guy comes in quite angry and lifts this chair up above his head and my nurse said, 'Oh, hey, Joe. That's not how we do it here. You know, if you want something, just ask and we'll sit down and discuss it. So maybe a cup of tea or something?'

"It was powerful because you're saying to the patients, you don't have to fight us. Because people have got used to coming into mental health services and needing to fight. It can be a frightening place to come because you get locked up."

Hoey spent time working on definitions and categories of coercion, to both support and assess clinicians. She also introduced to Queensland legislation that any incidents of seclusion and restraint had to be noted as a clinical incident.

"You've got to be careful because it only takes one person to get hurt and then you revert to the way things were, so I included in the policy that you can engage in physical restraint when you're being challenged or you think you're going to be threatened. But I included that restraint can cause death and that The Medical Emergency Response Team should be called at the same time as a restraint, which encourages people think about the fact that they could kill someone [by restraining them].

"Then, we introduced that if you were going to seclude someone for a second time, you had to phone the director of mental health on call at Queensland level."

Kindness, human rights and patient safety alongside staff safety must always be at the fore, suggests Hoey, who shares an example of managing a mental health unit that had bedroom doors that didn't lock, which failed to protect people. "I wouldn't have felt safe so why did we expect the patients to put up with that? So we got locks that enabled people to leave their room but ensured it was locked to other patients."

When Hoey presents to those in the sector on her progress, she is sometimes asked about aggressive behaviour in emergency departments. "I say that if someone is presenting high on ice, for example, that's not a mental health issue, it's a security issue. Let's concentrate on what we can achieve in a controlled environment with people we've had time to interact with, to understand and learn about their pressure points; once we've had time to put a safety plan in place."

Hoey shares an example of the power of building up this understanding. "We had a woman at a mental health unit who presented with very aggressive behaviour and kept trying to leave her room until she was secluded. We eventually learned that she had had a sexual trauma and couldn't sleep with the light off. Once she could sleep with a light she was never secluded again.

"You are often dealing with people with past trauma – childhood traumas, homelessness, sexual abuse – and yet instead of trying to understand that we exacerbate the trauma with coercion."

Despite her passionate plea for elimination, Hoey knows that it can be difficult. "I know it can be hard. Mental health units can be really scary places and it's hard for staff to show kindness if they're feeling scared."

But Hoey's experiences have shown that with training, procedures and planning in place, the needs of service users and clinical staff alike can be met in a safe and supportive environment.

4. ELEVATING LIVED EXPERIENCE PERSPECTIVES TO IMPROVE QUALITY OF CARE

Is it feasible, let alone ethical, to explore and design alternatives to coercion in mental health care without including the voice of those with lived experience? Researcher, consultant and inaugural Deputy Commissioner of the Mental Health Commission for New South Wales, Bradley Foxlewin, suggests it's not.

For Foxlewin, and many in the sector, the only meaningful way to address coercive practices such as seclusion and restraint – and put alternatives into practice – is to prioritise and elevate the voice of those with lived experience of mental illness and coercion.

To do this, Foxlewin uses co-production, a way of working put forth by leading mental health academics, Cath Roper, Flick Grey and Emma Cadogan and taken up by the state of Victoria's 10-year mental health plan as one of five approaches critical to improving mental health services.

The Victorian mental health plan outlines that co-production sees professionals and service users sharing power and making collaborative decisions on planning and delivery of support, acknowledging that contributions from both perspectives are vital to improve quality of care.

"We don't need singular opinion because that's where the problems have always lain," says Foxlewin. "Co-production to my mind encompasses co-design, but it also encompasses co-delivery, co-research, co-evaluation and co-decision making. It's about creating settings where learned and lived, everyone's experience and expertise is valued."

Over the last 15-odd years, Foxlewin has learnt both how challenging and how impactful this approach is.

"My first involvement with this was through the National Mental Health Seclusion and Restraint project known as the Beacon Site Project."

The Beacon Site Project ran from 2007 to 2009 and targeted eleven sites around Australia to look at strategies aimed at reducing and, where possible, eliminating the use of seclusion and restraint in public mental health services.

"At the time, around 36 percent of patients in New South Wales were being secluded or restrained as part of their acute admission, so this was back in the day where it was still understood that seclusion was a feature of a therapeutic approach," says Foxlewin.

One of the sites that came onboard with the Beacon Project was the Psychiatric Services Unit at the Canberra Hospital in the Australian Capital Territory (ACT). "At the time the ACT had seclusion and restraint rates of about 8 percent but Peggy Brown, who was the director of mental health services in the ACT, took a very 'we can do better than that' kind of approach to this."

A Seclusion and Restraint Working Group was established by Mental Health ACT. The group, including Foxlewin, rapidly set up a weekly Seclusion and Restraint Review Meeting which brought together lived experience representatives, nurses, ward services personnel, allied health workers and doctors to unpack coercive situations. This is where the hard work began.

"Each week we examined every incident of seclusion and restraint, and situations where seclusion and restraint were avoided (i.e. "near misses") to find out what happened, what could have been done differently, or what staff had done to prevent seclusion," says Foxlewin.

"It was super hard to do; it was so discomforting. There were times when I walked away from those meetings in tears thinking, 'How the hell could that have happened? Why is that still happening?'"

But ultimately, Foxlewin says that by avoiding blaming and shaming of staff, who may not have been equipped to deal with a situation differently, the meetings became a space of both empathy and situational analysis rather than finger pointing.

"What happened in that process was that as lived experience representatives started unpacking their lived experience from a visceral, emotional and rational standpoint, then staff started doing that as well. We'd have nurses or wardspeople saying things like, 'I got the person into the room because I was frightened' or 'I didn't know how I could deal with the situation differently'.

> "We started unpacking how acuity actually works in the environment. So it became, rather than a problem for the nurse or a problem for the consumer, but an exploration of settings that has allowed for seclusion to occur."

There was also training for staff on trauma-informed care and how to provide early support and intervention, including Early Support and intervention Teams responding to situations at the earliest possible opportunity before it gets out of hand. The response was overwhelmingly positive.

"One of the main things that came out of it for me was hearing wardsmen say, 'It's so good to have a relationship with people where I can say, 'Listen Fred, this could all turn to shit quite quickly, right? And I don't want it to. And you know me and I know you. And I reckon we can get through this together.' Whereas without that relationship, the wardsman felt like they were just being used as bouncers."

Foxlewin says that the repeated conversations that were emerging through the weekly meetings – and awareness amongst the consumers that staff were trying their utmost to get to zero seclusion, including two hours per shift where all staff were on the floor establishing and planning together for best outcomes – benefitted people in the wards and led to greater trust and calm.

"Interestingly, the nurses station door started getting left open and people started popping their head in because they felt like they could say 'I really need this or that' because they felt safe to do that. Things like that started happening," says Foxlewin.

"All this cultural change was happening in the worst of bricks and mortar settings," he adds, laughing. "The flashy units with big hallways and open spaces and all of that kind of stuff can make some difference, but spending time and resources on cultural change; you'll get a better outcome."

Remarkably, within a year of the Seclusion and Restraint Review Meetings being established, restraint and seclusion rates fell to 2.3 percent and staff injuries also reduced. The second year in, instances had reduced to less than 1 percent.

"Less than 1 percent seclusion," says Foxlewin, deservedly proud of what the hospital achieved in just two years, "That's unheard of."

Further reading:

Cath Roper, Flick Grey & Emma Cadogan. (2018). Co-production Putting principles into practice in mental health contexts. University of Melbourne.

Slay, J. & Stephens, L. (2013). Co-production in mental health: A literature review. London: New Economics Foundation.

Foxelwin, B. (2012). What is happening at the Seclusion Review that makes a difference? – a consumer led research study. ACT Mental Health Consumer Network

5. THE TRANSFORMATION OF ONE OF AUSTRALIA'S MOST COERCIVE FACILITIES

As the State Government's Chief Psychiatrist in Western Australia, South Australia, and then Tasmania, it isn't surprising that Dr Aaron Groves has seen his fair share of mental healthcare facilities. But as an advocate for alternatives to coercion, Dr Groves has gone above and beyond in his roles, ensuring vigorous reviews of services of concern during his times at the helm.

It was during one of these reviews, while South Australia's Chief Psychiatrist, that Dr Groves and his review team uncovered arguably Australia's most coercive mental health facility for older persons in recent memory – and supported its transformation.

"When I became South Australia's Chief Psychiatrist in 2015, I found that the state had not done well in reducing seclusion and restraint, as if this national safety priority had eluded them," recalls Dr Groves. "The data was concerning and there was probably significant under-reporting as well."

While reviewing the state's data, Dr Groves noticed that one health service – Oakden's Older Persons Mental Health Service – had particularly concerning figures on restraint and coercion. When the Chief Executive Officer of the Northern Adelaide Local Health Network contacted him expressing her own concerns about the level of clinical care provided at the facility, Dr Groves contacted the facility.

"I wrote to the director of Oakden to say they really needed to put a plan in place to address their rates of restraint and was told that they would, but 18 months went by and I still wasn't seeing any change in their rates."

Eventually, after a resident who had died of an alleged overdose was found with bruises, caused by the use of restraints, Dr Groves was invited to undertake a review. He was joined by Professor Nicholas Procter, University of South Australia, Dr Duncan McKellar, working at the time for the Central Adelaide Local Health Network and Del Thomson, then Clinical Risk Manager, Office of the Chief Psychiatrist.

"What we found at Oakden was that it had the highest instance of seclusion and restraint in the country. In fact, there were more instances of mechanical restraint than all the other older persons mental health services in Australia put together. We're talking over 4000 episodes a year."

Dr Groves submitted his report to Government in 2017 outlining cultural issues such as poorly trained and unsupported staff, and within two weeks the service was closed. Of course, closing a coercive facility is only the first step.

"One of my co-reviewers, Duncan McKellar, put up his hand up to become clinical director of the service. He then went about establishing a new service in a new facility with a new culture."

Dr McKellar recalls of the transitional process: "We went through and collected all the mechanical restraint devices and threw them in the bin. That was the easy part. We also had to look at the way that medication was used, how personal care was handled."

The review panel spoke to family members of residents to ascertain the culture of care. "There is trauma for family members whose loved ones have been shackled, and then allowed to roam around with nothing but incontinence devices on. It's hard for families to witness. Dehumanisation is all part of a culture of coercion."

Dr McKellar agrees with Dr Groves that coercion can be a product of a poor workplace culture. "Staff was neglected at Oakden, and they end up unloading that on the clients they worked with," he says.

"[We have to think about] the cultural aspects of how we deliver care – the humanising of care, the humanising of the workplace. It requires us to think completely differently about who we are and what we are doing. It has to be built around partnership and deliberate deconstruction of the power dynamics. We have to be kind and compassionate to each other, change the way that we speak to each other. If we do that, then there is this chance that we might provide better care for others. If we don't have that kind of aspiration then we are never going to get there."

For Dr McKellar, this meant employing staff with the right mindset. Del Thomson recalls: "One of the things that Duncan has done really well has been to employ people based on their attitude. You can teach people skills, but only if they have the right attitude – you can't teach kindness."

"It's crucial to remember, you have the key to the door. You get to go home at the end of the day. That is an extraordinary amount of power that you have. It's easy to forget when you're having a bad day, but it's important to employ people who get that."

Once the right staff were in place, training was provided. As Dr Groves says, "Giving autonomy in cases of dementia can be particularly tricky. It requires a lot of sophistication to be noncoercive. Good services with well-trained staff who can learn how to capture the moment and maintain dignity."

Thanks to the strong leadership and whole of system approach of Dr McKellar, Oakden now has "probably the lowest amount of coercive and restrictive practices of anywhere in older persons mental health in the country," says Dr Groves.

"It was a staggering turn around in the course of three years."

Further reading:

Groves A, Thomson D, McKellar D and Procter N. (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing.

Recommendations for transforming a coercive facility

The Oakden review team all agree that a whole of staff approach with strong leadership is essential to transforming the culture of a mental healthcare facility. But what else is required for such a transformation? Dr Groves says it is essential to understand the problems – to understand what you're trying to change – before implementing solutions.

The 152-page review of Oakden Older Persons Mental Health Service led by Dr Groves draws from analysis of problems and solutions to poor mental healthcare put forward by Professor Don Berwick in his landmark report for the UK NHS: 'A promise to learn – a commitment to act'.

The problems:

1. **Patient safety problems exist everywhere**. Like every other health system in the world there are repeated defects in patient safety and too many people suffer.
2. **Staff are generally not to blame**. Whilst there are a few exceptions the vast majority of staff wish to do a good job, reduce suffering and be proud of their work.
3. **Incorrect priorities do damage**. The prime directive should be "the needs of the patient come first".
4. **Warning sounds abound and are not heeded**. Loud and urgent signals were muffled and explained away.
5. **Responsibility is diffused and therefore not clearly owned**. When so many are in charge, no one is.
6. **Improvement requires a system of support**. The system should be devoted to continual learning, top to bottom and end to end. Review of Oakden Older Persons Mental Health Service Term of Reference – Quality and Safety of Care Page
7. **Fear is toxic to both safety and improvement**. Better not to know can become the order of the day

The solutions:

1. **Recognise with clarity and courage the need for wide systemic change**. Everyone must acknowledge the need to improve.
2. **Abandon blame as a tool**. Whilst misconduct merits censure, errors do not warrant punishment.
3. **Reassert the primacy of working with patients and carers to set and achieve goals**. Patients and carers must be at the centre of all we do.
4. **Use quantitative targets with caution**. The primary goal is better care, targets are merely a tool en route to this end. When the pursuit of targets is the over-riding priority the focus may become too narrow to ensure best care.
5. **Recognise that transparency is essential**. Expect and insist on it at all levels and with regard to all types of information. Everyone should be free to state openly their concerns about patient safety without reprisal.
6. **Ensure responsibility for safety and improvement are vested clearly and simply**.
7. **Give staff career-long help to learn, master and apply quality control, improvement and planning**.
8. **Make sure pride and joy in work, not fear, infuse the health service**.

6. THE ROAD TO ZERO SECLUSION IN NEW ZEALAND

In 2022, the Health Quality & Safety Commission of New Zealand published the *Zero Seclusion Change Package*, which provides a set of evidence-based interventions to improve the experience of care while moving towards the goal of zero seclusion. The package is aligned to the Six Core Strategies,[6] an evidence-based and globally recognised tool for addressing seclusion and restraint. Implementation of the change package will see Zero Seclusion project teams providing wider access and choice of effective interventions—including both Western clinical and holistic Māori[7] cultural approaches —to address seclusion and improve health equity.

The package has arisen from the Zero Seclusion project, which began in 2018 after a group of senior clinicians saw an opportunity to change the conversation surrounding quality improvement of mental health services. One service had come under the spotlight prompting a formal review, and the Health Minister was keen to pitch positive ideas to the public about how to make mental health services better.

The group of clinicians was also keen to shift attention towards a more future-focused view. They had recently learned of a promising programme in Scotland from a member of a peer support group for people with lived experience of mental health conditions.[8] The Scottish Patient Safety Program[9] quickly gained traction as a model that could be replicated in New Zealand.

A comprehensive six-month consultation process found that addressing coercive practices—seclusion in particular—was a matter of priority for improving quality of mental health care. Equity was a related priority, as the data on seclusion and restraint showed significant overrepresentation of Māori and Pacific Islander people. This gave rise to a question that would become central to the task of adapting the Scottish program to the context of New Zealand, which was how to bring Māori worldview into quality improvement.[10]

This question was brought to the forefront by the Waitangi Tribunal process,[11] which found that the crown had failed Māori and required massive change across the health sector. This restructure of entire health system, led by the Māori Health Authority alongside the Health Association of NZ, is still very much underway. When it comes to mental health, in particular, measurable improvement in patient outcomes has been observed when Māori support staff are present on a day-to-day basis. They bring important cultural perspectives on trauma-informed care.

For example, the centrality of relationships to healing is one element of Māori worldview that is influencing alternatives to coercion in New Zealand. Involving family (*whānau*) in all stages of care and planning has been named a key driver of high-quality service delivery. 'The Aunties' is another example of the approach promoted by the Zero seclusion project. Drawing from the traditional role of older women in Māori communities, mental health services are urged to implement hiring practices that deliberately recruit 'aunties' who are respected as sources of wisdom, compassion, guidance and patience. Cultivating partnerships with local leaders (iwi) to co-design culturally aligned treatments and early intervention supports is also encouraged as a mechanism for quality improvement.

Sensory modulation is another example of an alternative to coercion that draws from Māori cultural practices. Sensory modulation has been proven effective in calming people by supporting and guiding them on how to use sight, sounds, smells, touch, taste, and movement to self-manage and change their emotional state. The use of sensory tools (such as music, essential oils, rocking chairs, weighted items and massage chairs) supports individuals to self-sooth and change their emotional and behavioural responses to stressful situations.

The Zero Seclusion Change Package aims to eliminate seclusion from mental health services in New Zealand by the end of July, 2023. It includes a clinical bundle comprised of ideas collected through an extensive consultation process, and identified as effectively contributing to downward trends in seclusion and inequity. The package also illustrates system drivers for change, provides a list of possible measures for monitoring progress, and a learning system with tools for rapid testing of change interventions, reporting and maintaining gains. The package is available free of charge online, and offers mental health practitioners in New Zealand and around the world an innovative set of resources for implementing alternatives to coercion.

Further reading:

Health Quality & Safety Commission New Zealand (2022). *Zero seclusion: Safety and dignity for all – change package. [Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha – mōkī aroha].* Available on https://www.hqsc.govt.nz/resources/resource-library/zero-seclusion-change-package/.

Te Pou (2023) Sensory Modulation: Learning and development, e-learning and video resources, available on https://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/sensory-modulation.

6 Te Pou (2020). *Six Core Strategies© Service Review Tool: New Zealand adaption* (2nd edn). Auckland: Te Pou. Available on: www.tepou.co.nz/resources/six-core-strategies-2nd-edition-full.

7 Māori are the tangata whenua – the people of the land—who first inhabited New Zealand. In 2018 Māori comprised approximately 16.5% of New Zealand's population. (For more information see: Te Ahukaramū Charles Royal, 'Māori', Te Ara - the Encyclopedia of New Zealand, http://www.TeAra.govt.nz/en/maori)

8 C. Bensemann, D. Maxwell, and K. Wairama, personal communication, 13 July 2021.

9 Scottish Patient Safety Programme ihub (2022) https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/

10 C. Bensemann, D. Maxwell, and K. Wairama, personal communication, 13 July 2021.

11 Came, O'Sullivan, Kidd, and McCreanor (2020). The Waitangi Tribunal's WAI 2575 Report: Implications for Decolonizing Health Systems, *Health and Human Rights Journal*, Vol. 22 (1): 209-220.

7. LEARNING FROM THESE EXAMPLES: MECHANISMS OF CHANGE IN AUSTRALIA AND NEW ZEALAND

The examples presented in Sections 2-6 document the experiences of people who have led changes to policy and practice in Australia and New Zealand. The change-makers we interviewed include psychiatrists, nurses and people with lived experience of mental health conditions who, together, have accumulated decades of experience implementing alternatives to coercion.

Reflecting on their stories, four key mechanisms stand out as crucial to positive changes in Australia and New Zealand: (1) training and professional development; (2) meaningful involvement of service users and their families; (3) shifting mindsets, relationships and the culture of service delivery; and (4) policy and legislation that establishes transparency, service user involvement, and pathways forward.

7.1 Training and professional development

All the change-makers we interviewed talked about training and professional development as an essential mechanism for implementing alternatives to coercion.

Based on their experience, training is most effective when co-produced by people with lived experience of mental health conditions, delivered to **all staff** at mental health facilities to ensure that all who work with service users have appropriate working knowledge of:

- General principles of mental health, cognitive-behavioural therapy and drivers of behaviour
- Recovery-oriented care
- Trauma, trauma-informed care, and the potential harms caused by coercive practices
- Addressing cultural change elements of avoiding coercion, which may include approaches such as acceptance and commitment therapy, and narrative community development
- Safety plans, especially how to design and implement them
- Sensory interventions and other non-coercive techniques for helping people cope with states of agitation and de-escalate situations before coercion is perceived as necessary.

Even modest investments in training can generate significant reductions in seclusion and restraint, as well as other desirable outcomes. In Wendy Hoey's experience, for example, seven days of training for all staff over a three-week period resulted in fewer incidents of seclusion, reduced harm to staff, reduced use of medications, and $300,000 fewer costs after six months at the facility where she first implemented changes in Queensland.

Aaron Groves cautions that specialised training is crucial for service delivery staff working with older persons. Ensuring autonomy for people with dementia, in particular, is very challenging and requires sophisticated understanding of how to maintain the dignity of service users.

7.2 Meaningful involvement of service users and their families

Another driver for change that featured in all the stories we heard was meaningful involvement and influence of people with lived experience of mental health conditions and their families.

Bradley Foxlewin shared examples from many years of influencing mental health policy and practice as a lived experience advisor. One important takeaway from his experience is the importance of meaningful collaboration with service users and their families, as opposed to token involvement.

One example he shared of meaningful involvement was the implementation of Seclusion and Restraint Review Meetings to address coercion in the Australian Capital Territory (ACT). These meetings established a weekly gathering of lived experience representatives, nurses, ward services personnel, allied health workers and doctors to examine every incident of seclusion and restraint, as well as 'near misses' to promote understanding and dialogue about what happened, what could have been done better, and what worked well to prevent coercive practices. In addition to the learnings this produced, Bradley explained that the meetings also generated awareness among service users that staff were trying to eliminate seclusion, which in turn led to greater trust and calm.

Another approach to meaningful involvement of service users and family members is co-production, which encompasses cooperative design, delivery, research and evaluation of mental health services. Foxlewin explained that crucial to the success of co-production is creating settings where professionals, service staff, people with lived experience and their family members all contribute and everyone's expertise is valued.

The psychiatrists and nurses we interviewed also emphasised the value of lived experience involvement. Wendy Hoey, for example, talked about when the Queensland Department of Health established a reference group of mental health service users and family carers. They found this brought nuance to conversations about coercion. For example, service users brought up the point that telling nurses to stop secluding people is unlikely to be effective unless they are offered alternative ways of supporting people through crisis.

In New Zealand, family involvement has been identified as a key driver of quality improvement in mental health services. Māori cultural perspectives and worldview also extends importance to involvement of extended family and community leaders. The Zero Seclusion Change Package recently published there recommends that mental health services develop partnerships with tribal (*iwi*) leaders to co-design early intervention and treatment strategies that align with local cultures and traditions.

7.3 Shifting mindsets, relationships and the culture of service delivery

All of the people who contributed to this study described the importance of shifting mindsets, cultivating positive relationships and changing organisational cultures to improve the quality of mental health service delivery. Several, reflecting back on when they started this work, mentioned that seclusion and restraint were commonly seen as a feature of effective therapeutic practice. Over the years they have witnessed many people shift their mindset towards understanding that coercive practices can cause serious harm and that better alternatives are available.

In addition to this key shift in mindset recognising that improvements can and should be made, the change-makers we interviewed shared the following ways in which mindsets, relationships and cultural changes can lead to improving quality of mental health care:

- Person-centred care should be at the forefront of people's minds – patients' needs come first and staff's primary concern should be working with them and their loved ones to achieve their goals.
- Principles of kindness, compassion, human rights and patient safety alongside staff safety should be prioritised.
- Building strong relationships between service users, orderlies, nurses and doctors can enable clear, person-to-person communication and early de-escalation of agitated situations.
- Deconstructing power dynamics is crucial to ensuring that service users and staff alike are respected and treated as equals.
- To address inequities, special attention should be directed toward bringing diverse cultural perspectives into service design and delivery, including deliberate hiring practices to employ respected people from communities that are overrepresented in incidents of seclusion and restraint.
- Cultivating understanding among staff that mental health facilities can be a frightening place for service users, especially when they have experienced coercion in the past. This can prompt staff to set a different tone and communicate, 'That's not how we do it here.'
- Strong leadership is needed at all levels of service delivery to encourage transparency and acknowledgement when improvements are needed.
- Staff should be well-trained, supported and feel safe at work.
- Blaming and shaming of staff should be avoided. Creating a space of empathy and situational analysis promotes continuous improvement.
- Forming Early Support and intervention Teams can help mental health facilities respond to challenging situations at the earliest possible opportunity to create an environment where everyone feels safe and supported.

7.4 Policy and legislation that establishes transparency, service user involvement, and pathways forward

All of the people we interviewed have been involved in changing policy and legislation to implement alternatives to seclusion and restraint in mental health systems and improve quality of service delivery and care. These have included measures to establish transparency about the use of seclusion and restraint, involve service users and family members, and clarify pathways for implementing alternatives to coercion in mental health care.

Measures for establishing safety and transparency discussed by the people we interviewed included:

- **Requiring all incidents of seclusion and restraint to be recorded** as a clinical incident
- **Noting that restraint can cause death** and that The Medical Emergency Response Team should be called at the same time as a restraint, prompting health facility staff to consider the extent of potential harm that can result.
- **Requiring a phone call to the director of mental health** on call at the state level anytime a person is secluded for a second time.
- **Collection and publication of nationwide data** on the number and duration of restraint and seclusion incidents to generate ownership, demand for change, and pride in progress.

Measures to establish meaningful involvement by service users and family members include:

- **Seclusion and Restraint Reduction Forum** brought together consumers, carers, clinicians and bureaucrats in Australia to share experiences, report on projects they were implementing, and articulate strategies for change.
- **Seclusion and Restraint Review Meetings** to address coercion in the Australian Capital Territory (ACT). These weekly meetings of service users, family members and service delivery staff are described in Section 7.2.

Measures to clarify pathways for implementing alternatives to coercion in mental health care included:

- **The Beacon Site Project** was funded by the Australian government to develop data through the work of eleven sites around the country to demonstrate methods and outcomes for changing coercive practices, especially seclusion and restraint.
- **The National Framework for Recovery-Oriented Mental Health Services** in Australia renewed focus on standards and professional education. It focused on providing pathways to help mental health practitioners see a different future with a different culture.
- **The Zero Seclusion Project** in New Zealand set a target for eliminating the use of seclusion in mental health services by July 31, 2023 and provided a suite of culturally-informed tools resources for realizing that goal.

8. CONCLUSION

The six stories of change examined here offer a range of different starting points for implementing alternatives to coercion in mental health care. In some cases, change began with providing training and support for staff members at a single acute care facility. In other cases, it resulted from state- and nation-wide policy measures. No matter where the starting point, the change-makers we spoke with emphasised the value of involving people with mental health conditions and their family members in ways that genuinely incorporate their insights and preferences. All of the changes to policy and practice we heard about in Australia and New Zealand have required shifts in mindsets, relationships and the culture of service delivery. At the most fundamental level, these changes begin with acknowledging the crucial role of implementing alternatives to coercion as a key component of improving the quality of mental health care.

It is important to acknowledge that there is still significant work needed to address coercive practices in Australia and New Zealand. This case study has focused on what has been working so far to implement alternatives, but seclusion and restraint are still overused in both countries. The need for ongoing work was acknowledged by the Ministry of Health in New Zealand just before publication of this study, with the issuance of new guidelines for reducing and eliminating seclusion and restraint in mental health care.[12] These guidlines emphasise person-centred and culturally appropriate approaches to safely avoid the use of these practices. Advocates in both Australia and New Zealand continue to work towards these important improvements in the quality of mental health services.

12 Ministry of Health. 2023. Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.

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