



**NATIONAL MENTAL HEALTH  
CONSUMER & CARER FORUM**

# Ending Seclusion and Restraint in Australian Mental Health Services



**A POSITION STATEMENT BY THE  
NATIONAL MENTAL HEALTH CONSUMER & CARER FORUM  
(NMHCCF)**

# Acknowledgements

This Statement has been prepared by the National Mental Health Consumer & Carer Forum (NMHCCF) Working Group on Seclusion & Restraint. The NMHCCF identified seclusion and restraint as a key priority focus for its 2007-08 Strategic Plan and this Statement follows on from that initial work.

The NMHCCF would like to thank those consumers and carers who were interviewed by NMHCCF members and provided their often harrowing insights into seclusion and restraint practices in mental health services.

The NMHCCF also thanks the individuals and organisations who provided input on the consultation draft of this Statement.

The NMHCCF acknowledges that mental health care is delivered through a multidisciplinary approach. Where this statement focuses on nursing practice it is because in many cases it is the senior registered nurse on duty who is authorised to make the decision to enact seclusion and restraint in emergency situations.

In outlining the NMHCCF position on seclusion and restraint, we acknowledge those clinicians who work to ensure that their patients are cared for in a humane and respectful manner. We value and encourage collaboration between mental health professionals, consumers and carers to end involuntary seclusion and restraint.

The NMHCCF dedicates this to every consumer who has been secluded or restrained, and acknowledges those who have died from experiencing seclusion or restraint.

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Copies of this Statement can be downloaded at [www.nmhccf.org.au](http://www.nmhccf.org.au)

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# Foreword

The frequent requirement to seclude and restrain people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality care.

Seclusion and restraint are often used despite the lack of evidence that they offer positive health outcomes. Indeed, seclusion and restraint are commonly associated with further trauma, risk of violence and potential human rights abuse. On commencing psychiatry, I found myself frequently questioning my own role in this common clinical scenario. Many years later it saddens me that we appear to have made little progress towards implementation of real alternatives.

Why do we find it necessary to engage in these practices on a daily basis? The answer is depressingly straightforward. The predominant foci of acute mental health care in Australia today are the emergency departments of our large public hospitals and their associated acute psychiatric wards. In these locations, there are few alternatives available for the safe management of dangerous behaviours. In these inappropriate and under-resourced contexts, seclusion and restraint are the accepted practices.

We need to face the reality that too often we lose sight of both the short and longer-term welfare of those we seek to serve. Subject to the trauma of seclusion and restraint, those with mental disorders are much less likely to seek our help again. The ongoing practice contributes to the community's fear of treatments and may help to explain, in part, the low use of services by those with mental disorders (a mere 35% according to the last Australian Bureau of Statistics Survey).

Despite the rapid change in community views of mental health, health services generally but mental health services in particular, have become obsessed with ensuring the safety of staff. This is not unreasonable but choices about the physical design and location of services are now usually made with these concerns uppermost. Mental health units now regularly feature a strong security presence, with guards patrolling the wards. This fundamentally detracts from the therapeutic environment and creates the confrontational atmosphere in which seclusion and restraint flourishes.

Quality mental health care requires time, resources and space to allow health professionals to deliver health care to meet the unique needs of patients. In a nutshell, we do not have what we need to practice people-centric mental health care.

Perhaps more dangerously, health professionals have become inured to this situation, not thinking about or seeing the harm caused by current approaches. Not only is this a poor outcome for patients, it also makes for an unpleasant workplace. Our efforts to attract the next generation of mental health workforce will be stymied if the care we provide continues to be associated with patient harm rather than positive health outcomes. Who wants to work there?

The underlying issue here is the ongoing failure to invest in any alternative models of care, particularly community-based services. The fact is that acute hospital care has become almost the only place where people with complex mental health problems can receive care.

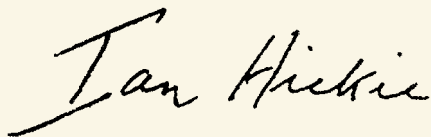
Our acute psychiatry wards are overflowing and health professionals are discharging people quicker than ever in order to free up services to meet ceaseless demand. The 'revolving door' is spinning faster than ever.

Until alternative locations for care and service are established, people requiring mental health care will be forced to attend psychiatric units characterised by their use of seclusion and restraint, not as a measure of last resort but as the default means of keeping order.

As with so many areas of mental health, it is not as if we lack an evidence-based approach, we just choose not to fund or deploy it. There is now clear evidence from overseas about a better and more effective approach to patient care. Early indications from the Australian pilot of the same approach seem to demonstrate its merit when applied here, rendering seclusion and restraint unjustifiable and outmoded forms of clinical practice.

This Statement is quite a measured contribution by consumers and carers against the practice of seclusion and restraint. But read between the lines and there is a completely justifiable anger that consumers are subject to a level of physical, mental and emotional violence unlike any other group receiving health care in Australia.

The consumer and carer voice is now clear in this statement. It poses a fundamental challenge to us as health professionals to refuse to continue to compromise on the quality of the care we provide to the community.

A handwritten signature in black ink that reads "Ian Hickie". The signature is fluid and cursive, with the first name "Ian" being more prominent than the last name "Hickie".

Professor Ian Hickie AM MD FRANZCP

Executive Director

Brain & Mind Research Institute

# What is Seclusion and Restraint?

The NMHCCF defines these terms as follows:

## Seclusion

Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.<sup>1 2</sup>

## Restraint

There are three distinct types of restraint:

- **Physical Restraint:** Physical restraint is the restriction of an individual's freedom of movement by physical or mechanical means (e.g. handcuffs, harnesses, straps). This applies to consumers receiving specialist mental health care regardless of the setting.<sup>3</sup>
- **Chemical Restraint:** Chemical restraint occurs when medication that is sedative in effect is prescribed and dispensed to control the person's behaviour rather than provide treatment.<sup>4</sup>
- **Emotional Restraint:** Emotional restraint in the mental health care system occurs 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.<sup>5</sup> Emotional restraint can also be coercive and threatening in nature (e.g. a consumer being told if they will not calm down they will be secluded).

The NMHCCF recognises that some Australian jurisdictions have removed chemical or pharmacological restraint as an intervention in their mental health services. However, chemical restraint has been part of the experience of consumers and carers in the mental health system and continues to be used in some jurisdictions. This is particularly the case where patients require transportation, often by air, involving multiple service providers and carriers in the process. This is an exceptionally dangerous experience for people with a mental illness, as documented previously by the Mental Health Council of Australia.<sup>6</sup>

Chemical restraint is unacceptable as a form of involuntary restraint in any circumstance.

# The National Mental Health Consumer & Carer Forum (NMHCCF) Position on Seclusion and Restraint

It is the position of the NMHCCF that involuntary seclusion and restraint:

- should be eradicated from use in Australia's mental health services
- are currently used at unacceptably high levels in mental health services
- are commonly associated with human rights abuse
- are not evidence-based therapeutic interventions
- highlight a failure in care and treatment when they are used
- are avoidable and preventable practices
- cause short and long term emotional damage to consumers
- epitomise a workplace culture of tension and antagonism between the powerless (consumers and carers) and the powerful (clinical staff)
- preclude the development of trust and respect between consumers, carers and clinical staff, leading to fear and distress among consumers and a breakdown of therapeutic relationships.

The NMHCCF recognises that there may be specific circumstances where involuntary seclusion and restraint are required for the safety of the individual and other people.

Involuntary seclusion and restraint should only ever be used as a last resort emergency safety measure and in those instances carried out in a respectful way, with checks and balances, by appropriately trained staff.

The NMHCCF agrees with the United Nation's *Principles for the protection of persons with mental illness and the improvement of mental health care*.<sup>7</sup>

*Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.*

The NMHCCF contends that both the prevalence and execution of seclusion and restraint demonstrate its current use in Australia is far more widespread and pernicious than as a last resort emergency measure.

# Prevalence and Patterns of Seclusion and Restraint

The lack of data in Australia in relation to the effects of seclusion and restraint has been commented on elsewhere<sup>8</sup> and confirmed by a full Cochrane Review<sup>9</sup> which, despite considering 2155 citations and 35 articles of full studies, was unable to establish an evidence base to support seclusion and restraint as interventions.

Nevertheless, the use of involuntary seclusion and restraint in all forms are an everyday occurrence, particularly in Australia's public acute inpatient facilities. This is despite the fact that consumers, carers, clinicians and staff have experienced and witnessed the direct and tragic harm that these practices can cause.

The Australian Institute of Health and Welfare reported just under 119,000 total admitted patient mental health separations (discharges<sup>10</sup>) from public and private hospitals in 2005-06.<sup>11</sup>

The Australian Council of Healthcare Standards (ACHS) *Clinical Indicator Report for Australia and New Zealand 1998-2005* indicated that the proportion of patients having seclusion is 10%.<sup>12</sup>

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On this basis, it is reasonable to suggest that there are just under 12,000 episodes of seclusion in Australia each year, or put another way, that seclusion occurs 33 times across Australia each day.

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It is worth noting that this figure is probably conservative, given that data and definitional problems across most Australian jurisdictions preclude accurate reporting of the prevalence of seclusion and restraint. ACHS data is more robust in Victoria than in other jurisdictions and the rate of seclusion reported in that jurisdiction was 14.4%.<sup>13</sup>

At least as concerning as this data is the ACHS finding that over the period 1998-2005, there was an increase in the rate of seclusion for more than four hours of 9% to 31%.<sup>14</sup> The ACHS suggests the reasons for this could include a lack of intensive care beds, staff turnover, the number of staff available and the prevailing culture within mental health units.

More generally, studies have investigated links between the prevalence of seclusion and restraint and a range of patient and environmental factors such as:

- the legal status, age, gender, diagnosis or medication of the patient;
- staff factors such as numbers, age and experience;
- the geographic location of the psychiatric unit (metro vs non-metro); and
- ward culture.

This study also found seclusion to be most frequent on Mondays and on the ward's busiest days, and lowest on weekends.<sup>15</sup>

The standard of reporting of Australian mental health services regarding rates of seclusion and restraint and the basis for this is patchy. There is no clear, regular and reliable public reporting available Australia-wide.



# The Reality of Seclusion and Restraint

## Thomas's Story<sup>16</sup>

Thomas presented at his local hospital Emergency Department (ED), concerned about his level of anger towards one of his children and his thoughts about harming himself and his family.

Thomas underwent a psychiatric assessment at the ED, where his level of distress was given a context: a history of torture and trauma as a political prisoner in another country.

Thomas and his family had migrated to Australia many years ago, however his medical notes indicated that he recently experienced depression following victimisation and bullying in his workplace.

Following his voluntary admission to the hospital's psychiatric inpatient unit, Thomas underwent further assessment. According to his medical notes, "last evening [Thomas] became very upset and lost his temper ... and felt out of control. So he packed his bags with the intention of getting away so that he would not harm anyone. He had no intention of harming anyone. He went into the Emergency Department because he felt he needed help."

The medical notes at every stage of Thomas's admission indicated the risk of harm to himself and to others as "significant" and made a further alert that he was "homicidal/suicidal".

Thomas was seen by a psychiatrist who recommended he see a social worker and be linked to counselling services. At no stage did Thomas receive information about his rights as a voluntary patient. He was not provided with services for his pre-existing diabetes, nor was he checked for 'sharps' or any other dangerous goods despite being noted as "homicidal/suicidal".

Nursing staff noted that Thomas had a poor appetite, however there were no notes indicating referral to a dietician. Of greater concern was the food he was provided with, which was inappropriate for his religious background.

After some time, Thomas became concerned that his 'treatment' involved nothing more than medication and did not include any referral to a social worker, psychologist, or community counselling service, despite this being recommended by a psychiatrist.

These concerns were expressed to both a hospital doctor and nurse. When no action was forthcoming, Thomas informed the hospital of his intention to discharge himself, which was his right as a voluntary patient.

Thomas was not told at this time that if he attempted to leave, or refused his prescribed medication, then his patient status would change to 'involuntary'.

Not confident about his standard of treatment, Thomas refused medication and attempted to leave the ward. According to his medical notes, he was "aggressive and argumentative".

Thomas was consequently reclassified as an involuntary patient and put into seclusion.

The Approval of Authority for Seclusion form indicated the view that Thomas was secluded in part because he was an absconding risk.

Thomas spent 6 ½ hours in seclusion. Thomas was stripped of his clothing and woke up in seclusion clothed only in his underpants.

No consideration was given to Thomas's past history of political imprisonment and torture, or his religious beliefs regarding the removal of clothing. Thomas was not provided with an explanation of his change of patient status (voluntary to involuntary) nor why he was being placed in seclusion.

He did not receive a debriefing session after his seclusion experience.

Having supposedly met the criteria for involuntary admission throughout the time he was secluded, Thomas was then found to be well enough to be discharged as a voluntary patient the next day without any follow up planned.

Thomas's seclusion suggests it was used as a punishment rather than a 'therapeutic intervention'.

As a result of his involuntary seclusion, Thomas now experiences insomnia, nightmares, stress, tension, pain and a lack of trust in the public mental health care service. He continues to have flashbacks of torture, flashbacks of hospitalisation and now has chronic depression.

Thomas says his life has "stood still" since his hospitalisation.

# Six Key Strategies to End Seclusion and Restraint

- 1. Better Accountability**
- 2. Implementation of Evidence Based Approaches to Ending Seclusion and Restraint**
- 3. Adherence to Standards and Public Reporting**
- 4. Support for Mental Health Professionals Towards Cultural and Clinical Practice Change**
- 5. Better Care Planning**
- 6. Review Relevant Mental Health Legislation**

The NMHCCF believe the following strategies are vital to ending seclusion and restraint in Australian mental health services.

## **1. Better Accountability**

The Australian Government *National Safety Priorities in Mental Health – a national plan for reducing harm*<sup>17</sup> acknowledges that seclusion and restraint are sources of harm to consumers. It proposes strategies to reduce and where possible eliminate the practices of seclusion and restraint in Australia. However, measurable progress towards ending seclusion and restraint is not currently available.

The NMHCCF urges the Australian Government, Australian Health Ministers Advisory Council (AHMAC) and the Mental Health Standing Committee (MHSC) to pursue the implementation of the strategies outlined under this plan as a matter of urgency.

A measure to monitor the rate of involuntary seclusion and restraint across Australia should form part of the accountability process to be established under the 4th National Mental Health Plan and be publicly reported.

## **2. Implementation of Evidence Based Approaches to Ending Seclusion and Restraint**

It is now clear from research undertaken in the United States and elsewhere by the National Association of State Mental Health Program Directors (NASMHPD) that neither involuntary seclusion nor restraint have a therapeutic value and that the abhorrence felt by consumers, carers, staff and clinicians about these practices are healthy responses to inappropriate interventions.<sup>18</sup>

There should be Australia-wide implementation of the NASMHPD evidence-based approach to reducing seclusion and restraint in mental health services, with regular and public reporting of its take-up by Australian mental health services.

The need for this to occur is already well understood in Australia. The Australian Government has acknowledged that the reduction of seclusion and restraint is a national safety priority in mental health.<sup>19</sup> To this end, it recently implemented the National Seclusion and Restraint Project, with the aim of reducing and, wherever possible ending the use of seclusion and restraint in public mental health services.<sup>20</sup>

The National Seclusion and Restraint Project, undertaken through the Safety and Quality Partnership Subcommittee of the AHMAC and its MHSC, is seen as a first step in reducing and eliminating seclusion and restraint in public mental health services. The Project developed and tested a range of data standards, performance indicators and best practice resources. A key component of the Project was the availability of scholarships to undertake study tours to a range of countries.

The Project investigated and learnt from evidence based best practice examples. Of particular interest was the work of the NASMHPD, which is overseeing a program that promotes implementation and evaluation of best practice approaches to prevent and reduce the use of seclusion and restraint in mental health services. The program's strategies have been successful in reducing seclusion and restraint in mental health settings across the US.<sup>21</sup>

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In Australia in February 2009, the National Beacon Demonstration Sites produced data highlighting the impact of implementing best practice. There were significant reductions in seclusion and restraint incidents across the eleven sites.

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The NMHCCF urges that the achievements of the National Seclusion and Restraint Project be widely disseminated across all mental health units along with advice as to why these results have occurred, what strategies were employed and the role of leadership in achieving such reductions.

### **3. Adherence to Standards and Public Reporting**

Where involuntary seclusion and restraint continue to be used, they can demonstrate a failure by clinical staff to carry out care to the standards set out by their profession. For example, Australian competency standards for registered nurses include a requirement that an individual and holistic patient assessment occurs and a nursing care plan is established, implemented and evaluated with the patient's active involvement. A return to this highly skilled and fundamental practice of nursing could mitigate the need for involuntary seclusion or restraint.

The NMHCCF recommends a key strategy to end seclusion and restraint is simply that there should be regular monitoring of the application of relevant clinical standards, such as, for example, mental health nurse compliance with the Australian Competency Standards for the Registered Nurse, and other relevant standards.

Further, each nurse registration authority and other relevant professional bodies should develop:

- a clear position on the requirement of all relevant clinicians to comply with the relevant professional and competency standards in relation to care planning; and
- their own position papers on seclusion and restraint that outline best practice with regard to the role, responsibilities and accountabilities of the relevant clinician when participating in seclusion and/or restraint practices.

The frequent use of involuntary seclusion and restraint can also reflect a failure by individual psychiatrists to undertake an independent assessment of the necessity of seclusion and restraint for particular consumers. This is despite their duty of care and their role and responsibilities outlined under the various Mental Health Acts and/or related policies pertaining to seclusion and restraint.

It is the NMHCCF view that current habits of clinical practice, as opposed to the standards of practice required, significantly contribute to patient distress and anger, which can result in patient seclusion.

The Office of Chief Psychiatrist (or equivalent) in each state and territory should, as part of its clinical practice reviews, ensure that each psychiatric inpatient unit is complying with the relevant clinical standards.

#### **4. Support for Mental Health Professionals Towards Cultural and Clinical Practice Change**

The NMHCCF acknowledges that the foundation stone for change with regards to seclusion and restraint lies with the culture of health professionals. In order to foster the necessary cultural change, mental health consumers and carers would strongly support:

- the provision of education, training and support for clinicians in trauma informed care<sup>22</sup> and the use of advanced communication, conflict resolution skills and de-escalation techniques;
- the provision of education and support for clinicians regarding their duty of care to comply with mental health and other related legislation and policy;
- the provision of education and support for consumers and carers regarding their rights around seclusion and restraint;
- a change in clinical and organisational culture to support and encourage internal professional reflection regarding day-to-day professional habits of practice;
- the establishment of regular clinical audits that ensure compliance with professional standards of practice;
- the introduction of regular audits of consumer and carer experience of seclusion and restraint to be carried out by consumers and carers with the results used to guide quality improvement activities; and
- the introduction of environmental interventions that assist in reducing not only the stress levels of consumers, but also those of clinical staff.

It is on this basis that clinicians can be equipped to use the range of best practice alternatives available to seclusion and restraint interventions before they consider their use, ensuring involuntary seclusion and restraint are only used as a last resort.

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Seclusion and restraint should never be used as first line or treatment interventions in mental health care.

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Where seclusion or restraint are used as a last resort the period of seclusion or type of restraint should be kept to the minimum necessary to ensure the safety of the person(s) at risk and only for the time required to enable less restrictive options to be put in place.

In instances where a person is experiencing suicidal ideation and is therefore at risk to themselves, the provision of a nurse “special” (one-on-one care) should occur in order to facilitate the emotional support necessary to relieve the consumer’s distress. Seclusion and/or restraint should never be used in these circumstances.

There should be active support of the principle that the needs of consumers and carers override funding pressures when it comes to “specialling” and in instances where clinicians decide involuntary seclusion and/or restraint is a cheaper option, a critical incident report should be completed. The use of seclusion and restraint in this instance should always be regarded and reported as a critical incident and analysis of results used to enhance genuine learning and improve practice.

While the NMHCCF acknowledges that some consumers consider that their seclusion or restraint was unavoidable we also strongly advocate that all consumers should be assisted to explore the range of best practice alternatives to involuntary seclusion and restraint before seclusion and restraint are used.

In instances where a consumer has experienced seclusion and/or restraint they should be offered an empathetic briefing as an integral part of post seclusion and/or restraint practice and where necessary offered private counselling (funded by the service) to assist in overcoming the trauma of being secluded or restrained.

The NMHCCF acknowledges that for services to be able to achieve these approaches to seclusion and restraint, comprehensive training, support strategies and resources need to be in place to assist practitioners and services to make necessary changes to their current practice. This includes strategies addressing consumer and carer/family roles in services, leadership, workforce development, prevention action plans and trauma informed care.<sup>23</sup>

Services and policy makers should continue to seek out and be informed by consumer and carer voices and experiences as part of their evidence base for practice.

## 5. Better Care Planning

Mental health services should ensure that consumers in inpatient psychiatric units have individual and holistic assessments that are informed by contemporary practice and are involved in the development of their own care plans, which include strategies that are trauma informed and minimise distress.

From this assessment clinicians should develop, in conjunction with the consumer and their carer, a care plan that encompasses contemporary practice with particular emphasis being paid to strategies that minimise consumer distress. At a minimum the care plan must be:

- holistic and take into account the complex and individual nature of each consumer and the range of accepted interventions required to provide holistic care;
- inclusive of multidisciplinary expertise;
- inclusive of family or other carer input and needs as agreed by the consumer to assist in the consumer’s key supportive relationships;
- developed in partnership with the consumer and reflecting their wishes with respect to the use of best practice alternatives to seclusion and restraint (e.g. alternative methods of managing consumer distress and aggression);
- regularly evaluated and updated to reflect the considered support needs of each consumer as their needs change; and
- descriptive and outline actions for administrative staff and others who are involved in interactions with the consumer such as cleaners and other ward staff where appropriate.

Ideally, individual and holistic forward care planning should be established collaboratively by the consumer and their carer/s and clinicians while the consumer is well, to overcome circumstances where the consumer is too unwell on admission to have effective input to their care. The development of prevention and early intervention strategies is also recommended to reduce acute treatment and care involving seclusion and restraint.

## 6. Review Relevant Mental Health Legislation

Australia has recently ratified the UN Convention on the Rights of People with Disabilities. As a consequence there is an urgent requirement to assess the compatibility of each jurisdiction's mental health legislation and policy to ensure consistency with international law protecting the rights of people with disabilities. This assessment would include specific auditing of arrangements with regards to seclusion and restraint.

Each state and territory should:

- outline in its Mental Health Act and related policies the circumstances under which seclusion and/or restraint can and cannot be implemented;
- review its Mental Health Act and related policies to ensure the requirement that any person secluded and/or restrained must be examined by the authorised psychiatrist as soon as practicable (within one hour) after being secluded and/or restrained and that approval for ongoing seclusion and/or restraint cannot be approved until after this examination has occurred;
- ensure that its Mental Health Act and related policies requires that each mental health service provides their Office of Chief Psychiatrist (or equivalent) with monthly reports of the services using seclusion and restraint practices including a copy of the interventions used to prevent seclusion and restraint. This information should be part of regular public reporting; and
- review its Mental Health Act and related policies to include the requirement that each nursing registration authority receive monthly reports of seclusion practices and further, that nursing registration authorities should also be given the power to carry out investigations of nursing practice in regard to seclusion and restraint and where necessary implement disciplinary action.

Each state and territory should review its Mental Health Act and related policies to ensure that:

- public accountability measures exist to guarantee accountability when there is non-compliance with the Mental Health Act and regulations;
- the Office of Chief Psychiatrist (or equivalent) is independent of health departments;
- a clear statement exists regarding the role and responsibilities of the Office of Chief Psychiatrist (or equivalent);
- public accountability measures exist pertaining to the Office of Chief Psychiatrist (or equivalent); and
- public accountability measures exist pertaining to the authorised psychiatrist (or equivalent).

# About the National Mental Health Consumer & Carer Forum

The National Mental Health Consumer & Carer Forum (NMHCCF) is the combined national voice for consumers and carers participating in the development of mental health policy and sector development in Australia.

Through its membership, the NMHCCF gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform.

The NMHCCF aims to:

- utilise our lived experience and unique expertise in mental health to identify what does and does not work in the mental health sector
- identify important and innovative ways to bring about positive change within the mental health system
- be a powerful, respected, combined national voice for mental health consumers and carers.

One of the most urgent priorities identified by consumers and carers on the NMHCCF is that of the use of seclusion and restraint in mental health services.

The NMHCCF will continue to work towards a mental health system where consumers and carers are true partners in their own health care through genuine participation in the reduction and eventual elimination of these often abhorrent practices.



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- 2 Seclusion is not the same as the practice of 'time out' where a consumer is asked to agree to voluntary social isolation for a period of time.
- 3 NSW Health *Restraint, Seclusion and Transport Guidelines for Patients with Behavioural Disturbances Version 9*.
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- 15 Livingstone A, *Seclusion Practice, A Literature Review*, Victorian Quality Council and Chief Psychiatrist's Quality Assurance Committee, Department of Human Services, Victoria, 5 February 2007, page 21.
- 16 NMHCCF received permission to use this story.
- 17 Department of Health and Ageing, *National Safety Priorities in Mental Health – a national plan for reducing harm*, DOHA, Canberra, 2005.
- 18 NASMHPD, *Training Curriculum for the Reduction of Seclusion and Restraint*. National Technical Assistance Centre for State Mental Health Planning, 2006.
- 19 Department of Health and Ageing, *National Safety Priorities in Mental Health – a national plan for reducing harm*, DOHA, Canberra, 2005.
- 20 For more information, see <http://www.nmhsrp.gov.au/c/mh>. Accessed August 2009.
- 21 NASMHPD, *Training Curriculum for the Reduction of Seclusion and Restraint*. National Technical Assistance Centre for State Mental Health Planning, 2006.
- 22 Trauma informed care is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services. Without the use of such care, research shows that trauma is compounded, exacerbating poor outcomes and difficulties in recovery. Trauma informed care has been successfully used by NASMHPD in the United States.
- 23 NASMHPD, *Training Curriculum for the Reduction of Seclusion and Restraint*. National Technical Assistance Centre for State Mental Health Planning, 2006.