Report 10th National Seclusion and Restraint Reduction Forum 2015

The 10th National Seclusion and Restraint Reduction Forum was held in Melbourne on 28th and 29th of May 2015. The Forum continues the work to give respect to mental consumers and help with their issues without force being used against them.

The National Mental Health Commission (NMHC) launched its position paper "A case for change" which featured consumer workers, however it avoided the forced medication issue. It acknowledged the use of force as "a failure of care."

However the direct voices of those suffering seclusion and restraint were absent from the Forum. There was no attempt to bring those affected to speak or produce a joint statement about their experiences.

The Forum also failed to examine the hidden reality of forced medication. However Justice Action raised this issue at the Forum and distributed flyers http://tiny.cc/xmcqzx to all participants.

The Forum was also missing representation of the consumer worker movement, which provides crucial alternatives to forced seclusion and restraint.

National Mental Health Commission Position Paper

The NMHC launched its Position Paper on the second day of the Forum, titled *'A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services.'*[1] The paper supports working towards "reducing the use of involuntary practices…and jurisdictions must contribute to a national data collection with public reporting on all involuntary treatment…from 2013".

Nevertheless, the NMHC avoided forced medication as a method of restraint. By defining "chemical restraint" as medication administered primarily to control a person's behaviour, not to treat a mental illness or physical condition,[2] the NMHC sidestepped the issue of forced medication, despite referring to 'involuntary treatment orders' later in the paper as a "form" of restrictive practice.[3]

The NMHC position paper endorsed the role of consumer workers to reduce seclusion and restraint, citing the need for an approach that involves consumers and carers as one of the six core strategies to combat the issue.[4]

One strategy was "consumer roles in inpatient settings" p3.
"Peer support should be readily available in mental health services" p.7.
"Consumer led research and involvement in local evaluations and system research" p.11
"Employment of peer workers…where seclusion and restraint frequently occur" p.13
"The value of peer workers … to support people in crisis and on inpatient units" p.20

Direct voices of those affected

Although the Forum's specified objective was to "stimulate a robust dialogue that will shape the path beyond achievements to date,"[5] no mental health consumers currently suffering seclusion and restraint were present on the day, nor were their perspectives heard via prepared statements. The voices of those consumers should have been the centrepiece of the Forum. Their perspectives are essential to establish an effective overview.

Bradley Foxlewin, Deputy Commissioner of the NSW Mental Health Commission, was presented as the significant mental health consumer and

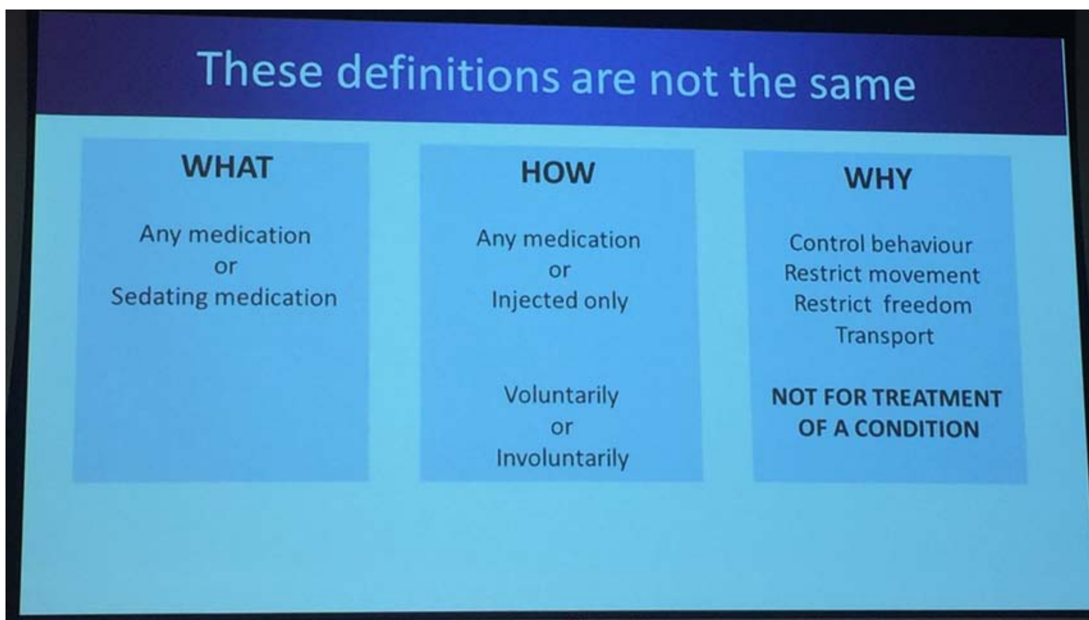
[1] National Mental Health Commission, 'A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services' (Paper presented at 10th National Seclusion and Restraint Reduction Forum, Melbourne, 29 May 2015).
[2] Ibid 2.
[3] Ibid 2.
[4] Ibid 3.
[5] *Program of Events,* 10th National Seclusion and Restraint Reduction Forum 2015, 1.

gave a keynote speech. He said: “we don’t want to bully the profession.”[6] That statement does not assert the centrality of the consumer and is very far from the reality.

Forced Medication

Justice Action distributed the flyers to focus discussion on the issue of forced medication prior to the afternoon of the first day.

In the ‘*Chemical Restraint: Is it possible to define and measure?’ s*eminar, there was in-depth discussion about defining chemical restraint. The Panel afterwards included A/Prof John Allan Queensland Chief Psychiatrist, and Dr Grant Sara from NSW Health. The use of the terms ‘emergency’ and ‘risk aversion’ for ensuring a ‘safe workplace’ were presented as key considerations for protecting the rights of workers and consumers alike.



However such definitional questions cloud the fact that both physical and chemical restraints are examples of forced control imposed upon the consumer. Forced medication whatever is intended by its imposition, whether described as treatment or due to crisis, is coercion and should be honestly admitted as such. The power and authority imbalance is overwhelming, so honesty is a fair concession in the discussion. Consumer preference is the only test of whether it is coercion. The 45,000 Community Treatment Order is the evidence.

[6] Bradley Foxlewin, ‘Consumer Voice: Empirical or Delusional, That is the Question’ (Speech delivered at the 10th National Seclusion and Restraint Reduction Forum 2015, Melbourne, 29 May 2015).

Panel members acknowledged the point. However later in conversation a NMHC member said that consumers hadn't raised it as a problem and only JA was doing so. "It is your job to get those voices out" we were told.

Consumer Workers

The Forum overlooked the consumer worker movement. The program contained no paper on the use of consumer workers as an alternative to seclusion and restraint. No research had been done.

This omission led us to question whether there is a gap between the rhetoric and the reality of the situation. In NSW, agreements with the Health Department after Tribunal recommendations on focus people have been totally unsupported in practice.

Organisational culture change, through an emphasis on recovery, trauma-informed care, human rights, consumer workers and interdisciplinary activity, were advocated in the NMHC's position paper,[7] as alternatives to coercion.

Consumer workers are employed for their expertise developed from their lived experience of mental illness, their personal commitment to their own recovery and shared experience of mental illness. These skills as social support are the links consumers crave, and are invaluable in a clinical setting.

Sally: Code black

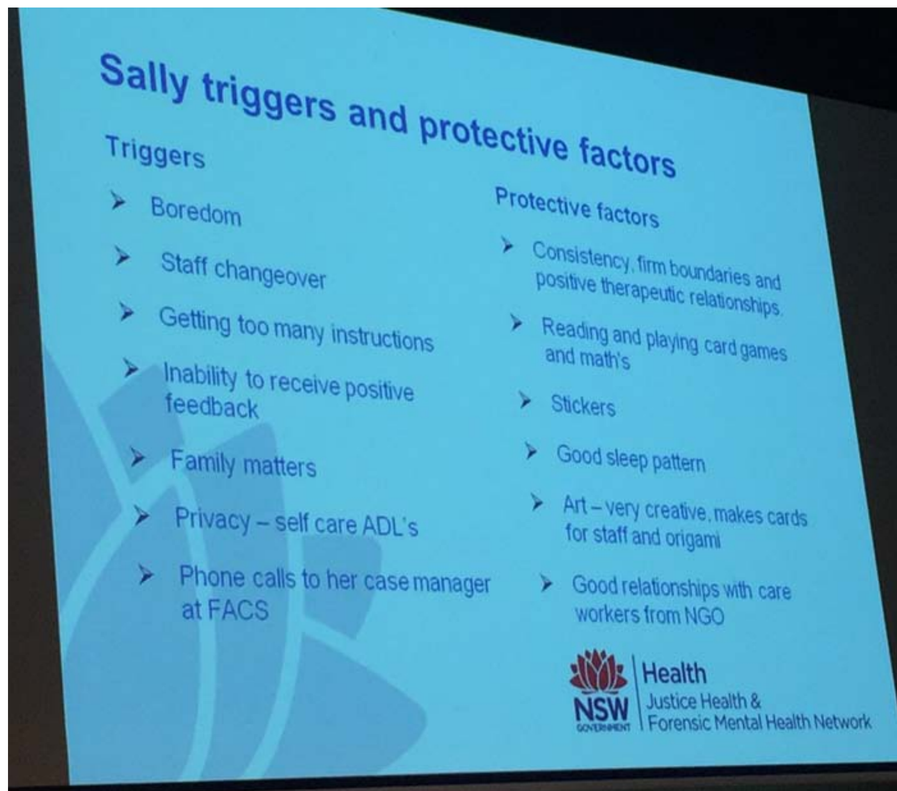
A/Prof Ruth Black from Melbourne Health, emphasised the need to reinstate control in the seminar *'An examination of Code Black (armed threat) incidents in the acute adult mental health inpatient setting'.* Anti-psychotic medications were presented as a necessary solution to armed threat scenarios, as it was argued that other methods of management of violent patients are simply too costly and risky

In response to these issues, the *'Walking the tightrope: Balance and decision – Should seclusion ever be an option'*, Panellists Chris Marsland, Lisa McCormack, Esther Dzvindu, Caren Fairweather and Shannon Simons from Justice Health & Forensic Mental Health Network NSW raised a confronting case study of 13-year-old 'Sally'.

Sally's story was incredibly tragic, detailing a long history of abuse and life in foster care, and an instance where she attempted to attack mental health staff provoked a "Code Black" scenario where Police were summoned. As a

[7] Ibid 3.

result, Sally was placed in seclusion. Eventually, Sally was eligible for release. However, she had nowhere to go and the day before her release she attacked a nurse once again.



As the seminar posed, seclusion can be a highly traumatising experience for individuals, particularly for young children and adolescents. Questions regarding the amount of interaction that staff actually had with Sally in the short time she was institutionalised and when the police were called should be raised. Where were the consumer workers or the NGO that she trusted. Alternate ways of handling the situation could also have been considered to avoid the repetition of such scenarios of violence.

It was a stark reminder of how far away reality is for adults when thirteen year olds get treated that way.

Justice Action
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