Mental Health & Wellbeing Commission

Supporting consumers' rights through improved understanding of complaints about restrictive practices

First Insight Report

January 2025

OFFICIAL

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Summary

The issue

The Mental Health and Wellbeing Commission (MHWC, the Commission) recognises that restriction of anyone's human rights is a critically important matter for a civil society and should only occur within the legal frameworks put in place to protect these fundamental rights.

Consumers of mental health and wellbeing services may have their human rights constrained legally when designated mental health services use restrictive practices in a way that is consistent with the relevant laws and guidance materials. The Victorian *Mental Health and Wellbeing Act 2022* (MHW Act) and previous *Mental Health Act 2014* (MH Act 2014), together with guidance from the Office of the Chief Psychiatrist (OCP), set out the circumstances, practices and record keeping procedures that must be followed by designated mental health services regarding the use of restrictive practices, including the use of chemical restraint.

The MHWC and its predecessor the Mental Health Complaints Commission (MHCC) receive complaints from consumers, their families, carers, supporters and kin about the use of restrictive practices at designated mental health services. These complaints are taken very seriously, recognising the harm that restrictive practices may cause, and the fundamental human rights involved.

Sometimes, after receiving a complaint about the use of restrictive practices, the MHWC (and MHCC) has been unable to access all the information we need to be confident that the designated mental health service has followed the required steps and record keeping procedures.

Availability of reliable, robust information about the use of restrictive practices is very important as Victoria moves towards reduction and elimination of these practices. Recommendation 54 of the Royal Commission into Victoria's Mental Health System (the Royal Commission) proposed eliminating restrictive practices within 10 years. This supports the widely held view that restrictive practices cause distress and trauma, are not therapeutic and don't contribute to the person's recovery (Mental Health Victoria, 2021; Office of the Chief Psychiatrist, 2024).

What we did

The MHCC developed a questionnaire to improve the quality of complaint handling when complaints were received about the use of restrictive practices by gathering more complete and consistent information from designated mental health services more quickly. The MHCC and subsequently the MHWC (referred to as 'we') were particularly concerned to know if the requirements of the relevant Act and the guidance of the OCP on use of restrictive practices were being met. We also aimed to reduce the administrative burden on services of providing complete information when responding to our requests following receipt of a complaint.

The MHCC and MHWC developed and refined the questionnaire with input from lived experience advisors, mental health services and the OCP. The first version of the questionnaire focused on the use of bodily restraint. The MHCC started using the questionnaire in July 2022 when the *MH Act 2014* was in force. The *MHW Act 2022* replaced the *MH Act 2014,* coming into force on 1 September 2023.

Insights

IMPORTANT LIMITATION

The MHCC/MHWC's questionnaire about the use of restrictive practices is only completed when we receive a complaint about these practices. This represents a small proportion of instances where restrictive practices are used. Therefore, we cannot and do not infer any generalised, system-wide findings about the use of

restrictive practices across the mental health and wellbeing system based on the information gathered through this process. We also acknowledge that a lack of documentation or reporting of specific actions does not mean correct actions weren't taken.

The questionnaires do provide important insights about the use of restrictive practices that will inform our activities in supporting the rights of consumers, promoting compliance with the MHW Act 2022, and monitoring the performance, quality and safety of the mental health and wellbeing system.

The main insights we drew from analysing the questionnaires are listed below.

1. **Utility of the questionnaire**: the questionnaires have been helpful in improving consistency in our handling of complaints regarding the use of restrictive practices because we have more complete and consistent information. The questionnaires have also been useful for identifying issues in the use of restrictive practices that may drive complaints, and potential ways to reduce use of such practices.
2. **Documenting the use of restrictive practices in designated mental health services**: we are concerned about the high level of inaccuracy and incompleteness of documentation found. Accurate and complete recording of the use of restrictive practices is required. It assists in the protection of rights, and in the resolution of complaints.
3. **Reporting the use of restrictive practices in designated mental health services**: we are concerned about the number of instances where reporting to the Chief Psychiatrist required under Section 108 of the MH Act 2014 and Section 138(4) of the MHW Act did not occur. We also found that not all incidents that should have been recorded in the Victorian Health Incident Management System (VHIMS) were recorded. Failing to notify the appropriate bodies about the use of these practices can be problematic for identifying strategies to prevent and reduce their use.
4. **Completing experience of care reviews**: we found issues concerning compliance with the Chief Psychiatrist's guidelines regarding experience of care reviews. These reviews are important. Their purpose includes identifying what might have been done differently to prevent or minimise the use of restrictive practices. This helps the consumer better understand their experience and services identify possible systemic issues that need to be addressed regarding the use of restrictive practices.
5. **Protecting consumers' dignity**: Facilities and supplies provided to ensure the person's dignity is protected, as well as trauma-informed, gender-sensitive and person-centred steps, were often not documented, or details were not provided of what was done to achieve these requirements. Similarly, notification to a related person and non-legal mental health advocacy services about the use of restraint was often not conducted or not documented. Support in the form of a medical review following restrictive intervention and debriefing were also often not carried out or not documented.
6. **Use of restrictive practices in emergency departments**: the most common location in which restrictive practices were used was emergency departments (EDs). We also noted some correlation between the duration of the restraint and the location in which the bodily restraint was used. Restrictive practices used in the ED were the longest in duration. We found issues with documentation and/or reporting to the OCP in all the complaints about restrictive interventions in the ED examined in this project.

We note that the specific incidents discussed in this document did not meet the criteria for conducting an investigation or issuing compliance notices to services based on the MHW Act and the MHWC's approach to compliance.

Actions

The MHWC has taken or will take action to address the issues identified. These actions are listed below.

- We made a referral to the Chief Quality and Safety Officer within Safer Care Victoria (SCV) in conjunction with the OCP to raise issues of compliance and reporting of the use of restrictive practices in EDs. Noting SCV have responded with a range of actions the MHWC will monitor.
- We have expanded and improved the questionnaire and are developing other questionnaires.
- We have drawn attention to the issues by disseminating this report to services, the OCP, SCV and the Department to highlight areas for improvement and further monitoring by the MHWC.
- The MHWC will continue to monitor the issues surrounding documentation and reporting of restrictive practices, as well as the low rates of advance statements of preferences, debriefing, and experience of care reviews conducted after the use of restraint. Follow up actions will be carried out when needed if issues are found to be persistent, including using a variety of the MHWC's compliance actions to investigate further. Additionally, the MHWC will continue to work closely with services regarding individual complaints about the use of these practices.

The MHWC aims to further support services to protect consumers' rights by:

- Adjusting the questionnaires where possible to reduce the administrative burden on services and doing so in collaboration with the OCP.
- Developing resources about the completion of questionnaires as a tool for services to understand the requirements and expectations the MHWC has when it comes to documenting and reporting uses of restrictive practices.
- Collaborating with the OCP to provide training on the requirements surrounding restrictive practices, particularly focusing on areas observed as issues in the questionnaires. The training developed by the department is still available on the website here: Reducing restrictive interventions (health.vic.gov.au)

Recommendations

The MHWC encourages services to use this report to drive improvement surrounding restrictive practices. While the observations discussed may not be representative of the use of restraint across services, they provide a snapshot of some areas where work should be done to improve the experience of consumers when seeking mental health and wellbeing services. The MHWC specifically recommends:

- Services carry out post-restrictive intervention debriefing with the consumer and experience of care reviews following the use of restrictive practices to drive learning and prevent further use of restrictive interventions where possible.
- The existence of, and use of, advance statements of preferences regarding restrictive practices were low overall. We encourage services to work with consumers to ensure that these documents are in place and considered in their treatment and care.
- Services ensure that documentation is completed adequately, and reporting to the OCP and Independent Mental Health Advocacy (IMHA) about the use of restrictive practices are carried out and provide regular training to staff around these requirements to ensure that the system has a clear picture of the use of these practices and can identify preventive measures to reduce them.
- EDs continue to be supported in meeting the requirements of the MHW Act and the OCP's guidance regarding restrictive practices.

Introduction

This report

The purpose of this first insight report is to support the protection of the rights of consumers who receive treatment at designated mental health services in Victoria. Our analysis of information gained from questionnaires completed by services as part of the resolution process following complaints to the MHWC and previous MHCC regarding use of restrictive practices in designated mental health services provides insights for consideration, discussion, further exploration and potentially service improvement.

Additionally, we hope this report helps services in further supporting EDs of designated mental health services regarding the changes in the regulation of restrictive practices which occurred in April 2024, thus further supporting the protection of consumers' rights.

The information discussed in this report comes mostly from the analysis of questionnaires about bodily restraint under the MH Act 2014, used between 1 July 2022 and 31 August 2023. The questionnaires since the MHW Act came into force on 1 September 2023 have been analysed and included for comparative purposes, as was information from other complaints about restrictive practices.

The MHWC intends to analyse the information gathered through questionnaires used when complaints are received about restrictive practices in designated mental health services under the MHW Act in February 2026. This will allow consideration of a larger sample size to show trends over time, including how services have responded to this first insight report and the MHWC's actions considering these insights. A more comprehensive report will be circulated on completion of the subsequent evaluation.

Background

It is widely recognised that restrictive practices cause distress and trauma, while not being therapeutic and not contributing to the person's recovery (Mental Health Victoria, 2021; Office of the Chief Psychiatrist , 2024). In 2021 the Royal Commission into Victoria's Mental Health System published its recommendations to improve the mental health system. Priority areas including elimination of restrictive practices within 10 years (Recommendation 54) and reduction of compulsory treatments (Recommendation 55) (State of Victoria , 2021).

The goal of eliminating the use of restrictive practices is a priority area of Victoria's mental health reform and for the MHWC. An objective of the *Mental Health and Wellbeing Act 2022* (MHW Act) is to "enable a reduction in the use of restrictive interventions" (Department of Health, Victoria , 2023), noting that they may only be used after all less restrictive options have been tried and when necessary to prevent serious and imminent harm to the person or another person. Restrictive practices include bodily restraint (physical and mechanical restraint), chemical restraint, and seclusion.

Role of the MHWC

The MHWC, and its predecessor the MHCC, receive complaints about the mental health and wellbeing system including when restrictive practices are used. Another of the MHWC's primary roles is to report on the performance, quality and safety of Victoria's mental health and wellbeing system through system oversight and monitoring. One avenue of monitoring is analysing the complaints data routinely collected by the MHWC. This information can provide insights into issues that occur systematically in mental health services, including about restrictive practices.

The questionnaire

Since July 2022 the MHCC and MHWC have used a questionnaire when reviewing complaints which concern the use of restraint on a person under the current or previous Act and while in a designated mental health service. Initially, a questionnaire for the use of bodily restraint was developed in consultation with lived experience advisors, mental health services and the OCP.

The purpose of the questionnaire included:

- improving the handling of complaints by strengthening and ensuring consistency in the process of reviewing episodes of bodily restraint, including through improving the availability of timely and complete information
- improving services' knowledge of the legal requirements regarding the use of restrictive practices
- identifying insights that may help designated mental health and wellbeing services to better support the rights of consumers when the use of restrictive practices is being considered
- providing consumers, their families, carers, supporters and kin, mental health and wellbeing services, government, and other stakeholders with advance notice of areas of specific interest to the MHWC with respect to the use of restrictive practices.

Of particular importance to the Commission is whether the requirements of the relevant Act and the guidance of the OCP surrounding restrictive interventions have been met. An important focus is whether less restrictive practices were attempted and what efforts were made to reduce the likelihood of restraint or seclusion being used, as well as whether these practices are being adequately documented and reported.

Project method

The MHWC has analysed the data from the completed questionnaires to assess themes in the complaints about restrictive practices both under the MH Act 2014 and the MHW Act. Additionally, feedback was obtained by MHWC staff from mental health service staff and from MHWC staff involved in completing the questionnaire to support the development of other questionnaires. The analysis was conducted with the purpose of:

1. Assessing the questionnaire's utility in improving the way complaints about restrictive practices are reviewed and managed, and understanding what, if any, changes to the questionnaire could be made to improve its impact.
2. Identifying insights about the use of restrictive practices in designated mental health services from the data of the questionnaires.
3. Identifying issues regarding compliance with the requirements of the MH Act 2014, the MHW Act, and the Chief Psychiatrist's guidance on restrictive practices with a view to identifying areas to improve compliance and potentially decrease the use of bodily restraint and other restrictive practices in designated mental health services.
4. Identifying factors contributing to the use of bodily restraint and other restrictive practices in services.

Analysis of the questionnaires about restrictive practices was carried out employing quantitative and qualitative methods.

A database was created to collect data from the completed questionnaires. The data was then analysed to identify trends about the use of restraint. A quantitative analysis was carried out, and percentages and medians were calculated where relevant.

Several responses to the questionnaire were in the form of free text; these were analysed to identify themes. This included fields where details were provided, particularly about the factors contributing to the use of bodily restraint, compliance with the Act(s) and the Chief Psychiatrist's guidance, and facilities, supplies and steps taken to ensure the person's dignity during the episode of restraint.

Additional information to support our knowledge of the use of restrictive practices in designated mental health services was sought through analysing complaints about the use of restraint in which the questionnaires were not used, including complaints which raised issues of chemical restraint before this was in scope for the MHWC; and complaints with multiple episodes or particularly lengthy episodes of restraint, where other complaint resolution methods were used.

Limitations

Although the analysis of the quantitative and qualitative data from the completed questionnaires might suggest common themes in the use of restrictive practices in services, this information does not consider all the factors leading to the use of bodily restraint in services because the sample size is small in comparison to the total number of instances where restrictive practices were used in designated mental health services.

Analysis of questionnaire data

This section presents the analysis of questionnaire data from complaints involving the use of restrictive practices received by the MHCC and the MHWC. The analysis is presented in two sections. The first section relates to complaints made under the MH Act 2014 and the second section to complaints made under the MHW Act 2022.

Complaints received

The following table provides information about the number of complaints received by the MHCC and MHWC regarding restrictive practices between 1 July 2022 and 30 June 2024.

Time period	Number of complaints raising concerns about restrictive interventions	Relevant legislation	Source
1 July 2022 to 30 June 2023	46*	*Mental Health Act 2014*	MHCC, 2023
1 July 2023 to 31 August 2023	12*	*Mental Health Act 2014*	MHCC, 2023
1 September 2023 to 30 June 2024	61**	*Mental Health and Wellbeing Act 2022*	MHWC, 2024

*Complaints related to bodily restraint and seclusion

**Complaints related to bodily and chemical restraint, and seclusion

NOTE: the MHCC ceased operation on 31 August 2023, MHWC commenced operation on 1 September 2023

These figures represent a relatively low rate of complaints when compared to the 7,557 (2021-22 period) and 6,540 (2022-23 period) instances of bodily restraint reported by the OCP (Office of the Chief Psychiatrist, 2023). However, the complaints about these practices provide insights into issues that might be occurring surrounding restriction in mental health services.

Complaints under the Mental Health Act 2014

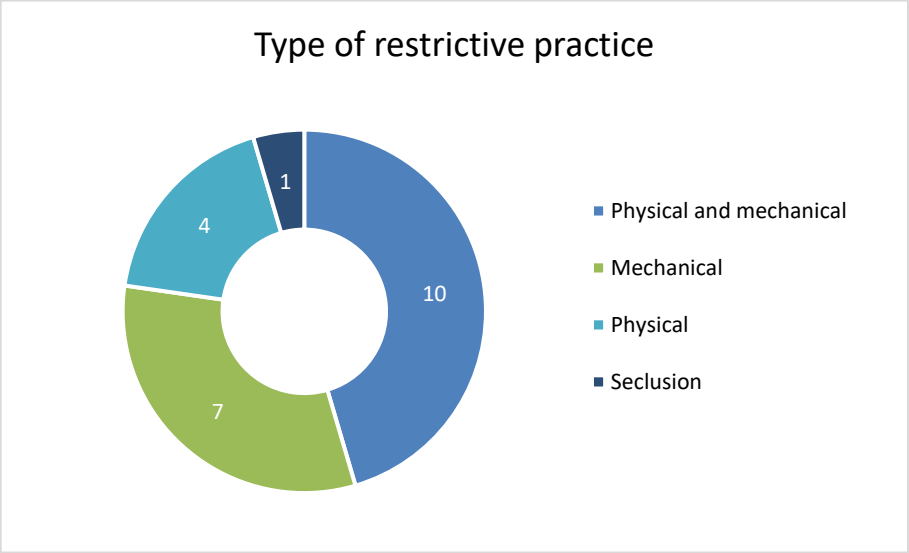
The questionnaires about restrictive practices under the MH Act 2014 were implemented as part of the complaint handling review process in 22 complaints about the use of bodily restraint which occurred between 1 July 2022 and 1 September 2023. This includes complaints made to the MHWC about events which occurred prior to 1 September 2023 when the new MHW Act came into force.

The questionnaire was not used for the remaining 36 complaints received about restrictive practices in this period for the following reasons:

- the complaint was out of scope
- the complaint did not progress due to an inability to establish contact with the person or their desire to discontinue the complaint process
- the questionnaire was not considered appropriate to review the complaint. These circumstances include multiple episodes of restraint in one admission, particularly lengthy episodes of restraint which require different forms of review, or that the restrictive practice was not under the MH Act 2014.

Type of restrictive practice

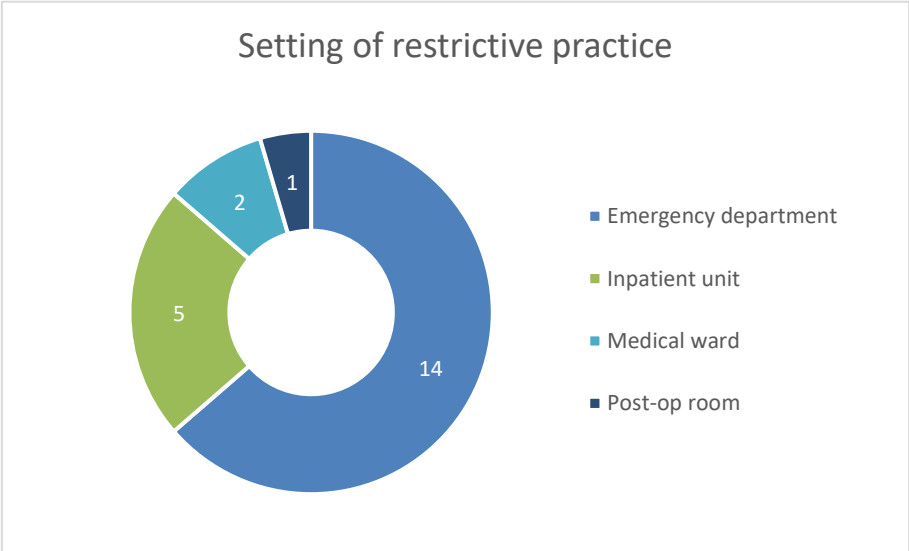
The type of restraint reported as used in the 22 complaints analysed include 10 (45.5 %) where physical and mechanical forms of bodily restraint were used, 7 (31.8%) where mechanical restraint was used, 4 (18.2%) where only physical restraint was used, and 1 (4.5%) where seclusion was used.



Setting of restrictive practice

Restrictive practices most commonly occurred in EDs (14 of 22). Among the 14 people on whom bodily restraint was used in the ED, 9 were brought into the hospital under Section 351 of the MH Act 2014. Eleven of the 14 people were subsequently admitted to a medical ward or inpatient unit for further treatment and 3 were discharged.

Five of the episodes of restraint occurred in inpatient units, 2 in a medical ward, and 1 in a post-operating room.



Use of medication

In 20 of the 22 complaints the person was given medication during the episode of restraint. The two most common medications reported in the questionnaires were Droperidol and Olanzapine.

Advance statement of preferences

Designated mental health services knew that the person had an advance statement of preferences in place in only 3 of the 22 complaints. The advance statement was considered in one instance, and it was reported not to be known if it had been considered in the other two. However, when responding to the questionnaire, one service noted that despite not knowing if it had been considered, the advance statement did not reference restrictive practices.

Duration

The duration of the restraint varied across a broad range, with the shortest being duration of one minute in total (two complaints) and the longest being 12 hours and 20 minutes. Overall, the shortest durations of restraint were reported where it was carried out in an inpatient setting and the longest durations were in EDs.

Less restrictive practices

The questionnaires record that less restrictive practices were considered and used in all the complaints, although one instance reported that less restrictive practices were used but did not detail what these entailed. When analysing the less restrictive practices used, the most reported were verbal de-escalation, providing or offering oral medication, and one-on-one conversation. Other practices included conducting a medical review, supporting the consumer to make a call to their family, and explaining the discharge policy. The use of procedures provided by the 'safe wards' guidance was only reported as an attempted less restrictive practice in one of the questionnaires (Department of Health , 2016).

All these less restrictive practices were found to be unsuccessful leading to the use of bodily restraint or seclusion. The reasons these were reported as unsuccessful (in order of most common to least) included continued agitation, refusal of oral medication, inability to treat the person, inability to maintain the person's safety or other people's safety, aggression, and risk of harm to self.

Reason for use of bodily restraint

The most common reason reported for the use of bodily restraint in accordance with those listed in the MH Act was the prevention of imminent and serious harm to the person, reported in 18 of the 22 questionnaires. The other two commonly reported reasons were the prevention of imminent and serious harm to others in 16 of the 22 questionnaires and the administration of treatment which was reported in 13 of the 22 questionnaires. The administration of medical treatment (to treat non-mental health-related symptoms or conditions) was only reported in 3 of the 22 questionnaires, 2 of them being the cases in which bodily restraint was used on a medical ward.

When analysing further details within these reasons, factors included agitation, aggression towards staff, risk of absconding, not being responsive to staff, erratic or unpredictable behaviour, refusal of oral medication, medical complications without treatment, and ensuring a safe transfer.

Authorisation

Authorisation of bodily restraint under sections 114 and 115 of the MH Act 2014 were reported to have been carried out appropriately in most episodes of bodily restraint, although in 3 instances it was not known or clear. In one instance there were inconsistencies in the questionnaire regarding authorisation by the Authorised Psychiatrist and notification to them.

In regard to the notification to a related person of the use of a restrictive intervention, this was deemed to be adequately carried out and documented in 12 of the 22 responses.

Medical reviews

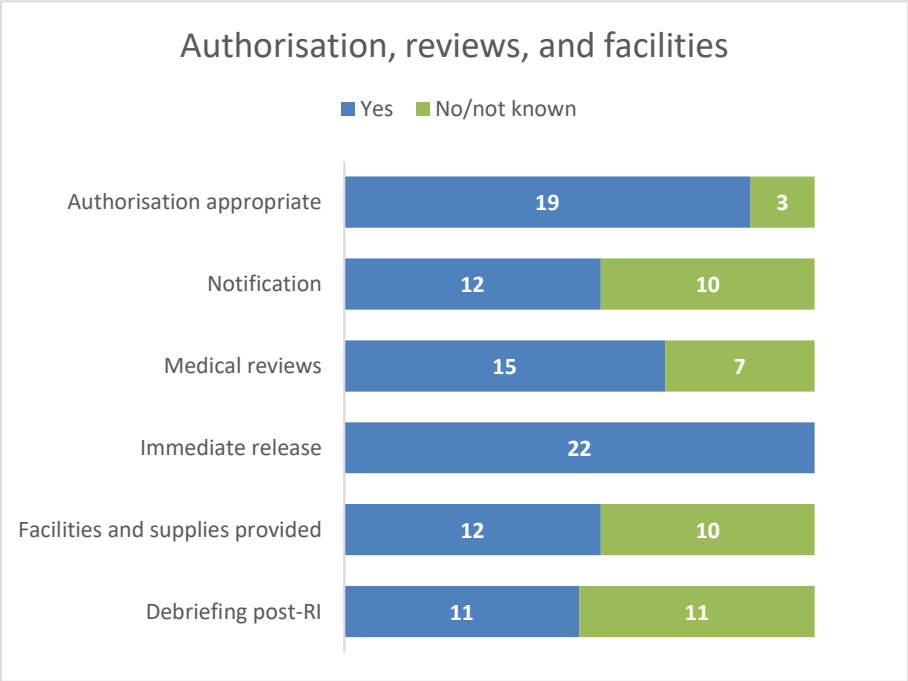
Medical reviews, including continuous observation, a clinical review every 15 minutes, and a medical review every 4 hours, were carried out in accordance with Section 116 of the MH Act 2014 in 15 of the 22 cases. The remaining cases did not have clearly documented evidence that hourly release of restraints and progressive removal of restraint points was employed in accordance with the requirements of the Act. Immediate release of restraint when no longer necessary was conducted in all 22 complaints, with subsequent seclusion in one instance.

Facilities supplied

Regarding the provision of facilities and supplies to ensure the person's dignity is protected, this was reported as documented in 12 of the 22 responses analysed. Those most commonly reported included providing water and food, providing a bedpan or other facilities for toileting, and privacy curtains.

The most reported trauma-informed, gender-sensitive and person-centred steps taken in line with the OCP's guideline were the presence of a female nurse when the person restrained was female, provision of medication, a nurse providing company, reassurance or explanation about any changes, privacy, and supporting contact with the person's family. However, these were not documented or only documented that 'needs were met' in 7 of these 12 responses.

Medical review following the restrictive intervention was reported as carried out in 13 of the 22 responses. Debriefing support post-restrictive intervention was only reported to have been conducted in 11 complaints.

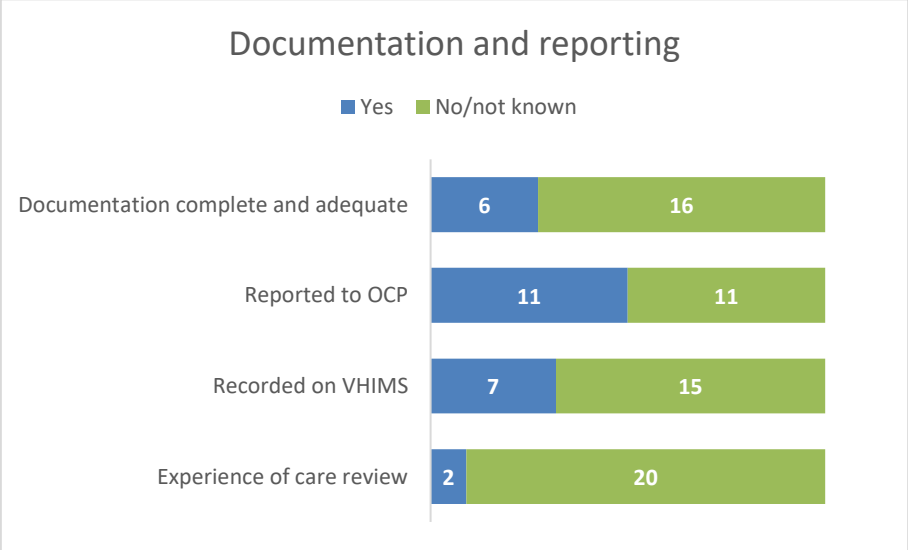


Documentation and reporting

Only 6 of the responses were able to demonstrate complete documentation of all factors regarding the requirements under the Act, which means there were issues noted and gaps with documentation in 16 questionnaire responses. The issues that were reported and identified included lost forms, incomplete forms, completion of only some of the required forms, inconsistencies between forms and notes, and clinical reviews not being recorded adequately.

Of the 22 complaints where questionnaires were completed, 11 instances of the use of restraint were reported to the Chief Psychiatrist. Responses to the questionnaire indicate it was not reported in 6 or not known whether it was reported in the other 5.

While the MHWC cannot corroborate that reporting did not occur, we encourage services to self-audit while responding to the questionnaire to ensure reporting requirements have been met and the responses to the questionnaire are accurate. Regarding reporting the bodily restraint as an incident in VHIMS, although it is not a requirement under the Act; some services do so, but this was not carried out for 15 uses of bodily restraint. Experience of care reviews, which are required to be conducted, were not conducted or not known to have been conducted in 20 of 22 complaints. Bruising or pain following the restrictive intervention was reported in 7 of the questionnaires. There were no reports of serious harm or death.



Complaints under the MHW Act 2022

The MHWC began operation on 1 September 2023, which coincided with the MHW Act coming into force. Between 1 September 2023 and 1 July 2024, 61 complaints were received by the MHWC concerning the use of restrictive practices. The questionnaire was used in the review of 15 complaints. Four questionnaires have not been returned to the MHWC at the time of writing, and therefore are not included in this report.

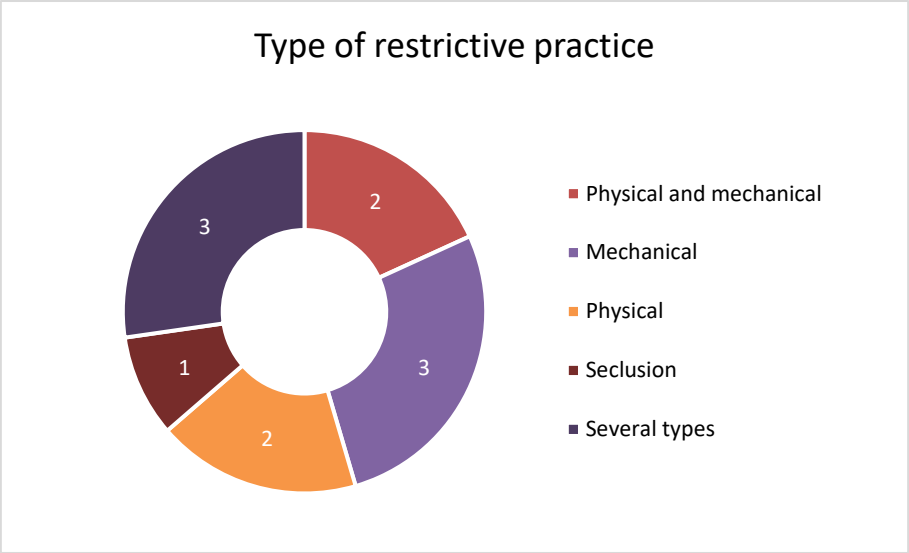
The questionnaire was not used for the remaining 46 complaints received about restrictive practices in this period for the following reasons:

- the complaint was out of scope
- the complaint did not progress due to an inability to establish contact with the person or their desire to discontinue the complaint process
- the questionnaire was not considered appropriate to review the complaint. These circumstances include multiple episodes of restraint in one admission, particularly lengthy episodes of restraint which require different forms of review, or that the restrictive practice was not under the MHW Act.

Type of restrictive practice

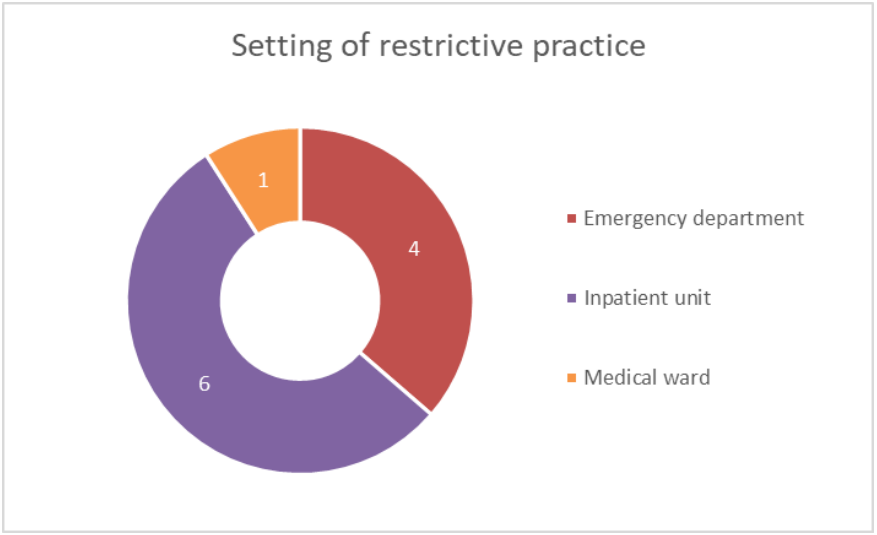
In the 11 completed questionnaires, 7 (63.6%) were only about bodily restraint, including 3 about the use of mechanical restraint, 2 about the use of physical restraint, and 2 about the use of both forms of bodily restraint

(physical and mechanical). One complaint was in regard to the use of seclusion. The remaining 3 (27.3%) complaints involved a combination of bodily restraint and chemical restraint or bodily restraint and seclusion; noting chemical restraint has been included as a type of restraint under this Act, allowing the MHWC to take complaints about this practice.



Setting of restrictive practice

The most common location reported was in an inpatient unit (6 of 11), followed by the ED (4 of 11) and the medical ward (1 of 11). This observation differs from the assessment of questionnaires under the MH Act 2014 in that most of those complaints were regarding the use of restrictive practices in EDs. Of the 4 people restrained in an ED all were subsequently admitted to a medical ward or inpatient unit for further treatment.



Use of medication

In 7 of the 9 complaints which were not about chemical restraint, the person was given medication during the episode of bodily restraint or seclusion. The most common medications reported in the questionnaires were Droperidol and Olanzapine, the same as those reported as most common in questionnaires under the previous Act.

Advance statement of preferences

In only one complaint did the person have an advance statement of preferences in place; in 3 questionnaires the respondent did not know if the person had an advance statement or not. The advance statement was considered in one instance, however, the complainant later informed the service that they wanted to update their statement.

Duration

The duration of the restraint varied widely, with the shortest being less than one minute in total and the longest being 4 hours and 40 minutes. Consistent with the observations about complaints under the MH Act 2014, the duration of restraint tended to be longer in EDs when compared to inpatient units.

Less restrictive practices

The questionnaires record that less restrictive practices were considered and used in all the complaints. When analysing these, the most reported were verbal de-escalation, providing or offering oral medication, and providing reassurance. Other practices that were employed included providing the person with an explanation of legal paperwork regarding their status under the MHW Act and explaining the use of personal phones policy. 'Safe wards' interventions were not reported as attempted in any of the questionnaires. All these less restrictive practices were found to be unsuccessful, leading to the use of restrictive practices. The reasons these were reported as unsuccessful remain similar when compared to the questionnaires under the MH Act 2014.

Reason for use of bodily restraint

The most common reason reported for the use of bodily restraint in accordance with those listed in the MHW Act was the prevention of imminent and serious harm to others, reported in 8 of the 11 questionnaires. The other two commonly reported reasons were the prevention of imminent and serious harm to the person in 6 of the 11 questionnaires, and the administration of treatment which was reported in 5 of the 11 questionnaires.

When analysing the details behind these reasons, factors that were reported to have led to the use of bodily restraint included aggression towards staff, increased agitation, known history of aggression, verbal threats to staff, risk of absconding, and refusal of medication.

Authorisation

Authorisation of bodily restraint under sections 132 and 134 of the MHW Act were reported to have been carried out appropriately in most episodes of restraint, except in one complaint where it was not known. There was one instance in which it is reported that authorisation was carried out as per the MHW Act, but documentation was not completed so verification is not possible. Again, this remains similar to the observations about restrictive practices under the MH Act 2014. Regarding the notification to a related person and to a non-legal mental health advocacy service of the use of a restrictive intervention (Section 135 of the MHW Act), this was not carried out at the time of the event or not documented in 6 of the 11 and 7 of the 11 questionnaires respectively. Notification has remained low, despite the addition of the requirement to inform a non-legal mental health advocacy service.

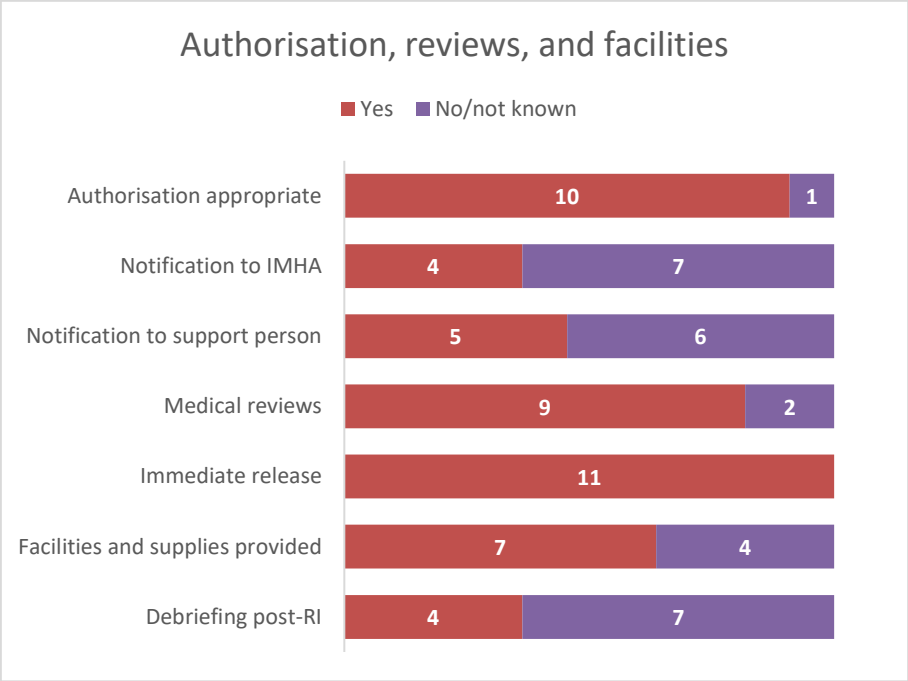
Medical reviews

Medical reviews, including continuous observation, a clinical review every 15 minutes, and a medical review every 4 hours, was reported as carried out in accordance with Section 137 of the MHW Act in 9 of 11 cases. However, there were instances in which these reviews were not recorded in the person's clinical records or not documented in the MHW Act paperwork.

Facilities supplied

Regarding the provision of facilities and supplies provided to ensure the person's dignity is protected, this was reported in 7 of the 11 responses analysed. Those that were most commonly reported included the provision of food and fluids, ensuring toileting facilities, and ensuring privacy by either having the person in a separate room or only removing clothing partially to provide medication. The most common trauma-informed, gender-sensitive and person-centred steps taken in line with the OCP's guidance reported in 8 of the questionnaires were the presence of a female staff when the person restrained was female and male staff when the person was male, and provision reassurance and explanation. The rate of demonstrated provision of these steps is similar to the complaints made and reviewed under the previous Act.

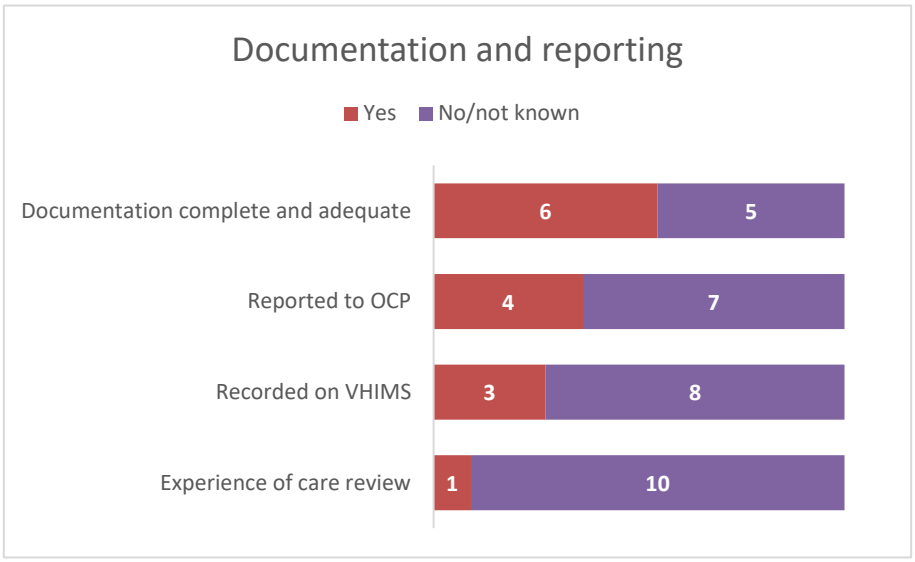
A medical review following the restrictive intervention was carried out in 10 of the 11 instances. Debriefing support post-restrictive intervention was only reported to have been conducted in 4 questionnaires, and not known whether it had been carried out in the remaining 7. This suggests post-restrictive intervention debriefing with the consumer continues to be low.



Documentation and reporting

There were issues with documentation and reporting of restrictive practices in 5 of the 11 complaints. The issues that were reported and identified included missing or incomplete MHW Act forms, and completion of the Electronic Medical Record (eMR) but not the MHW Act forms, which are now required under the MHW Act. Three of the 11 completed questionnaires noted that the use of restraint was not reported to the Chief Psychiatrist, and in 4 instances it was not known whether use of restraint had been reported.

Three services recorded the use of restraint as an incident in VHIMS, even though this is not a requirement. Experience of care review was not conducted or not known to have been conducted in all but one of the 11 complaints, continuing to be extremely low. Only one questionnaire reported an injury following the restrictive intervention and there were no reports of serious harm or death.


Documentation and reporting
Yes
No/not known
Documentation complete and adequate
6
5
Reported to OCP
4
7
Recorded on VHIMS
3
8
Experience of care review
1
10

Insights, actions and recommendations

This section presents the insights we gained through our analysis, describes the actions that have been taken and those that are anticipated, and makes recommendations for improvement.

Insights

Utility of the questionnaire

The questionnaires have been helpful in improving consistency in our handling of complaints regarding the use of restrictive practices because we have more complete and consistent information.

The questionnaires have also been useful for identifying issues in the use of restrictive practices that may drive complaints, and potential ways to reduce use of such practices.

Documentation

Accurate and complete recording of the use of restrictive practices is required. It assists in the protection of rights, and in the resolution of complaints, particularly when consumers and services' records reflect different experiences. Incomplete documentation resulted in further follow up with the service requesting clarification or further information after the completion of the questionnaire, making the review of a complaint lengthier and more complicated for all. It is unclear if some of the inconsistencies might be due to different staff completing different documentation leading to inaccuracies in the data reported on the questionnaires.

While many questionnaires refer to the use of mechanical restraint exclusively, it is well known that in many situations physical restraint will be required in order to mechanically restrain a person. It is important that services document and report these situations appropriately. Most people were given some form of medication during the use of bodily restraint or seclusion; this was the case regardless of whether the person was being restrained to provide treatment or not. Additionally, medication was given as part of the restraint in all settings. While it may be necessary to provide medication, now that chemical restraint is regulated by the MHW Act, it will be important that services ensure they are documenting the use of medication appropriately. The adequate documentation of providing medication during an episode of restraint should include the reasons for use and, when relevant, a justification of why it is considered treatment and not chemical restraint.

Reporting

We identified issues with reporting. In accordance with Section 108 of the MH Act 2014 and Section 133 of the MHW Act, the use of restrictive interventions needs to be reported to the Chief Psychiatrist, however this was not always done. Similarly, incidents were often not recorded in VHIMS. Failing to notify the appropriate bodies about the use of these practices can be problematic for keeping accurate records of their use within services and identifying strategies to prevent and reduce them.

Experience of care review

Another area where there were issues of compliance was with the Chief Psychiatrist's guidelines regarding conducting an experience of care review. An experience of care review was not conducted, or not known to have been conducted, in all but three complaints across both samples. Although an experience of care review might require time and staffing resources, the purpose is to identify what might have been done differently to prevent or minimise the use of restrictive practices, as well as to review areas where the service may not have complied fully with the Act. This process helps services identify possible systemic issues that need to be

addressed regarding the use of restrictive practices and helps the consumer understand their experiences, which could reduce complaints.

Protecting consumers' dignity

Facilities and supplies provided to ensure the person's dignity is protected, as well as trauma-informed, gender-sensitive and person-centred steps, were often not documented, or details were not provided of what was done to achieve these requirements. Similarly, notification to a related person and non-legal mental health advocacy services about the use of restraint was often not conducted or not documented. Support in the form of a medical review following the restrictive intervention and the provision of debriefing were also often not carried out or not documented. This does not necessarily mean that compliance with these areas of the Act and the Chief Psychiatrist's guidelines was lacking, but it does highlight that documentation of these practices is insufficient.

Emergency departments

Overall, the most common location in which restrictive practices were used was EDs, in a total of 18 of the 33 questionnaires analysed. In 11 of these 18, more than one type of restraint was used, most commonly physical and mechanical. Further, medication was given at the time of bodily restraint in all but one of these complaints (17 of 18). Only one of those 17 was recorded as bodily and chemical restraint. There was also some correlation between the duration of the restraint and the location in which the bodily restraint was used. Those instances in which the restrictive practices were used in the ED were the longest in duration. Issues with documentation and/or reporting to the OCP were recorded in all of the 18 complaints about restrictive interventions in the ED.

Actions

The MHWC has taken certain actions to address some of the issues identified. These include:

- Making a referral to the Chief Quality and Safety Officer within Safer Care Victoria (SCV) in conjunction with the OCP to raise issues of compliance and reporting of the use of restrictive practices in EDs. Noting SCV have responded with a range of actions the MHWC will monitor.
- Expanding and improving the questionnaire(s), as well as developing other questionnaires. Feedback was taken into consideration providing clarity to services about some of the MHW Act and OCP guideline requirements around the use of restrictive practices. For consistent review of complaints about all kinds of restrictive practices, new questionnaires were developed for the review of chemical restraint and seclusion.
- Disseminating this report to services, the OCP, SCV and the Department to highlight areas for improvement and further monitoring by the MHWC.

The MHWC aims to further support services by:

- Adjusting the questionnaires where possible to reduce the administrative burden on services and doing so in collaboration with the OCP.
- Developing resources about the completion of questionnaires as a tool for services to understand the requirements and expectations the MHWC has when it comes to documenting and reporting uses of restrictive practices.
- Collaborating with the OCP to provide training on the requirements surrounding restrictive practices, particularly focusing on areas observed as issues in the questionnaires. The training developed by the department is still available on the website here: Reducing restrictive interventions (health.vic.gov.au)

The MHWC will continue to monitor the issues surrounding documentation and reporting of restrictive practices, as well as the low rates of advance statements of preferences, debriefing, and experience of care reviews conducted after the use of restraint. Follow up actions will be carried out when needed if issues are found to be persistent, including using a variety of the MHWC's compliance actions to investigate further. Additionally, the MHWC will continue to work closely with services regarding individual complaints about the use of these practices.

We note that the specific incidents discussed in this document did not meet the criteria for conducting an investigation or issuing compliance notices to services based on the MHW Act and the MHWC's approach to compliance.

Recommendations

The MHWC encourages services to use this first insights report to drive continuous improvement surrounding restrictive practices. While the observations discussed may not be representative of the use of restraint across services, they provide a snapshot of some areas where work should be done to improve the experience of consumers when seeking mental health and wellbeing services. The MHWC specifically recommends:

- Services carry out post-restrictive intervention debriefing with the consumer and experience of care reviews following the use of restrictive practices to drive learning and prevent further use of restrictive interventions where possible.
- The existence of, and use of, advance statements of preferences regarding restrictive practices were low overall. We encourage services to work with consumers to ensure that these documents are in place and considered in their treatment and care.
- Services ensure that documentation is completed adequately, and reporting to the OCP and Independent Mental Health Advocacy (IMHA) about the use of restrictive practices are carried out and provide regular training to staff around these requirements to ensure that the system has a clear picture of the use of these practices and can identify preventive measures to reduce them.
- EDs continue to be supported in meeting the requirements of the MHW Act and the OCP's guidance regarding restrictive practices.

Conclusion

We do not suggest that the insights we've drawn from analysis of the questionnaires associated with complaints made to the MHCC and MHWC are representative of the use of restrictive practices across mental health services in Victoria.

However, we do believe that analysis of these complaints identifies important areas for improvement, as well as actions that can be considered by mental health services to improve outcomes for consumers and support the goal of eliminating restrictive practices.

We are concerned about the issues that analysis of these questionnaires has raised. Restriction of people's human rights should only occur within the legal frameworks designed to protect these fundamental rights. These frameworks have been carefully prepared to protect consumers and those who treat, care and support them. Adherence to these mandatory requirements is essential.

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