The Royal Australian & New Zealand College of Psychiatrists

Victorian Branch

RANZCP Victorian Branch Submission

STRATEGY TOWARDS ELIMINATION OF SECLUSION AND RESTRAINT

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Recognition of Lived Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the peak organisation representing the medical speciality of psychiatry in Australia and New Zealand with over 7900 members; the RANZCP is responsible for training and educating psychiatrists in addition to advocating on their behalf for excellence and equity in the provision of mental healthcare.

The RANZCP Victorian Branch (the Branch) has more than 1900 members including around 1300 qualified psychiatrists and over 500 members who are training to qualify as psychiatrists. Psychiatrists have a critical role within the mental health and wellbeing system as medical specialists, including through the provision of best practice treatment, care and support, academia and research, service improvement, and clinical leadership roles.

Notes about this submission.

The recommendations contained within this submission are based on consultations with the RANZCP Victorian Branch membership and the RANZCP Victoria Branch Committee, an expert committee comprising of psychiatrists, trainees and community members with lived and living experiences of mental health challenges and recovery.

The Branch acknowledges that language and the way we use it can affect how people think about different issues. We acknowledge the need to consider the words we choose when communicating with and about people with a lived and living experiences of mental health challenges and recovery. We recognise there are a variety of terms people prefer to use, such as ‘client’, ‘consumer’, ‘patient’, ‘peer’, and ‘expert by experience’.

To discuss this document please contact Jo Balmforth, RANZCP Victorian Branch Policy and Advocacy Advisor, ranzcp.vic@ranzcp.org

Foreword

The Royal Australian New Zealand College of Psychiatrists (RANZCP) Victorian Branch (the Branch) appreciates the opportunity to respond to the *Engage Victoria Consultation Paper* and assist in the development of the Victorian Strategy Towards Elimination of Seclusion and Restraint (the Strategy).

The RANZCP is committed to the humane and compassionate practice of psychiatric care consistent with Victoria's obligations to the core human rights conventions to which Australia is a co-signatory. This includes a commitment to reducing, and where possible eliminating, the use of seclusion and restraint in a way that provides safe and improved care for consumers and supports good clinical practice.

In approaching the questions raised, Branch members have drawn on the best available evidence and research; and considered the role of psychiatrists in relation to seclusion and restraint.

To support the strengthening or implementation of alternative options to seclusion and restraint, the Branch recommends ensuring that:

- leadership is collaborative and shared between service users, the clinical, non-clinical and lived experience workforces, organisations involved in service delivery and government.
- the nature, complexity and risks of severe mental illness are understood and recognised in discussions about alternatives to restrictive interventions.
- an approach to eliminating restrictive interventions remains largely focused on systems factors and less so on shaming and blaming individual practitioners, including psychiatrists.

The Branch commends the Victorian Government's long-term vision and commitment to improving the mental health and wellbeing of the Victorian community, and its significant commitment to reform. The Branch further commend the leadership provided by the Victorian Department of Health and the Division of Mental Health and Wellbeing. Psychiatrists are committed to advocating for improvements which will benefit the mental health and wellbeing of the Victorian community and we look forward to continuing to work collaboratively to this end.

A/Prof Simon Stafrace
Chair, RANZCP Victorian Branch

Draft vision for the strategy

'why' statement - the vision: *'Committed to human rights and centred on lived experience, Victoria's mental health and wellbeing system promotes healing and strives toward eliminating seclusion and restraint by 2031'.*

'how' statement - how the vision will be realised: *'…through a system that is safe for all, has clear accountabilities, and is properly resourced to provide compassionate, equitable, culturally safe, evidence-informed therapeutic care, in partnership with consumers, carers, and all those who work in it.'*

Does the 'why' statement reflect everything you feel it should?

- Yes
- No

The Branch recognises the importance of establishing a shared vision for enabling the application and implementation of the Strategy, and suggests the following:

'Committed to human rights and centred on the needs of people with lived experience of mental health challenges who use its services, Victoria's public mental health system will promote healing and strive towards eliminating seclusion and restraint by 2031.'

Does the 'how' statement reflect everything you feel it should?

- Yes
- No

Draft principles for the strategy

How important are each of the principles described in the discussion paper?

1. Lived experience led: people with lived experience of mental illness or psychological distress, family members, carers and supporters, as well as local communities, drive the planning and delivery of mental health treatment, care and support.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch suggests the following alternative wording:

Lived Experience Centre, collaboratively-led. Using co-design or co-production, *the planning and delivery of mental health treatment, care and support will be centred on the needs of people with lived and living experience of mental illness or psychological distress; their family members, carers and supporters, and their local communities. It will be, collaboratively led by them and the mental health and wellbeing workforce.*

The Branch agrees that people who have a lived and living experience and have used public mental health services should be at the centre of the planning, design and delivery of mental health care to reduce and eliminate seclusion and restraint. The Branch recommends that the principle of "lived experience-led" should be replaced by "lived-experience centred, collaboratively led". Consistent with the Royal Commission into Victoria's Mental Health System's (RCVMHS) Final Report, the Branch agrees that leadership of mental health services should be collaborative. Further to this, a collaborative approach, allowing for inclusion of a broad evidence-base including both quantitative and qualitative data, will improve

the outcomes and experience of acute mental health services delivering care to consumers with severe and complex mental illnesses.

The Branch supports integrated care, involving partnerships between people with lived and living experience, mental health and social care professionals (including psychiatrists), and general practitioners working in private, non-government, health service and social care settings will provide the best outcomes for consumers, and their families, carers and supporters. Leadership must be flexible, adaptive, and emerge from many sources.

2. Appropriately resourced system: services and the workforce are well-resourced to provide responsive, high-quality treatment, care, support and opportunities for healing.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

To enable an appropriately resourced system the RANCZP emphasises the essential requirement for continued commitment and leadership to changing practice and organisational culture as well as continued investment in delivering high quality care. As a priority, the Branch recommends:

- system wide development and implementation of evidence-based policies, resources and frameworks aimed at minimising, and working towards eliminating, the use of seclusion and restraint.
- Ensuring the development of practices that support elimination of restrictive interventions, including the provision of appropriate trauma-informed post-incident debriefing to patients and staff who have been exposed to incidents of seclusion and restraint.
- That workforce leaders utilise embedded models of reflective practice to facilitate all post-incident debriefing as a lessons-learnt approach to inform future best practice.

The Branch also recognises the commitment to the design, construction and refurbishment of services with a view to reducing the rates of seclusion and restraint. The Branch also recommends that qualitative and quantitative data about restrictive interventions (RIs) is collected comparing legacy services (built before 2000) and acute mental health inpatient services built after 2010 for the purpose of providing a measure of the impact of design features in the built environment on practice including the use of RIs.

3. Collaboration and communication: in all parts of the system, there is a commitment to listen and learn from and with others, and an openness to change and adapt to new opportunities and understandings.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The RANZCP affirms the essential requirement in mental healthcare of effective communication and collaboration. In line with this, the RANZCP recognises the evidence-base that details the effectiveness in improving health practice and outcomes of partnering with people with a lived experience through the principles of co-design and co-production.
The Branch would further highlight the importance of integration of care, through multidisciplinary approaches within mental health teams (including peer support workers and mental health professionals (including psychiatrists) and across service settings in health services (eg. Inpatients, community services

and emergency departments), general practitioners, and non-government and government agencies delivering health and social services funded by state and commonwealth.

4. Embracing First Nations wisdom: Aboriginal and Torres Strait Islander communities have thrived for 80,000+ years and have a deep understanding of Social and Emotional Wellbeing. The mental health and wellbeing system values Aboriginal and Torres Strait Islander ways of knowing, being and doing.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The RANZCP is committed to supporting the rights of all Aboriginal and Torres Strait Islander peoples to access optimal mental health care and appropriate mental health services. The RANZCP supports a vision for reconciliation where equal access to mental health and psychiatric care is delivered within an environment that is cultural safety and strengthens cultural approaches that are effective at reducing seclusion and restraint including, for example, partnering with carers.

The Branch would also highlight a need for improving representation of Aboriginal and Torres Strait Islander persons in the mental health workforce to support the implementation of the Strategy.

5. Equity and responsiveness to diversity: persons receiving mental health services have their individual needs – such as their gender, family circumstances, culture, language, religion, sexual and gender identity, age and disability - recognised and responded to in a safe and sensitive way. Intersectionality is acknowledged and addressed.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch agrees that equitable access and responsiveness to diversity is critical within mental health services, and will reduce practices and risks that lead to the use of restrictive interventions. The Branch recommends taking particular care to facilitate access for vulnerable groups and the importance of ensuring that the mental health workforce reflects the diversity of the community it serves.

The Branch also notes that equity and responsiveness is dependent on ensuring the intersectional needs of consumers and their support networks being recognised and responded to by services across a variety of settings. Settings of particular sensitivity in this regard include emergency departments, forensic healthcare systems, and services providing multiple specialist inputs for complex needs.

6. Evidence-based practice: mental health and wellbeing services use data and continuing research, evaluation and innovation – including lived experience-led research and evidence – to provide therapeutic, recovery-oriented, trauma informed and relational care, using alternatives to seclusion and restraint.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch recommends recognising the existing framework of improvement science as potentially useful in this setting, and makes the following suggested alternative wording:

Evidence-based practice: *mental health and wellbeing services promote cultures of continuous improvement that value both quantitative and qualitative data - including lived experience-led research and evidence - and utilises research, evaluation and innovation to ensure the implementation of therapeutic, recovery-oriented, trauma informed and relational care, including alternatives to seclusion and restraint.*

7. Family inclusive: family members, carers and supporters of people living with mental illness or psychological distress have their contributions recognised, respected and supported.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch acknowledges the vital role of information sharing with families, carers, supporters and kin to assist in improving the patient's recovery outcomes, whilst also enabling them to be involved and receive support. Information sharing may relate to the planned treatment and care; services available to the patient; emotional support options; rights-upholding mechanisms such as non-legal advocacy; legal representation; and safeguards to support decision-making such as advance statements and nominated persons.

The Branch notes it is critical to ensure information provided to supports is appropriate, sensitive and transferred in real time with safeguards in place to protect privacy and confidentiality. In line with this is the need recognise situations in which the needs of an individual patient are at odds with those of their families, carers, or supporter, or their preferences have changed.

Psychiatrists are trained to understand information sharing as an essential and integrated part of clinical practice. Within multidisciplinary teams, psychiatrists work in partnership with the wider mental health and wellbeing workforce and external services to support families, carers, and supporters in receiving information. Necessary also, is ensuring protected time for the mental health and wellbeing workforce to partner with carers through a variety of specialist advice. The availability of specialist advice is a necessary consideration when a consumer does not have family/carer supports available, or indeed they do not wish their carers to be involved.

8. Human rights: the inherent dignity of people living with mental illness or psychological distress is respected, and with the least possible restriction of rights and autonomy. People are free to be themselves and heal without fear of consequence or coercion.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The RANZCP recognises that prevention, early intervention, and holistic care can prevent mental illness and psychological distress from worsening and is supportive of human rights. The RANZCP also agrees that strategies should also recognise the role of cultural bias and institutional racism in the use of seclusion and restraint.

9. Safety for all: all Victorians – including people living with mental illness or psychological distress, their families, carers and supporters, the workforce, and the broader community – experience safety in their interactions with the mental health and wellbeing system.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch agrees with the importance of supporting services to fulfill their responsibility to 'safety for all' in all decision making related to the implementation of the Strategy. As noted by the RCVMHS Final Report, the 'design of inpatient units may be contributing to high rates of restrictive practices, as may overcrowding, excess noise and lack of privacy' and that improved design of units has significant potential to reduce and eliminate such practices.

The Branch agrees there needs to be alternative protective guard and safety for consumers as well as clinicians in place such as infrastructural modifications, and availability of enough skilled workforce to address such clinical situations.

10. Transparency: at both the service and system level, data about the use of seclusion and restraint and decision-making processes that lead to restrictive practices is reported and accessible.

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant
- Not at all important

The Branch considers data transparency an important principle. In addition, RANZCP advocates for consistency of definitions and data across jurisdictions. The Branch makes the following suggested changes:

Data transparency: *at both the service and system level, data about the use of seclusion and restraint and about the experience of harm to patients and workforce in the inpatient setting* ***are reported and accessible.***

Please comment on those (Principles) identified as less important.

The Branch has no further comments on the principles.

Are there any additional principles that should guide the design, implementation and monitoring of this strategy?

The Branch has no additions to recommend.

Draft pillars for the strategy

1. Are the six pillars proposed in the discussion paper the right priority areas for the strategy?

- Yes
- No

2. If yes, should the strategy identify any additional priority areas to create the greatest impact and help us achieve our vision?

The Branch has no recommendations for additional priority areas.

3. If no, which priority areas are needed to create the greatest impact and help us achieve our vision?

Not applicable.

Potential actions

(i) Leadership and culture

At both the system and service levels, leaders are committed to working towards elimination of seclusion and restraint. There is a culture where restrictive interventions are not an acceptable practice, and it is everyone's responsibility to work towards elimination. There is a culture of continuous learning, capability building and improvement, that seeks feedback from consumers, carers and supporters.

The Branch agrees that embedding skilled, ethical leadership in practice areas is critical to long-term successful change and essential to supporting and developing a well-resourced workforce committed to delivery mental health care practices without the use of seclusion and restraint.

In the context of changing practices and developing cultures that enable alternative practices to seclusion and restraint, services and teams must be empowered to develop and enact local level strategic plans that meet local priorities and needs and implement processes for change utilising collaborative processes. The Branch agrees that leadership roles at a local level are key to empowering individuals and teams to utilise specialist knowledge, skills and capabilities and engage with best practice alternatives

The Branch would also highlight the importance of leadership commitment and accountability provided through the Victorian Department of Health as well as health service CEOs and Boards, who may be identified as holding critical responsibility as enablers in this process of reform, including their support for enacting the leadership including that provided by Clinical Directors of Mental Health Services and Authorised Psychiatrists. Further consideration is also required of the role and responsibilities of Regional Boards and Mental Health and Wellbeing Commission.

The Branch has consulted with psychiatrists in clinical leadership positions regarding system reform of the Victorian public mental health and wellbeing system, including Clinical Directors of Mental Health Services. There is agreement that where practices of seclusion or restraint have been reduced or eliminated within clinical practice settings, the process has been facilitated by leaders explicitly appointed and supported to work with their teams, including those with a lived experience – not by externally set targets. Psychiatrists agree that reflective practice activities involving the whole team are a crucial element to learning from and within practice activity. Additionally, at the service level, a comprehensive communication strategy that includes phasing would support those in leadership positions.

The Branch recommends the following actions:

- Identify and support leadership roles in services and teams with appropriate training and resources that enable the workforce to increase skills and abilities for:
    - co-design and co-production
    - leadership development
    - change management strategies
    - reflective practice activities
    - continuous learning, capability building and improvement
    - implementing alternative practices to seclusion and restraint

- Ensure people with lived and living experiences are provided leadership roles and opportunities in key teams, committees and projects.

- Utilise principles of co-design and co-production so that leaders are empowered to support their services and teams to:
    - develop local level strategic plans and implementation processes utilising co-design and co-production.
    - identify and constructively address resistance to change and develop cultures of continuous learning, capability building and improvement

- Develop a communication strategy that includes phases for implementation of best-practice changes and evaluation processes at a local level, to assist in highlighting where change is needed and to celebrate success.

- Support to develop local strategies for implementation, monitoring, as well as resourcing and support for change across the wider mental health and wellbeing workforce to include ongoing education, training opportunities, and formal clinical supervision.

- Investment in resources for change to support leadership activity include:
    - models of care, policies and procedures
    - education and training
    - continuous monitoring and evaluation of activity
    - embedded reflective practice activities

(ii) Data and accountability

There is regular, accessible and comprehensive reporting against relevant measures, by system, service and setting. Data is used to inform practice, monitor variations and understand where additional efforts to reduce seclusion and restraint are needed, and monitor the impact of initiatives to reduce the use of restrictive interventions. There are clear accountabilities and oversight mechanisms, at both the system and service level.

The RCVMHS reported that overall rates of seclusion and restraint in Victorian services are consistently higher than the national average and reporting rates varied. The Branch agrees with the RCVMHS conclusion that data collection and transparency has the potential to assist services to reduce or eliminate such practices. The Branch notes definitions are inconsistent, which would also affect reporting rates. Strategies for change need to address these inconsistencies.

Effective and continuous monitoring and evaluation processes need to be embedded across the system and within services. Information needs to be collected strategically and shared sensitively. Further, while data may be utilised to change practices, it could also be used to better understand the use of practices and to inform areas requiring further research.
Governance and funding arrangements need to ensure that government and services are held to account for the consistent funding and delivery of high-quality mental health care. Commissioning structures need to be implemented effectively to ensure that the mental health and wellbeing system is equipped to deliver services based on local priorities and needs.

Importantly funding structures should also be developed to support the system and not fragment it further. the RANZCP recommends a focus on the importance of governance and funding models to support and incentivise person-centred and integrated care, rather than creating competition for funding amongst different services. Competition between services, when resourcing is limited, needs to be mitigated, as it contributes to inequitable access to treatment, care and support.

The Branch recommends the following actions:

- Data processes and methods of sharing are transparent and developed collaboratively with the mental health and wellbeing workforce and people with lived and living experiences.

- Evaluation and monitoring strategies are targeted and aimed at improving mental health and wellbeing outcomes for patients, families and significant others, and the workforce, including “safety for all”.

- Data collection and reporting processes do not reduce workforce capacity to provide treatment, care and support.

- Processes provide consistency of definitions and data across the system and are contextualised where needed to the local priorities and needs of the service.

- Methods include quantitative and qualitative measures based on evidence-based patient outcomes, as well as available and implemented models of care, policies and procedures

- That there is transparency of data and analysis, and recommendations are shared sensitively and thoughtfully, ensuring complexity of lived and living experiences are not lost in data reporting

- Data is utilised to inform improvement of the system, to better understand the use of seclusion and restraint practices, and to inform future research.

- Effective accountability and commissioning structures are implemented.

- Governance arrangements ensure that government and services are held to account for the consistent funding and delivery of high-quality mental health care based on local priorities and need.

- There is clarity and agreement for key definitions, such as that of seclusion and of chemical, mechanical, and physical restraint.

- Appropriate administrative support is essential to support the clinical workforce to prioritise clinical care.

(iii) Best practice

Mental health and wellbeing service delivery promotes human rights and patient choice, is trauma-informed, and considers the whole of the person's journey. Mental health and wellbeing service providers use evidence-based alternatives to seclusion and restraint and reduction tools. Work to reduce and eliminate restrictive interventions builds on the foundations of the Six Core Strategies.

The Branch recognises the Strategy as a major step to supporting implementation of best practice strategies to minimise and work towards elimination of seclusion and restraint within the Victorian mental health and wellbeing system. The Branch considers it essential that 'best practice' considers the nature of severe and complex mental illness and aims to ensure that mental illness is treated to an extent that allows consumers to recover and lead contributing lives in the community.

The Branch also considers it essential that best practice reflects an integration of research with clinical and lived expertise, alongside the values, preferences and local priorities identified by consumers, families, carers, supporters and other identified stakeholders. This should occur in line with the principles of co-design and co-production. Consistent and coordinated data collection targeted to identify local needs and priorities will support continuous improvement.

The Branch recommends the following actions:

- Mental Health Services are supported to implement best practice by establishing long-term research programs into resources, models and strategies which work towards minimising, and where possible, eliminating the use of seclusion and restraint, while providing treatment, care and support to consumers and significant others, and safety for all.
- All Mental Health Services develop and implement best practice policies, resources and frameworks aimed at minimising, and ideally eliminating the use of seclusion and restraint.
- A culture is fostered and encouraged that uses seclusion and restraint only as a last resort – and then, designed utilising co-design and co-production processes.
- The processes for defining evidence to inform best practice are co-designed and co-produced by people with lived and living experiences and the workforce working in collaborative partnerships.
- Co-design and co-production support best practice through minimising, working towards eliminating, the use of seclusion and restraint by:
    - Identifying improved mental health outcomes
    - Supporting services to identify, produce and implement models of care, policies, resources and frameworks
- Improved mental health outcomes are informed primarily by locally acquired evidence, best practice, evaluation based on our own research, studies and data.
- Research evidence is explicitly valued and includes:
    - research processes that are co-designed and co-produced, including peer researchers with lived and living experiences.
    - preference for, and building on local research, evidence, and clinical and academic expertise.
    - appropriate support to generate new research at the local level.
    - long-term research programs into resources, models and strategies which work towards minimising, and where possible, eliminating the use of seclusion and restraint.

  - opportunities for research included in funding arrangements and prioritised as an essential element for development of mental health care and treatment.
  - joint clinical and academic positions as a feature within the new mental health system

- Data collection is consistent and coordinated, including on patient outcomes, through quality activities such as benchmarking is embedded in services and teams.

- Implementation of and learning from practice is supported through proper consideration to how the principles and pillars will be translated into practice.

(iv) Workforce
The mental health and wellbeing workforce has the right skills, is of the right mix, and is supported to safely use alternatives to seclusion and restraint in each setting.

The Branch recognises that all registered clinicians practicing within the current mental health system have completed a training program that ensures their ability to deliver evidence based holistic treatment and care options. The RCVMHS clearly acknowledged that a poorly funded and broken system impaired their ability to deliver on this training.

Branch members report that where restrictive interventions have been reduced, clinicians are invested in and supported by building on and developing their existing skills and capabilities and empowered to make best practice changes. The Branch therefore further emphasises the importance of clinical leadership, together with learning from lived experience to ensuring support to use alternatives to seclusion and restraint in each setting. In addition, the availability of best practice guidelines and policies, models of care, ongoing professional development, and fit-for-purpose infrastructure. Psychiatrists have also reported a correlation between regular opportunities for reflective practice and reducing restrictive interventions, which is well supported within the literature.

The RANZCP recognises the potential experience of trauma/re-traumatisation resulting from incidents of seclusion and restraint for the individual concerned and carers and also the workforce. As such, the Branch recommends it essential to ensure trauma-informed post-incident debriefing that utilises options for discussing whether alternatives would apply and their application to inform future best practice. This may also include developing an understanding of risks and impacts of violence on staff members and co-clients and safety and supports around that.

The Branch further acknowledges the need for a strategic plan that addresses immediate workforce retention, and distribution and recruitment of the mental health and wellbeing workforce, including psychiatrists and members of the lived and lying experience workforce. In addition, a longer-term strategic plan to address the system-wide shortage of the specialist workforce which impacts the delivery of services including projected future planning, expansion and transformation plans for every mental health service.

The Branch recommends the following actions:

- Appropriate resourcing for training, education, and change management activities.

- Undertaking a workforce project to identify the existing system-wide and service-specific mental health workforce shortages.

- Ensuring people, including staff, who have experienced or been exposed to seclusion and restraint are provided with appropriate trauma-informed post-incident debriefing and ongoing support. All post-

incident debriefing should inform future best practice and be discipline-appropriate, including considerations for the lived and living experience workforce.

- Alignment with state/national OHS/WHS Acts where employers have a legislated duty of care to provide environments conducive to mental and physical wellbeing.

- Analysis of workforce administrative requirements in public mental health settings. This should consider where these extra demands impact mental health outcomes, and where additional support staff are be needed.

(v) Environment and infrastructure

The environment and infrastructure are fit for purpose and enable therapeutic, safe and supportive care.

The RCVMHS Final report identified that the "*design of inpatient units may be contributing to high rates of restrictive practice - as may overcrowding, excess noise and lack of privacy*" and recommended a fundamental system re-design. The Branch recognises research that identifies safe, sensitive and responsive environments as inextricably linked to the provision of good mental health care, and the correlation with reductions in trauma, compulsory treatment, restrictive practices and risks of self-harm and suicide - whilst promoting community resilience. For the workforce, such environments contribute to decreases in distress, workplace burnout and violence.

The Branch recommends the following actions:

- Assessing all Area Mental Health and Wellbeing Services in terms of their adequacy and ability to provide safe and therapeutic environments at all points of contact. This includes emergency departments, community care and inpatient services with priority for acute mental health inpatient units.

- Refurbishing Area Mental Health and Wellbeing Services to ensure specialist care is delivered in safe and appropriate spaces that are welcoming and therapeutic for consumers, carers, and staff. Capital investment is needed to build new inpatient units for projected demand and workforce needs, on a fair and equitable basis.

- Ensuring that all evaluation and improvements are co-designed and co-produced with people with lived and living experiences.

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(vi) Cohort-specific responses

There are tailored approaches or care pathways for people with specific needs (such as Aboriginal and/or Torres Strait Islander people, people with disability, people from culturally and linguistically diverse backgrounds, people with concurrent mental health and alcohol and other drug use issues, people in contact with the justice system).

The Branch agrees that the Victorian mental health and wellbeing system needs to provide tailored approaches to meet the specific mental health needs of diverse and intersectional groups that may experience more vulnerability to mental health challenges and barriers to support. Access to mental health care needs to be free from stigma. Different settings, particularly emergency departments, custodial health, and the forensic systems require particular attention. The Branch highlights the following:

Serious Mental Illness

The implementation of the Strategy must also recognise and address the specialist clinical needs of those Victorians already struggling with a severe mental illness – estimated at over 200,000 Victorians. (*RCVMHS Final Report estimated that 3 per cent of people living in Victoria experience 'severe' mental illness – equating to over 200,000 people*).

Aboriginal and Torres Strait Islanders peoples

Aboriginal and Torres Strait Islander people have a higher prevalence of psychological distress than the non-Indigenous population. This demonstrates the importance of reconciliation and cultural safety within the mental health system, including system-wide recognition of the role of culture and community in the healing process. There is a need for better access to Aboriginal and Torres Strait Islander support workers, community services, and Elders as well as access to other chosen support services. The RANZCP's submission to the National Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 highlights the underrepresentation of Aboriginal and Torres Strait Islander persons in the mental health workforce.

Cultural Safety

The Branch highlights the importance of universal cultural safety in mental health systems, services and care. What cultural safety looks like is determined by each person with lived and living experience; the outcome of culturally safe health systems and services is people with lived and living experiences and staff feeling comfortable and secure accessing care. The need for cultural safety in mental health services is exemplified by the experiences of Aboriginal and Torres Strait Islander peoples in Australia and Māori in Aotearoa/New Zealand and is also relevant to all people across culturally and linguistically diverse communities, beliefs, values, ethnic groups, religion or faith, age, ability, sexual orientation and gender identity.

Involuntary mental health treatment in custody

The Branch recommends ensuring that prisoners receive mental health treatment in appropriate settings. While concerning psychiatric treatment, the RANZCP acknowledges similar concerns for involuntary physical treatment in custody, including the ability of custodial services to enforce examinations and treatment on prisoners.

Mental health needs of people with Intellectual disabilities

The Branch is cognisant of the significant challenges and unmet mental health needs for people with intellectual disabilities.

Thinking about what is needed to reduce and work towards elimination of seclusion and restraint, what three actions would you prioritise? Why have you nominated these?

The RANZCP Position Statement #61 identifies seven recommendations to reduce and work towards elimination of seclusion and restraint and includes evidence to support them.

1. Ensure all mental health services have appropriate policies, resources and frameworks aimed at minimising, working towards eliminating, the use of seclusion and restraint and a culture which uses seclusion and restraint only as a last resort.

2. Ensure people with lived and living experiences of mental health challenges and recovery are involved in designing policies, frameworks and spaces for best methods to minimise the use of seclusion and restraint in mental health services.

3. Provide consistency of definitions and data across services to allow for accurate data collection on the use of seclusion and restraint in Australia.

4. Establish long-term research programs into resources, models and strategies which work towards minimising, and where possible, eliminating the use of seclusion and restraint.

5. Strengthen cultural approaches that are safe, appropriate, and responsive when reducing seclusion and restraint among Aboriginal and Torres Strait Islander peoples.

6. Ensure individuals and staff who have been exposed to seclusion and restraint are provided with trauma-informed post-incident debriefing.

7. Implementation of and learning from practice is supported through proper consideration to how the principles and pillars will be translated into practice. Six core strategies for reducing seclusion and restraint [Te Pou]

Further comment/s considerations

Is there anything further you would like to contribute to inform the future-focussed strategy? This could include other ideas you have, including those related to implementation of the strategy.

The Branch recommends that the use of chemical restraint is given appropriate consideration in the implementation of the Strategy. The Branch acknowledges that the RCVMHS recommends that use of chemical restraint is 'legislatively regulated', and notes that the use of medication is an important aspect of how episodes of certain mental illnesses are treated.

The Branch suggests Victoria adopt a regulatory approach like Tasmania's, where chemical restraint is defined broadly within the Mental Health Act and Office of the Chief Psychiatrist guidelines as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'. Excluded is medication to treat a mental illness or physical condition that may have a sedating effect. Rather, 'chemical restraint occurs when medication is intentionally given to exert control over a patient's movements or behaviour'.

The Branch acknowledges the introduction of a definition around chemical restraint is challenging, with a thorough review process required to identify the scenarios of concern.