Accepted version of: Yvette Maker and Bernadette McSherry, 'Regulating Restraint Use in Mental Health and Aged Care Settings: Lessons from the Oakden Scandal' (2019) 44(1) *Alternative Law Journal* 29 <https://doi.org/10.1177/1037969X18817592>

Regulating Restraint Use in Mental Health and Aged Care Settings: Lessons from the Oakden Scandal

Keywords

aged care, mental health services, chemical restraint, physical restraint, mechanical restraint, coercive practices, human rights

Introduction

In 2015, Robert Spriggs was treated at the Repatriation General Hospital in Adelaide for Parkinson's disease and Lewy body dementia before moving to the Oakden Older Person's Mental Health Service ('Oakden') as a permanent resident. Following this move, Mr Spriggs' wife and family noted a rapid deterioration in his condition. In February 2016, Mr Spriggs was taken to the Royal Adelaide Hospital with unexplained and significant bruising on his hip and thighs. With the help of Maurice Corcoran, the Principal Community Visitor,[1] Mr Spriggs' family made a formal complaint to South Australian aged care and mental health officials about Mr Spriggs' treatment at Oakden.[2]

Mr Spriggs died on the 18th July 2016, aged 66. His family subsequently learned that while a resident at Oakden he had been given 500mg of the anti-psychotic medication Seroquel instead of the prescribed 50mg and that the bruising he had experienced was likely caused by his being strapped into a chair. It was only after Mr Spriggs' family went to the media that the full extent of what had been occurring at Oakden over decades finally became public.

[1] The position of Principal Community Visitor was established under section 50(1) of the *Mental Health Act 2009* (SA).

[2] Aaron Groves, Del Thomson, Duncan McKellar and Nicholas Procter, *The Oakden Report: The Report of the Oakden Review* (Report, SA Health, South Australian Department of Health and Ageing, 10 April 2017) 2 <http://www.sahealth.sa.gov.au/wps/wcm/connect/4ae57e8040d7d0d58d52af3ee9bece4b/Oakden+Report+Final+Email+Version.pdf?MOD=AJPERES&CACHEID=4ae57e8040d7d0d58d52af3ee9bece4b>.

South Australia's Chief Psychiatrist and his colleagues,[3] and the state's Independent Commissioner Against Corruption,[4] both issued damning reports about the quality and management of care provided at Oakden. Those inquiries, and a third Commonwealth review that examined failures in the aged care quality regulation process,[5] criticised many aspects of the service and the behavior of those charged with its administration. These included poorly designed and maintained facilities that were inappropriate for older persons with 'severe and incapacitating mental illnesses';[6] insufficient staff knowledge of clinical governance processes and responsibilities;[7] poor record-keeping and complaints handling practices;[8] and 'grossly inappropriate conduct' towards residents including rough handling, inadequate hygiene practices, mocking, ridicule, and failure to treat people with respect.[9]

The 'ongoing, repeated use of restrictive practices',[10] especially mechanical restraint (where devices such as straps or belts are used to control a person's movement) was a focus of the criticisms of Oakden. The inquiries were also critical of the failure to accurately record and report each instance of restraint use.[11]

The Oakden case presented particularly shocking evidence of the mistreatment of residents in a mental health and aged care facility. Amongst many concerns, it highlights the issue of the (over)use of various forms of restraint in health care settings across Australia.

Despite the negative consequences and human rights implications of these practices, there are gaps in the regulation of restraint in health care settings. Several of the inquiries into Oakden called for reform to legislation, policy and practice in this regard.[12] This article

[3] Groves et al, above n 2.
[4] Bruce Lander, *Oakden: A Shameful Chapter in South Australia's History* (Report of the South Australian Independent Commissioner Against Corruption, 28 February 2018) <https://service.sa.gov.au/cdn/icac/ICAC_Report_Oakden.pdf>.
[5] Kate Carnell and Ron Paterson, *Review of National Aged Care Quality Regulatory Processes* (Report to the Commonwealth Minister for Aged Care, October 2017).
[6] Groves et al, above n 2, 57.
[7] Groves et al, above n 2, 74; Lander, above n 4, 18.
[8] Groves et al, above n 2, 74; Lander, above n 4, 226.
[9] Groves et al, above n 2, 82, 95-99; Lander, above n 4, 18.
[10] Groves et al, above n 2, 113.
[11] Ibid 106, 109, 113.
[12] Carnell and Paterson, above n 5, 45, 125-6; Lander, above n 4, 306-8, 312.

explores the shortcomings of the existing regulatory approach in Australia and identifies options for addressing them, with a view to the elimination of restraint altogether.

Definition of and justifications for the use of restraint

The term 'restraint' in the health care context generally refers to an action performed for the purpose of controlling a person's behaviour. Three forms of restraint are typically identified: physical restraint (bodily restriction, such as holding someone on the ground); mechanical restraint (the use of devices like straps, belts and jackets); and chemical restraint (the administration of medication, usually for sedation).[13] Other types of restraint are also identified in some instances, including emotional restraint (where a person feels constrained from openly expressing his or her views) and environmental restraint (where buildings or rooms are designed to control behaviour).[14] The use of restraint in health care settings is generally permitted by policy or legislation when it is considered necessary to protect against harm to the self or others.[15] In some Australian jurisdictions, restraint is also permitted when it is necessary to prevent damage to property that involves a risk of harm to the person.[16] In the aged care sector, the use of restraint is commonly justified on the basis that it reduces the risk of falls. In the Chief Psychiatrist's report, Groves and his colleagues reported that the staff at Oakden 'routinely reported' falls risk as the reason for using mechanical restraint.[17]

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[13] S P Sashidharan and Benedetto Saraceno, 'Is Psychiatry Becoming More Coercive?' (2017) *The BMJ* 357, 357 <https://doi.org/10.1136/bmj.j2904>.; see also *Mental Health Act 2013* (Tas) s 3.

[14] See Melbourne Social Equity Institute, *Seclusion and Restraint Project – Report* (Research Report, University of Melbourne, August 2014) <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>.

[15] See for example *Mental Health Act 2015* (ACT) s 65(2); Mental Health and Drug and Alcohol Office (NSW), (2012) *Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales* (Policy Directive of New South Wales Ministry of Health No. PD2012_035, 26 June 2012) 9 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_035.pdf>.; *Mental Health Act 2016* (Qld) s 272(3); *Disability Services Act 2006* (Vic) s 140; Disability Services Commission (WA), *Code of Practice for the Elimination of Restrictive Practices. Government of Western Australia* (Positive Behaviour Framework Document of the Disability Services Commission, November 2014) 6 <http://static1.1.sqspcdn.com/static/f/1546495/25715521/1417183469157/Code+of+Practice+Final+Nov+2014.pdf?token=rMjwZztTIqL7F9jmUeVHu0Ejo10%3D>.

[16] For example, *Disability Services Act 2006* (Vic) s 140; *Disability Services Act 2006* (Qld) ss 143, 144; *Mental Health and Related Services Act 1998* (NT) s 61.

[17] Groves et al, above n 2, 110.

Negative consequences of the use of restraint

Various negative consequences have been identified that conflict with the primary rationale for the use of restraint, namely, the prevention of harm.[18] People who have been subject to restraint have raised concerns that these interventions are used unnecessarily or unethically;[19] that restraint causes fear, pain and psychological harm;[20] that it is traumatising or re-traumatising for people who have previously experienced violence or abuse;[21] and that it does not have therapeutic benefits.[22] Negative impacts on staff and the workplace have also been recorded, in terms of trauma and damage to morale and therapeutic relationships.[23]

There is a lack of evidence that restraint prevents or minimises harm from falls. In fact, the use of restraint may increase the risk of falls and subsequent injuries.[24] According to a Senate Committee inquiry in 2012, restraints in aged care are often overused to compensate

[18] Peter Bartlett and Ralph Sandland, *Mental Health Law, Policy and Practice* (Oxford University Press, 4th ed, 2014).
[19] Tania D Strout, 'Perspectives on the Experience of Being Physically Restrained: An Integrative Review of the Qualitative Literature' (2010) 19(6*) International Journal of Mental Health Nursing* 416; Diana Rose et al, 'Service User Perspectives on Coercion and Restraint in Mental Health' (2017) 14(3) *BJPsych International* 59; Rebecca Fish and Chris Hatton, 'Gendered Experiences of Physical Restraint on Locked Wards for Women' (2017) 32(6) *Disability & Society* 790;
[20] Heather Sequeira and Simon Halstead, '"Is It Meant to Hurt, Is It?": Management of Violence in Women with Developmental Disabilities' (2001) 7(4) *Violence Against Women* 462; G Bonner et al, 'Trauma for All: A Pilot Study of the Subjective Experience of Physical Restraint for Mental Health Inpatients and Staff in the UK' 9(4) *Journal of Psychiatric and Mental Health Nursing* 465; Rebecca Fish and Eloise Culshaw, 'The Last Resort?: Staff and Client Perspectives on Physical Intervention' (2005) 9(2) *Journal of Intellectual Disabilities* 93; Strout, above n 19.
[21] Rose et al, above n 19; Ruth Gallop et al, 'The Experience of Hospitalization and Restraint of Women Who Have a History of Childhood Sexual Abuse' (1999) 20(4) *Health Care for Women International* 401.
[22] Gallop et al, above n 21.
[23] For example Bonner et al, above n 20; S Bigwood and M Crowe, '"It's part of the job, but it spoils the job": A phenomenological study of physical restraint' (2008) 17(3) *International Journal of Mental Health Nursing* 215; Surabhi Kumble and Bernadette McSherry, 'Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective' (2010) 17(4) *Psychiatry, Psychology and Law* 551.
[24] Department of Health and Ageing (Cth), *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (Decision-Making Tool Document, 2012) 4 <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2014/residential_aged_care_internals_fa3-web.pdf>.

for poor programming or inadequate staffing and training, and for the 'convenience and protection of the facility, rather than the clinical needs of the patient.'[25]

The use of restraint has also been associated with serious injury and death.[26] Bellenger and her colleagues reported that the deaths of five people living in accredited Australian nursing homes between the years 2000 and 2013 were attributable to the use of mechanical restraints, with people being choked by seatbelts or otherwise trapped and suffocated by a mechanical restraint.[27] Coronial inquests have also implicated the use of physical restraint,[28] mechanical restraint,[29] and chemical restraint[30] in the deaths of individuals around the country.

The use of restraint as infringing human rights

Increased recognition of the negative consequences of the use of restraint has been accompanied by a shift in the way restraint is characterised in much of the research literature and wider public discourse.[31] The use of restraint (among other coercive

[25] Senate Community Affairs References Committee, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia (BPSD)* (2014); see also Australian Commission on Safety and Quality in Health Care, *Guidebook for Preventing Falls and Harm from Falls in Older People: Australian Residential Aged Care Facilities* (Short Version Best Practice Guidelines for Australian Residential Aged Care Facilities, 2009) 63-65 <https://www.safetyandquality.gov.au/wp-content/uploads/2009/01/30454-RACF-Guidebook1.pdf>; David Evans, Jacquelin Wood and Leonnie Lambert, 'Patient Injury and Physical Restraint Devices: A Systematic Review' (2003) 41(3) *Journal of Advanced Nursing* 274.

[26] See Wanda K Mohr, Theodore A Petti and Brian D Mohr, 'Adverse Effects Associated with Physical Restraint' (2003) 48(5) *The Canadian Journal of Psychiatry* 330.

[27] Emma Bellenger et al, 'Physical restraint deaths in a 13-year national cohort of nursing home residents' (2018) 46(1) *Age and Ageing* 688.

[28] Inquest into the Death of Mark Ian Hare, Coroners Court of New South Wales, 29 July 2009, Deputy State Coroner Milovanovich; Inquest into the Deaths of Robert Plasto-Lehner and David Gurralpa aka Moscow, [2009] NTMC 014, Coroner Cavanagh; Inquest into the Deaths of Justin Fraser and Adam White, Coroners Court of Victoria, 13 March 2013, Coroner White; Inquest into the Death of Warwick Andrew Ashdown, Coroners Court of Western Australia, 23 November 2011, Coroner Hope.

[29] Inquest into the Death of Ruth Ann Dicker, Coroners Court of South Australia, 15 September 2013, Coroner Johns.

[30] Inquest into the Death of David James Lee, Coroners Court of Western Australia, 6 June 2012, Coroner Hope; Inquest into the Death of Antoinette Williams, Coroners Court of Western Australia, 25 February 2014, Coroner King.

[31] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

practices) is now characterised as a serious breach of individuals' human rights,[32] especially since the passage of the United Nations *Convention on the Rights of Persons with Disabilities* ('the CRPD'). The United Nations Committee on the Rights of Persons with Disabilities ('the Committee') has described 'the use of forced treatment, seclusion and various methods of restraints' as 'not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment'.[33] Similarly, the United Nations Special Rapporteur on Torture, Juan Mendez, has called for 'an absolute ban on all coercive and non-consensual measures, including restraint … of people with psychological or intellectual disabilities … in all places of deprivation of liberty, including in psychiatric and social care institutions.'[34] Similar statements have come from both the United Nations High Commissioner for Human Rights[35] and its Special Rapporteur on the Right to Health in recent years.[36] Through its QualityRights Initiative, the World Health Organization has also encouraged the elimination of the use of seclusion and restraint in mental health and related service worldwide.[37]

Concerns have also been raised at the international level about the use of restraint in Australia. In its first periodic review of Australia's compliance with the CRPD, the Committee singled out for criticism the use of 'unregulated behaviour modification or

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[32] Bernadette McSherry and Ian Freckelton (eds), *Coercive Care: Rights, Law and Policy* (Routledge, 2013); Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010).

[33] CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities*, 14th sess, September 2015, para 12 https://www.ohchr.org/Documents/HRBodies/CRPD/.../GuidelinesOnArticle14.doc>.

[34] Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez*, 22nd sess, UN Doc A/HRC/22/53 (1 February 2013) para 63.

[35] See Michelle Funk and Natalie Drew, 'WHO QualityRights: transforming mental health services' (2017) 4(11) *Lancet Psychiatry* 826; Human Rights Council, *Mental health and human rights: Report of the United Nations High Commissioner for Human Rights*, 34th sess, UN Doc A/HRC/34/32 (31 January 2017) para 33.

[36] Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 35th sess, UN Doc A/HRC/35/21 (28 January 2017) paras 65, 95(f).

[37] Department of Health and Substance Abuse (WHO), *Strategies to End the Use of Seclusion, Restraint and Other Coercive Practices – Training to Act, Unite and Empower for Mental Health (Pilot Version)* (QualityRights Document of World Health Organization, 2017) <http://apps.who.int/iris/bitstream/10665/254809/1/WHO-MSD-MHP-17.9-eng.pdf?ua=1>; see Bernadette McSherry and Yvette Maker, 'International Human Rights and Mental Health: Challenges for Law and Practice' (2018) 25 *Journal of Law and Medicine* 315.

restrictive practices such as chemical, mechanical and physical restraints … in various environments, including schools, mental health facilities and hospitals'.[38] The Committee's criticisms echoed existing concerns about the inconsistent and piecemeal regulation of the use of restraint across jurisdictions and sectors in Australia, and the fact that regulation is frequently not aimed at minimising or eliminating the use of these practices.[39] Calls for reform have grown in volume in recent years. For example, in 2014, the Australian Law Reform Commission highlighted concerns about the improper use and inadequate regulation of restrictive practices in general and called upon the Federal Government and the Council of Australian Governments to 'develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care'.[40]

Regulation of restraint: gaps and inconsistencies

In Australia, the regulation of the different forms of restraint occurs primarily under mental health and disability services legislation, as well as through a range of policy directives and guidelines. The use of restraint in South Australia is dealt with through multiple regulatory frameworks, with the patchy, often inconsistent, regulation of the use of restraint in mental health and aged care sectors highlighted as one cause of the problems that beset the service at Oakden.[41] Groves and his colleagues noted that Oakden's dual role as a specialist mental health service and accredited aged care facility 'led to confusion at all levels of the Health System [sic] in South Australia'.[42] Regulation in other states and territories is similarly

[38] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Australia*, 10th sess, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) paras 35-6.
[39] See for example National Mental Health Working Group *National Safety Priorities in Mental Health: A National Plan for Reducing Harm* (Document of Commonwealth Department of Health and Ageing, 2005) 3; Australian Institute of Health and Welfare, *Use of Restricted Practices During Admitted Patient Care* (Mental Health Services in Australia Document, 2012); Catherine Lourey, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention* (Report of the National Mental Health Commission, 2012) 13.
[40] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 256.
[41] Carnell and Paterson, above n 5, 45; Lander, above n 4, 306-8, 312.
[42] Groves et al, above n 2, 31.

fragmented and different jurisdictions deal with restraint differently.[43] The ensuing sections outline some key regulatory differences and gaps in the aged care and mental health sectors across the country. We highlight these jurisdictional differences to indicate the overly complex nature of the current system and make the case for a more consistent, national approach.

Aged care

The use of restraint in aged care facilities is not currently addressed in Commonwealth legislation. In their review of aged care accreditation processes and outcomes at Oakden, Carnell and Paterson observed that the current national aged care Accreditation Standards[44] do not adequately address concerns about the use of restraint in aged care, and argued that '[r]egulation should target the things that are important and the problems that are known'.[45]

The Commonwealth Department of Health has 'for some years'[46] produced two 'decision-making tools' to guide the use of restraint in residential and community aged care facilities respectively.[47] The tools advocate a 'restraint free approach', which means 'the use of any restraint must always be the last resort after exhausting all reasonable alternative management options'.[48] The tools provide guidance on subjects including '[r]estraint free options', '[f]alls prevention' and '[s]afe walking areas to accommodate wandering'.[49]

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[43] Kumble and McSherry, above n 23; Bernadette McSherry, 'The Legal Regulation of Seclusion and Restraint in Mental Health Facilities' (2013) 21(2) *Journal of Law and Medicine* 251.
[44] Quality of Care Principles, made under section 96-1 of the *Aged Care Act 1997* (Cth), include Accreditation Standards as 'standards for quality of care and quality of life for the provision of residential care' as per section 54-2 of this same Act.
[45] Carnell and Paterson, above n 5, 45.
[46] Department of Health and Ageing (Cth), Submission to Senate Standing Committee on Community Affairs, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia*, May 2013, 7.
[47] Department of Health and Ageing (Cth), *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (Decision-Making Toll Document, 2012) <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2014/residential_aged_care_internals_fa3-web.pdf>.
[48] Ibid 1.
[49] Ibid 2-6.

A Senate Committee inquiry into dementia observed in 2014 that these tools do not offer incentives to minimise the use of restraint or set out penalties for inappropriate use.[50] The Senate Committee also expressed its concern that the existence of the guidance did not appear to be well-known, and 'different providers were reported to still have differing ideas of what constitutes a restraint'.[51] Similarly, Carnell and Paterson observed that the use of restrictive practices, including physical restraints and sedation, 'have been, and continue to be, a concern across aged care', despite which, 'there is no regulation that explicitly addresses their use'.[52] Proposed changes to the Aged Care Quality Standards do make explicit reference to monitoring, reporting, and minimising the use of restraint, but it is unclear how these matters will be defined and assessed in practice.[53]

Mental health

The South Australian *Mental Health Act 2009* was amended in 2016 to refer to 'restrictive practices', which include 'the use of physical, mechanical or chemical means to restrain the patient'.[54] The Act simply states a general principle that restraint must be used as a last resort, with policy and guideline documents providing more detail. The Office of the Chief Psychiatrist has published a *Restraint and Seclusion in Mental Health Services Policy Guideline* ('Restrictive Practices Guideline'), which is designed to support the implementation of SA Health's *Restraint and Seclusion Reduction Policy Directive*.[55]

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[50] Senate Community Affairs References Committee, above n 25, para 6.45; see also Carnell and Paterson, above n 5, 26.
[51] Senate Community Affairs References Committee, above n 25, paras 6.43, 6.45.
[52] Carnell and Paterson, above n 5, 45. Note that the Office of the Public Advocate (SA) issued a policy in 2015 that addresses the use of restraint on people under guardianship who reside at a residential aged care facility. It is also focused on minimising and preventing the use of restrictive practices, including chemical, physical and mechanical restraint; see Office of the Public Advocate (SA), *Guardian Consent for Restrictive Practices in Residential Aged Care Settings* (Document of the South Australian Office of the Public Advocate, 2015) <http://www.opa.sa.gov.au/files/227_guardian_consent_for_restrictive_practices_in_aged_care_settings_v6.pdf>.
[53] Department of Health (Cth), *Draft Aged Care Quality Standards* (December 2017) <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/01_2018/draft_aged_care_quality_standards_-_word_version.pdf>.
[54] *Mental Health Act 2009* (SA) as amended by *Mental Health (Review) Amendment Act 2016* s 5(15).
[55] Office of the Chief Psychiatrist (SA), *Restraint and Seclusion in Mental Health Services Policy Guideline* (Policy Guideline of SA Health, South Australian Department of Health and Ageing, 7 May

In the Chief Psychiatrist's report on Oakden, the authors noted that the Restrictive Practices Guideline uses 'the six core strategies as a structural basis' for reducing the use of restraint.[56] These 'six core strategies' were originally developed by the National Technical Assistance Center for State Mental Health Planning in the United States.[57] These strategies, which include 'leadership towards organizational change', 'use of seclusion and restraint reduction tools' and 'debriefing techniques', are generally considered to reflect best practice in the use and minimisation of the use of restraint.[58]

The Restraint Practices Guideline defines 'restraint' to include chemical, physical and mechanical restraint, and states that such practices 'may be used only as a last resort' to ensure safety (if not outweighed by the risk of harm), to ensure essential provision of medication or treatment, or to prevent an involuntary patient from leaving.[59] The Guideline furthermore sets 'mandatory requirements' for the use of restraint, including compulsory reporting requirements. However, Groves and his colleagues noted that 'the reporting from Oakden was almost non-existent … as if Oakden simply believed rules did not apply to

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2015) <https://www.sahealth.sa.gov.au/wps/wcm/connect/5dd2f58048f79928929df70e3d7ae4ad/Guideline_restraint+and+seclusion_july2015.pdf?MOD=AJPERES&CACHEID=5dd2f58048f79928929df70e3d7ae4ad>. The Chief Psychiatrist has also issued two standards relating to the use of restraint and seclusion pursuant to s 90(2) of the *Mental Health Act 2009* (SA): Office of the Chief Psychiatrist, *Restraint and Seclusion: Application and Observation Chief Psychiatrist Standard* (Policy Document of SA Health, South Australian Department of Health and Ageing, 30 July 2015) <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/restraint+and+seclusion+application+and+observation+requirements+chief+psychiatrist+standard>; Office of the Chief Psychiatrist, *Restraint and Seclusion: Recording and Reporting Chief Psychiatrist Standard* (Policy Document of SA Health, South Australian Department of Health and Ageing, 30 July 2015) <https://www.sahealth.sa.gov.au/wps/wcm/connect/69dde780494d7b329ac7ba63e3a03091/Restraint+and+Seclusion+Recording+and+Reporting_July2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-69dde780494d7b329ac7ba63e3a03091-lYywBFg>.

[56] Groves et al, above n 2, 104.

[57] National Technical Assistance Center for State Mental Health Planning, *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Training Curriculum of the National Association of State Mental Health Program Directors, 2005) <https://www.ot-innovations.com/wp-content/uploads/2014/09/2._six_core_sr20plan20template20with20cover207-05.pdf>.

[58] Melbourne Social Equity Institute, above n 14, 13, 44.

[59] Office of the Chief Psychiatrist (SA), *Restraint and Seclusion in Mental Health Services Policy Guideline*, above n 55, 11.

them'.[60] This review also found 'that the use of mechanical restraint [at Oakden] was contrary to all SA Health policies'.[61]

The Oakden findings call into question the extent to which policies described as 'mandatory' are either enforced or enforceable. For instance, where penalties for non-compliance are not specified,[62] or where monitoring, oversight or complaints-handling is lacking.[63] The accreditation process for health care services may provide an opportunity to check on restraint practices, although the relevant criterion refers generally to reducing and where possible eliminating, rather than the specifics of compliance with policy and legislation.[64]

Restraint in mental health settings is defined and permitted in different circumstances, and through different mechanisms, in other states and territories. In New South Wales, restraint is not mentioned in mental health legislation at all,[65] but various forms of restraint are addressed and permitted in policy.[66] In some jurisdictions, only some forms of restraint are explicitly permitted. For example, the Northern Territory's *Mental Health and Related Services Act 1998* only defines mechanical restraint and prohibits its use except in certain circumstances – namely, for the purposes of medical treatment, to prevent injury, to prevent persistent destruction of property, or to prevent absconding.[67] However, the legislation also permits the use of 'reasonable force' to 'restrain' a person to prevent self-harm or the harm of another or to 'maintain good order and security' of a facility.[68]

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[60] Groves et al, above n 2, 106.
[61] Ibid 111.
[62] For example, *Mental Health Act 2009* (SA) s 90; *Mental Health Act 2014* (WA) ss 190-191, 547; *Mental Health Act 2016* (Qld) ss 26(2), 273, 305(3).
[63] For example, in his report on Oakden, South Australia's Independent Commissioner Against Corruption indicated that the then Chief Psychiatrist of South Australia, Dr Aaron Groves, 'should have done more to address Mrs Spriggs' complaint' and that 'it would have been better if he had' conducted unannounced visits prior to 15 December 2006 pursuant to his statutory responsibilities: Lander, above n 4, 257, 258.
[64] Australian Commission on Safety and Quality in Health Care, *Accreditation Workbook for Mental Health Services* (National Safety and Quality Health Service Standard Document, March 2014) 16 <https://www.safetyandquality.gov.au/wp-content/uploads/2014/03/Accreditation-Workbook-for-Mental-Health-Services-March-2014.pdf>.
[65] *Mental Health Act 2007* (NSW).
[66] See Mental Health and Drug and Alcohol Office (NSW), above n 15.
[67] *Mental Health and Related Services Act 1998* (NT) s 61.
[68] Ibid s 165.

Approaches to chemical restraint are particularly diverse across jurisdictions.[69] Tasmania's *Mental Health Act 2013* is the only legislation to comprehensively address its use, permitting the chemical restraint of involuntary patients where it is necessary for facilitating treatment, ensuring the safety of the patient or others, or to effect transfer of the patient.[70] In other jurisdictions, chemical restraint and the administration of medication,[71] including in some instances administration involuntarily or by force, are distinguished in legislation or policy.[72] While they may have the same consequences as chemical restraint (such as sedation), legitimate uses of medication are defined as those with a therapeutic purpose, such as reducing or managing symptoms of mental health conditions or 'the disordered behavior … [associated with] delirium or dementia'.[73] In the ACT and Victoria, therapeutic uses (including forced medication in the ACT) are explicitly permitted, while chemical restraint is not.[74] Under the Queensland and South Australian legislation, the use of medication is permitted for both therapeutic and 'safety' or harm prevention (restraint) purposes.[75] These examples indicate the diversity of approaches to defining and regulating restraint and the complexity and confusion that results.

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[69] For example *Mental Health Act 2014* (Vic); *Mental Health Act 2014* (WA); *Mental Health Act 2015* (ACT); *Mental Health Act 2007* (NSW).

[70] *Mental Health Act 2013* (Tas) ss 3, 57.

[71] Chief Civil and Forensic Psychiatrist (Tas), *Chemical Restraint: Chief Civil Psychiatrist Clinical Guideline 10* (Clinical Guideline Document of the Tasmanian Department of Health and Human Services, 1 July 2017) 2 <http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/252751/CCP_Clinical_Guideline_10_-_Chemical_restraint.pdf>.

[72] For example, *Mental Health Act 2015* (ACT) s 65(4); Mental Health and Drug and Alcohol Office (NSW), above n 15, 5.

[73] Chief Civil and Forensic Psychiatrist (Tas), above n 71.

[74] *Mental Health Act 2015* (ACT) s 65(4); Chief Psychiatrist (Vic), *Restrictive interventions in designated mental health services* (Chief Psychiatrist Guideline Document of Victorian Department of Health, 2 July 2014) 6 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Restrictive-interventions-in-designated-mental-health-services>.

[75] The *Mental Health Act 2016* (Qld) conflates the two concepts – s 272(1) holds that medication must only be administered when 'clinically necessary for the patient's treatment and care for a medical condition'; s 273(1) clarifies that 'a patient's treatment and care for a medical condition includes preventing serious imminent harm to the patient or others.' See also *Mental Health Act 2009* (SA) ss 3, 7(1)(g); and Office of the Chief Psychiatrist (SA), *Restraint and Seclusion in Mental Health Services Policy Guideline*, above n 55.

Options for reform

The inquiries into the Oakden scandal brought into sharp focus the negative consequences of mechanical and chemical restraint and indicated the need for change. Oakden itself was closed in September 2017,[76] but many of the issues the Oakden inquiries raised are relevant to the wider mental health and aged care systems. For example, South Australia's Independent Commissioner Against Corruption called for new mandatory standards to regulate the use of restrictive practices across mental health services.[77] Carnell and Paterson in their review on behalf of the Commonwealth noted that 'the current regulatory mechanisms failed to protect residents' at Oakden in regard to the use of restraint, and recommended that the Accreditation Standards for aged care, which apply nationwide, be amended to 'limit the use of restrictive practices in residential aged care'.[78]

United Nations bodies and international user/survivor organisations have made it clear that the minimisation, and ultimately elimination, of the use of restraint without consent should be the goal of all those involved in care and service provision.[79] Yet as long as these practices continue to be lawful, it is crucial that they are subject to adequate regulation and monitoring. Consistent, comprehensive regulation across jurisdictions and sectors could make a significant contribution to the goals of minimisation and elimination. This may include, for instance, the introduction of uniform definitions of the different forms of

[76] Lander, above n 4, 112.
[77] Ibid 312.
[78] Carnell and Paterson, above n 5, 115, 126.
[79] See for example, Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez*, 22nd sess, UN Doc A/HRC/22/53 (1 February 2013) para 63; CPRD Committee, *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities*, 14th sess, September 2015, para 12 CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities*, 14th sess, September 2015, para 12 <https://www.ohchr.org/Documents/HRBodies/CRPD/.../GuidelinesOnArticle14.doc>; Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 35th sess, UN Doc A/HRC/35/21 (28 January 2017) paras 65, 95(f); World Network of Users and Survivors of Psychiatry (WNUSP), *Human Rights Position Paper of the World Network of Users and Survivors of Psychiatry* (Position Paper approved by the WNUSP General Assembly in Vancouver, 2001) <http://www.wnusp.net/index.php/human-rights-position-paper-of-the-world-network-of-users-and-survivors-of-psychiatry.html>; European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP) *Forced Psychiatric Interventions Constitute a Violation of Human Rights and Disable Care* (Report, 29 March 2016) <https://absoluteprohibition.org/2016/03/29/enusp-forced-psychiatric-interventions-constitute-a-violation-of-rights-and-disable-care/>.

restraint and clear limits on their use, penalties for breach and enforcement mechanisms, uniform and mandatory monitoring and reporting requirements (for instance through the offices of the Chief Psychiatrist and Senior Practitioner in the various states and territories) and obligations to consider alternatives and work towards elimination.

There are three broad options for improving and streamlining regulation of the use of restraint. The first is regulation through legislation, such as National Uniform Legislation, which has previously been developed in areas including corporations law,[80] consumer law,[81] and occupational health and safety.[82] As discussed above, this approach is used in most Australian jurisdictions, but with significant gaps and inconsistencies.

The second option is regulation through policy documents such as guidelines, codes of practice, policies and procedures. This approach complements or takes the place of legislation in most Australian jurisdictions. In the mental health sector, some of this guidance has been issued pursuant to Chief Psychiatrists' legislative authority to issue binding standards, guidelines, policies and/or practice directions.[83] Policy also predominates in some mental health care contexts in England, Wales and Scotland, where the power to restrain is based on the common law power of hospitals to manage patients and arises from the fact of detention under relevant mental health legislation.[84] Policies relating to restraint must comply with the *European Convention on Human Rights* and the *Human Rights Act 1998* (UK).[85]

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[80] *Corporations Act 2001* (Cth).
[81] *Competition and Consumer Act 2010* (Cth).
[82] *Work Health and Safety Act 2011* (Cth); see Renee Gastaldon, 'National Scheme Legislation' (Research Brief 2011/No 27, Parliamentary Library, Parliament of Queensland, 2011 <http://www.parliament.qld.gov.au/documents/explore/ResearchPublications/ResearchBriefs/2011/RBR201127.pdf>.
[83] *Mental Health Act 2014* (Vic) s 121; *Mental Health Act 2013* (Tas) s 57(5); *Mental Health Act 2009* (SA) s 90; *Mental Health Act 2014* (WA) ss 515(2), 547(2), (3); *Mental Health Act 2016* (Qld) ss 26(2), 273, 305(3). Offices of the Senior Practitioner in some states and territories have similar functions in regard to disability services, education and other sectors: for example, *Senior Practitioners Act 2018* (ACT); *Disability Act 2006* (Vic) s 23(2)(a).
[84] *Pountney v Griffiths* [1976] AC 314 (HL).
[85] Bartlett and Sandland, above n 18; Sam Karim (ed), *A Human Rights Perspective on Reducing Restrictive Practices in Intellectual Disability and Autism* (BILD Publications, 2014); see for example, Social Care, Local Government and Care Partnership Directorate (UK), *Positive and Proactive Care:*

The third option is regulation through a body with powers of inspection, enforcement and/or accreditation, used for example in the Netherlands and the United States. In the Netherlands, the Dutch Health Care Inspectorate ('the Inspectorate') has extensive powers to investigate and assess the quality of health services. All restrictive and coercive interventions in psychiatric facilities and hospitals with psychiatric wards,[86] including the use of involuntary medication, must be reported to the Inspectorate.[87] In the United States, an accreditation model is used to regulate physical and mechanical restraint through hospital accreditation standards.[88] For public health services these are set by the Centers for Medicare and Medicaid Services and the Joint Commission, an independent body that accredits and certifies many health care organisations and programs across the United States. In Australia, various state/territory offices of the Chief Psychiatrist and the Senior Practitioner, the Australian Aged Care Quality Agency, and the Australian Commission on Safety and Quality in Health Care all perform some monitoring and authorisation functions.

Each option has advantages and disadvantages, suggesting that a multi-dimensional approach will be optimal. For instance, it would be difficult to design a legislative framework that will apply across eight state/territory mental health jurisdictions and the Commonwealth's aged care jurisdiction, each with long histories and distinct, entrenched features. On the other hand, while standards, policies, guidelines and/or accreditation may be more flexible and adaptable to different settings, they would not enable the imposition of penalties for non-compliance unless specified in associated legislation. It is therefore

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reducing the need for restrictive interventions (Policy Document of United Kingdom Department of Health, April 2014) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf>.

[86] Tilman Steinert, Eric O Noorthoorn and Cornelis L Mulder, 'The use of coercive interventions in mental health care in Germany and the Netherlands. A comparison of developments in two neighboring countries' (2014) 2(141) *Frontiers in Public Health* 2.

[87] FJ Vruwink et al, 'The Effects of a Nationwide Program to Reduce Seclusion in the Netherlands' (2012) 12(1) *BMC Psychiatry* 231; Steinert, Noorthoorn and Mulder, above n 86; EO Noorthoorn et al, 'Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals?' (2016) 67(12) *Psychiatric Services* 1321.

[88] For example, in relation to hospitals, see *Conditions of Participation: Patients Rights* 42 CFR § 482.13(e) (2011) (Conditions of Participation for Hospitals).

likely that an approach that combines legislation and guidelines would be more comprehensive, by providing detail in guidelines and penalties for non-compliance in legislation.[89]

Recent initiatives, while still confined to particular sectors, demonstrate the growing momentum for a uniform approach in Australia and could provide a starting point for reform. These include the 'National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector' endorsed by the Disability Reform Council in 2014[90] and the 'National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services' issued in 2016 by the Safety and Quality Partnership Standing Committee of the Australian Health Ministers' Advisory Council.[91] Both documents propose definitions of key terms (such as physical and mechanical restraint) and principles to support the goal of reducing and eliminating the use of restraint within a human rights framework. Other reforms and review processes – most notably the forthcoming Royal Commission into Aged Care Quality and Safety – will present other important opportunities to rethink our approach to restraint.[92]

[89] Kumble and McSherry, above n 23, 558.
[90] Disability Reform Council, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (Framework Document of the Commonwealth Department of Social Services, 2014) <https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf>.
[91] Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee, *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint* (Principles Document of the Australian Health Ministers' Advisory Council, 15 December 2016) <http://www.apha.org.au/wp-content/uploads/2017/05/Att-A-Nat-Principles-mechanical_physical-_restraint-2.pdf>.
[92] Prime Minister of Australia, 'Royal Commission into Aged Care Quality and Safety' (Media Release, 16 September 2018) <https://www.pm.gov.au/media/royal-commission-aged-care-quality-and-safety>; see also the new approach to the 'use of force' in the *Mental Health (Secure Facilities) Act 2016* (ACT) and *Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2016* (ACT).

Conclusion

The members of Robert Spriggs' family were determined to achieve justice for his mistreatment at Oakden.[93] Their efforts precipitated the public exposure of entrenched practices that contravened legislation and policy, including the misuse of restraint, over a long period of time.[94] Groves and his colleagues reported that the 'first indication that Oakden may have been experiencing quality issues was in 2001'.[95] Oakden failed to meet over half of the Accreditation Standards for aged care facilities in late-2007, and was subject to several other reviews and inspections prior to the inquiries that led to its closure in 2017.[96] This failure of the system to identify and correct longstanding problems strongly suggests that the current approach to regulating the use of restraint is inadequate.

The inquiries into Oakden also indicate that legislative and policy reform will be insufficient on their own to ensure the minimisation and elimination of restraint in mental health and aged care settings.[97] Major concerns were raised in each of the reviews about a culture of secrecy, conflict, and hostility to scrutiny and change, as well as inadequate leadership, at Oakden.[98] Changes to leadership and culture, including oversight and accountability measures, and the provision of adequate support, information and training to staff will be necessary in some (if not most) sites of health care services to ensure that service users' needs are met and their human rights respected. Such training and culture change must include people with lived experience of restraint at all stages, and must focus

[93] Nicola Gage, 'Oakden Mental Health Facility Closure: Family Finds Closure after Long Fight for Answers about Nursing Home Care', *ABC News Online*, 20 April 2017, < <https://www.abc.net.au/news/2017-04-21/oakden-mental-health-nursing-home-spriggs-family-finds-closure/8460048>.

[94] Groves et al, above n 2, 111-113.

[95] Groves et al, above n 2, 25.

[96] Ibid; see for example Simon Stafrace and Alan Lilly, *Final Report on the Review of the Makk and McLeay Nursing Home* (21-22 February 2008) <http://www.sahealth.sa.gov.au/wps/wcm/connect/20a29e0040e4b822868ba73ee9bece4b/Final+Report+%E2%80%93+Makk+%26+McLeay+Nursing+Home.pdf?MOD=AJPERES&CACHEID=20a29e0040e4b822868ba73ee9bece4b.Accessed> and the Chief Psychiatrist's 2016 inspection discussed in Groves et al, above n 2, 107.

[97] See also Alice Keski-Valkama et al, 'The Reason for Using Restraint and Seclusion in Psychiatric Inpatient Care: A Nationwide 15-year Study' (2010) 64(2) *Nordic Journal of Psychiatry* 136.

[98] Groves et al, above n 2, 93-5; Lander, above n 4, 208-10; Carnell and Paterson, above n 5, 42, 105, 152-3.

on the implementation of a human rights-based approach to care in general, and eliminating the use of restraint in particular.[99]

[99] See for example Groves et al, above n 2, 70-1, 100, 113; Lander, above n 4, 208-10; Carnell and Paterson, above n 5, 151; National Technical Assistance Center for State Mental Health Planning, *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool*, above n 57.