Fostering Trauma-Free Mental Health Workplace Cultures and Reducing Seclusion and Restraint

DYANN ROSS, JAMES CAMPBELL AND ALEX DYER

Literature on the factors which precipitate the use of seclusion and restraint on mental health consumers is typically confined to their behaviour and/or the behaviour and attitudes of the involved clinical staff. These understandings do not sufficiently take account of workplace cultural factors and political influences within a societal context of prejudice against people with mental illness. The elimination of coercive and restrictive clinical practices is called for by mental health carer forums, national and state level mental health reports and policies, and concerned mental health clinicians. The authors argue this will require radical change by all staff in the mental health system as violence is a systemic issue which creates a culture where clinical practices are prone to reinforcing this systemic violence. A mapping template and a warrants schema are presented as examples of tools to enable trauma-informed cultural change in mental health systems.

Introduction: The Problem of Seclusion and Restraint

The problem with the use of seclusion and restraint practices in mental health inpatient facilities in Australia is that they can result in considerable human suffering, including death, for people receiving care (National Association of State Mental Health Program Directors [NASMHPD 2014: n.p.] and injuries for clinical staff providing that care (Fisher 1994: 1584-1591). People receiving care in mental health facilities as inpatients, where this may be without their consent and occurring under the authority of the Mental Health Act 2000, are hereafter referred to as mental health consumers. The article argues there is a need for significant cultural and organisational change to occur in one of the most challenging places where consumers' basic human rights and dignity can too readily be abused. The change focus needs to be on eliminating the incidences of seclusion and reducing restraint of consumers in public mental health facilities as these practices may indicate systems failure in managerial and clinical practices (NMHCCF 2009: 7).

According to the Mental Health Act (Queensland Government 2000: 109), restraint involves ‘a restrictive intervention that relies on external controls to limit the movements or responses of a person’ and seclusion is defined as ‘the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented’. For the purposes of this paper we acknowledge that calls for the total elimination of restraint, while morally desirable, may not be feasible in some instances due to the need to exercise a duty of care toward the mental health consumer and/or other persons in their proximity.

Our point nevertheless regarding the harm caused by violence, including restraint as a form of violence, still stands (Finke 2001: 186). We do not hereafter separately make this point and use the term ‘seclusion and restraint’ as an umbrella term for the spectrum of behaviours and all levels of violence toward mental health consumers, aware this area needs further research. Further, we wish to acknowledge that clinical staff in mental health inpatient facilities may be potentially morally conflicted as they are responsible on behalf of society for negotiating the tension between the care and control dimensions of their roles (Okitikpi 2011: vii). It is important that as allies to both the clinical staff and mental health consumers we avoid creating an ‘injurious division’ (Reynolds 2012: n.p.) with staff and consumers in seeking to contribute to the issue.

We write from a critical humanist, anti-oppressive theoretical approach (Thompson 2011: xviii), which accents non-violence, equality, democratic and collaborative relationships and trauma-informed clinical practice. This approach is also premised on recovery-oriented values such as respect for peoples’ dignity, self-determination and recognising consumers as experts in their own lives (Queensland Health 2005: 1). The use of seclusion and restraint in the context of providing care for people with mental illness is problematic both ideologically for us and for the people experiencing it (Saks 2012: n.p.). However this is not the main focus of the paper, as a survey of the relevant research leaves us with unanswered questions about the influence of organisational and broader political factors. As Hickie recognises:
Quality mental health care requires time, resources and space to allow health professionals to deliver health care to meet the unique needs of patients. In a nutshell, we do not have what we need to practice people-centric mental health care (cited in NMHCCF 2009: 2).

**The Research Gap: The Need to Address Indirect Power Issues**

International research that shows the dangers of seclusion and restraint (Sailas and Fenton 2000: 8) was important for helping us as mental health allies to understand the need for change as a professional and ethical priority. We came to realise that concerted efforts to create safe mental health workplaces, and thereby cultural safety, will be central to the elimination of seclusion and reduction of restraint. Cultural safety is the opposite to injustice and violence of all kinds in human organisations (Bloom and Farragher 2013: 250). Violence refers to the use of direct force or intimidation against a person or whole groups of people, specifically people with mental illness (Saks 2012: n.p.). It can also be indirect through inadequate procedures or failure to adhere to democratic workplace processes (Bloom and Farragher 2013: 250) and inadequate funding and resources to ensure quality care for mental health consumers (Mental Health Council of Australia 2005;2011). Violence occurs where a person feels unsafe or demeaned to some extent, possibly even to the extent of their life being threatened. Research shows that violence increases for both staff and consumers where seclusion and restraint are practised (Altimari 1998; Finke 2001: 186). Cultural safety is created by actions and processes that reduce or negate the need for seclusion and restraint; this is a pre-requisite for both clinical staff and consumers’ safety, and well-being in mental health inpatient facilities.

We have yet to find research on the issue that is presented from the experiences of clinical staff seeking to enable the elimination of seclusion and restraint. We believe this is an area of research and scholarship that is urgently needed to help build a language of possibility. First hand, in-depth narrative accounts would also create a sense of the emotionality, humanity, professionalism, challenges and do-ability of breakthroughs in changing mental health workplace cultures that are prone to violence. This approach in future research would seek to build an appreciation of the embodied, lived experience of clinical practice in contemporary mental health. Such a research orientation has its starting point in this exploratory theoretical paper, which situates clinical practices of seclusion and restraint in the larger, complex power dynamics of mental health systems of care. Evidence for this idea of mental health workplaces having violence-prone cultures is provided by reputable national reports into the state of mental health systems of care in Australia (Human Rights and Equal Opportunity Commission 1993; Mental Health Council of Australia 2005; 2011, Dept. of Health (UK) 2005; NASMHPD 2014).

The mental health literature has begun to allude to the need for broader systemic change (Cutcliffe and Riahi 2013: 568), but we found few studies that theorise how power dynamics operating beyond the immediate situation indirectly impact on each seclusion and restraint event. These indirect power dynamics or ‘relations of ruling’ (Smith 1993: 6) relate to the range of effects from broader societal prejudices against people with mental illness (Mental Health Council of Australia 2011) to the largely unscreened managerial decisions and practices in mental health systems. Additionally, the political and policy context which impacts indirectly on how clinical staff respond to mental health consumers in inpatient facilities also tends not to be scrutinised. The neoliberalist, medicalised and individualistic bias to mental health policy (Sawyer and Savy 2014: 253-254) which manifests as a micro-managing and containing approach by the Queensland Government to perceived problematic social groups (Wardill 2013) is well recognised.

**Background: The Nature and Extent of Human Suffering**

Much of the research emerging principally in the United States demonstrates that the use of seclusion and restraint has devastating impacts upon consumers and those who care for them within mental health inpatient facilities. For example, it has been estimated that up to 90% of mental health consumers receiving care through public mental health services have a pre-existing trauma history (Fisher 1994: 1584-1591). In relation to this, the use of seclusion and restraint was found to be not only non-therapeutic but was re-traumatising and increases the risk of physical and emotional injury to consumers and staff (Fisher 1994: 1584-1591). Further, the Hartford Courant publication (Altimari 1998) reveals that in America 142 deaths occurred during or shortly after seclusion and/ or restraint over the 10 years preceding 1998.

A national report by carers of people with a lived experience of mental illness who have been subjected to seclusion or restraint in Australian mental health facilities claims:

> ... the use of seclusion and restraint should be eradicated from use within Australia’s mental health services ... [further] the use of seclusion and restraint is at unacceptably high levels and demonstrates treatment failure when used (NMHCCF 2009: 7).

This claim is supported by mental health consumer accounts of their experiences of being secluded and
restrained in America (Substance Abuse Mental Health Services Administration [SAMHSA] 2014) and includes accounts documented in the influential training resource created by the National Association of State Mental Health Program Directors (National Mental Health Consumer and Carer Forum [NMHCCF] [2014). Such experiences led the Citizen Commission on Human Rights (CCHR) to claim that it is a human right to:

Refuse any treatment the patient considers harmful … [and] no person shall be given psychiatric or psychological treatment against his or her will (2014: n.p.).

How the professional and political responses to the complex tension between individual rights and societal rights are negotiated in specific situations is largely not open to public scrutiny, informed debate or accountability. Concerted efforts have since been made in the United States to reduce seclusion events with some success, using a range of strategies (SAMSHA 2014). However, the NASMHPD (2014: n.p.) currently estimate through improved data reporting systems that as many as 150 deaths continue to occur in psychiatric and residential mental health facilities each year in the United States. The human cost of experiencing seclusion and restraint is profound and deeply concerning, this being the case even with the apparent decline in the number of seclusion events on the public record. Australian information on the extent of seclusion and restraint provided by the Mental Health Services in Australia shows a slow decline in the number of events with approximately 10 seclusions for every 1000 bed days in 2013 down from 15 seclusions for every 1000 bed days in 2008 (2014: 1).

On the basis of an estimated proportion of 10 percent of patients being subjected to seclusion and restraint reported in the Clinical Indicator Report for Australia and New Zealand (1998-2005):

It is reasonable to suggest that there are just under 12,000 episodes of seclusion in Australia each year, or put another way, that seclusion occurs 33 times across Australia each day (NMHCCF 2009: 8).

The statistics cannot convey the human suffering even one seclusion event can have on a person. For example, the following real life scenario of a person given the name of Thomas conveys some of the practice context details and harm experienced:

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

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

The Approval of/Authority for Seclusion form indicated the view that Thomas was secluded in part because he was an absconing risk. Thomas spent 6 ½ hours in seclusion. Thomas was stripped of his clothing and woke up in seclusion clothed only in his underpants.

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

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

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

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

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

Thomas says his life has ‘stood still’ since his hospitalisation (NMHCCF 2009: 9).

Queensland’s Mental Health Policy Context

Since 1997, the National Standards for Mental Health Services have been used in Queensland to guide service development to promote best practice for mental health consumers. For example, Standard 11 ‘Delivery of Care’ promotes the principle that all consumers are entitled to receive the least restrictive care (NMHWG 2007: 26). In 2005, the National Safety Priorities in Mental Health: A National Plan for Reducing Harm was published which identifies four priority areas for improving safety within mental health services including the reduction of and, where possible, elimination of seclusion and restraint. In an effort to identify and implement best practice strategies, the Seclusion and Restraint Project (2007-2009), referred to as the Beacon Project, was established to progress initiatives and work collaboratively with states and territories.
In keeping with the imperatives of the national initiatives, in 2008 Queensland Health demonstrated its commitment to reducing seclusion and restraint through the publication of a policy statement that identified expected outcomes through the implementation of specified strategies. The Queensland Mental Health Clinical collaborative was key in driving the implementation of these strategies, including the development of improved data information collection and performance indicators (Mental Health Branch 2008: 5-6).

The Queensland Government’s policy statement on reducing and where possible eliminating restraint and seclusion states:

Safety is a vital component of quality mental health service delivery [which is demonstrated by a commitment to] a range of initiatives including a Mental Health Clinical collaborative on seclusion and restraint, a state-wide training program, participation in the National Mental Health Seclusion and Restraint Project, and co-ordination and construction of national data standards and performance indicators (Mental Health Branch 2008: 2).

Further, the Queensland Health policy document claims that:

Restraint and seclusion are interventions used as a final response to emergency situations where a patient’s risk is assessed to be imminently dangerous to themselves or others and no other less restrictive option is available (Mental Health Branch 2008: 2).

However, this claim is challenged by research that suggests these interventions are not used as a last resort and can in fact be used for relatively minor incidents but with tragic consequences (SAMHSA 2014: n.p.). One such case on the public record was that of David ‘Rocky’ Bennett, aged 38 years, who died in a United Kingdom mental health inpatient unit after being racially abused by a white consumer and lashing out at a nurse. After 25 minutes of restraint by five staff members Rocky died. An inquest into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional racism’ in the National Health Service and led to an inquiry that resulted in an inquiry into his death identified ‘institutional raci...
occurred, the entire group has failed to prevent it, not just the individuals immediately involved. We see the violent person as the weak link in a complex web of interaction that culminates in violence after a cascade of previous, apparently non-violent events has occurred, creating another vicious cycle (2013: 150).

Cutcliffe and Riahi claim that despite the public perception of people with mental illness being violent, ‘studies tend to show either a decline in the rates of violence perpetuated by individuals with mental health problems or that the findings are equivocal and inconclusive’ (2013: 569). On the other hand, less recognised and debated is the possibility that a violence-prone workplace culture is operating to some extent when staff treat each other unfairly, engage in bullying, harassment, and other forms of behaviour which are not permitted by professional and organisational standards and values (Thompson 2011: 187).

The Possibility of Change in Mental Health Systems

A successful change effort of the order required for this issue to be addressed needs a number of alignments to occur which can make it seem like ‘Yes, we can do this!’ for a sufficient number and mix of clinical staff within the mental health system and their allies. It requires a conducive political context, progressive policies, supportive managers as well as collaboration with mental health community leaders and interest groups. Few change management references pay sufficient attention to these alignments, especially the amount of emotional investment required to effect change from the inside (see for example, Spector 2013: 158). The change project needs to have a clear goal which people can make a concerted effort toward. For our purposes, the main indicator of the needed broad ranging changes occurring will show as success in reducing the intolerably high level of seclusion and restraint incidences.

At the same time too little credence is given to how all levels of the mental health care system need to change. It is too simplistic to limit change to local actions of clinical staff in the mental health inpatient facilities on the basis, for example, that they tend to make the majority of seclusion and restraint incidences. Spector writes of change enablers as involving organisational leaders recognising employee resistance not only as negative, but also as opportunities to learn (2013: 11). It is well known nonetheless, that failure to engage employees is a disabler of managed change processes succeeding in organisations (Spector 2013: 13). The assumption is that it is only the rank and file staff who need to change.

The change needs to start at the top of the hierarchy in modelling non-violent and non-coercive management practices towards staff. While writing about the business world, Crane and Matten call for a re-humanising of workplaces ‘by empowering the employee’ (2010: 330). The experience of seclusion and restraint can be dehumanising and disempowering for both staff, who are directly and indirectly involved, and mental health consumers. Sustained change relating to eliminating seclusion and restraint is not possible without a whole of service dedication and concerted collaborative effort over time. For this to occur it would require all aspects of the mental health system to become recovery embedded (Adams and Bateman 2013: 9) and trauma-informed (Bloom and Farragher 2013: 475). Trauma-informed organisations are those places where members explicitly work towards eliminating any behaviours or policies which might harm or traumatising staff and consumers. Bloom and Farragher’s (2013) work directly links violence with traumatising organisations and Bloom argues that authoritarian leadership practices are the main power dynamic underpinning this violence (2000; 2014: n.p.).

The broader political context also needs to be included in the power dynamics which impact on the use of seclusion and restraint in mental health facilities. For example, in recent years an attempt to move towards having the mental health facility doors open experienced a set back. Clinical efforts to open inpatient facility doors were impeded by the directive from the Minister of Health, Lawrence Springborg, in late 2013 that all mental health facilities in Queensland had to be kept locked at all times. The stigmatising newspaper report commenced with the claim that:

Hundreds of mentally ill patients – including killers and rapists deemed unfit to incarcerate for their crimes – are absconding each year, forcing state-run facilities to adopt a new locked door policy (Wardill 2013: 7).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) issued a press release countering this decision and argued that:

To make this the standard of care for everyone is unnecessarily brutal and goes against the standard of care Queensland has been proud to offer vulnerable patients since introducing de-institutionalisation many years ago (Patton cited in RANZCP 2013: 1).

This reminds us of the very political nature of mental health and of the change process needing to be multi-
The organisation as a whole becomes unable to talk about the issues that are the most emotionally evocative, that are causing the most problems and that remain, therefore, unsolvable (Bloom and Farragher 2013: 17).

Further to the already noted use of power which can have harmful effects, another way power operates in complex organisations is by making one group of staff more or less important than other groups of staff (Earles and Lynn 2012: 11). For example, it is well known that community-based acute care mental health clinicians are likely to be regarded with higher esteem by their peers than staff who work on the mental health wards of hospitals (Carr 2008: 19). The potential for negative constructions of hospital-based clinicians can have the effect of leaving them with an unfair burden of responsibility for the use of seclusion and restraint sanctioned by the mental health service. This provides further credence for the need for organisational cultural change over time to create safe, non-violent, egalitarian, trauma-informed spaces and places for all clinical and support staff and consumers.

We argue that attention needs to be given to achieving respect, safety and fair processes within the broader workplace and organisational setting. Cropanzano, Bowen and Gilliland describe this as organisational justice where:

Members’ sense of moral propriety of how they are treated – is the glue that allows people to work together effectively. Justice defines the very essence of individuals’ relationship to employers. In contrast, injustice is like a corrosive solvent that can dissolve bonds within the [organisational] community. Injustice is harmful to individuals and harmful to organisations (cited in Bloom and Farragher 2013: 250).

To the extent that violence, both direct and indirect and coercive as well as subtle, is occurring in mental health systems it can be understood as interpersonal and organisational injustice. The complex mix of bureaucratic, legalistic and clinical practices in public mental health facilities creates enormous challenges for maintaining safe and therapeutic care for consumers. This context has an intricate and ongoing influence on the ability of staff and consumers to avoid violence and in particular, to avoid violence relating to seclusion and restraint.

**Keys to Organisational Cultural Change**

Where clinical staff and mental health consumers experience violence, this will interconnect with other dynamics of power abuse in the mental health and broader political system. In such circumstances an ‘organisational alexithymia’ can occur where ‘an increasing amount of important information becomes “undiscussable” … [and] the organisation as a whole becomes … unable to talk about the issues that are the most emotionally evocative, that are causing the most problems and that remain, therefore, unsolvable’ (Bloom and Farragher 2013: 17).

We are indebted to the practice based research work of Bloom (1994, 2000, 2014) and Bloom and Farragher (2013) for the work done in naming the nature of traumatised organisations. A major implication of their work is there needs to be a dedication to the recovery work of the whole staff group because otherwise the trauma creates a reactivity and ongoing cycles of abuse and suffering. To our knowledge this level of work is not happening in Australian mental health systems.

In this section we offer two keys that can support on-the-ground or bottom-up change (Ife 2013: 138) towards opening the doors through all layers of the mental health system. The first key is a flexible template for mapping the main dynamics, levels of influence, resources and stakeholders. We give this tool the title ‘multi-focal change template tool’ (see opposite page). The work that sits within this mapping needs to be undertaken from a community development approach over time (Ife 2013: 158) within the organisational context. The change template is populated with some examples of what could contribute to the elimination of seclusion and the reduction of restraint.

Space does not permit an elaboration of points in the template but the ideas are consistent with our preceding arguments and draw on our combined professional experiences over many years. Many linked templates may be needed for different aspects of the issues. Each area of the template needs to be invested in, and weakness in one area will alert change agents to what needs attention or to the possible limits of the change efforts.

The second key concerns establishing warrants or agreements for the change work where a set of powersensitive questions are outlined. We call this key ‘warrants for trauma-informed and recovery organisations’. These questions can help change agents to gauge if the change effort is on-track and if all the relevant people are sufficiently invested in the change work. This power-sensitive tool for helping progressive change agents in mental health systems gauges whether there is sufficient political will: to consider commencing a change effort; to persist with it; or to seriously consider stopping change efforts. The ideas which are adapted from Fox and Miller (cited in Ross 2013: 202) will allow a power analysis that will show if there is adoption by the people needed to legitimate the desired changes and whether they are sufficiently willing themselves to change.

In practice situations at crucial times, the following questions might be asked of the powerful people who are allowing the status quo of seclusion and restraint as
<table>
<thead>
<tr>
<th>Level</th>
<th>Social Alternatives</th>
<th>Vol. 33  No 3, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Micro:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships are non-violent, respectful, inclusive, negotiated and ensure accountability of powerful party. Consumers &amp; carers as equal partners. Staff value not dependent on position in hierarchy. Free legal aid for consumers. Range of models of mental illness/wellbeing, critical humanist values, trauma-informed ideas. Anti-discriminatory behaviour and non-stigmatising language. Sensory modulation, de-escalation, non-violence, deep listening, care, partnerships based on equality and inclusion, group based therapy, no seclusions and minimal force with restraint, open doors, negotiated safety rules and processes. Facilities that are dignity enhancing, aesthetic, open and adaptive to changing needs of clients. Funding of changes re staff rostering, staff mix and re-training. Funding of trauma-informed training to include ALL staff. Resource sharing with mental health NGOs. All staff to receive trauma-informed supervision, and to participate in debriefs, dialogue (equal value) meetings, reflective practice groups. Active promotion of care-based ethics especially of people who are marginalised or are being scapegoated. Active promotion of restorative justice for people causing harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team, group and service level debriefs, dialogues about shared concerns without blaming and recriminations, independent person facilitated. Follow through changes monitored. Cultural safety, anti-bullying and anti-mobbing ideas, systemic thinking, critical organisational theory, code of ethics, conflict of interest. Build collective moral capacity and responsibility. Provide consumer centred tools eg Deegan’s computer based interactive resource (2013) to enable shared decision-making. Identify and address stigmatising and us versus them clinical processes. Close and decommission seclusion rooms. Increase safe, welcoming, nature centred spaces for distressed people. Increase consumer allies, companions and advocates and pay for their expertise.Clinical staff to be regularly rested from inpatient facility work. Whole of system recovery training and implementation. Establish as a norm the consumer’s wishes being upheld and proactive measures taken to avoid coercion. External benchmarking and critical friends to improve cultural safety.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Societal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative justice for people causing harm. Mental health think tanks and community based dialogues to address stigma and fear. Accent training, practice and research with consumers, clinicians and managers together. Open the doors of the whole system to demystify and improve accountability and service relevance and responsiveness. Embed consumer led processes and knowledge to invert status of knowledge and expertise valued. Consumer in senior management group.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
accepted practice – have you:

1. Built a sincere relationship with mental health facility staff and the change agents, families, carers and the mental health consumers impacted by seclusion and restraint?

2. Stayed focused on the relevant shared issues with willing attention to the effect of power imbalances?

3. Ensured you have made substantive contributions to the change effort?

Dialogue with people who are not making substantive contributions may be difficult or unsafe, and if so then the progressive change agents might use the above questions as a reflective tool to determine feasible forward strategies.

Conclusion

Current research into the use of seclusion and restraint in mental health inpatient facilities stops short of asking the hard question of who is responsible for the system of care that allows the use of coercion in the name of care. An argument for turning the focus to the power issues underpinning workplace cultures where violence is occurring, as well as the broader systemic and political influences, was developed to respond to this gap in mental health research and related public debate.

Multi-pronged changes are needed which simultaneously address the violence – both overt and covert – in mental health workplace cultures and the use of seclusion and restraint against mental health consumers. Tracing the influences for each seclusion event to all possible sources may illuminate the many actors who directly and indirectly contribute to current practices. Building the accountability of people in senior positions of power through tools such as the ‘multi-focal change template tool’ and the set of questions to gauge their ‘buy-in’ to creating trauma-free workplaces and clinical practices, may have some value.

References


National Association of State Mental Health Program Directors (NASMHPD) 2014 Promoting Alternatives


National Mental Health Working Group (NMHWG) 2007 National Standards for Mental Health Services, AGPS, Canberra.


Royal Australian and New Zealand College of Psychiatrists 2013 Locking up Patients. A step back into history – Psychiatrists, Media Release, RANZCP, Brisbane.


Wardill, S. 2013 ‘Doors locked on mentally ill patients’, Courier Mail Brisbane, 10th December, Brisbane.


Authors

Dyann Ross is a Senior Lecturer in Social Work at the University of the Sunshine Coast. Her research interests are in the areas of corporate social responsibility, social sustainability and mental health. Dyann has been a social worker since the early 1980s in mental health, staff training and development and tertiary education.

James Campbell is a Mental Health Nurse with 25 years of experience working across the age spectrum ranging from Child and Youth Mental Health to Older Persons, within both community and inpatient settings. His main interest lies in the understanding, implementation and delivery of mental health services from a trauma-informed perspective and the impact of workplace culture upon service delivery and workforce management.

Alex Dyer has a BSc (Hons) Nursing Studies Mental Health and Masters in Mental Health Nursing, and has worked in mental health since he started his training in 1993.

Please direct enquiries about the article to Dyann Ross.

Unstable

Casuarinas, wattle & bottle brush in the scrub along the fore shores where the pale sand stretches from headland to bluff.

The beach is deserted; as yet, no footprint or long boat disturbs the solemn rise & thump of the green glass ocean.

That dark shade floating silent between the stunted t-trees back of the sand dunes leaves no impression; only the rust-streaked sails of the buccaneer unloading the future will now begin the root and branch erosion of a littoral past and stable.

Ron Pretty
Wollongong, NSW