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Gender, trauma and the regulation of the use of restraint on women in Australian mental health services

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Abstract

The use of physical, mechanical and/or chemical restraint is authorised by mental health legislation in most Australian jurisdictions. Research indicates that women have different experiences and needs in relation to the use of restraint, but legislation does not mention sex or gender as relevant considerations in the authorisation, use or monitoring of these practices. This is especially problematic in light of the potential for restraint use to traumatise, or retraumatise women service users. This article discusses the treatment of gender- and trauma-related considerations in Australian mental health legislation and supporting policy, pointing to several gaps and proposing appropriate changes to practice and regulation.

Keywords

Mental health law; restrictive practices; restraint; gender; women; trauma; trauma-informed practice

Introduction

Mental health legislation in many Australian jurisdictions identifies 'sex' or 'gender' as considerations in the provision of mental health services, both in general statements of principles and in relation to a small number of specific contexts, such as the conduct of personal searches involving the removal of clothing.[1]

Sex or gender are not, however, mentioned in regulatory provisions concerning the use of restraint or other restrictive practices on mental health service users. This is despite research, discussed below, indicating that restraint use and other efforts to control women's behaviour in mental health settings raise gender-specific considerations and concerns.

In this article, I discuss the treatment of gender- and trauma-related considerations in Australian mental health legislation and supporting policy documents in relation to the authorisation and use of restraint. Drawing on international research on women's experiences and requirements in relation to restraint use, I point to several apparent gaps in existing legislation and guidelines and suggest how they might be addressed via changes to practice and regulation.[2]

The legal context

The principles and objects sections of mental health legislation in all Australian jurisdictions refer to 'sex' or 'gender' as relevant considerations in the provision of services. They also state that services should meet the gender-related circumstances and needs of service users. These

[1] *Mental Health Act 2016* (Qld), ss 399(2), 400(2); *Mental Health Act 2013* (Tas), s 111.

[2] Note that regulation and research in this field generally uses the terms 'sex' or 'gender' to refer to binary categories of 'female' and 'male' or 'woman' and 'man'. Only one of the mental health statutes discussed in this chapter lists 'gender identity' as a consideration for service provision (*Mental Health Act 2009* (SA), s 7(1)(ca)(ii)). Discussions of gender-related considerations in mental health service provision in the literature usually focus on the exclusion of women's perspectives, or perspectives other than those of men. Most research has not explicitly included non-cisgender women, and as I note later in this article, further attention is required to the experiences and needs of trans and gender diverse mental health service users.

provisions do not generally specify what those needs might be, or how they might be ascertained. For example, Victoria's *Mental Health Act 2014* states that:

> *persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to*.[3]

Most of these statutes also permit the use of some forms of restraint to control the behaviour of mental health service users in some circumstances. Physical, mechanical and/or chemical restraint are allowed for specific 'emergency' or urgent purposes, such as preventing self-harm or harm to others;[4] preventing absconding;[5] and preventing damage to property.[6] While gender-disaggregated data is not available, national data on physical and mechanical restraint use in public sector acute mental health hospital services demonstrate the prevalence of these practices in Australia, with 991 mechanical restraint events and 18,690 physical restraint events reported in 2018-19.[7]

The legislation governing the use of restraint addresses a range of matters relating to the authorisation, application, monitoring and recording of restraint use. In no jurisdiction, however, does legislation mention sex or gender as relevant matters in relation to these practices.[8] Policies and guidelines addressing the use of restraint provide some guidance in most jurisdictions, but few of these give detailed attention to sex- or gender-related matters. Some briefly mention gender as a relevant consideration in the use of restraint, but do not impose clear obligations or offer meaningful advice. For example, a New South Wales Health policy on 'Aggression, Seclusion and Restraint in Mental Health Facilities' states a principle that, '[d]uring restraint and seclusion, the individual needs of the consumer are recognised, including sensitivity to cultural, spiritual, language and gender concerns'.[9]

Guidelines in some jurisdictions offer more comprehensive guidance. The Victorian Chief Psychiatrist's guideline on the use of restrictive interventions in mental health services, and the Tasmanian Chief Civil Psychiatrist's corresponding guidelines on the use of mechanical, physical and chemical restraint, all discuss '[g]ender safety and sensitivity'.[10] The Victorian

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[3] See also *Mental Health Act 2013* (Tas), sch 1, item 1(d); *Mental Health Act 2014* (WA), sch 1, item 6; *Mental Health Act 2007* (NSW), s 68(g); *Mental Health Act 2016* (Qld), s 5(f); *Mental Health and Related Services Act 1998* (NT), s 9(f)); *Mental Health Act 2015* (ACT), s 6(f); McSherry, B and Tellez, JJ, "Current Challenges for the Regulation of Chemical Restraint in Healthcare Settings" (2016) 24(1) *JLM* 15.

[4] For example, *Mental Health Act 2016* (Qld), ss 270(a), 375(2)(b); *Mental Health Act 2015* (ACT), s 65(2)(b)(i); *Mental Health Act 2013* (Tas), s 57(4)(a); *Mental Health Act 2014* (Vic), s 113(a); *Mental Health Act 2014* (WA), s 232(1)(ii).

[5] For example, *Mental Health Act 2015* (ACT), s 65(2)(ii).

[6] For example, *Mental Health and Related Services Act 1998* (NT), s 61; *Mental Health Act 2016* (Qld), s 270(c); *Mental Health Act 2013* (Tas), s 57(4)(b); *Mental Health Act 2014* (WA), s 232(1)(iii).

[7] Australian Institute of Health and Welfare, *Mental Health Services in Australia – Restrictive Practices* (Australian Government, 2020) table RP.8, www.aihw.gov.au/mhsa.

[8] Note that the *Mental Health Act 2007* (NSW) does not mention restraint use at all. Other statutes mention only some forms of restraint, or restraint generally (for example, *Mental Health Act 2014* (WA), s 227; *Mental Health Act 2014* (Vic), s 3).

[9] New South Wales (NSW) Health, *Aggression, Seclusion and Restraint in Mental Health Facilities in New South Wales* (NSW Government, Sydney, 2012). This is drawn directly from the 'key principles' stated in Mental Health Standing Committee, *National Documentation Relating to Seclusion and Restraint Reduction* (National Mental Health Seclusion and Restraint Project, Canberra, 2009).

[10] Department of Health (Vic), *Restrictive Interventions in Designated Mental Health Services* (Victorian Government, Melbourne, 2014); Department of Health and Human Services (Tas), *Mechanical and Physical*

guideline, for example, states that '[s]ensitivity to gender-specific needs is crucial'[11] and lists some matters that should be considered in this regard. It states, for example, that,

> *[a]rrangements for clothing, searches for dangerous objects, toileting and review should… be undertaken in regard to gender sensitivity. Consideration should also be given to the possibility of pregnancy in female consumers and the implications of this, especially if medications contraindicated during pregnancy are being considered.* [12]

As I discuss in more detail below, Victorian, Tasmanian and Western Australian guidelines also note the potential significance of past trauma to women's needs and experiences concerning restraint. The Tasmanian guideline on chemical restraint, for instance, states that 'services should ensure that staff demonstrate sensitivity' to patients' needs and wellbeing during restraint in light of:

> *the high incidence of previous experiences of trauma among involuntary patients and given that restrictive practices including chemical restraint may potentially retrigger previous experiences of trauma in some people*.[13]

While these provisions touch on issues affecting women in the use of mental health services generally, and when they are subject to restraint specifically, the research literature suggests they are insufficient on their own to adequately address women's needs and experiences.

Research on women's experiences and requirements in relation to restraint use

There has been relatively little research on Australian women's experiences of restraint and other forms of behaviour control in mental health services and other closed environments.[14] There is a similar dearth of research examining whether and how legislative principles and other guidance on gender and trauma are enacted at the service level. Some Australian studies as well as a larger body of international research do, however, suggest that issues of gender and trauma are not addressed appropriately, or in sufficient detail, in existing regulation to ensure that women's needs are met and their rights protected.

A central theme in the literature is the notion that mental health services are not 'gender aware'.[15] That is, gender is not treated as a relevant factor in service provision, including in the use of restraint, despite women having gendered experiences, responses and requirements and being subject to discrimination and other gender-based disadvantage. A primary criticism of services that are not gender aware is that approaches to behaviour control – including restraint use – fail to consider women's life experiences, particularly their experiences of trauma. Trauma in childhood and/or adulthood has been identified as a key social determinant of

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Restraint: Chief Civil Psychiatrist Clinical Guideline 10A (Tasmanian Government, Hobart, 2017a); Department of Health and Human Services (Tas), *Chemical Restraint: Chief Civil Psychiatrist Clinical Guideline 10* (Tasmanian Government, Hobart, 2017b).

[11] Department of Health (Vic), n 10 at 7.

[12] Department of Health (Vic), n 10 at 15; see the similar language in Department of Health and Human Services (Tas) *Mechanical and Physical Restraint*, n 10 at 7; Department of Health and Human Services (Tas), *Chemical* Restraint, n 10 at 8.

[13] Department of Health and Human Services (Tas), *Chemical* Restraint, n 10 at 8.

[14] On the general lack of research on women's experiences and needs, see Victorian Mental Illness Awareness Council, *Zero Tolerance for Sexual Assault: A Safe Admission for Women* (Victorian Mental Illness Awareness Council, Melbourne, 2013) https://www.abc.net.au/reslib/201305/r1115028_13591277.pdf.

[15] Aitken G and Noble K, "Violence and Violation: Women and Secure Settings" (2001) *Feminist Review* 68, 68.

women's mental health.[16] There is also research indicating mental health service users are at risk of witnessing or experiencing violence or abuse in psychiatric inpatient settings.[17]

Women who have been subject to restraint describe feeling pain, fear, humiliation and powerlessness during the experience, highlighting the fact that restraint constitutes a form of 'lawful violence'[18] and indicating its potential to traumatise or retraumatise women who are subject to it.[19] For example, Juliet Watson and colleagues interviewed Victorian women who had experienced gender-based violence during or as a result of a stay in an inpatient mental health unit.[20] Several of the women in their study reported that restraint was traumatic. One participant, Elizabeth, described the experience of having her underwear removed while she was being restrained and secluded and said she subsequently had 'flashbacks' and 'can't seem to get past it'.[21] Another participant, Amanda, said that she had survived past trauma and said 'it was like what they did was repeating the trauma'.[22]

Similar findings have been reported in comparable overseas jurisdictions. For example, Heather Sequiera and Simon Halstead examined the experiences of five women who were subject to 'emergency interventions' in an independent psychiatric hospital in England. They described similar themes in women's descriptions of their experiences, including physical pain or discomfort, anxiety and mental distress and feeling anger and aggressiveness during seclusion, restraint or tranquilisation. The women they spoke to said things like, '[i]t bloody hurts', '[n]urses and doctors they say you're awful and they give you one of these [mimes giving self an injection]' and 'I was just shouting, thinking of hitting people again'.[23]

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[16] Mental Health Complaints Commissioner (Vic), *The Right to Be Safe – Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report* (2018) 45, https://www.mhcc.vic.gov.au/Api/downloadmedia/%7B76BF660A-3A27-4B20-A30C-448376D319C0%7D; Stewart, D E "Social Determinants of Women's Mental Health" (2007) *Journal of Psychosomatic Research* 63(3) 223–224.

[17] Frueh, B C, Knapp, R G, Cusack, K J, Grubaugh, A L, Sauvageot, J A, Cousins, V C, Yim, E, Robins, C S, Monnier, J and Hiers, T G, "Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting" (2005) *Psychiatric Services* 56(9) 1123; Judd, F, Armstrong, S and Kulkarni, J, "Gender-sensitive Mental Health Care" (2009) *Australasian Psychiatry* 17(2) 105.

[18] Steele, L, "Disability, Abnormality and Criminal Law: Sterilisation as Lawful and 'Good' Violence" (2014) *Griffith Law Review* 22(3) 467.

[19] For example Gallop, R, McCay E, Guha, M and Khan, P "The Experience of Hospitalization and Restraint of Women Who Have a History of Childhood Sexual Abuse" (1999) *Health Care for Women International* 20(4) 401; Fish, R and Culshaw, E "The Last Resort?: Staff and Client Perspectives on Physical Intervention" (2005) *Journal of Intellectual Disabilities* 9(2) 93; Fish, R and Hatton, C, "Gendered Experiences of Physical Restraint on Locked Wards for Women" (2017) *Disability & Society* 32(6) 790; Mohr, W K, Mahon, M M and Noone, M J, "A Restraint on Restraints: The Need to Reconsider Restrictive Interventions" (1998) *Archives of Psychiatric Nursing* 12(2) 95; Johnson, M E "Being Restrained: A Study of Power and Powerlessness" (1998) *Issues in Mental Health Nursing* 19(3) 191; Sequiera, H and Halstead, S "'Is It Meant to Hurt, Is It?': Management of Violence in Women With Developmental Disabilities" (2001) *Violence Against Women* 7(4) 462; Aitken and Noble, n 15.

[20] Watson, J, Maylea, C, Roberts, R, Hill, N and McCallum, S, *Preventing Gender-based Violence in Mental Health Inpatient Units* (Research Report, ANROWS, Sydney, 2020) https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2020/01/20215312/ANROWS-Watson-RR-VAW_MH_Units.pdf.

[21] Watson, Maylea, Roberts, Hill and McCallum, n 20 at 37.

[22] Watson, Maylea, Roberts, Hill and McCallum, n 20 at 37.

[23] Sequiera and Halstead, n 19 at 467, 468.

A related issue raised in the literature is the tendency of services to ignore the significance of the gender of staff involved in restraint, despite service users and/or staff raising concerns about men's involvement in restraining women.[24]

Options for reform

A 'trauma-informed' approach to services has been proposed as an essential response to women's experiences of violence and abuse, including their experiences of restraint. Trauma-informed approaches 'are based on a recognition and comprehensive understanding of the widespread prevalence and effects of trauma'.[25] In relation to the use of restraint and other forms of coercion, this requires recognition that people's presentation, including 'challenging' behaviour, anger, aggression and self-harm – all of which may precede the use of restraint – may be a consequence of past or present trauma and a coping strategy in stressful or threatening situations.[26]

The impacts of trauma, and the need for a trauma-informed approach, is not addressed in detail in Australia's regulatory frameworks. Only the Australian Capital Territory's *Mental Health Act 2015* and South Australia's *Mental Health Act 2009* mention both 'gender' and 'trauma' as potentially relevant considerations in the provision of mental health services. For example, section 6 of the Australian Capital Territory statute states that:

> *(f) a person with a mental disorder or mental illness has the right to be able to access services that*
>
> > *(i) are sensitive and responsive to the person's individual needs, including in relation to age, gender, culture, language, religion, sexuality, trauma and other life experiences….*[27]

While this constitutes some level of acknowledgment of both gender and trauma to women's experiences and needs, Penelope Weller has observed that such statements of principles or objects are essentially symbolic and unenforceable.[28] Provisions explicitly mandating the avoidance of restraint in favour of alternatives, and imposing penalties for violation, are likely to be necessary to support progress towards a trauma-informed approach.

As touched on above, guidelines on restraint use in some jurisdictions delve into issues of gender and trauma in some more detail. The Western Australian Department of Health's

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[24] For example Bonner, G, Lowe, T, Rawcliffe D and Wellman, N, "Trauma for All: A Pilot Study of the Subjective Experience of Physical Restraint for Mental Health Inpatients and Staff in the UK" (2002 *Journal of Psychiatric and Mental Health Nursing* 9(4) 465 at 468; Gallop et al, n 19 at 410; Potier, M A, "Giving Evidence: Women's Lives in Ashworth Maximum Security Psychiatric Hospital" (1993) *Feminism and Psychology* 3(3) 335; Fish and Hatton, n 19 at 798; Watson, Maylea, Roberts, Hill and McCallum, n 20 at 36-7.
[25] Sweeney, A, Filson, B, Kennedy, A, Collinson, L and Gillard, S, "A Paradigm Shift: Relationships in Trauma-Informed Mental Health Services" (2018) 24(5) Bjpsych Advances 319 at 323.
[26] Sequiera and Halstead, n 19 at 473 and citing Whittington, R and Mason, T, "A New Look at Seclusion: Stress, Coping and the Perception of Threat" (1995) *The Journal of Forensic Psychiatry* 6(2) 285; see also Stafford, P, *Defining Gender Issues… Redefining Women's Services* (Report, Women in Secure Hospitals (WISH), 1999) https://www.womenatwish.org.uk/wp-content/uploads/2010/03/Defining_Gender_Issues.pdf; Dowse, L, "Disruptive, Dangerous and Disturbing: The 'Challenge' of Behaviour in the Construction of Normalcy and Vulnerability" (2017) *Continuum* 31(3) 447.
[27] *Mental Health Act 2015* (ACT), s 6(f(i); *Mental Health Act 2009* (SA), s 7(ca)(vi).
[28] Weller, P, "The Contradictions of Gender: Women, Men and Violence in Mental Health Research-Policy, Law and Human Rights" (2016) *Griffith Law Review* 25(1) 87.

'Principles of Best Practice' in relation to people 'who may be at risk of becoming violent or aggressive' note the need for clinicians to 'be aware of the significant gender differences in the way that trauma is normally experienced and in the resultant symptoms and responses'.[29] The Victorian and Tasmanian Chief Psychiatrists' guidelines go further, identifying women's experiences of trauma as a key issue in delivering gender-sensitive services. The Victorian guideline states that 'a key component of providing gender sensitive care is to understand trauma and how it manifests in people when they are in acute distress'.[30] Both sets of guidelines mention that restraint may trigger 'extreme' responses in people who have a history of trauma. The Tasmanian guidelines suggest that 'as a universal precaution, it should be presumed that every person in a treatment setting has been exposed to trauma'.[31] Neither guideline, however, goes so far as to provide detailed practical guidance concerning inquiring about or responding to trauma. Nor do they characterise past or potential trauma as a reason to avoid restraint use altogether.

Several changes to practice and regulation are therefore likely to be necessary to promote trauma-informed service provision in relation to restraint use. The first is the introduction of formal processes of routine and sensitive inquiry about all service users' experiences of trauma, and procedures and systems for responding to all disclosures of trauma, including trauma in service settings.[32] These processes should include clear and comprehensive staff training on the prevalence and impacts of trauma and violence, including the social and structural conditions that normalise and perpetuate violence against women.[33] They should also include comprehensive coverage of the relevance of '[c]ultural, historical and gender contexts', including the high prevalence of trauma among women with intellectual disability, Aboriginal and Torres Strait Islander women, women from migrant and refugee backgrounds and people who identify as LGBTI, and the potentially compounding impacts of 'racism, ableism, sexism, homophobia or ageism'.[34] Formal structures for involving peer workers, family and other supporters and advocates in planning have been proposed as another important element of trauma-informed practice that can reduce restraint use.[35]

The prioritisation of alternatives to restraint use, including measures that reduce the likelihood of matters escalating to the point where restraint is deemed necessary, is another essential element of trauma-informed service provision. From a practice point-of-view, a common suggestion for the avoidance of restraint and its negative effects for women is the introduction of services and processes that prioritise positive interactions and strong therapeutic

[29] Department of Health (WA), *Principles and Best Practice for the Clinical Care of People with Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive* (Government of Western Australia, Department of Health, 2019) 2 https://ww2.health.wa.gov.au/-/media/Files/Corporate/Policy-Frameworks/Mental-Health/Policy/Clinical-Care-of-People-with-Mental-Health-Problems/Supporting-information/Violence-Aggression-Policy-Supporting-Information-Document.pdf.
[30] Department of Health (Vic), n 10 at 15.
[31] Department of Health and Human Services (Tas) *Mechanical and Physical Restraint*, n 10 at 7; Department of Health and Human Services (Tas), *Chemical* Restraint, n 10 at 7.
[32] Mental Health Complaints Commissioner (Vic), n 16 at 50-51.
[33] Williams, J, Scott, S and Waterhouse, S, "Mental Health Services for 'Difficult' Women: Reflections on Some Recent Developments" (2001) *Feminist Review* 68(1) 89 at 100.
[34] Mental Health Complaints Commissioner (Vic), n 16 at 50-51.
[35] Azeem, M W, Augla, A, Rammerth, M, Binsfeld G and Jones, R B, "Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital" (2011) *Journal of Child and Adolescent Psychiatric, Nursing* 24(1) 11 at 13.

relationships between staff and service users.[36] This requires well-resourced, appropriately staffed services where good relationships can be fostered – meaning relationships characterised by empathy and responsiveness to need, as well as space for women to express distress and be met with supportive responses.[37] It also requires the implementation of alternative strategies that enable service users to express themselves and feel comfortable while also preventing escalation that might lead to restraint.[38] In terms of regulation, this may necessitate mandated staffing ratios to give staff the time and space to cultivate positive relationships[39] and individualised planning mechanisms that prioritise discussion and recording of issues relating to service users' gender-related requirements, including those associated with behaviours that might lead to the use of restraint and experiences of trauma.[40]

While restraint use is still permitted and used, another potentially beneficial change to practice and regulation would be the recognition of the gender of staff involved in, or present during, the use of restraint as a relevant consideration. This might include mandating that only staff of the same gender are involved in restraint (as is the case in some jurisdictions in regard to staff involved in personal searches)[41] and consultation of service users about their preferences in terms of the gender of staff involved in restraint.[42]

The role and gender of staff in meeting gender-related needs is currently mentioned in some Australian guidelines on restraint use. For example, the Tasmanian Chief Civil Psychiatrist guidelines state that, 'services should ensure that staff demonstrate sensitivity to individual patient's [sic] needs and wellbeing in carrying out such interventions, particularly with regard to gender' in light of the impact of past trauma and restraint.[43] They explain that restraint itself might 'be experienced… as particularly traumatic or humiliating' where staff are predominantly male or female. Both these and the Victorian guidelines suggest that patient preferences should be 'sought and responded to' where possible.[44] Australian Capital Territory Health guidelines on the use of physical or mechanical restraint or forcible giving of medication directs staff to consider 'the presence of gender appropriate staff and application of gender

[36] Victorian Women and Mental Health Network (VWMHN), *Increasing Safety and Gender Sensitivity in Mixed Sex Psychiatric Units: Gathering Information about Clinical Mental Health Service Initiatives* (VWMHN, Elsternwick, 2009).
[37] Gallop et al, n 19 at 412.
[38] Gallop et al, n 19 at 412; see also Williams, Scott and Waterhouse n 33; Lunsky, Y and Gracey, C, "The Reported Experience of Four Women with Intellectual Disabilities Receiving Emergency Psychiatric Services in Canada: A Qualitative Study" (2009) *Journal of Intellectual Disabilities*, 13(2) 87; Archer M, Lau, Y and Sethi F, "Women in Acute Psychiatric Units, Their Characteristics and Needs: A Review" (2016) *BJPsych Bulletin* 40(5) 266.
[39] Fish and Hatton, n 19.
[40] Soininen, P, Välimäki, M, Noda, T, Puuka, P, Korkeila, J, Joffe, G and Putkonen, H, "Secluded and Restrained Patients' Perceptions of Their Treatment" (2013) *International Journal of Mental Health Nursing* 22(1) 47.
[41] For example, *Mental Health Act 2014* (WA), s 163; *Mental Health Act 2016* (Qld), s 399.
[42] Sequiera and Halstead, n 19 at 475; see also Watson, Maylea, Roberts, Hill and McCallum, n 20 at 48; Fish and Hatton, n 19 at 798-799; Williams, Scott and Waterhouse n 33; Byrt, R, Lomas, C, Gardiner, G and Lewis, D, "Working with Women in Secure Environments" (2001) *Journal of Psychosocial Nursing & Mental Health Services* 39(9) 42 at 48; Parry-Crooke, G, Oliver, C and Newton, J, *Good Girls: Surviving the Secure System* (Report, Women in Secure Hospitals (WISH), 2000) https://www.womenatwish.org.uk/wp-content/uploads/2010/03/GoodGirls_SurvivingtheSecureSystem.pdf.
[43] Department of Health and Human Services (Tas) *Mechanical and Physical Restraint*, n 10 at 7; Department of Health and Human Services (Tas), *Chemical* Restraint, n 10 at 8.
[44] Department of Health and Human Services (Tas) *Mechanical and Physical Restraint*, n 10 at 7; Department of Health and Human Services (Tas), *Chemical* Restraint, n 10 at 8; Department of Health (Vic), n 10 at 15.

diverse practices, (for example, a female staff member may need to be present even if not involved in the actual restraint)'.[45] Such statements could be strengthened by prescribing a particular approach in legislation and offering detailed guidance on how this can be implemented and monitored. The appropriateness of these measures requires further investigation, however, as it is unclear from existing research whether they are effective from the perspective of women service users themselves.

Conclusions

The manner and extent to which restraint use is currently informed by gender- and trauma-related considerations at the service level is not clear. The preceding analysis suggests, however, that existing mental health legislation, policies and guidelines on the use of restraint in mental health services across Australia are unlikely to be sufficient to address women's needs in relation to the use of restraint. At best, they offer brief, high-level observations about the relevance of gender and the significance of trauma, but always in the context of a system that presumes and permits the ongoing authorisation and use of restraint and other restrictive practices. Even those documents that acknowledge the role of restraint in creating or perpetuating harm do not go so far as to prescribe processes and procedures to ensure that gender- and trauma-related considerations are addressed in practice.

The potential for restraint use to cause or perpetuate trauma, and to cause injury or distress, suggests its ongoing use is incompatible with a trauma-informed, gender aware approach. This means the purpose and goal of regulation should be the avoidance and elimination of the use of restraint through, for example, mandating the use of alternatives. Adequate guidance and resources should be provided to staff as to how and why restraint must be avoided, and what can take its place. This is broadly consistent with the goal of '[r]educing use of, and where possible eliminating, restraint and seclusion' adopted by the Australian Health Ministers' Advisory Council in its 'National Safety Priorities in Mental Health'.[46] Further research is necessary to inform changes to regulation and practice including, for example, research on gender-appropriate alternatives to restraint, and research to understand similarities and differences in the experiences and needs of women according to multiple, potentially intersecting dimensions of difference including sexuality, gender identity, class, 'race', ethnicity, cultural background and religion.[47] The leadership and meaningful involvement of the full diversity of women (and trans and gender diverse) service users and their representative organisations will ensure that service users' perspectives – so often missing from these conversations – are at the forefront of future reform efforts.[48]

[45] ACT Health (2016) *Restraint of a Person – Adults Only* (ACT Government, Canberra, 2016) 8.
[46] National Mental Health Working Group, *National Safety Priorities in Mental Health: A National Plan for Reducing Harm* (Australian Government, Department of Health and Ageing, 2005) 3.
[47] See Weller, n 28.
[48] See Clark C, Becker, M, Giard, J, Mazelis, R, Savage A and Vogel, W, "The Role of Coercion in the Treatment of Women with Co-Occurring Disorders and Histories of Abuse" (2005) *The Journal of Behavioral Health Services & Research* 32(2) 167; Long, C G, Fulton, B and Hollin, C, "The Development of a 'Best Practice' Service for Women in a Medium-Secure Psychiatric Setting: Treatment Components and Evaluation" (2008) *Clinical Psychology and Psychotherapy* 15(5) 304.