Debra Jackson
Tamara Power
Annmarie Gusti Raka

—

15 March 2019

SAFE IN CARE, SAFE AT WORK

A framework for ensuring safety in care and safety for staff in Australian mental health services

CONTENTS

—

ACKNOWLEDGEMENTS

SAFE IN CARE, SAFE AT WORK

While mental health care is a multidisciplinary area of practice, in this document, we recognise the essential and distinctive contribution nurses make to the provision of mental health services across Australia. Thus, the unique contribution of this document is its major focus on the role of nurses – on the safety of nurses, of nurses being safe; and feeling safe and confident to practice in environments that are safe, and ensuring nurses are free from fear in the workplace. The safety of nurses is an essential element in the overall strategy to reduce seclusion and restraint in mental health services.
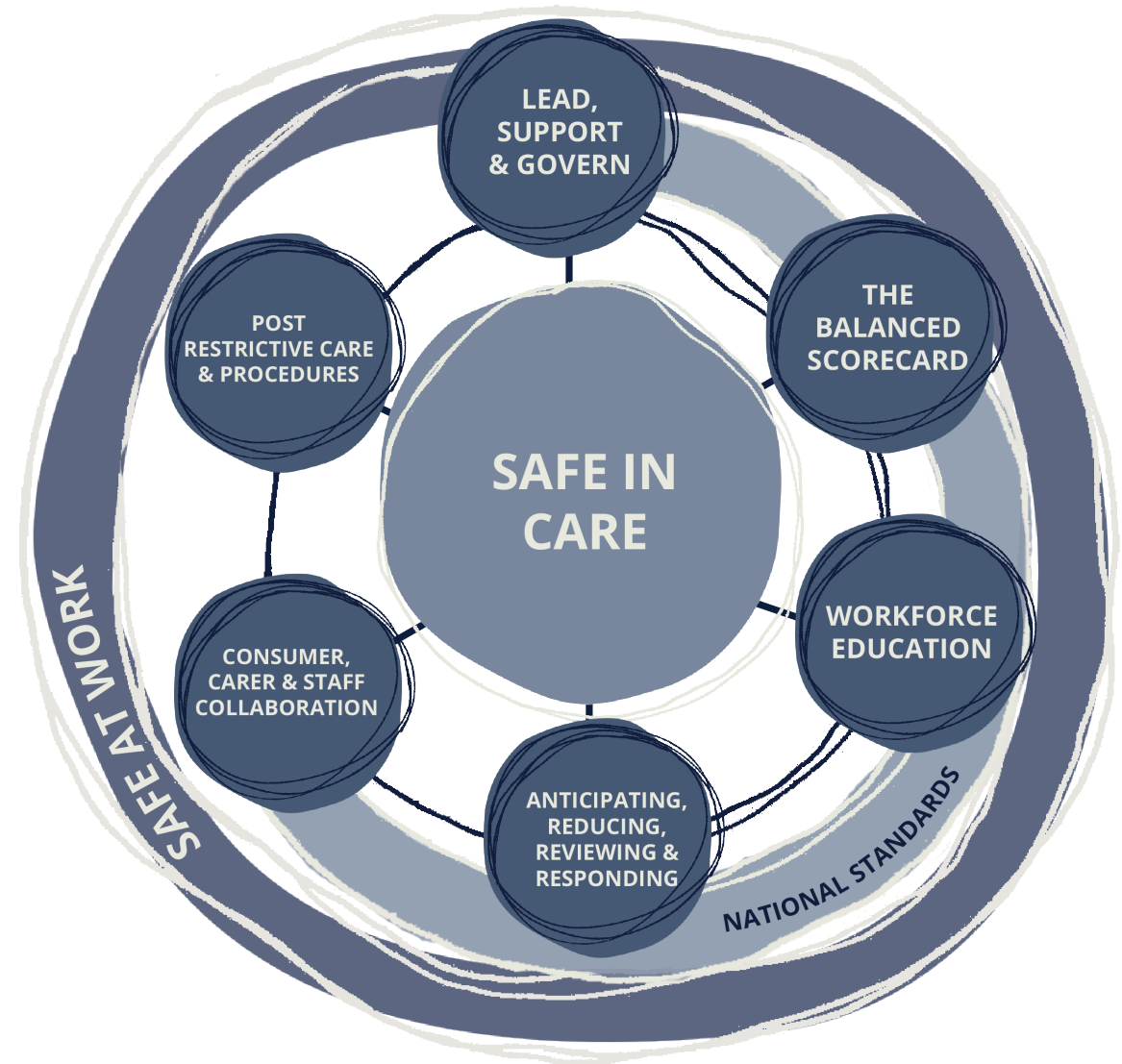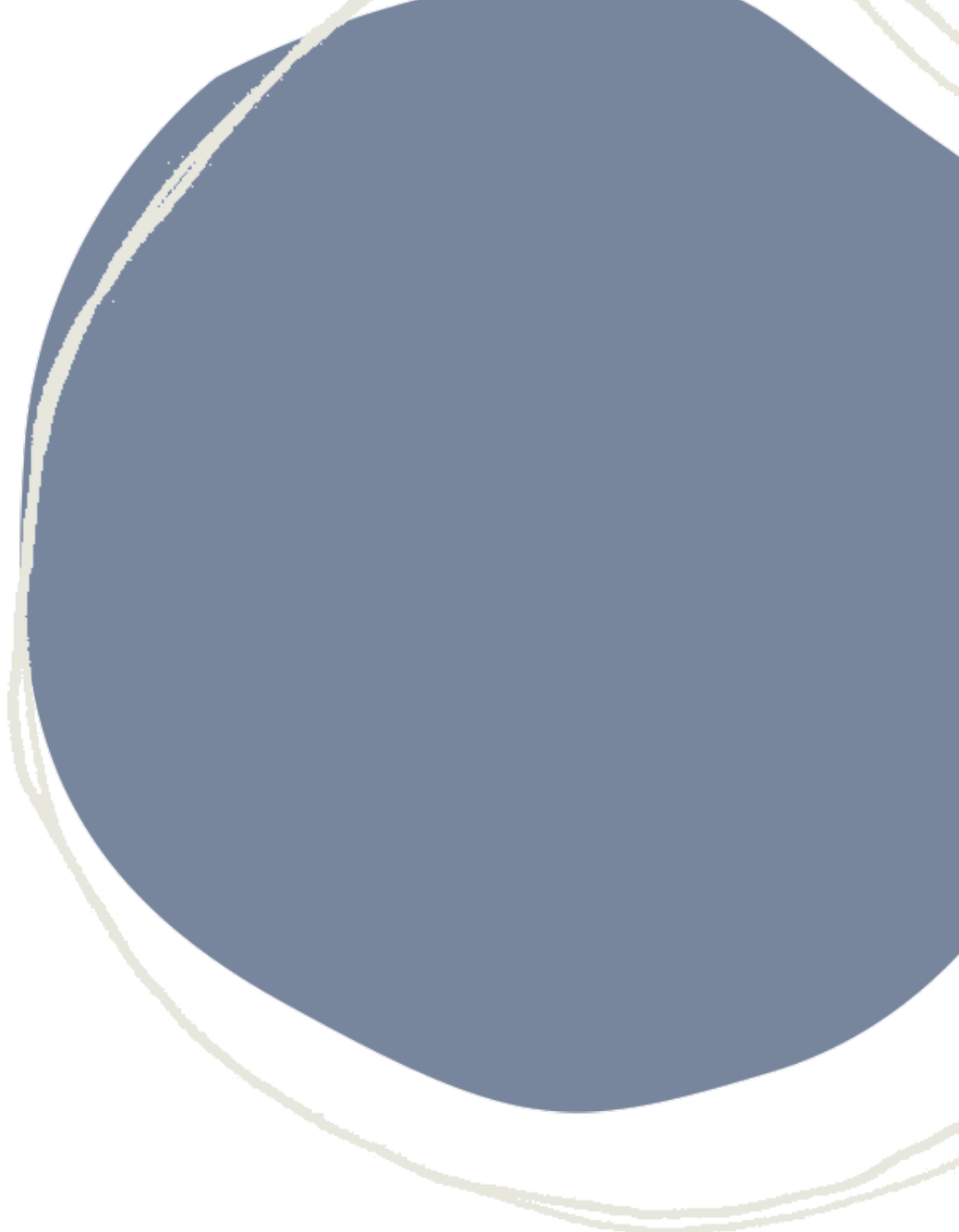
INTRODUCTION

—

Least restrictive practice has long been a focus and aspiration in mental health care, is framed as an indicator of care quality in mental health settings, and in many jurisdictions, is legally mandated. Concern to achieve least restrictive practice is reflected in the volume of policies, guidelines and other guiding documents that are in place locally, nationally and internationally. *The Safe in Care, Safe at Work* framework has been developed to facilitate safety in care, and safety for staff in Australian mental health services, and extends previous work undertaken by the Australian College of Mental Health Nurses (ACMHN) in the 2017 National Mental Health Commission (NMHC) funded project, *Supporting Mental Health Nurses towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in inpatient mental health settings in Australia.* The document reflects a recognition of the importance of safety in care and at work and is a response to an ongoing dialogue with key stakeholders, including the ACMHN, NMHC.

Staff feelings and perceptions of their own personal safety have been associated with use of coercive containment methods such as seclusion and restraint in mental health settings (Ching, Daffern, Martin & Thomas 2010). In honouring the commitment to ensure best possible care for service users, and aiming to reduce seclusion and restraint reduction in Australian mental health settings, it has become clear that increasing safety in care and enhancing safety for staff, particularly nursing staff is a crucial aspect of achieving further reductions in use of seclusion and restraint.

This framework is underpinned by essential background documents including (see Appendix 1 for full list):

* *Supporting mental health professionals towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in mental health settings in Australia (Australian College of Mental Health Nurses Inc. 2017);*
* *Six Core Strategies Checklist Te Pou Adaption;*
* National and state policy documents such as *A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services (National Mental Health Commission 2015);*
* *Providing a safe environment for all: Framework for reducing restrictive interventions (Victorian Government 2013); and*
* *Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint (Muir-Cochrane, O'Kane & Oster 2018).*

SAFE AT WORK

LEAD, SUPPORT & GOVERN

THE BALANCED SCORECARD

POST RESTRICTIVE CARE & PROCEDURES

SAFE IN CARE

WORKFORCE EDUCATION

CONSUMER, CARER & STAFF COLLABORATION

ANTICIPATING, REDUCING, REVIEWING & RESPONDING

NATIONAL STANDARDS

SCOPE AND AUDIENCE

This toolkit is designed to complement and support existing national and state guidelines and frameworks in place throughout Australia. This document is intended to support the Six Core Strategies to Reduce Seclusion and Restraint, and to provide a range of options to support services, managers, and nurses themselves to create safer services and support nurses in feeling safe. We believe enhancing the safety of nurses will contribute to safer environments more generally, and better enable workplaces to use least restrictive practices.

UNDERSTANDING SAFETY IN THE CONTEXT OF SECLUSION AND RESTRAINT

——

The right to be safe, or free from harm has been positioned as a human right (Mohan 2003), and the concept of safety is central to the provision of health care. Safety is an ongoing concern for modern healthcare systems (Feo et al. 2016) and can be considered to have various separate but inter-related elements; physical, psychosocial (including cultural safety), and environmental safety. Staff safety in an issue of key importance to health services and administrators.

Physical safety involves ensuring safety from physical harm (Feo et al. 2016). Seclusion and restraint are often used in the mental health care setting as a last resort measure as a means to prevent injury to themselves and/or others (Muir-Cochrane et al. 2017). However, evidence shows that seclusion and restraint may be associated with physical harm to both consumers and staff and that there are significant physical safety risks associated with restraining consumers, including injury and potentially catastrophic consequences, such as sudden death (NSW Ministry of Health, 2018). Use of force in restraint has also been associated with injury and even death (Hollins 2010; NSW Ministry of Health, 2018).

Psychosocial safety reflects concern with emotional and psychological wellbeing and is regarded as equally important as ensuring physical safety. Seclusion and restraint have been found to negatively impact the psychosocial safety of consumers and staff, causing harm such as trauma and psychological injury (Muir-Cochrane et al. 2017). Consumers often report feeling angry, abandoned, vulnerable, humiliated and worthless (NSW Ministry of Health, 2017); while mental health nurses have reported experiencing moral distress due to the fear and blame associated with the use of seclusion and restraint measures (Muir-Cochrane et al. 2018).

Cultural safety encompasses spiritual, social and emotional safety and occurs within environments that are 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening' (Australian Human Rights Commission 2011), and involves understanding the cultural context of an individual, including their beliefs and values (Feo et al. 2016). Seclusion and restraint, and fear, clearly represent a threat to cultural safety.

Environmental safety refers to the need for the physical environment to be clean, safe and secure (Conroy et al. 2017; Feo et al. 2016). The physical environment is vital as it can either facilitate or impede recovery (NSW Ministry of Health 2018). Consumers report that a comforting and well-designed environment can support personal recovery; however, the environment of seclusion has been described as 'small, noisy, cold rooms, often with no natural light, no activities to distract, no chair to sit on, no one to talk to, and only a foam mattress and blanket on the floor' (NSW Government 2017c, p. 38). This environment can hinder the recovery of the consumer and negatively impact their psychosocial safety.

BACKGROUND

Seclusion and restraint have been established as harmful practices that are traumatising to consumers, staff and organisations (Brophy, Hamilton, et al. 2016; Oster et al. 2016; Riahi et al. 2016; Rose et al. 2017); and are considered to represent a breach of human rights (National Mental Health Consumer & Carer Forum (NMHCCF) 2009). The NMHCCF states that seclusion and restraint are 'not evidence-based therapeutic interventions' but rather are 'commonly associated with human rights abuses', 'cause short- and long-term emotional damage to consumers' and overall 'demonstrate a failure in care and treatment when they are used' (NMHCCF 2009, p7). Thus, all Australian governments have been steadfast in the commitment to ensuring the reduction and elimination of seclusion and restraint across all settings (Melbourne Social Equity Institute 2014; National Mental Health Working Group 2005). This commitment is in line with the largely negative consumer perceptions of the use of seclusion and restraint (Brophy, Roper, et al. 2016; Kinner et al. 2017; Kontio et al. 2012; Van Der Merwe et al. 2013).

The use of seclusion and restraint breaches the therapeutic relationship and trust between staff and consumer and has been found to adversely impact both patient and staff safety (Muir-Cochrane, Baird & McCann 2015; NSW Ministry of Health 2018). Progress has been made nationally towards the reduction of seclusion and restraint over the past decade and overwhelming support has been garnered for its reduction and elimination. However, there is evidence that these practices continue to be widely used in mental health settings and that much restraint is initiated by nurses (Allan et al. 2017; Bigwood & Crowe 2008; Bowers et al. 2017; Bullock et al. 2014; Gerace et al. 2014; Muir-Cochrane & Gerace 2014; Muir-Cochrane, O'Kane & Oster 2018; Oster et al. 2016; Te Pou oTe Whakaaro Nui 2015).

Early intervention and the confidence of staff to manage aggression have been identified as being influential on practices around coercive containment and strategies to enhance the confidence of staff in this area are crucial (Martin & Daffern 2006). It is important to recognise that use of restraint and seclusion are most often responsive and reactive, and because of this, there could be a greater risk of injury to both consumers and nurses due to lack of readiness, inadequate resources, and the risk of harm to nursing staff can be exacerbated when staff have health issues or physical weakness (features of an aging workforce) themselves (Renwick et al. 2019).

Though considered by some to be 'part of the job' and 'inevitable' (Bigwood & Crowe 2008, p. 221), nurses also experience distress in using coercive containment measures and often blame themselves and experience emotional reactions and personal conflict, including uneasiness when incidents of seclusion and/or restraint occur (Bigwood & Crowe 2008; Muir-Cochrane, O'Kane & Oster 2018). These findings align with work by Conroy et al. (2017) who suggest that patient and nurse safety are interconnected, as risks to patient safety also pose risks to nurse safety, and vice versa. Research capturing nurses' views and experiences suggest that maintaining control in the acute in-patient setting is considered essential to maintaining a safe environment for all, and that factors such as fear associated with the threat of impending danger and physical harm are a factor in decision-making around the implementation of restraint (Bigwood & Crowe 2008). It is also suggested that emotional processes felt and expressed by nurses during the management of aggressive situations can affect and shape staff behaviour in ways that could trigger or maintain patient aggression (Jalil et al. 2017).

The role of nurses' emotions such as anger and fear in seclusion and restraint is complex and as yet, not fully understood. Anger arising from exposure to patient aggression in the form of name-calling, humiliating, discriminatory remarks and personal insults have been shown to have some association with greater approval and involvement of mental health nurses in restraint; whereas guilt was shown to be negatively correlated with seclusion (Jalil et al. 2017). However, recent Australian research evidence suggests nurses have concerns and can experience fear associated with managing aggressive or violent patients without restrictive measures (Muir-Cochrane, O'Kane & Oster 2018). The issue of fear at work as a feature of clinical practice in mental health nursing is as yet not fully elucidated, though there is a need to explore this more comprehensively, given findings reported by Bigwood and Crowe (2008), Muir-Cochrane et al. (2018) and others.

That fear is an issue for mental health nurses is perhaps not surprising when considering that mental health nurses experience a higher rate of physical aggression than nurses in any other health care setting (Jalil et al. 2017), and other professionals within the mental health environment (van Leeuwen & Harte 2017). The lifetime risk of assault for nurses in mental health settings is estimated to be 'approaching 100%' (Renwick et al. 2019, p. 2). This high risk of assault is known to negatively influence emotional, social and psychological well-being in nurses and can generate a range of physical injuries such as open wounds, bruising and sprains and emotional injuries including self-doubt, confusion, anger, guilt, shame and an increased risk of developing post-traumatic stress disorder (Jalil et al. 2017). Fear of assault has also been shown to influence clinical decision-making in relation to management of aggression, seclusion and restraint (Bigwood & Crowe 2008; Muir-Cochrane, O'Kane & Oster 2018). Thus, workplace safety for nurses is a significant issue in achieving organisational and professional goals around reduced incidence of seclusion and restraint. Accordingly, addressing the work environment to enhance actual and perceived safety of nurses is essential to achieving further reductions in seclusion and restraint in mental health setting.

THE SIX CORE STRATEGIES

The complexities around the use of seclusion and restraint means that no single solution will adequately address the issue. Rather, a number of integrated and comprehensive strategies, with all members of the mental health team, including carers and peer workers, working collaboratively, with organisational support, to adopt them have been shown to be most successful. The National Association of State Mental Health Program Directors (NASMHPD), to provide explicit and evidence-based guidelines to decrease the use of seclusion and restraint, proposed the Six Core Strategies to Reduce Seclusion and Restraint in the early 2000's, as a strategy to improve recovery-based practice. The Six Core Strategies encompass: (1) leadership towards organisational change; (2) using data to inform practice; (3) workforce development; (4) use of preventative, proactive seclusion/restraint reduction tools; (5) consumer roles in inpatient settings; and, (6) debriefing techniques (Huckshorn 2006). These strategies are mapped against the National health care standards in appendix 2.

Internationally, nurses have engaged with the Six Core Strategies, and have produced research evidence to show that they are effective in reducing seclusion and restraint and can be implemented relatively quickly and are sustainable over time (Azeem et al. 2017; Riahi et al. 2016). Additionally, implementation of the Six Core Strategies has been positively associated with stronger nursing leadership, reduced staff absenteeism, turnover and injury and increased staff satisfaction, as well as reduced length of stay, medication use and readmission for consumers (LeBel et al. 2014).

One of the features of the Six Core Strategies is that each of the strategies are able to be applied flexibly to meet the needs of particular service settings, so that bespoke and context-appropriate solutions can be developed to meet the needs of local services and communities. In addition to benefits for consumers and nursing staff, the Six Core Strategies also provide opportunities for each service to develop custom initiatives that will support their services to reduce restraint and seclusion and be a catalyst for service innovation and activities that contribute to staff confidence. They encompass diversity and help facilitate safe, respectful, recovery-focussed therapeutic environments. Riahi et al. (2016) describe implementing an initiative called Recovery Rounds, which initially were framed as a strategy for implementing Core Strategy 2 (using data to inform practice) but also linked strongly to Core Strategy 1 (leadership towards organisational change) and served to link use of data with leadership and care activities in the clinical setting.
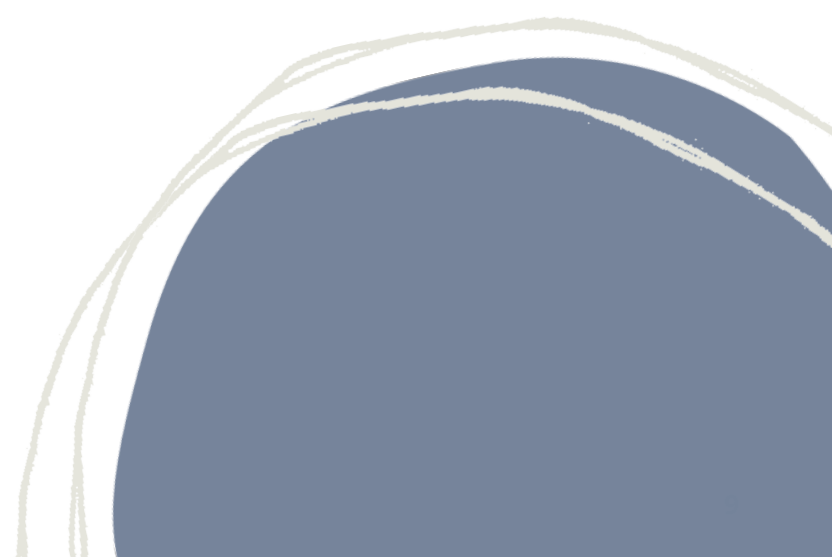
SUMMARY

Given the threat to safety that restrictive practices represent to the safety of consumers and nurses, and the influence of nursing staff fear on actual use of seclusion and restraint, it is timely to re-examine approaches to safety in the context of mental health service provision, and to recognise and promote strategies for nurses to be and feel safer at work, build confidence in nursing practice around early recognition, intervention and de-escalation skills, and for nursing leadership to facilitate respectful, inclusive relationships. The framework for Ensuring safety in care and safety for staff in Australian mental health services has been developed to provide guidance and a systemic framework for creating safer environments for nurses in Australian mental health settings. Enhancing the safety of nurses, services will better enable the use of least restrictive practices and the Six Core Strategies to Reduce Seclusion and Restraint are a guideline to improving the mental health environment and promoting recovery-based practice.

USING THIS PACKAGE

This document has been designed to guide mental health services, leaders, staff and consumers to examine their organisations policies and processes, staff education, workplace culture, physical environment, use of data and relationships with consumers and other stakeholders, in the context of eliminating the use of seclusion and restraint in Australian mental health services. The package is comprised of a toolkit which provides brief evaluative criteria, suggested actions and points for reflection. This is followed by the Australian adaption of the 6 Core Strategies© which provides a step by step checklist for service reflection and reform. In appendix 3 is a range of documents and tools that may be useful as services seek to anticipate and respond to consumer distress in order to thwart the need for seclusion and restraint while not compromising on safety in care and safety at work.

TOOLKIT

—
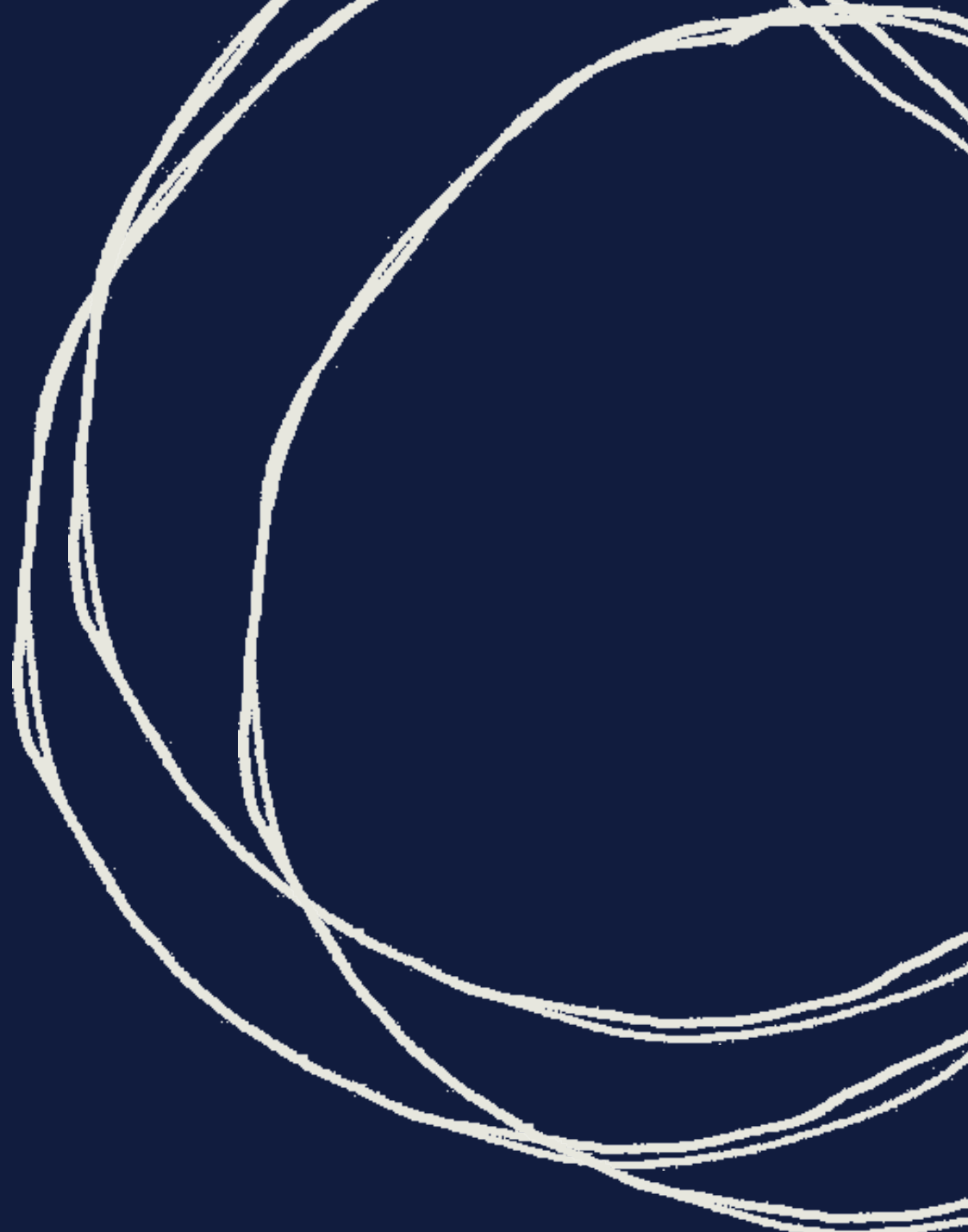
1. LEAD, SUPPORT AND GOVERN FOR SAFE IN CARE AND SAFE AT WORK

Effective leadership is essential to achieving cultural change. Energetic influential leaders not only champion and model positive change, but more importantly, they create the vision for how things can be different and engage those around them in working towards the desired change, and they ensure the resources and processes are in place to achieve the vision. It must also be recognised that leadership happens at all levels within an organisation and is not limited to only those in formal leadership positions. Engaging informal leaders is also important to achieving sustainable change.

Leadership encompasses accountability, governance, commitment and consistency, and has a crucial role in empowering others. It is important that the roles and responsibilities of those in leadership positions to effect optimally safe environments are specifically stated and clearly understood, and that there is accountability mechanisms that reflect those roles and responsibilities.

LEAD, SUPPORT & GOVERN

EVALUATIVE CRITERIA

- A clear vision for safety in care and safety at work is articulated and shared, resulting in inclusive and respectful environments for consumers, carers and mental health staff including the specific needs of Aboriginal and Torres Strait Islander people;
- Site-specific safety plans that meet all relevant standards are developed, implemented, regularly reviewed and revised;
- Staff, carer and consumer concerns, actual and potential safety issues or breaches to safety for consumers, carers and staff are anticipated, acknowledged and addressed in a non-punitive process; and
- Successes are recognised and celebrated.

ACTIONS

- Develop an organisation plan with specific goals, timeframes and accountabilities, to reduce the incidence of seclusion and restraint
- Ensure principles of recovery and trauma informed care, underpin organisational values and are reflected in clinical and administrative processes.
- Prioritise respect and dignity for all staff and stakeholders to eliminate coercion and violence contributing to safety in care and safety in work
- Regularly review progress with input from all stakeholders and develop a system of recognition and reward for achievement of institutional and individual successes.
(Hucksorn 2006; Te Pou o te Whakaaro Nui 2013)

POINTS FOR REFLECTION

- Does the organisation vision specifically address reduction of seclusion and restraint?
- Do all nursing staff understand how systems, processes and policies and their own role in enactment influence the provision of safe, respectful and inclusive environments?
- Do nursing staff at all levels recognise their own capacity for leadership in creating safe, respectful and inclusive environments?
- Is there a mechanism for any nurse with safety concerns to raise them?

2. THE BALANCED SCORECARD FOR SAFE IN CARE AND SAFE AT WORK

Timely access to accurate data provides a crucial means of measuring performance, of identifying areas of excellence as well as areas for improvement and is therefore essential to inform practice, organisational and systems changes. Thus data, if sufficiently robust, should provide the impetus for positive change and systems improvement.

However, in order for data to be optimally useful it should be: auditable; accurate; accessible; timely; and, provide adequate detail. There is a need to effectively measure and evidence any threats to or breaches of safety in care or at work, and to ensure data can be used to drive the change needed to enhance safety in care and at work.

THE BALANCED SCORECARD

EVALUATIVE CRITERIA

- Following baseline data collection, standardised, auditable instruments that can be used across settings and all states and territories are employed to provide national measurable indicators to inform systems and strategies to enhance safety in care and at work;
- New technologies to improve safety in care and safety at work are utilised;
- Data is systematically collected on consumer characteristics and consumer, carer and staff experiences to inform change. Data is shared with interested parties;
- Access to data literacy training is provided for all appropriate staff.

ACTIONS

- Collaborate nationally to agree on a universal data collection instrument and design systems so that data can be compared internally to analyse institutional data (ward, shift, staff member, consumer) and nationally across states and territories and health services;
- Collect baseline data, set realistic reduction goals and national benchmarks and ensure they are communicated to staff;
- Experiment with technology and systems that have the potential to contribute to the reduction of seclusion and restraint while enhancing the safety of consumers and staff;
- Make service level data accessible so that consumers and staff can see progress toward goals.
(Huckshorn 2004, 2006; Te Pou o te Whakaaro Nui 2013)

POINTS FOR REFLECTION

- What current baseline of data regarding seclusion and restraint exists and what reduction should the institution be aiming for?
- Nationally, who is leading the reduction of seclusion and restraint and ensuring a safe work environment and how have they achieved these results?
- Are staff equipped to meaningfully collect and make sense of data?
- Can consumers, carers, staff and family members provide feedback through non-punitive channels?

3. WORKFORCE TRAINING FOR SAFE IN CARE AND SAFE AT WORK

A skilled and resilient workforce is fundamental to creating safer health care environments for consumers, carers and staff. Full engagement with all those within the workplace is essential to achieving meaningful change. In planning workforce development strategies, it is necessary to recognise the diversity within the workplace. This diversity comprises interdisciplinary health professionals, peer workers and carers, and encompasses cultural and social diversity.

WORKFORCE EDUCATION

EVALUATIVE CRITERIA

- Values and expectations are visible in recruitment and performance review processes, policies and procedures, leading to a culture of respect and understanding;
- Appropriate, well-resourced, ongoing training in person-centred, trauma informed, recovery-orientated and strengths-based care is provided; resulting in, minimum mandatory skill standards. Where possible training is co-produced and co-delivered with consumers;
- Learning environments are fostered through adopting communities of practice/ communities of learning approaches;
- Staff are confident, equipped and empowered to promote safety in care and safety at work.

ACTIONS

- Provide ongoing staff education to ensure they are equipped to negotiate care with diverse consumers, deescalate and defuse situations and not instigate or exacerbate conflict;
- Empower staff to contribute to organisational policies, procedures and the discretion to be flexible with rules;
- Identify seclusion and restraint reduction champions and form teams or committees to oversee progress towards goals;
- Foster individual responsibility for the reduction of seclusion and restraint at all staffing levels.
(Huckshorn 2004, 2006; Te Pou o te Whakaaro Nui 2013)

POINTS FOR REFLECTION

- How is the expectation of safety in care and safety at work modelled and fostered in the health service?
- Are staff development opportunities well-resourced, contemporary and accessible?
- Are there formalised strategies to receive feedback on performance and for reflection on practice?
- Is there appropriate use of new technologies for enhancement of workforce skill to improve safety in care and safety at work such as micro-learning platforms and point-of-care decision aids?

4. ANTICIPATING, REDUCING, RESPONDING TO AND REVIEWING SECLUSION AND RESTRAINT

There should be a variety of validated, easy to administer tools available to suit individual consumer needs. Assessing for trauma, risk of violence or self-harm and a history of seclusion or restraint; documenting triggers and self-soothing techniques and having de-escalation and safety protocols will contribute to a calmer environment, safety in care and safety at work.

ANTICIPATING, REDUCING, REVIEWING & RESPONDING

EVALUATIVE CRITERIA

- Processes and tools to prevent escalation are in place supported by multi-phased post-event interventions;
- Consumers are included in all post-event responses including policy review or development of a learning activity;
- Nurses have appropriate knowledge of post-trauma and critical incident reactions and strategies to mitigate and support any affected consumers, carers and staff;
- Events are reported in line with statutory requirements and adequate details are recorded to facilitate optimal learning.

ACTIONS

- Assess consumers for risk of aggression and violence on entry to the service, results documented, and individual safety plans drawn up;
- Assess consumers to identify any conditions that contra-indicate restraint;
- Ensure individual consumer safety plans are easily accessible;
- Frame seclusion and restraint as a last resort and support this stance through guidelines, policies, procedures and environmental modification. (Huckshorn 2004, 2006; Te Pou o te Whakaaro Nui 2013)

POINTS FOR REFLECTION

- Are the tools and assessments used evidence-based and quick to administer?
- Are staff competent to administer and interpret tools?
- Do the tools accommodate diversity in staff, carers, consumers family and kin?
- Is the language in the tools respectful and appropriate for consumers from diverse backgrounds?

5. CONSUMER, CARER AND STAFF COLLABORATION FOR SAFE IN CARE AND SAFE AT WORK

The experiences, concerns and views of consumers, carers and staff are of crucial importance in developing and implementing effective long-term solutions that are sustainable over the longer term. Sustainable and effective change can best be achieved through collaborative co-design processes involving all stakeholders.

CONSUMER, CARER & STAFF COLLABORATION
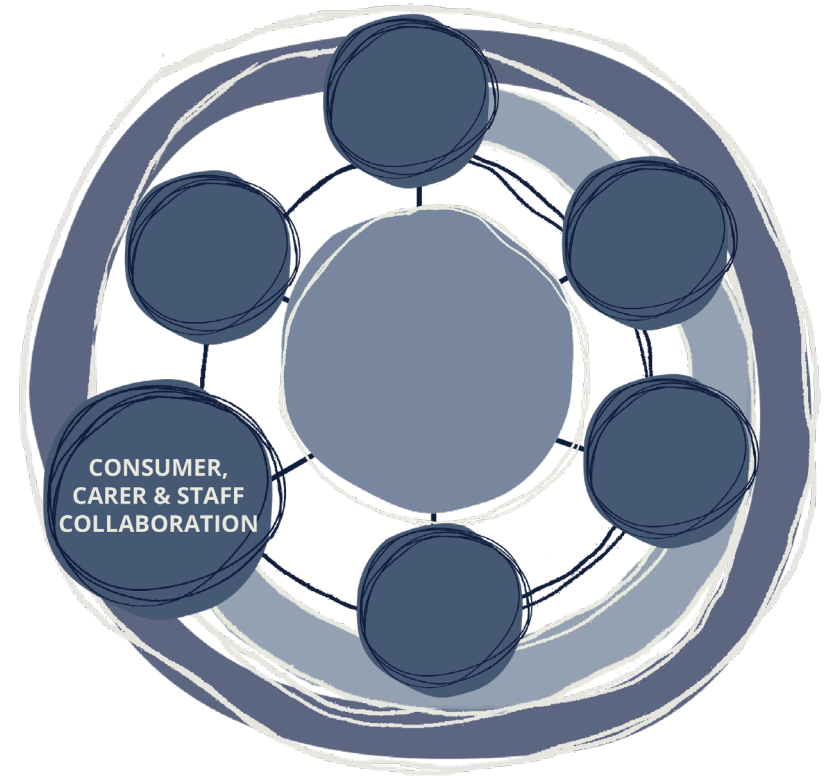
EVALUATIVE CRITERIA

- Strategies to facilitate increased stakeholder engagement and participation with the mental health care system are in place and the contribution and leadership of stakeholders is valued and acknowledged;
- Consumers, carers, community members, health providers and professional groups are included in collaborative co-design to develop models of care, safety strategies and therapeutic interventions and contribute to in service evaluation and policy;
- Consumers and carers past and present are considered experts in their own mental health;
- Staff understand the importance of facilitating the involvement of carers, family and kin in providing feedback and contributing to service planning and decisions.

ACTIONS

- Keep service users/consumers, carers, family members and kin informed regarding treatment choices and options and where possible accommodate autonomy;
- Employ service users/consumers from diverse backgrounds in the service and empower them in their roles and responsibilities;
- Ensure staff are inclusive and committed to facilitating the involvement of consumers, carers, family members and kin;
- Schedule routine stakeholder meetings that are preferably consumer led to gain feedback on policies, procedures and progress toward reducing seclusion and restraint.

(Huckshorn 2004, 2006; Te Pou o te Whakaaro Nui 2013)

POINTS FOR REFLECTION

- How are service users and consumers recruited for collaboration?
- Are consumers and service users from diverse backgrounds to ensure representation of minority and marginalised perspectives?
- Is the intrinsic need to collaborate with consumers and service users acknowledged and promoted within the organisation?
- What mechanisms exist to ensure that consumer and service users perspectives are reflected in strategies, policies and models of care?

6. POST- RESTRICTIVE CARE AND PROCEDURES

—

A breach of safety to staff or consumers is a serious event and requires appropriate support and effective subsequent review.

POST RESTRICTIVE CARE & PROCEDURES

EVALUATIVE CRITERIA

- The preservation of dignity and human rights of consumers throughout any event is paramount;
- Effective and prompt support and treatment is provided for any physical or psychological injuries or harm to consumers, carers and staff and processes to support multi-phased post-event interventions are automatically deployed;
- Staff are encouraged to self-care and be alert to signs of trauma or distress in self and others;
- Events are reported in line with statutory requirements and adequate details are recorded to facilitate optimal learning.

ACTIONS

- A senior staff member conducts an immediate debrief that is followed up by a formal debrief including root cause analysis;
- When appropriate, post-incident, the service user is supported to discuss their experience;
- Policies and procedures are comprehensive and guide all post-restrictive actions;
- The ongoing physical and emotional safety of all involved is considered paramount.

POINTS FOR REFLECTION

- Are incidents of seclusion and restraint viewed as opportunities to review and refine policies and processes to reduce further incidents in the future?
- Do incidents of seclusion or restraint catalyse a refined system of responses including safety protocols, debriefing and temporal reporting of events?
- Does analysis of each event result in recommendations to avoid similar future incidents?
- Are staff who initiate seclusion and restraint, consumers who experience seclusion or restraint and witnesses to the event supported to reflect on the chain of events?

SIX CORE STRATEGIES CHECKLIST

AUSTRALIAN ADAPTION

INTRODUCTION

—

Welcome to the Australian adaption of the Six Core Strategies© checklist. This checklist is a tool for leaders and managers to use to ensure reduction and elimination of the seclusion and restraint. The Australian College of Mental Health Nurses (ACMHN) recognizes seclusion and restraint as harmful practices that cause trauma to consumers, staff and families and view any episode of seclusion or restraint as a 'failure in care'. This document has been designed to be used as printed document, as a tool to help you make decisions about the next steps to successfully apply the Six Core Strategies©.

The checklist includes four columns:

1. Description of performance indicators for each strategy
2. Examples of things to do to achieve the objectives in that area
3. For the service to identity if they are meeting the objective
4. For services to outline what their next steps will be to fulfil that objective

BACKGROUND OF THE SIX CORE STRATEGIES

—

The Six Core Strategies©, on which this checklist is based, were developed in the United States of America by the National Association of State Mental Health Program Directors Medical Directors Council (NASMHPD). This was in response to the release of several influential reports and more especially the growing voices of service users and other stakeholders saying that seclusion and restraint were traumatising, both to people receiving services and to staff.

The strategies were developed after collecting and analysing all seclusion and restraint literature and research available at the time, including anything on violence in inpatient settings, staff development strategies, risk assessments, service user and staff stories about seclusion and restraint, and media publications. Also at this time, leaders and managers who were known to have made progress in reducing seclusion and restraint were brought together for a series of think tank meetings. From these, critical elements of success were identified and were narrowed down to the Six Core Strategies©.

Following this, a training programme was developed for the Six Core Strategies© and trainings were held in selected pilot sites. The outcomes were evaluated, and it was found that significant reductions in seclusion and restraint were found in all facilities, even though they had different specialties, levels of security, ownership, and size.

To support the utilisation and effectiveness of the Six Core Strategies© a checklist was created. This checklist has been reviewed and adapted for the Australian environment.

GETTING STARTED

STRATEGY ONE
LEAD, SUPPORT AND GOVERN FOR SAFE CARE
Unless senior leadership is aligned and committed to supporting, applying and resourcing seclusion and restraint reduction initiatives, the results will be spasmodic and reliant on individuals. This lessens by far the degree of success possible and the durability and sustainability of the project work.

Under Strategy One, seclusion and restraint reduction project team/s will be formed with appropriate representation and input. A good way of progressing efficiently is to delegate responsibility for each of the other five strategies to the leader or champion for change most aligned to each. They then address that part of the checklist and report back.

STRATEGY TWO
THE BALANCED SCORECARD FOR SAFE IN CARE AND SAFE AT WORK
Staff who have an interest and skill in collecting and analysing information. This will include routinely collected data but will also include new information as identified in the checklist.

STRATEGY THREE
WORKFORCE TRAINING FOR SAFETY IN CARE AND SAFETY AT WORK
This may include a variety of staff members but needs to have an identified lead to oversee and centralise workforce development initiatives. This could be the service or unit manager, clinical nurse educator or training and development coordinator.

STRATEGY FOUR
ANTICIPATING, REDUCING, RESPONDING TO AND REVIEWING SECLUSION AND RESTRAINT
Staff who lead or co-ordinate the assessments, tools and plans used in the unit.

STRATEGY FIVE
CONSUMER, CARER AND STAFF COLLABORATION FOR SAFETY IN CARE AND SAFETY AT WORK
Staff who hold lead service user roles in the service.

STRATEGY SIX
POST-RESTRICTIVE CARE RESPONSES
Ward managers with service user leaders.

CULTURAL LEADERSHIP AND PARTICIPATION

——

Culture is important to this work at so many levels, and recognition of this can be seen throughout this document. Culture is a very broad term and organizational culture, unit culture, therapeutic culture and the influence of culture/ ethnicity all have a bearing on seclusion and restraint.

Finding the right cultural leaders and advisors and including them from the start not only supports our promises and responsibilities. It will also ensure that the over representation of Aboriginal and Torres Strait Islander Peoples in mental health and addiction services has the best chance of being understood and redressed. There must be a clear voice and practical input into the project.

Similarly, places that have high migrant, refugee or other minority populations should ensure those voices are also included.

While there is a clear strategy (Strategy Five) around service user involvement, families and cultural kinship networks are also vital in this process. Using family advisors and their networks will further increase the level of success of initiatives. We have endeavoured to weave these throughout the checklist.

Once the leads of each strategy gather the checklist findings, these will be brought back to the seclusion and restraint project group. This information is used to develop a plan that includes allocated responsibilities, identification of resourcing and timelines.

Using the strategies and the checklist is the very best chance services have of successfully reducing seclusion and restraint events. They will also support the service to meet its legislative and standards requirements, workforce development initiatives, change culture/organisation projects and quality improvement work. Most importantly of all will provide more positive and successful outcomes for people that use services and their families, kinship networks and communities.

SIX CORE STRATEGIES
FOR REDUCING SECLUSION
AND RESTRAINT CHECKLIST

—

**Based on the NASMHPD Six Core Strategies
for Reducing Seclusion and Restraint
Use © planning tool.**
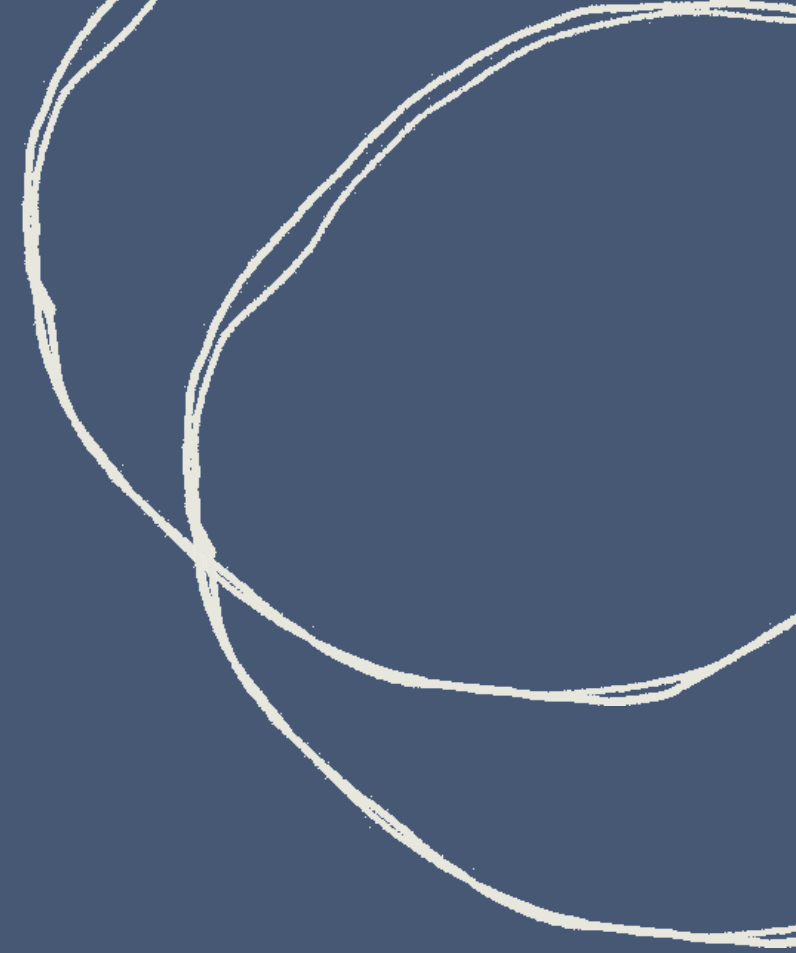
1. LEAD, SUPPORT AND GOVERN FOR SAFE IN CARE AND SAFE AT WORK

GOAL ONE

To reduce and eliminate the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values and ensuring the development of a seclusion and restraint reduction plan and plan implementation. The guidance, direction, participation and on-going review by executive/senior leadership is clearly demonstrated throughout seclusion and restraint reduction and elimination projects, plans and service delivery.

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
1. Does the organisation and service mission/vision statement, philosophy, and core values reflect the intent of seclusion reduction initiatives?	Evidence of congruency with principles of recovery, trauma informed systems, violence and coercion-free safe environments for service users and staff.		
2. Has the service developed a seclusion and restraint policy statement that includes beliefs to guide use that is congruent with mission, vision, values and recovery principles?	Inclusion of statements such as "seclusion and restraint are not treatments, but a safety measure of last resort and include the services commitment to the reduction/elimination of seclusion and restraint."		
3. Has the service leadership developed an individualised service-based seclusion and restraint reduction action plan? Is this included in overall service strategic plans such as District Annual Plans?	Plan includes: a) Performance improvement and prevention approach as the overarching principle b) The assignment of seclusion and restraint reduction champion for change and or team c) A consistent and clear understanding of the legal definition of seclusion d) The creation of goals, objectives and action steps assigned to responsible individuals with timelines e) Targets identified for reducing rates including over what period of time f) Consistent reviews and revisions with executive/senior management oversight and review g) Plan is included in overall service strategic plans such as District Annual Plans, service development and quality plans h) Plan holds the safety of people's emotional, mental and physical health as a priority		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
4. Has service leadership committed to create a collaborative, non-punitive environment, including: identifying and working through problems; communicating expectations to staff; being consistent in maintaining effort?	This step could include a statement to staff that while individual staff members might act with best intent, it may be determined later that other avenues or interventions could have been taken. It is only through staff's trust in service leadership that they will be able to speak freely of the circumstances leading up to a seclusion and restraint event so that the event can be carefully analysed and learning can occur. However, the rules defining abuse and neglect are clear and the previous statement does not lift accountability for those kinds of performance issues. Advice should be sought from cultural advisors to identify potential cultural solutions.		
5. Are all staff aware of the role and responsibility of the general manager or service leader to direct seclusion and restraint reduction initiatives?	Evidence of senior level involvement in motivating staff including commitment from the service clinical director. A "kickoff" event for the rollout of this initiative is recommended or a celebration if the service is already involved in a reduction effort. This step calls for active, routine and observable activities such as the inclusion of status report at all management meetings.		
6. Has leadership evaluated the impact of reducing seclusion and restraint on the whole environment?	Potential issues are identified such as: a) Extended time involved in de-escalation attempts b) Additional admission assessment questions c) Debriefing activities d) Processes to document event e) Increased destruction of property		
7. Has the leadership set up a staff recognition project to reward individual staff, unit staff and seclusion and restraint champions for change for their work on an on-going basis?	Recognition for staff for strengths and achievement of goals mirrors recovery and values-based service philosophies and role models good practices.		
8. Does the executive/senior leadership approved seclusion and restraint reduction plan delegate tasks and hold people accountable through routine reports and reviews?	Regular reporting in executive/senior management meetings of progress and updates.		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
9. Has leadership addressed staff culture issues, training needs and attitudes? (See also Workforce Development)	This includes a programme of staff training and development in knowledge, skills and abilities, including choice of training program for seclusion and restraint application techniques and will include human resources (HR). Survey of what staff want from their service and how to go about achieving this – training to reinforce this. Survey of what staff see as organisational values and how they demonstrate those.		
10. Has leadership reviewed the service's plan for clinical treatment activities to ensure that active, daily, people- centred, effective treatment activities are available and offered to all people receiving services?	This would include that people receiving the service have some personal choice in what activities they attend. The minimum criteria to meet under this objective are to ensure that service users are not spending their days in enclosed areas without effective useful activity choices occurring. These may include living, learning, recreational and working activities and skill development.		
11. Has executive/service leadership ensured oversight accountability by watching and elevating the visibility of every event 24 hours a day, seven days per week?	This includes assigning specific duties and responsibilities to multiple levels of staff including on-call management, on-site nursing unit or service supervisors, psychiatrists, direct care staff, consumer advisors and advocates. Institute formal "rounding" where people's emotional states are regularly observed.		
12. Has service leadership ensured service user inclusion, leadership and perspectives are part of all seclusion and restraint reduction plans, initiatives and evaluations?	Service user leaders are sought and included in all seclusion and restraint reduction activities. Should also include a service user champion for change involved in groups and reporting.		
13. Has service leadership ensured Aboriginal and Torres Strait Islander inclusion, leadership and perspectives are part of all seclusion and restraint reduction plans, initiatives and evaluations?	Given the high numbers of Aboriginal and Torres Strait Islander consumers, it is vital that Indigenous Australians are sought and included in all seclusion and restraint reduction activities. Should also include Indigenous representation in groups and reporting.		
14. Has service leadership ensured family inclusion and perspectives in seclusion and restraint reduction initiatives?	Family and kinship perspectives and input are included, Champion for change identified.		

2. THE BALANCED SCORECARD FOR SAFE IN CARE AND SAFE AT WORK

GOAL TWO

To reduce the use of seclusion and restraint by using f=data in an empirical, non-punitive manner. This includes:

•   Using data to analyse characteristics of service usage by unit, shift, day, and staff member
•   Identifying service baselines
•   Setting improvement goals and comparatively monitoring use over time in all care areas, units and services

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
1. Has the service collected and graphed baseline data on seclusion and restraint events?	Includes, at a minimum, incidents, hours, use of involuntary medication and injuries. See section 3 for more detailed suggestions.		
2. Has the service set goals and communicated these to staff?	Includes: a) Setting realistic data improvement thresholds b) Encouraging non-punitive, healthy competition among units or sister services by posting data in general treatment areas and through letters of agreement with external services Ensuring all staff are informed and responsibilities identified		
3. Has the service chosen standard core and supplemental measures?	Should include: a) Seclusion and restraint incidents and hours by shift, day, unit, time b) Use of involuntary IM medications c) Service user and staff related injury rates d) Type of restraint e) Service user involvement in event debriefing activities f) Grievances g) Service user demographics including gender, race, diagnosis and other measures as desired h) Specific Aboriginal and Torres Strait Islander People's demographics i) Relevant routinely collected data Display current statistics where staff and service users can see them (graphs of seclusion hours/incidents)		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
4. Does the appropriate leadership have access to data that represents individual staff member involvement in seclusion and restraint events? Is this information kept confidential and used to identify training needs for individual staff members?	Access to individual staff member data is restricted and may include access for supervisors, team leaders, managers and workforce development leaders.		
5. Is the service able to observe and record "near misses" and the processes involved in those successful events?	Collection of this information would be used to support learning of best practices to reduce seclusion and restraint. Near misses are when a restraint or seclusion event did not happen but nearly did. This can be valuable information to collect to inform understanding of how to do things differently. This can also inform a recognition of positive staff interventions initiative.		

3. WORKFORCE TRAINING FOR SAFE IN CARE AND SAFE AT WORK

GOAL THREE

To create an environment where policy, procedures and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on people. This includes understanding the prevalence of these experiences in people who receive mental health services and the experiences of staff. The characteristics and principles of trauma informed care systems need to be included. It also includes the principles of recovery-orientated systems and models that support people-centred care, choice, respect, dignity, partnerships, self-management and full inclusion.

The goal is to create an environment that is less likely to be coercive or 'conflictual'. It is implemented primarily through staff training and education and human resource activities. This includes safe and least-coercive seclusion and restraint training, and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. Also includes the provision of effective treatment activities on a daily basis that are designed to support life skills.

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
1. Has staff development training included recovery/resiliency, prevention, and performance improvement theory and rational to staff?	All staff regularly receive training on and understand recovery/ resiliency, prevention and performance improvement theories and rationales. Training is included in new staff orientation.		
2. Has the organisation and service revised the organisational and service mission, philosophy, and policies and procedures to address the above theory and principles?	Seclusion reduction professionals and/or teams ensure alignment of organisation and service mission, vision, philosophy, policies and procedures to seclusion and restraint reduction initiatives and policies.		
3. Has the service appointed a team/ committee and chair/leader/ champion for change to address workforce development agenda and lead this organisational change? Includes HR	Seclusion and restraint workforce development is guided by appointed team/committee and chair/ leader/champion for change and is included in general mental health and addiction workforce development groups.		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
4. Has the service insured education/ training for staff at all levels in theory and approaches of seclusion and restraint reduction?	Includes but not limited to: a) Experiences of service users and staff - include service user stories of what they believe led to incidents b) Common assumptions and myths c) Trauma -Informed Care d) Psychological first aid model e) Neurobiological effects of trauma f) Public Health prevention models g) Performance improvement principles h) Seclusion and Restraint Reduction Core Strategies as appropriate i) Risk for violence j) Medical/physical risk factor for injury or death k) Use of safety planning tools or Advance Directives l) Core skills in effective engagement and building therapeutic and strengths-based relationships m) Safe restraint application procedures including pain free holds and face-to-face monitoring while a person is in restraint n) Non-confrontational limit setting o) Recognition of early warning signs of distress or violence p) Understanding of peoples triggers and avoiding setting them off q) Cultural capability skills r) Indigenous awareness		
5. Has the service encouraged staff to explore unit "rules" with an eye to analysing these for logic and necessity?	Some inpatient services may have historical or unofficial "rules" that are habits or patterns of behaviour that are not congruent with a non-coercive, recovery facilitating environment. Solutions may include: a) Time at staff meetings to explore this topic b) Regular reviews by staff c) Encouragement of staff feedback and initiatives		
6. Has the service addressed staff empowerment issues?	Includes: a) Staff having input into rules and regulations b) Allowing staff discretion for flexibility within defined parameters		
7. Does the service support staff empowerment?	Includes: a) Self-schedule or flexible rostering b) Ability to switch assignments and tasks c) Regular supervision d) Inclusion in unit decision making and broader shard governance opportunities?		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
8. Does the service ensure that all staff at all levels are responsible, capable adults, that may be injured by trauma, and communicate this value to all?	Includes: a) Regular supervision b) Performance appraisability of EAP (Employee Assistance Programmes) c) A culture of acceptance and non-judgemental valuing of people's experiences and skills		
9. Has the service included Human Resources in the planning and implementation of workforce development seclusion and restraint reduction efforts?	Includes: a) The development and insertion of knowledge, skills and abilities considered mandatory in job descriptions b) Competencies for all staff at every level of the organisation c) May include both technical competence and attitudinal competence and how these are demonstrated. d) Co-existing capability should also be included in workforce expectations		

4. ANTICIPATING, REDUCING, RESPONDING TO AND REVIEWING SECLUSION AND RESTRAINT

GOAL FOUR

To reduce the use of seclusion and restraint through the use of a variety of tools and assessments that integrated into each individual service user's treatment stay and planning. Including the use of assessment tools to identify risk factors, identification and recognition of early warning signs, any seclusion and restraint history, use of a trauma assessment, tools to identify people with risk factors for death and injury, the use of de-escalation or safety plans and advance directives, environmental changes to include sensory rooms and other meaningful clinical approaches that support people in emotional self-management.

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
1. Has the service implemented assessment tools to identify risk factors for inpatient incidents of aggression and violence?	Includes: a) Risk assessments that include service user history including triggers and warning signs. This information should be shared with staff, so all are aware of potential triggers b) Unit environment volatility scales c) Co-existing problems assessments		
2. Has the service implemented assessment tools on the most common risk factors for death or serious injury caused by restraint use?	Assessments include: a) Cardio-metabolic issues b) History of respiratory problems including asthma c) Recent ingestion of food d) Identified medications and interactions of medications e) History of cardiac problems f) History of acute stress disorder or PTSD		
3. Has the service implemented the use of a trauma history assessment that identifies people's risk for re-traumatization and addresses signs and symptoms related to untreated trauma sequelae?	Service user assessments include opportunities to identify any trauma history. Staff are trained in trauma-informed practices. Staff understand that untreated trauma can lead to mental health and physical problems.		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
4. Has the service implemented a de-escalation tool or safety planning assessment that includes the identification and recognition of early warning signs, individual triggers and personally chosen and effective emotional self-management strategies?	All service user plans such as treatment, recovery, relapse prevention plans include the identification of identification and recognition of early warning signs, individual triggers and personally chosen and effective emotional self-management strategies.		
5. Has the service implemented engagement, communication techniques/conflict mediation procedures? Are there processes that pick up environmental signs of overt/ covert coercion that lead to change?	Includes: a) Staff are trained in engagement, communication techniques/ conflict mediation procedures b) Seclusion and restraint reduction plans include ways of measuring and checking the environmental signs of overt/ covert coercion c) The environment reflects seclusion and restraint reduction approaches d) Include real life stories showing the causes and beliefs held by service users involved in seclusion and restraint events in trainings e) Consider use of dashboard or noticeboard at the facility level		
6. Has the service utilised an aggression control behaviour scale that assists staff to discriminate between agitated, disruptive, destructive and dangerous behaviours and decrease the premature use of restraint/seclusion?	Includes: a) An agreed tool that all staff are trained in using that supports staff to understand and identify risk early and use other strategies first b) Only using seclusion and restraint as an intervention of last resort c) Rounding to identify patients' emotional states (as part of 15/60 observations)		
7. Has the service written policies and procedures for use of the above interventions and disseminated these to all staff? Are these easily to all staff?	Includes: a) Guideline, policy and procedure development that ensure effective and safe use of identified tools b) Staff communication and training in the tool c) Regular evaluation of staff knowledge, skill and usage of tools		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
8. Has the service created a way that individual safety planning or de- escalation information is readily available in a crisis and is integrated in the treatment plan?	Includes: a) Systems and processes ensure all service user information, plans, Advance Directives and treatment histories are easily accessible and regularly updated b) individual safety or de-escalation plans easily and quickly identified and accessed c) Service users carry copies of plans with them d) Staff are trained and create a culture of ensuring plans are up to date and quickly accessible. Service users must receive the updated version. e) Use information on what has worked for people in previous admissions and have a process for ensuring this information is available and an expectation that it is acted on f) Can develop family and kinship-centred treatment plans		
9. Has the service made available expert and timely consultation with appropriately trained staff or consultants to assist in developing individualized, trauma informed, overall support and behavioural support interventions for service users who demonstrate consistently challenging behaviours?	Includes: a) Identifying and training staff in this specialist area b) Regular staff training in working with people who have challenging behaviours c) Regular staff supervision groups with this as a focus		
10. Does the service have outlined alternatives to seclusion and restraint activities that are included in service user orientation and treatment plans?	Includes: a) Sensory modulation approaches and room b) Pacing or physical activity areas c) Quiet private spaces d) Occupational activities available including weekends e) Available areas for music, television and craft f) Peer support options		

5. CONSUMER, CARER AND STAFF COLLABORATION FOR SAFE IN CARE AND SAFE AT WORK

GOAL FIVE

To assure for the full and formal inclusion of service users/consumers or people personally experienced in recovery, carers and families, in a variety of roles in the service to assist in the reduction of seclusion and restraint.

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
1. Does the service have integrated service user choices at every opportunity? For children and young people's treatment programs this also focuses on family member choices.	Includes: a) Service users are given full information about the service and treatment choices and options. It's important to note that while some choices may have to be made in crisis this information and choice should be a continuous process, regularly updated and provide a good point of engagement b) Service users are included in all treatment and recovery planning and their personal choices documented and respected c) Family members are given appropriate information and included in service users' treatment and service planning		
2. Has the service used vacant FTE's to create full or part-time roles for older adolescent/adult service user/ consumer positions?	Includes: a) Service user/consumer advisors and consultants b) Peer support workers c) Service user/consumer trainers d) Service user/consumer evaluators e) Service user/consumer trained in debriefing f) Service user/consumer supervisors g) Service user roles should be included in team meetings for information sharing and a sense of inclusion		
3. Has the service educated staff as to the importance and need to involve service users/consumers at all operational levels, both through respectful inclusion in operations decisions and in the consistent attention to the provision of choices?	Includes: a) Staff commitment to providing service users with information and choices at every stage of treatment, plans are always kept updated as people recover b) Service users are formally included in and contribute to unit operational decisions and planning c) People using inpatient services have opportunities to give quality authentic feedback d) Service users are included and participate in service reviews		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
4. Has the service included service user/consumer leadership in key committees and workgroups throughout the organisation?	This includes service users involved in: a) Quality groups b) Seclusion and restraint reduction groups c) Staff training d) Senior management meetings e) Service evaluation groups f) Service planning groups g) Incident or sentinel events review groups h) Recruitment and retention groups i) Workforce development groups		
5. Has the service supported service users/consumers to do their service related jobs at the highest level and supported this work?	Includes: a) Clear job descriptions that include responsibilities and delegated authority b) Regular supervision c) Workforce development and training plans d) Regular direct report meetings e) Performance appraisals		
6. Has the service implemented service user/consumer satisfaction surveys with systems to effectively use the information gathered?	Includes systems that ensure: a) Results are discussed with staff b) Results are used to direct service provision and quality improvement initiatives. c) Use experience-based design/co-design surveys as part of this d) Authentic Indigenous Australian feedback processes		
7. Has the service invited external service user leaders, advocates, networks and groups to provide suggestions and be involved in operations?	Includes: a) Regular service user/consumer community meetings facilitated by service consumer advisor b) Regular times for advocates visits in the inpatient unit c) Employed service user roles include networking and community group meetings d) Employed service user roles facilitate service user sector views and advice. e) Service user run groups in the inpatient unit		
8. Has the service educated staff to the importance and need to involve family and cultural kinship networks at all operational levels, both through respectful inclusion in operations decisions and in the consistent attention to the provision of choices?	Includes: a) Staff commitment to providing family and cultural kinship networks with information and choices at every stage of treatment as appropriate b) Family and cultural kinship networks are formally included in and contribute to unit operational decisions and planning c) Family and cultural kinship networks of people using inpatient services have opportunities to give quality authentic feedback d) Family and cultural kinship networks are included and participate in service reviews		

6. POST-RESTRICTIVE CARE RESPONSES

GOAL SIX

To reduce the use of seclusion and restraint through knowledge gained from a rigorous analysis of seclusion and restraint events. Ensuring the use of this knowledge informs policy, procedures and practices to avoid repeats in the future. A secondary goal of this objective is to attempt to mitigate the adverse and potentially traumatising effects of a seclusion and/or restraint event for involved service users, staff and all witnesses to the event.

It is imperative that senior clinical and medical staff, including the clinical director and nurse leader, participate in these events.

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS

1. Has the service revised policy and procedures to include two activities for each event as follows:
a. Immediate post-event care affect onsite after each event.
b. A reflection or discussion and guided learning activity.
	The immediate response should be led by the senior on-site supervisor who immediately responds to that unit or area.
	The goals of this post-acute event intervention are:
	a) To assure that everyone is safe
	b) To ensure that the person in restraint is safe and being monitored appropriately
	c) That documentation is sufficient to be helpful in later analysis
	d) To briefly check in with involved staff, service users and witnesses to the event to gather information to ensure safety
	e) To try and return the unit to pre-event status
	f) To identify potential needs for policy and procedure revisions
	
	Post-event care should:
	a) Occur one to several days following the event
	b) Include attendance by the involved staff, treatment team members including the attending physician, and management
	c) Is run by a person well versed in objective problem solving and was not involved in the triggering event.
	d) Engage in a guided learning activity to identify
	    » what went wrong
	    » what knowledge was unknown or missed
	    » what could have been done differently
	    » how to avoid in the future.		

	Cultural consideration is very important as there may be risk of cross-cultural miscommunication or misunderstanding.		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
2. Has the service assured the involvement of the service user in all post-event activities either in person or by proxy?	Inclusion of the service user's experience or voice in post-event activities critical. If the service user cannot or chooses not to participate it is recommended that a service user advocate or advisor act as that person's advocate at the meeting. Service user involvement should always be done at a time of the service users choosing to lessen any potential for re-traumatisation and also to ensure collection of necessary information.		
3. Are the service's post-event policies and procedures clear and specific?	Post-event policies and procedures should cover: a) Goals of debriefing b) Who is present c) Responsibilities/roles d) Process e) Documentation f) Follow-up		
4. Has the service implemented post-event policies and procedure that address staff, service user and observer response and issues?	Post-event activities are critical. Policies and procedures include guidelines and frameworks that cover: a) Staff responses and issues b) Service user responses and issues c) Observers responses and issues		
5. Has the service provided training on how post-event activities will revise treatment planning	Staff training should include using post-event critical information to revise treatment planning including: a) Identifying early warning signs b) Identifying trigger points c) Using service user chosen alternative actions d) Using service user chosen self-soothing approaches e) Ensure staff are aware of the range of self-soothing that people might utilise – the service user choices need to be clear and understood by staff ideally before any escalation issues occur		
6. Does the service assist staff in their individual responses to seclusion and restraint events	This may include: a) The use of EAP (Employee Assistance Program) services b) Supervision c) Other staff identified supportive resources		

REFERENCES

ACT Government Health 2015, Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015, viewed 10 September 2018, http://health.act.gov.au/sites/default/files//new_policy_and_plan/Seclusion%20of%20Persons%20with%20Mental%20Illness%20or%20Mental%20Disorder%20Detained%20under%20the%20Mental%20Health%20Act%202015.docx

Allan, J.A., Hanson, G.D., Schroder, N.L., O'Mahony, A.J., Foster, R.M.P. & Sara, G.E. 2017, 'Six years of national mental health seclusion data: the Australian experience', *Australasian Psychiatry,* vol. 25, no. 3, pp. 277-81.

Australian College of Mental Health Nurses 2013, *Mental health nurses in Australia: Scope of practice 2013 and standards of practice 2010*, Australian College of Mental Health Nurses Inc., Canberra.

Australian College of Mental Health Nurses Inc. 2017, Supporting mental health professionals towards cultural and clinical change: facilitating ongoing reduction in seclusion and restraint in mental health settings in Australia - project summary, ACMHN, Canberra, ACT.

Australian Commission on Safety and Quality in Health Care 2017, National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state, ACSQHC, Sydney, NSW.

Australian Commission on Safety and Quality in Health Care 2018, National safety and quality health service standards: user guide for health services providing care for people with mental health issues, ACSQHC, Sydney, SW.

Australian Commission on Safety and Quality in Health Care 2019a, Comprehensive care, viewed 4 March 2019, <https://www.safetyandquality.gov.au/our-work/comprehensive-care/>.

Australian Commission on Safety and Quality in Health Care 2019b, National Safety and Quality Health Service Standard 2: Partnering with Consumers, ACSQHC, viewed 9 March 2019, <https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/national-safety-and-quality-health-service-standard-2-partnering-with-consumers/>.

Australian Commission on Safety and Quality in Healthcare 2019, *Australian Charter of Healthcare Rights,* viewed 9 March 2019, <https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>.

Australian Human Rights Commission 2011, 'Cultural safety and security: Tools to address lateral violence', Social Justice Report 2011, Canberra, ACT.

Azeem, M.W., Aujla, A., Rammerth, M., Binsfeld, G. & Jones, R.B. 2017, 'Effectiveness of Six Core Strategies based on trauma informed care in reducing seclusions and restraints at a Child and Adolescent Psychiatric Hospital', *Journal of Child and Adolescent Psychiatric Nursing*, vol. 30, no. 4, pp. 170-4.

Baborm, T.F., Higgins-Biddle, J.C., Saunders, J.B. & Monteiro, M.G. 2001, T*he Alcohol Use Disorders Identification Test (AUDIT): guidelines for use in primary care,* 2nd edn, World Health Organization, Geneva, Switzerland.

REFERENCES

Bigwood, S. & Crowe, M. 2008, "It's part of the job, but it spoils the job': a phenomenological study of physical restraint', *International Journal of Mental Health Nursing*, vol. 17, no. 3, pp. 215-22.

Bowers, L., Cullen, A., Achilla, E.B., J.A., Khondoker, M.R., Koeser, L., Biggin Moylen, L., Pettit, S., Quirk, A., Sethi, F., Stewart, D., McCrone, P. & Tulloch, A.D. 2017, 'Seclusion and Psychiatric Intensive Care Evaluation Study (SPICES): combined qualitative and quantitative approaches to the uses and outcomes of coercive practices in mental health services', Health Services and Delivery Research, vol. 5, no. 21, pp. 1-142.

Brophy, L.M., Roper, C.E., Hamilton, B.E., Tellz, J.J. & McSherry, B.M. 2016, 'Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups', *International Journal of Mental Health Systems*, vol. 10, no. 6.

Brophy, L.M.R., C.E., Hamilton, B.E., Tellez, J.J. & McSherry, B.M. 2016, 'Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings', *Australian Health Review,* vol. 40, no. 6, pp. 599-604.

Bullock, R., McKenna, B., Kelly, T., Furness, T. & Tacey, M. 2014, 'When reduction strategies are put in place and mental health consumers are still secluded: an analysis of clinical and sociodemographic characteristics', *International Journal of Mental Health Nursing,* vol. 23, no. 6, pp. 506-12.

Centre of Perinatal Excellence 2017, *Mental health care in the perinatal period" Australian clinical practice guideline,* viewed 3 March 2019, <https://cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf>.

Ching, H., Daffern, M., Martin, T. & Thomas, S. 2010, 'Reducing the use of seclusion in a forensic psychiatric hospital: assessing the impact on aggression, therapeutic climate and staff confidence', T*he Journal of Forensic Psychiatry & Psychology,* vol. 21, no. 5, pp. 737-60.

Conroy, T., Reo, R., Boucaut, R., Alderman, J. & Kitson, A. 2017, 'Role of effective nurse-patient relationships in enhancing patient safety', *Nursing Standard,* vol. 31, no. 49, pp. 53-63.

Department for Health and Ageing 2014, *Impaired decision-making factsheet: a clear path to care,* Government of South Australia, viewed 4 March 2019, <http://www.sahealth.sa.gov.au/wps/wcm/connect/8a241b804459db088a0daa76d172935c/Assessing+Capacity+Fact+Sheet+PC+20140613.pdf?MOD=AJPERES&CACHEID=8a241b804459db088a0daa76d172935c>.

Department of Health and Human Services, Tasmanian Government 2015, Rethink Mental Health Better Mental Health and Wellbeing: A long-term plan for mental health in Tasmania 2015-2025, viewed 10 September 2018, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/202496/DHHS_Rethink_Mental_Health_WEB.pdf

Department of Health, State of Western Australia 2008, Clinical Risk Assessment and Management (CRAM) in Western Australia Mental Health Services Policy and Standards, viewed 19 September, http://www.health.wa.gov.au/CircularsNew/attachments/826.pdf

Department of Health 2013, *Mental health triage tool,* viewed 9 March 2019, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-mh>.

REFERENCES

Department of Health 2014, *National Aboriginal and Torres Strait Islander suicide prevention strategy,* viewed 9 March 2019, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy>.

Department of Health & Human Services 2018, *Safewards,* Melbourne, Vic, viewed 9 March 2019, <https://www2.health.vic.gov.au/safewards>.

Department of Veterans' Affairs 2019, *At ease: Resources for health professionals treating veterans with common mental health disorders,* viewed 3 March 2019, <https://at-ease.dva.gov.au/professionals>.

Feo, R., Conroy, T., Alderman, J. & Kitson, A. 2016, 'Engaging patients and keeping them safe', in J. Crisp, C. Douglas, G. Rebeiro & D. Waters (eds), *Potter & Perry's fundamentals of nursing,* Elsevier Australia, Chatswood, NSW, pp. 30-44.

Gaskin, C. & Dagley, G. 2018, Recognising signs of deterioration in a person's mental state, viewed 14 March 2019, https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/Recognising-Signs-of-Deterioration-in-a-Persons-Mental-State-Gaskin-Research-Final-Report.pdf

Gerace, A., Pamungkas, D.R., Oster, C., Thomson, D. & Muir-Cochrane, E. 2014, 'The use of restraint in four general hospital emergency departments in Australia', *Australasian Psychiatry,* vol. 22, no. 4, pp. 366-9.

Health Victoria 2013. Providing a safe environment for all: Framework for reducing restrictive interventions, viewed 10 September 2018, https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/reducing-restrictive-interventions/framework-for-reducing-restrictive-interventions.

Hollins, L.P. 2010, 'Proposing a common sense approach to assessing the risks posed by physical intervention techniques', *Psychiatric and Mental Health Nursing,* vol. 17, no. 3, pp. 216-21.

Huckshorn, K.A. 2004, 'Reducing seclusion and restraint use inmental health settings: core strategies for prevention', *Journal of Psychosocial Nursing,* vol. 42, no. 9, pp. 22-33.

Huckshorn, K.A. 2006, 'Six core strategies for reducing seclusion and restraint use©', National Association of State Mental Health Program Directors,, Alexandria, Virginia, viewed 20 February 2019, <https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>.

Jalil, R., Huber, J.W., Sixsmith, J. & Dickens, G.L. 2017, 'Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: cross sectional questionnaire survey', *International Journal of Nursing Studies*, vol. 75, pp. 130-8.

Kessler, R.C., Andrews, G., Colpe, L.J., Hiripe, E., Mroczek, D.K., Normand, S.L., Walters, E.E. & Zaslavsky, A.M. 2002, 'Short screening scales to monitor population prevalence and trends in non-specific psychological distress', *Psychological Medicine,* vol. 32, no. 6, pp. 959-76.

Kinner, S.A., Harvet, C., Hamilton, B., Brophy, L., Roper, C., McSherrt, B. & Young, J.T. 2017, 'Attitudes towards seclusion and restraint in mental health settings: findings from a large, community-based survey of consumers, carers and mental health professionals', *Epidemiology and Psychiatric Sciences,* vol. 26, no. 5, pp. 535-44.

Kontio, R., G., J., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M. & Välimäki, M. 2012, 'Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives', *Perspectives in Psychiatric Care,* vol. 48, no. 1, pp. 16-24.

REFERENCES

LeBel, J.L., Duxbury, J.A., Putkonen, A., Spraque, T., Rae, C. & Sharpe, J. 2014, 'Multinational experiences in reducing and preventing the use of restraint and seclusion', *Journal of Psychosocial Nursing and Mental Health Services* vol. 52, no. 11, pp. 22-9.

Liverpool Hospital 2015, *Intensive Care Unit: Clinical Guideline - Physical restraints,* South Western Sydney Local Health District, Liverpool, NSW, viewed 9 March 2019, <https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/306451/liverpoolPhysical_Restraints.pdf>.

Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A. & Teeson, M. 2016, Guidelines on the management of of co-occurring alcohol and other drug and mental health conditions in drugand alcohol treatment settings, 2nd edn, Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, NSW.

Martin, T. & Daffern, M. 2006, 'Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting', *Journal of Psychiatric and Mental Health Nursing*, vol. 13, no. 1, pp. 90-9.

Melbourne Social Equity Institute 2014, *Seclusion and restraint project: report,* Melbourne, Vic.

Mental Health in Multicultural Australia 2013, *Practice resource: mental health in multicultural Australia (MHiMA) framework: towards culturally inclusive service delivery,* viewed 3 March 2019, <http://framework.mhima.org.au/framework/index.htm>.

Mind Australia and Helping Minds - Private Mental Health Consumer Carer Network (Australia) 2016, A practical guide for working with carers of people with a mental illness, Mental Health Carers Arafmi Australia and Mental Health Australia., viewed 4 March 2019, <https://mhaustralia.org/sites/default/files/docs/a_practical_guide_for_working_with_carers_of_people_with_a_mental_illness_february_0.pdf>.

Mohan, D. 2003, 'People's right to safety', Health and Human Rights, vol. 6, no. 2, pp. 161-9.

Morris, S. & Jacobs, R. 2016, 'The National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: a new strategy for inclusion and action', National LGBTI Health Alliance, Sydney, NSW, <https://lgbtihealth.org.au/resources/national-lgbti-mental-health-suicide-prevention-strategy/>.

Muir-Cochrane, E. 2017, 'Supporting mental health nurses towards cultural and clinical change: facilitating ongoing reduction in the use of seclusion and restraint in mental health settings in Australia - literature review', ACMHN, Canberra, ACT.

Muir-Cochrane, E. & Gerace, A. 2014, 'Containment practices in psychiatric care', in D. Holmes, J.D. Jacob & A. Perron (eds), *Power and the psychiatric apparatus: repression, transformation and assistance, Routledge*, London, UK.

Muir-Cochrane, E., O'Kane, D. & Oster, C. 2018, 'Fear and blame in mental health nurses' accounts of restrictive practices: implications for the elimination of seclusion and restraint', *International Journal of Mental Health Nursing*, vol. 27, no. 5, pp. 1511-21.

Muir-Cochrane, E.C., Baird, J. & McCann, T.V. 2015, 'Nurses' experiences of restraint and seclusion use in short-stay acute old age psychiatry inpatient units: a qualitative study', *Journal of Psychiatric and Mental Health Nursing*, vol. 22, no. 2, pp. 109-15.

REFERENCES

National Aboriginal and Torres Strait Islander Leadership in Mental Health 2018, *Health in culture - policy concordance,* viewed 3 March 2019, <https://natsilmh.org.au/sites/default/files/NATSILMH%20 Health%20in%20Culture%20Policy%20Concordance%20(2).pdf>.

National Institute for Health and Care Excellence 2013, Self-harm Quality standard [QS34], viewed 9 March 2019, <https://www.nice.org.uk/guidance/qs34>.

National LGBTI Health Alliance 2013, Cultural competency implementation framework: achieving inclusive practice with lesbian, gay, bisexual, trans and intersex (LGBTI) communities, viewed 3 March 2019, <https://www.lgbtihealth.org.au/sites/default/files/Cultural%20Competancy%20Implementation%20 Framework.pdf>.

National Mental Health Commission 2015, 'A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services'. viewed 19 September 2018, http://www. mentalhealthcommission.gov.au/media/123610/Position%20Paper%20-%20FINAL%20ENDORSED%20 20%20May%202015%20(D15-676902).PDF

National Mental Health Consumer & Carer Forum 2009, 'Ending seclusion and restraint in Australian mental health services', NMHCCF, viewed 13 March 2019, <https://nmhccf.org.au/sites/default/files/docs/ seclusion_restraint.pdf>.

National Mental Health Working Group 2005, *The Seclusion and Restraint Declaration,* viewed 14 March 2019, <http://www.mentalhealthcommission.gov.au/media/97455/NMHC_Seclusion_and_Restraint_ Dec.pdf>.

NHS Education 2017, *Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce,* Scottish Government, viewed 3 March 2019, <https://www.nes.scot.nhs.uk/media/3971582/ nationaltraumatrainingframework.pdf>.

NSW Government 2015, *Management of patients with acute severe behavioural disturbance in emergency departments,* vol. GL2015_007, North Sydney, NSW, viewed 9 March 2019, <https://www1.health.nsw. gov.au/pds/ActivePDSDocuments/GL2015_007.pdf>.

NSW Government 2017a, *Releasing time to care,* viewed 4 March 2019, <https://www.health.nsw.gov.au/nursing/ Pages/releasing-time-to-care.aspx>.

NSW Government 2017b, *Review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities,* <https://www.health.nsw.gov.au/mentalhealth/reviews/seclusionprevention/ Pages/about.aspx>.

NSW Government 2017c, *Review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities*, North Sydney, NSW, viewed 9 March 2019, <https://www.health.nsw.gov.au/ mentalhealth/reviews/seclusionprevention/Pages/about.aspx>.

NSW Ministry of Health 2018, Mental health safety and quality in NSW: a plan to implement recommendations of the review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities, NSW Government, Sydney, NSW, viewed 20 February 2019, <https://www.health.nsw. gov.au/mentalhealth/reviews/seclusionprevention/pages/default.aspx>.

REFERENCES

NSW Minstry of Health 2015, *Dignity, respect and choice: advance care planning for end of life for people with mental illness - a comprehensive guide,* viewed 4 March 2019, <http://www.health.nsw.gov.au/patients/acp/Publications/comprehensive-guide.pdf>.

Oster, C., Gerace, A., Thomson, D. & Muir-Cochrane, E. 2016, 'Seclusion and restraint use in adult inpatient mental health care: an Australian perspective', *Collegian*, vol. 23, no. 2, pp. 183-90.

Psychology Foundation of Australia 2018, D*epression Anxiety Stress Scales (DASS)*, viewed 4 March 2019, <http://www2.psy.unsw.edu.au/dass/>.

Queensland Government 2018, *Caring for a person who is aggressive or violent,* viewed 4 March 2019, <https://www.health.qld.gov.au/__data/assets/pdf_file/0031/444586/aggressive.pdf>.

Queensland Health 2017a, *Acute behavioural disturbance, management (including acute sedation) in Queensland health authorised mental health services (adults),* viewed 4 March 2019, <https://www.health.qld.gov.au/__data/assets/pdf_file/0025/665314/qh-gdl-452.pdf>.

Queensland Health 2017b, *Management of patients with acute severe behavioural disturbance in emergency departments*, viewed 4 March 2019, <https://www.health.qld.gov.au/__data/assets/pdf_file/0031/629491/qh-gdl-438.pdf>.

Queensland Health 2016, *Seclusion*, viewed 10 September 2018, https://www.health.qld.gov.au/__data/assets/pdf_file/0025/465163/cpp-seclusion.pdf

Renwick, L., Lavelle, M., James, K., Stewart, D., Richardson, M. & Bowers, L. 2019, 'The physical and mental health of acute psychiatric ward staff, and its relationship to experience of physical violence', I*nternational Journal of Mental Health Nursing*, vol. 28, no. 1, pp. 268-77.

Riahi, S., Dawe, I.C., Stuckey, M.I. & Klassen, P.E. 2016, 'Implementation of the six core strategies for restraint minimization in a specialized mental health organization', *Journal of Psychosocial Nursing and Mental Health Services,* vol. 54, no. 10, pp. 32-9.

Rose, D., Perry, E., Rae, S. & Good, N. 2017, 'Service user perspectives on coercion and restraint in mental health', *The British Journal of Psychiatry International,* vol. 14, no. 3, pp. 59-61.

SA Health 2012, *Challenging Behaviour Policy Framework*, Government of South Australia, Melbourne, Vic, viewed 9 March 2019, <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/challenging+behaviour+strategy/challenging+behaviour+policy+framework>.

SA Health 2015. *Restraint and Seclusion in Mental Health Services Policy Guideline,* viewed 10 September 2018, https://www.sahealth.sa.gov.au/wps/wcm/connect/5dd2f58048f79928929df70e3d7ae4ad/Guideline_restraint+and+seclusion_july2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5dd2f58048f79928929df70e3d7ae4ad-meNtaSa

Seclusion and Restraint New Zealand 2018. *The legal and administrative framework for the use of seclusion, segregation and restraint in New Zealand,* viewed 19 September 2018, <http://www.seclusionandrestraint.co.nz/appendix_3>.

REFERENCES

Te Pou o te Whakaaro Nui 2013, *Six core strategies checklist: New Zealand adaption,* Te Pou, Auckland, New Zealand, viewed 20 February 2019.

Te Pou o Te Whakaaro Nui 2015, Towards restraint-free mental health practice: supporting the reduction and prevention of personal restraint in mental health inpatient settings, Te Pou oTe Whakaaro Nui, Auckland, New Zealand.

The Department of Developmental Disability Neuropsychiatry 2012, *Intellectual disability mental health e-Learning,* viewed 3 March 2019, <http://www.idhealtheducation.edu.au/>.

The Royal Children's Hospital 2017, *Acute behavioural disturbance: code grey,* viewed 4 March 2019, <https://www.rch.org.au/clinicalguide/guideline_index/acute_behavioural_disturbance_code_grey/>.

The Royal Children's Hospital Melbourne 2017a, *Acute behavioural disturbance: acute management,* viewed 4 March 2019, <https://www.rch.org.au/clinicalguide/guideline_index/Acute_behavioural_disturbance__Acute_management/>.

The Royal Children's Hospital Melbourne 2017b, *Acute behavioural disturbance: assessment and verbal de-escalation,* viewed 4 March 2019, <https://www.rch.org.au/clinicalguide/guideline_index/acute_behavioural_disturbance_assessment/>.

The Royal Children's Hospital Melbourne 2018, *Mental State Examination,* viewed 4 March 2019, <https://www.rch.org.au/clinicalguide/guideline_index/Mental_state_examination/>.

The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017, National safety and quality health service standards user guide for Aboriginal and Torres Strait Islander health, ACSQHC, Sydney, NSW, viewed 10 March 2019, <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf>.

Van Der Merwe, M., Muir-Cochrane, E., JOnes, J., Tziqqili, M. & Bowers, L. 2013, 'Improving seclusion practice: implications of a review of staff and patient views.', *Journal of Psychiatric and Mental Health Nursing,* vol. 20, no. 3, pp. 203-15.

Van Leeuwen, M. & Harte, J.M. 2017, 'Violence against mental health care professionals: prevalence, nature and consequences', *The Journal of Forensic Psychiatry & Psychology,* vol. 28, no. 5, pp. 581-98.

Victorian Government 2013, *Providing a safe environment for all: framework for reducing restrictive interventions, Mental Health, Drugs and Regions Division,* Melbourne, Victoria, viewed 20 February 2019, <https://www2.health.vic.gov.au/about/publications/researchandreports/Providing-a-safe-environment-for-all-Framework-for-reducing-restrictive-interventions>.

APPENDIX 1:

Background Documents

Australian College of Mental Health Nurses 2017a, Supporting mental health nurses towards cultural and clinical change: Facilitating ongoing reduction in the use of seclusion and restraint in mental health settings in Australia – Focus Groups: Exploration of the barriers and enablers to reducing seclusion and restraint. .

Australian College of Mental Health Nurses 2017b, Supporting mental health nurses towards cultural and clinical change: Facilitating ongoing reduction in the use of seclusion and restraint in mental health settings in Australia – Survey to examine nurse perceptions of barrier and enablers to eliminating seclusion and restraint use in psychiatric inpatient settings and emergency departments. .

Australian College of Mental Health Nurses Inc. 2017, Supporting mental health professionals towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in mental health settings in Australia - project summary, ACMHN, Canberra, ACT.

Knott, J., Gerdtz, M., Dobson, S., Dantel, C., Graudins, A., Mitra, B., Bartley, B. & Chapman, P. 2016, Restrictive interventions in Victorian emergency departments: a review of current clinical practice, Australasian College for Emergency Medicine, viewed 14 March 2019, <https://acem.org.au/getmedia/dc976a35-816a-4a72-922e-4974f941e228/1145-Jonathan-Knott-PRESENTATION>.

Muir-Cochrane, E., O'Kane, D. & Oster, C. 2018, 'Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint', International Journal of Mental Health Nursing, vol. 27, no. 5, pp. 1511-21.

Needham, H. & Sands, M. 2010, 'Post-seclusion debriefing. a core nursing intervention', Perspectives in Psychiatric Care, vol. 46, no. 3, pp. 221-33.

NHS Clinical Commissioners 2018, Be the change - ensuring an effective response to all in psychiatric emergency equal to medical care: recommendations from the first international summit on urgent and emergency behavioural healthcare, International Crisis Health Recovery Consulting, viewed 14 March 2019, <http://bhltest2.com/wp-content/uploads/2018/10/Be-the-Change.pdf>.

NSW Health Illawarra Shoalhaven Local Health District 2014, 'Safety for all: promoting safety and minimising challenging interactions in mental health services - report: Pilot workshop (Category 1) conducted 17&18 June 2014,' NSW South Eastern Sydney Local Health District,.

Te Pou oTe Whakaaro Nui 2015, Towards restraint-free mental health practice: supporting the reduction and prevention of personal restraint in mental health inpatient settings, Te Pou oTe Whakaaro Nui, Auckland, New Zealand.

National & State Policy Statements

New Zealand - Seclusion and Restraint New Zealand (2018). The legal and administrative framework for the use of seclusion, segregation and restraint in New Zealand, viewed 10 September 2018, http://www.seclusionandrestraint.co.nz/appendix_3, viewed 19 September 2018.

Australia - National Mental Health Commission (2015). A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services, viewed 19 September 2018, http://www.mentalhealthcommission.gov.au/media/123610/Position%20Paper%20-%20FINAL%20ENDORSED%2020%20May%20 2015%20(D15-676902).PDF,

New South Wales - NSW Ministry of Health (2018). Mental Health Safety and Quality in NSW: A plan to implement recommendations of the review of seclusion,restraint and observation of consumers with a mental illness in NSW Health Facilities, viewed 10 September 2018, https://www.health.nsw.gov.au/patients/mentalhealth/Publications/implementation-plan.pdf

Victoria - Health Victoria (2013). Providing a safe environment for all: Framework for reducing restrictive interventions, viewed 10 September 2018, https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/reducing-restrictive-interventions/framework-for-reducing-restrictive-interventions

South Australia - SA Health (2015). Restraint and Seclusion in Mental Health Services Policy Guideline, viewed 10 September 2018, https://www.sahealth.sa.gov.au/wps/wcm/connect/5dd2f58048f79928929df70e3d7ae4ad/Guideline_restraint+and+seclusion_july2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5dd2f58048f79928929df70e3d7ae4ad-meNtaSa

Western Australia - Department of Health, State of Western Australia (2008). Clinical Risk Assessment and Management (CRAM) in Western Australia Mental Health Services Policy and Standards, viewed 19 September, http://www.health.wa.gov.au/CircularsNew/attachments/826.pdf

Queensland - Queensland Health (2016). Seclusion, viewed 10 September 2018, https://www.health.qld.gov.au/__data/assets/pdf_file/0025/465163/cpp-seclusion.pdf

Tasmania - Department of Health and Human Services, Tasmanian Government (2015). Rethink Mental Health Better Mental Health and Wellbeing: A long-term plan for mental health in Tasmania 2015-2025, viewed 10 September 2018, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/202496/DHHS_Rethink_Mental_Health_WEB.pdf

Australian Capital Territory - ACT Government Health (2015). Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015, viewed 10 September 2018, http://health.act.gov.au/sites/default/files//new_policy_and_plan/Seclusion%20of%20Persons%20with%20Mental%20Illness%20or%20Mental%20Disorder%20Detained%20under%20the%20Mental%20Health%20Act%202015.docx

APPENDIX 2:

—

SICSAW Mapped against National Standards
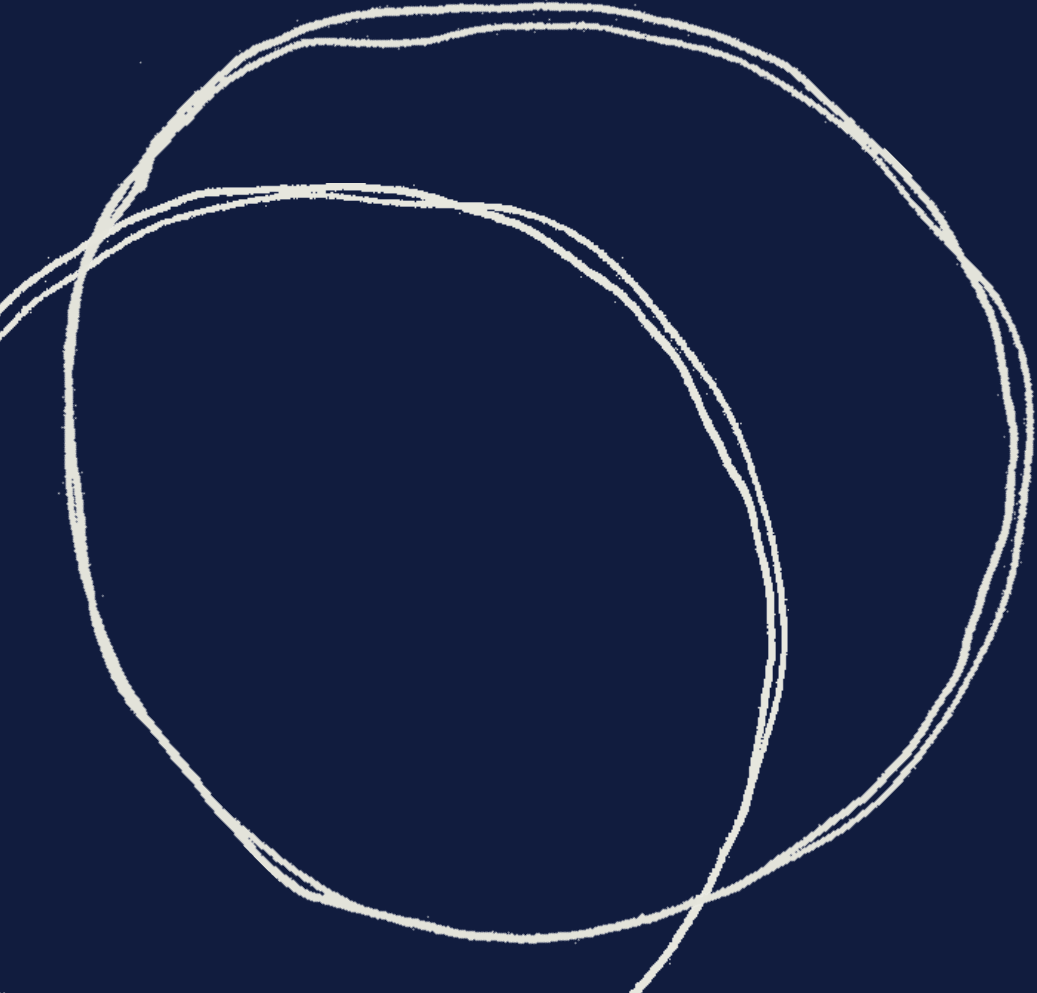
Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Lead, Support and govern for Safe Care	
To reduce and eliminate the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values and ensuring the development of a seclusion and restraint reduction plan and plan implementation. The guidance, direction, participation and on-going review by executive/senior leadership is clearly demonstrated throughout seclusion and restraint reduction and elimination projects, plans and service delivery. • A clear vision for safety in care and safety at work is articulated and shared, resulting in inclusive and respectful environments for consumers, carers and mental health staff including the specific needs of Aboriginal and Torres Strait Islander people; • Site-specific safety plans that meet all relevant standards are developed, implemented, regularly reviewed and revised; • Staff, carer and consumer concerns, actual and potential safety issues or breaches to safety for consumers, carers and staff are anticipated, acknowledged and addressed in a non-punitive process; and • Successes are recognised and celebrated.	• '1.1 The governing body: a) Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b) Provides leadership to ensure partnering with patients, carers and consumers c) Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d) Endorses the organisation's clinical governance framework e) Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f) Monitors the action taken as a result of analyses of clinical incidents g) Reviews reports and monitors the organisation's progress on safety and quality performance (Australian Commission on Safety and Quality in Health Care 2018, p. 9) • '1.2 The governing body ensures that the organisation's safety and quality priorities address the specific needs of Aboriginal and Torres Strait Islander people' (The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017, p. 3) • '1.6 Clinical leaders support clinicians to: a. understand and perform their delegated safety and quality roles and responsibilities b. operate within the clinical governance framework to improve the safety and quality of health care for patients' (Australian Commission on Safety and Quality in Health Care 2018, p. 65) • '5.35 Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: b. Govern the use of restraint in accordance with legislation (Australian Commission on Safety and Quality in Health Care 2018, p. 80) • '5.36 Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: c. Govern the use of seclusion in accordance with legislation (Australian Commission on Safety and Quality in Health Care 2018, p. 84)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards

The balanced scorecard for Safe in Care and Safe at Work

'To reduce the use of seclusion and restraint by using data in an empirical, non-punitive manner. This includes:
- using data to analyse characteristics of service usage by unit, shift, day and, staff member
- identifying service baselines
- setting improvement goals and comparatively monitoring use over time in all care areas, units and services'.

- Following baseline data collection, standardised, auditable instruments that can be used across settings and all states and territories are employed to provide national measurable indicators to inform systems and strategies to enhance safety in care and at work
- New technologies to improve safety in care and safety at work are utilised;
- Data is systematically collected on consumer characteristics and consumer, carer and staff experiences to inform change. Data is shared with interested parties;
- Access to data literacy training is provided for all appropriate staff.

- '1.11 The health service organisation has organisation-wide incident management and investigation systems, and:
  a) Supports the workforce to recognise and report incidents
  b) Supports patients, carers and families to communicate concerns or incidents
  c) Involves the workforce and consumers in the review of incidents
  d) Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
  e) Uses the information from the analysis of incidents to improve safety and quality
  f) Incorporates risks identified in the analysis of incidents into the risk management system
  g) Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems'
  (Australian Commission on Safety and Quality in Health Care 2018, p. 21)
- '1.13 The health service organisation:
  a) Has processes to seek regular feedback from patients, carers and families about their experience and outcomes of care
  b) Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
  c) Uses this information to improve safety and quality systems' (Australian Commission on Safety and Quality in Health Care 2018, p. 23)
- '1.14 The health service organisation has an organisation-wide complaints management system, and:
  a) Encourages and supports patients, carers and families, and the workforce to report complaints
  b) Involves the workforce and consumers in the review of complaints
  c) Resolves complaints in a timely way
  d) Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken
  e) Uses information from the analysis of complaints to inform improvements in safety and quality systems
  f) Records the risks identified from the analysis of complaints in the risk management system
  g) Regularly reviews and acts to improve the effectiveness of the complaints management system (Australian Commission on Safety and Quality in Health Care 2018, p. 25)
- '1.15b The health service organisation identifies groups of patients using its services who are at higher risk of harm' (Australian Commission on Safety and Quality in Health Care 2018, p. 59)
- '1.15c The health service organisation incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care' (Australian Commission on Safety and Quality in Health Care 2018, p. 19).
- '1.16a The health service organisation has healthcare record systems that make the healthcare record available to clinicians at point of care' (Australian Commission on Safety and Quality in Health Care 2018, p. 62)
- '1.7c The health service organisation uses a risk management approach to review compliance with legislation, regulation and jurisdictional requirements' (Australian Commission on Safety and Quality in Health Care 2018, p. 39)
- '1.3 The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality (Australian Commission on Safety and Quality in Health Care 2018, p. 18).

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
The balanced scorecard for Safe in Care and Safe at Work	• '1.8 The health service organisation uses organisation-wide quality improvement systems that: a) Identify safety and quality measures, and monitor and report performance and outcomes b) Identify areas for improvement in safety and quality c) Implement and monitor safety and quality improvement strategies d) Involve consumers and the workforce in review of safety and quality performance and systems' (Australian Commission on Safety and Quality in Health Care 2018, p. 18). • '1.7 The health service organisation uses a risk management approach to: • Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols • Monitor and take action to improve adherence to policies, procedures and protocols • Review compliance with legislation, regulation and jurisdictional requirements' (Australian Commission on Safety and Quality in Health Care 2018, p. 15) • '1.9 The health service organisation ensures that timely reports on safety and quality systems and • performance are provided to: a) The governing body b) The workforce c) Consumers and the local community d) Other relevant health service organisations' (Australian Commission on Safety and Quality in Health Care 2018, p. 17) • '1.10 The health service organisation: a) Identifies and documents organisational risks b) Uses clinical and other data collections to support risk assessments c) Acts to reduce risks d) Regularly reviews and acts to improve the effectiveness of the risk management system e) Reports on risks to the workforce and consumers f) Plans for, and manages, internal and external emergencies and disasters' (Australian Commission on Safety and Quality in Health Care 2018, p. 19) • 1.12 The health service organisation: a) Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b) Monitors and acts to improve the effectiveness of open disclosure processes (Australian Commission on Safety and Quality in Health Care 2018, p. 22) • '1.13 The health service organisation: a) Has processes to seek regular feedback from patients, carers and families about their experience and outcomes of care b) Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c) Uses this information to improve safety and quality systems (Australian Commission on Safety and Quality in Health Care 2018, p. 23) • '1.14 The health service organisation has an organisation-wide complaints management system, and: a) Encourages and supports patients, carers and families, and the workforce • to report complaints b) Involves the workforce and consumers in the review of complaints

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
The balanced scorecard for Safe in Care and Safe at Work	c) Resolves complaints in a timely way d) Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e) Uses information from the analysis of complaints to inform improvements in safety and quality systems f) Records the risks identified from the analysis of complaints in the risk management system g) Regularly reviews and acts to improve the effectiveness of the complaints management system' (Australian Commission on Safety and Quality in Health Care 2018, p. 25) '1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: b) The workforce c) Consumers and the local community' (Australian Commission on Safety and Quality in Health Care 2018, p. 25) '2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care (Australian Commission on Safety and Quality in Health Care 2018, p. 26) '5.35 Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: c) Report use of restraint to the governing body (Australian Commission on Safety and Quality in Health Care 2018, p. 80) '5.36 Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: c) Report the use of seclusion to the governing body (Australian Commission on Safety and Quality in Health Care 2018, p. 84) '5.8 The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems' (The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017, p. 3) 6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians (Australian Commission on Safety and Quality in Health Care 2018, p. 22) 8.7 The health service organisation has processes for patients, carers or families to directly escalate care (Australian Commission on Safety and Quality in Health Care 2018, p. 22)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Workforce training for Safety in Care and Safe at Work	

'To create an environment where policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on people. This includes understanding the prevalence of these experiences in people who receive mental health services and the experiences of staff. The characteristics and principles of trauma informed care systems need to be included. It also includes the principles of recovery-oriented systems and models that support people-centred care, choice, respect, dignity, partnerships, self-management, and full inclusion.

The goal is to create an environment that is less likely to be coercive or 'conflictual'. It is implemented primarily through staff training and education and human resource activities. This includes safe and least-coercive seclusion and restraint training, and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. Also includes the provision of effective treatment activities on a daily basis that are designed to support life skills'.

- Values and expectations are visible in recruitment and performance review processes, leading to a culture of respect and understanding.
- Appropriate, well-resourced, ongoing training in person-centred, trauma informed, recovery-orientated and strengths-based care is provided; resulting in, minimum mandatory skill standards. Where possible training is co-produced and co-delivered with consumers.
- Learning environments are fostered through adopting communities of practice/ communities of learning approaches;
- Staff are confident, equipped and empowered to promote safety in care and safety at work.

- '1.20 The health service organisation uses its training systems to:
  a) Assess the competency of its training needs
  c) The health service organisation uses its training systems to provide access to training to meet its safety and quality training needs' (Australian Commission on Safety and Quality in Health Care 2018, p. 40)
- '1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients' (Australian Commission on Safety and Quality in Health Care 2018, p. 69)
- '1.26 The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
  2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care' (Australian Commission on Safety and Quality in Health Care 2018, p. 14)
- '5.5 The health service organisation has processes to:
  a) Support multidisciplinary collaboration and teamwork
  b) Define the roles and responsibilities of each clinician working in a team
- 5.6 Clinicians work collaboratively to plan and deliver comprehensive care' (Australian Commission on Safety and Quality in Health Care 2018, p. 64)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards

Anticipating, Reducing, Responding to and Reviewing Seclusion and Restraint

To reduce the use of seclusion and restraint through the use of a variety of tools and assessments that are integrated into each individual service user's treatment stay and planning. Including the use of assessment tools to identify risk factors, identification and recognition of early warning signs, any seclusion and restraint history, use of a trauma assessment, tools to identify people with risk factors for death and injury, the use of de-escalation or safety plans and advance directives, environmental changes to include sensory rooms and other meaningful clinical approaches that support people in emotional self-management.

- Processes and tools to prevent escalation are in place supported by multi-phased post-event interventions;
- Consumers are included in all post-event responses including policy review or development of a learning activity;
- Nurses have appropriate knowledge of post-trauma and critical incident reactions and strategies to mitigate and support any affected consumers, carers and staff;
- Events are reported in line with statutory requirements and adequate details are recorded to facilitate optimal learning.

- '1.7 The health service organisation uses a risk management approach to:
  a) Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols
  b) Monitor and take action to improve adherence to policies, procedures and protocols
  c) Review compliance with legislation, regulation and jurisdictional requirements' (Australian Commission on Safety and Quality in Health Care 2018, p. 20)
- '1.29 The health service organisation maximises safety and quality of care:
  a) Through the design of the environment
  b) By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that is fit for purpose (Australian Commission on Safety and Quality in Health Care 2018, p. 34)
- '1.30 The health service organisation:
  a) Identifies service areas where there is a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce
  b) Provides access to a calm and quiet environment when it is clinically required' (Australian Commission on Safety and Quality in Health Care 2018, p. 35)
- '1.33 The health service organisation demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people' (The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017, p. 3).
- '5.10 Clinicians use relevant screening processes:
  a) On presentation, during clinical examination and history taking, and when required during care
  b) To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
  c) To identify social and other circumstances that may compound these risks' (Australian Commission on Safety and Quality in Health Care 2018, p. 28)
- '5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression' (Australian Commission on Safety and Quality in Health Care 2018, p. 35)
- '5.34 The health service organisation has processes to support collaboration with patients, carers and families to:
  a) Identify patients at risk of becoming aggressive or violent
  b) Implement de-escalation strategies
  c) Safely manage aggression, and minimise harm to patients, carers, families and the workforce' (Australian Commission on Safety and Quality in Health Care 2018, p. 20)
- '5.35 Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:
  a) Minimise and, where possible, eliminate the use of restraint (Australian Commission on Safety and Quality in Health Care 2018, p. 80)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Anticipating, Reducing, Responding to and Reviewing Seclusion and Restraint	
	• '5.36 Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a) minimise, and where possible, eliminate the use of seclusion' (Australian Commission on Safety and Quality in Health Care 2018, p. 84) • '6.9 Clinicians and multi-disciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a) Clinicians who can make decisions about care (Australian Commission on Safety and Quality in Health Care 2018, p. 66) • '8.5 The health service organisation has processes for clinicians to recognise acute deterioration in mental state, including patients at risk of developing delirium: a) Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b) Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c) Assess possible causes for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d) Determine the required level of observation e) Document and communicate observed or reported changes in mental state' (Australian Commission on Safety and Quality in Health Care 2018, p. 98) • '8.6b The health service has protocols that specify criteria for escalating care, including agreed indicators of deterioration in mental state (Australian Commission on Safety and Quality in Health Care 2018, p. 60) • 8.6e The health service has protocols that specify criteria for escalating care, including worry or concern in members of the workforce, patients, carers and families about acute deterioration' ' (Australian Commission on Safety and Quality in Health Care 2018, p. 94)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Consumer, Carer and Staff Collaboration for Safe in Care and Safe at Work	

'To assure for the full and formal inclusion of service users/consumers or people personally experienced in recovery in a variety of roles in the service to assist in the reduction of seclusion and restraint'

- Strategies to facilitate increased stakeholder engagement and participation with the mental health care system are in place and the contribution and leadership of stakeholders is valued and acknowledged;
- Consumers, carers, community members, health providers and professional groups are included in collaborative co-design to develop models of care, safety strategies and therapeutic interventions and contribute to in service evaluation and policy;
- Consumers and carers past and present are considered experts in their own mental health;
- Staff understand the importance of facilitating the involvement of family and kin in providing feedback and contributing to service planning and decisions.

- '1.15 The health service organisation:
  a) Identifies the diversity of the consumers using its services
  b) Identifies groups of patients using its services who are at higher risk of harm
  c) Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care' (Australian Commission on Safety and Quality in Health Care 2018, p. 27).
- '1.4 The health service organisation implements and monitors strategies to meet the organisation's
- safety and quality priorities for Aboriginal and Torres Strait Islander people' (Australian Commission on Safety and Quality in Health Care 2018, p. 30)
- '2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs' (Australian Commission on Safety and Quality in Health Care 2018, p. 69)
- '2.4 The health service organisation ensures that its informed consent processes comply with legislation and best practice (Australian Commission on Safety and Quality in Health Care 2018, p. 39)
- '2.5 The health service organisation has processes to identify:
  a) The capacity of a patient to make decisions about their own care
  b) A substitute decision maker if a patient does not have the capacity to make decisions for themselves' (Australian Commission on Safety and Quality in Health Care 2018, p. 40)
- '2.6 The health service organisation has processes for clinicians to partner with patients and/or their substitute decision maker to plan, communicate, set goals and make decisions about their current and future care' (Australian Commission on Safety and Quality in Health Care 2018, p. 42)
- '2.7 The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care' (Australian Commission on Safety and Quality in Health Care 2018, p. 44)
- '2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
- '2.11a The health service organisation involves consumers in partnership in the governance of, and to design, measure and evaluate, health care' (Australian Commission on Safety and Quality in Health Care 2018, p. 26)
- '5.3 Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:
  a) Actively involve patients in their own care
  b) Meet the patient's information needs
  c) Share decision-making' (Australian Commission on Safety and Quality in Health Care 2018, p. 58)
- '5.8 The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems' (The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute 2017, p. 3)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Consumer, Carer and Staff Collaboration for Safe in Care and Safe at Work	• 5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan (Australian Commission on Safety and Quality in Health Care 2018, p. 43) • '5.14 The workforce, patients, carers and families work in partnership to: d) Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occurs (Australian Commission on Safety and Quality in Health Care 2018, p. 64) • 5.31 The health service organisation has systems to support collaboration with patients, carers and families to: a) Identify when a patient is at risk of self-harm b) Identify when a patient is at risk of suicide c) Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed (Australian Commission on Safety and Quality in Health Care 2018, p. 20) • '6.3 Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a) Actively involve patients in their own care b) Meet the patient's information needs c) Share decision making' (Australian Commission on Safety and Quality in Health Care 2018, p. 91) • '6.9 Clinicians and multi-disciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: b) Patients, carers and families in accordance with the wishes of the patient (Australian Commission on Safety and Quality in Health Care 2018, p. 66)

Safe in Care, Safe at Work Strategy & Evaluative Criteria	National Safety and Quality Health Service Standards
Post- Restrictive Care Responses	
'To reduce the use of seclusion and restraint through knowledge gained from a rigorous analysis of seclusion and restraint events. Ensuring the use of this knowledge informs policy, procedures, and practices to avoid repeats in the future. A secondary goal of this objective is to attempt to mitigate the adverse and potentially traumatising effects of a seclusion and/or restraint event for involved service users, staff and all witnesses to the event. It is imperative that senior clinical and medical staff, including the clinical director and nurse leader, participate in these events' • The preservation of dignity and human rights of consumers throughout any event is paramount; • Effective and prompt support and treatment is provided for any physical or psychological injuries or harm to consumers, carers and staff and processes to support multi-phased post-event interventions are automatically deployed; • Staff are encouraged to self-care and be alert to signs of trauma or distress in self and others; • Events are reported in line with statutory requirements and adequate details are recorded to facilitate optimal learning.	• '5.35 Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: c) Report use of restraint to the governing body (Australian Commission on Safety and Quality in Health Care 2018, p. 80)

APPENDIX 3:

—

**Documents to Guide the Reduction
of Seclusion and Restraint**

LEAD, SUPPORT AND GOVERN FOR SAFE CARE

- Advance care planning for end of life for people with mental illness (NSW Minstry of Health 2015)
- Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Healthcare 2019)
- Comprehensive care (Australian Commission on Safety and Quality in Health Care 2019a)
- Impaired decision-making fact sheet (Department for Health and Ageing 2014)
- Safewards Victoria (Department of Health & Human Services 2018)
- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)

THE BALANCED SCORECARD FOR SAFE IN CARE AND SAFE AT WORK

- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)

WORKFORCE TRAINING FOR SAFE IN CARE AND SAFE AT WORK

- Challenging Behaviour Policy Framework (SA Health 2012)
- Management of patients with acute severe behavioural disturbance in emergency departments (NSW Government 2015)
- Releasing time to care (NSW Government 2017a)
- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Top tips for clinical liaison nurses (Australian College of Mental Health Nurses 2013)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)
- Transforming psychological trauma: A knowledge and skills framework for the Scottish workforce (NHS Education 2017)

ANTICIPATING, REDUCING, RESPONDING TO AND REVIEWING SECLUSION AND RESTRAINT

- Acute behavioural disturbance management (including sedation) (Queensland Health 2017a)
- Acute behavioural disturbance: assessment and verbal de-escalation (children) (The Royal Children's Hospital Melbourne 2017b)
- Acute behavioural disturbance: acute management (children) (The Royal Children's Hospital Melbourne 2017a)
- Acute behavioural disturbance: code grey (children) (The Royal Children's Hospital 2017)
- The Alcohol Use Disorders Identification Test (Baborm et al. 2001).
- Caring for a person who is aggressive or violent (Queensland Government 2018)
- Comorbidity guidelines (Marel et al. 2016)
- Depression Anxiety Stress Scales (DASS) (Psychology Foundation of Australia 2018)
- Intensive Care Unit: Clinical Guideline – Physical Restraint (Liverpool Hospital 2015)
- Kessler Psychological Distress Scale K10 (Kessler et al. 2002)
- Management of patients with acute severe behavioural disturbance in emergency departments (Queensland Health 2017b)
- Mental health triage tool (Department of Health 2013)
- Mental State Examination (The Royal Children's Hospital Melbourne 2018)
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Department of Health 2014)
- National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state (Australian Commission on Safety and Quality in Health Care 2017)
- Recognising signs of deterioration in a person's mental state (Gaskin & Dagley 2018)
- Review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities (NSW Government 2017b)
- Self-harm quality standard for initial management of self-harm and longer-term support (National Institute for Health and Care Excellence 2013)
- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)

CONSUMER, CARER AND STAFF COLLABORATION FOR SAFE IN CARE AND SAFE AT WORK

- A practical guide for working with carers of people with a mental illness (Mind Australia and Helping Minds - Private Mental Health Consumer Carer Network (Australia) 2016)
- At Ease: Resources for health professionals treating veterans with common mental health disorders (Department of Veterans' Affairs 2019)
- Cultural competency implementation framework: achieving inclusive practice with lesbian, gay, bisexual, trans and intersex (LGBTI) communities (National LGBTI Health Alliance 2013)
- National Safety and Quality Health Service Standard 2: Partnering with Consumers (Australian Commission on Safety and Quality in Health Care 2019b)
- The National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A new strategy for inclusion and action (Morris & Jacobs 2016)
- Health in culture – policy concordance (National Aboriginal and Torres Strait Islander Leadership in Mental Health 2018)
- Intellectual disability: mental health e-Learning (The Department of Developmental Disability Neuropsychiatry 2012)
- Mental health care in the perinatal period: Australian clinical practice guideline (Centre of Perinatal Excellence 2017)
- Practice resource: mental health in multicultural Australia (MHiMA) framework: towards culturally inclusive service delivery (Mental Health in Multicultural Australia 2013)
- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)

POST-RESTRICTIVE CARE AND PROCEDURES

- Six core strategies to reduce the use of seclusion and restraint planning tool (Huckshorn et al. 2005)
- Towards restraint-free mental health practice: Supporting reduction and prevention of personal restraint in mental health inpatient settings (Department of Health & Human Services 2018)