

SAFE IN CARE, SAFE AT WORK

*Ensuring safety in care and safety for staff in
Australian mental health services*



Safe in Care
Safe at Work



the Australian College
of Mental Health Nurses Inc.

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ACMHN Dedication

This document is dedicated to the thousands of mental health nurses caring for consumers, carers, family and kin across Australia, in acknowledgement of the valuable work that you do.

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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.

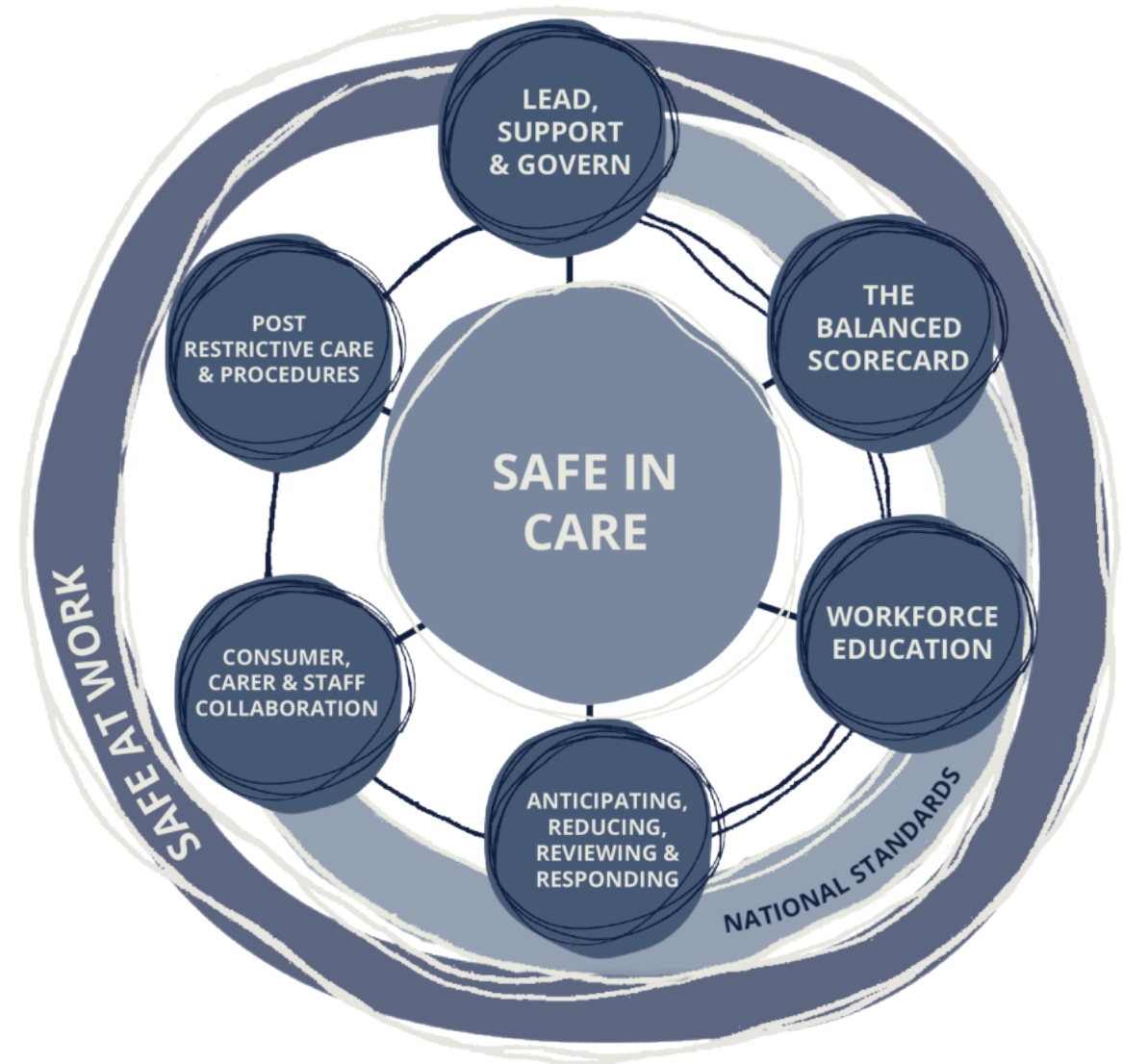
INTRODUCTION

Least restrictive practice has long been a focus and aspiration in mental health care and is framed as an indicator of care quality in mental health settings. 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 by the Australian College of Mental Health Nurses (ACMHN), in a project funded by the National Mental Health Commission (NMHC) to facilitate safety in care, and safety for staff in Australian mental health services. This project extends previous work undertaken by the ACMHN in the 2017 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. This 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 mental health nurses, service users and industry.

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 et al. 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 toolkit 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).*





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 is 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.

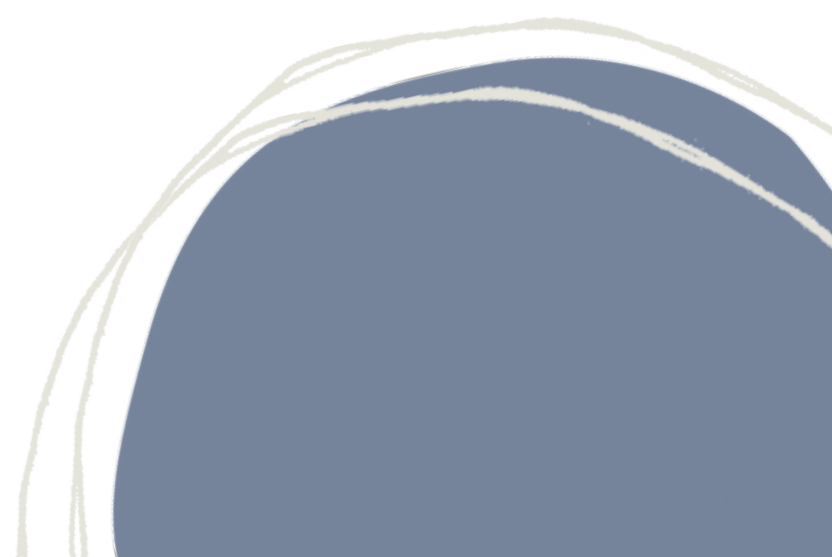
THE SIX CORE STRATEGIES

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. This document *Ensuring safety in care and safety for staff in Australian mental health services* has been developed to provide guidance and a systemic approach to 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. This will be achieved by working through the Australian adaption of the 6 Core Strategies© which provides a step by step checklist for service reflection and reform.





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 identify 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
<p>1. Does the organisation and service mission/vision statement, philosophy, and core values reflect the intent of seclusion reduction initiatives?</p>	<p>Evidence of congruency with principles of recovery, trauma informed systems, violence and coercion-free safe environments for service users and staff.</p>		
<p>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?</p>	<p>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."</p>		
<p>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?</p>	<p>Plan includes:</p> <ul style="list-style-type: none"> 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
<p>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?</p>	<p>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.</p>		
<p>5. Are all staff aware of the role and responsibility of the general manager or service leader to direct seclusion and restraint reduction initiatives?</p>	<p>Evidence of senior level involvement in motivating staff including commitment from the service clinical director.</p> <p>A "kickoff" event for the rollout of this initiative is recommended or a celebration if the service is already involved in a reduction effort.</p> <p>This step calls for active, routine and observable activities such as the inclusion of status report at all management meetings.</p>		
<p>6. Has leadership evaluated the impact of reducing seclusion and restraint on the whole environment?</p>	<p>Potential issues are identified such as:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Recognition for staff for strengths and achievement of goals mirrors recovery and values-based service philosophies and role models good practices.</p>		
<p>8. Does the executive/senior leadership approved seclusion and restraint reduction plan delegate tasks and hold people accountable through routine reports and reviews?</p>	<p>Regular reporting in executive/senior management meetings of progress and updates.</p>		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
<p>9. Has leadership addressed staff culture issues, training needs and attitudes? (See also Workforce Development)</p>	<p>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).</p> <p>Survey of what staff want from their service and how to go about achieving this – training to reinforce this.</p> <p>Survey of what staff see as organisational values and how they demonstrate those.</p>		
<p>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?</p>	<p>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.</p>		
<p>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?</p>	<p>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.</p> <p>Institute formal “rounding” where people's emotional states are regularly observed.</p>		
<p>12. Has service leadership ensured service user inclusion, leadership and perspectives are part of all seclusion and restraint reduction plans, initiatives and evaluations?</p>	<p>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.</p>		
<p>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?</p>	<p>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.</p>		
<p>14. Has service leadership ensured family inclusion and perspectives in seclusion and restraint reduction initiatives?</p>	<p>Family and kinship perspectives and input are included, Champion for change identified.</p>		

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
<p>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?</p>	<p>Access to individual staff member data is restricted and may include access for supervisors, team leaders, managers and workforce development leaders.</p>		
<p>5. Is the service able to observe and record “near misses” and the processes involved in those successful events?</p>	<p>Collection of this information would be used to support learning of best practices to reduce seclusion and restraint.</p> <p>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.</p> <p>This can also inform a recognition of positive staff interventions initiative.</p>		

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
<p>4. Has the service insured education/ training for staff at all levels in theory and approaches of seclusion and restraint reduction?</p>	<p>Includes but not limited to:</p> <ul style="list-style-type: none"> 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 		
<p>5. Has the service encouraged staff to explore unit “rules” with an eye to analysing these for logic and necessity?</p>	<p>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.</p> <p>Solutions may include:</p> <ul style="list-style-type: none"> a) Time at staff meetings to explore this topic b) Regular reviews by staff c) Encouragement of staff feedback and initiatives 		
<p>6. Has the service addressed staff empowerment issues?</p>	<p>Includes:</p> <ul style="list-style-type: none"> a) Staff having input into rules and regulations b) Allowing staff discretion for flexibility within defined parameters 		
<p>7. Does the service support staff empowerment?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>9. Has the service included Human Resources in the planning and implementation of workforce development seclusion and restraint reduction efforts?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>1. Has the service implemented assessment tools to identify risk factors for inpatient incidents of aggression and violence?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>2. Has the service implemented assessment tools on the most common risk factors for death or serious injury caused by restraint use?</p>	<p>Assessments include:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Service user assessments include opportunities to identify any trauma history. Staff are trained in trauma-informed practices.</p> <p>Staff understand that untreated trauma can lead to mental health and physical problems.</p>		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
<p>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?</p>	<p>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.</p>		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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) 		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>10. Does the service have outlined alternatives to seclusion and restraint activities that are included in service user orientation and treatment plans?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>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.</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>2. Has the service used vacant FTE's to create full or part-time roles for older adolescent/adult service user/ consumer positions?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>4. Has the service included service user/consumer leadership in key committees and workgroups throughout the organisation?</p>	<p>This includes service users involved in:</p> <ul style="list-style-type: none"> 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 		
<p>5. Has the service supported service users/consumers to do their service related jobs at the highest level and supported this work?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>6. Has the service implemented service user/consumer satisfaction surveys with systems to effectively use the information gathered?</p>	<p>Includes systems that ensure:</p> <ul style="list-style-type: none"> 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 		
<p>7. Has the service invited external service user leaders, advocates, networks and groups to provide suggestions and be involved in operations?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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 		
<p>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?</p>	<p>Includes:</p> <ul style="list-style-type: none"> 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
<p>1. Has the service revised policy and procedures to include two activities for each event as follows:</p> <ul style="list-style-type: none"> a. Immediate post-event care affect onsite after each event. b. A reflection or discussion and guided learning activity. 	<p>The immediate response should be led by the senior on-site supervisor who immediately responds to that unit or area.</p> <p>The goals of this post-acute event intervention are:</p> <ul style="list-style-type: none"> 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 <p>Post-event care should:</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> » what went wrong » what knowledge was unknown or missed » what could have been done differently » how to avoid in the future. 		
	<p>Cultural consideration is very important as there may be risk of cross-cultural miscommunication or misunderstanding.</p>		

SERVICE OBJECTIVES	EXAMPLES	OBJECTIVE MET	NEXT STEPS
<p>2. Has the service assured the involvement of the service user in all post-event activities either in person or by proxy?</p>	<p>Inclusion of the service user's experience or voice in post-event activities critical.</p> <p>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.</p>		
<p>3. Are the service's post-event policies and procedures clear and specific?</p>	<p>Post-event policies and procedures should cover:</p> <ul style="list-style-type: none"> a) Goals of debriefing b) Who is present c) Responsibilities/roles d) Process e) Documentation f) Follow-up 		
<p>4. Has the service implemented post-event policies and procedure that address staff, service user and observer response and issues?</p>	<p>Post-event activities are critical. Policies and procedures include guidelines and frameworks that cover:</p> <ul style="list-style-type: none"> a) Staff responses and issues b) Service user responses and issues c) Observers responses and issues 		
<p>5. Has the service provided training on how post-event activities will revise treatment planning</p>	<p>Staff training should include using post-event critical information to revise treatment planning including:</p> <ul style="list-style-type: none"> 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 		
<p>6. Does the service assist staff in their individual responses to seclusion and restraint events</p>	<p>This may include:</p> <ul style="list-style-type: none"> a) The use of EAP (Employee Assistance Program) services b) Supervision c) Other staff identified supportive resources 		

REFERENCES

- 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 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 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.
- 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., Tellez, 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.
- 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', *The 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.
- 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.
- 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.
- 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. 2006, 'Six core strategies for reducing seclusion and restraint use©', National Association of

REFERENCES

- 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.
- 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.
- LeBel, J.L., Duxbury, J.A., Putkonen, A., Sprague, 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.
- 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.
- Mohan, D. 2003, 'People's right to safety', *Health and Human Rights*, vol. 6, no. 2, pp. 161-9.
- 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.
- National Mental Health Commission 2015, 'A case for change: Position paper on seclusion, restraint and restrictive practices in mental health services'.
- 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>.

REFERENCES

- NSW Government 2017, *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>>.
- 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.
- 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', *International 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.
- 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 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.
- 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>>.

