Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

Appendices

Appendix A – Comparison of seclusion and restraint laws in Australian jurisdictions

	NSW	A.C.T	VIC	QLD	SA	WA	TAS	NT
Relevant Principles	68 (f) Principles for care and treatment	88 Treatment during detention	11 (1) (a) Mental health principles	Part 2 Principles for administration of Act	7 (b) Guiding principles on providing the least restrictive environment	Schedule 1 – Charter of Mental Health Principles 170 Principles relating to detention 228 Principles relating to use of bodily restraint	Schedule 1 (b) least restrictive care	
Definitions			3 Definitions relating to Seclusion and Bodily restraint	268 (1) Meaning of physical restraint 13 Meaning of less restrictive way	Preliminary—Part 1 Restrictive practices includes (a) the use of physical mechanical or chemical restraint (b) the use of seclusion	4 Treatment does not include bodily restraint, seclusion 212 Seclusion meaning 227 Bodily restraint meaning	3 Interpretation Definition of chemical restraint, restraint, and seclusion	61 (1) Mechanical restraint 62 (16) Seclusion of patients

	NSW	A.C.T	VIC	QLD	SA	WA	TAS	NT
Powers to restrain, seclude	81 General transport provisions authorise the restraint of persons in any way that is reasonably necessary in the circumstances.	114 (5) Powers to restrain in relation to forensic community care order 144D (5) (b) Power to apprehend if person escapes from secure mental health facility and the requirement to record the nature and extent of any restraint, involuntary seclusion 65 (2) (b) Powers of the chief psychiatrist to authorise psychiatric treatment including seclusion 73 (2) (c) Powers in relation to community care order to subject persons to involuntary seclusion			34 Confinement and other powers relating to involuntary inpatients includes seclusion and restraint	213. Seclusion must be authorised 229. Bodily restraint must be authorised Regulations 14 Specific powers of mental health advocates to record seclusion and restraint (Act s. 359(1)(g))	Part 5, Division 3. Powers to use Force, seclusion and restraint	30 (4) (a) (b) Mechanical restraint and seclusion powers during detention by medical practitioner or nurse 62 I (2) (1) Use of restraint during detention by ambulance officer

	NSW	A.C.T	VIC	QLD	SA	WA	TAS	NT
Examination, observation, monitoring, of seclusion and restraint		(3) Requirement for examination in each 4-hour period in seclusion	112 (3) (4) Requirement to monitoring persons in seclusion not less frequently than every 4 hours	256 Requirements for seclusion of relevant patients		222 (3) (4) Requirements to observe every 2 hours in seclusion 223, 239 Requirements to examine persons released from seclusion or restraint 238 Requirements to review bodily restraint t every 30 minutes and 6 hours by psychiatrist	56 (2), 57 (2) Requirements to clinically observe, examine seclusion and restraint every 15 minutes, and examination every 4 hours.	(b) Requirement to review seclusion by a psychiatric practitioner (7)(c) Requirement to examine a person in mechanical restraint at intervals not longer than 4 hours; (8) (a) (b) requirement for observation of restraint
External review mechanisms		83 (1) Authorised persons and facilities to record the nature and extent of any restraint, seclusion or forcible giving of medication used and inform the public advocate		264 Requirement for a seclusion and restraint reduction and elimination plan for patients		224, 240 Requirement to report seclusion and restraint to Chief Psychiatrist and the Mentally Impaired Accused Review Board	58 (2) (b) (3) & 187, Requirements relating to Tribunal review of seclusion and restraint	

	NSW	A.C.T	VIC	QLD	SA	WA	TAS	NT
Reporting and recording of seclusion and restraint		73 (4) Recording of restraint, involuntary seclusion by care coordinator 73 (5) Recording of restraint, involuntary seclusion by the chief psychiatrist 144D (5) (b) (6) (b) Recording of restraint, involuntary seclusion by Director – General and Authorised persons. 266. Requirement to report and record of use of restraint		224 Requirement to report to the Chief Psychiatrist and Mentally Impaired Accused Review Board when persons released from seclusion 240 Requirement to report to the Chief and Mentally Impaired Accused Review Board when persons released from restraint		222 (3) (4) Requirements to record seclusion and the examination of persons released from seclusion 216(1) Requirement to record continuation of seclusion 221 Requirement to record seclusion order expiring 237 Requirement to record bodily restraint order expiring	96 Records controlling authority must document seclusion, restraint	61 (12) Facilities must record mechanical restraint and seclusion 61 (6) The period the patient is to be kept in seclusion must be noted in the patient's case notes
Authorisation of seclusion and restraint			111 Use of seclusion to be authorised 114 Use of bodily restraint to be authorised 115 Urgent use of bodily restraint without authorisation	256 (2) Requirements and authorisation for seclusion of relevant patients 258 Authorisation of seclusion by authorised doctor	56 (3) Powers of authorised officers extend to restraint	213 -15 Seclusion authorisation and orders 216-19 Criteria for authorisation, revocation and release from seclusion	56 (1) (b) Authorisation of Seclusion 57 (1) (b) Authorisation of Restraint	61 (4) Authorised persons to approve seclusion

	NSW	A.C.T	VIC	QLD	SA	WA	TAS	NT
Authorisation of seclusion and restraint *continued*				261 Removal from seclusion before authorisation ends 267 Seclusion of the relevant patient complies 270 Authorisation of physical restraint		229 – 231 Bodily restraint authorisation 232 – 34 Criteria for authorisation, variation, revocation, and release from bodily restraint.		61 (5) Authorisation notification to senior psychiatric practitioner as soon as practicable
Requirements to extend seclusion				259 Requirement for extension of period of seclusion		218 Requirements of extending seclusion orders	(2) (d) Criteria if seclusion extends beyond 7 hours unless	
Powers of the Chief Psychiatrist		87 Chief Psychiatrist may review treatment		257, 267 Chief psychiatrist may give written directions and approve a reduction and elimination plan	90 Chief Psychiatrist's functions (1) (b) to monitor the use of restrictive practices		147 Power of direct intervention in assessment treatment or care including seclusion, restraint	

Appendix B – Literature review

Literature reviews that have informed the review team's report include:

- Department of Health (2013) *Reducing restrictive interventions: literature review and document analysis.* Melbourne: Department of Health, Victorian Government.
- Gaskin CJ, Elsom SJ, and Happell B (2007) Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. *British Journal of Psychiatry* 191 298-303.
- Melbourne Social Equity Institute (2014) *Seclusion and Restraint Project: report.* Melbourne: University of Melbourne.
- O'Hagan M, Divis M and Long J (2008) *Best Practice in the Reduction and Elimination of Seclusion and Restraint: seclusion: time for change.* Auckland: Te Pou Te Whakaaro Nui
- Te Pou (2014) Do Seclusion Reduction Initiatives Increase Risk to Staff Safety? *An integrative review of evidence of association and causality from 2004 to 2014, with recommendations for practice.* Auckland: Te Pou o Te Whakaaro Nui

Of particular interest were studies that reported the elimination or reduction of seclusion or restraint without an increase in consumer or staff injuries. These include:

- LeBel J and Goldstein R (2005) The economic cost of using restraint and the value added by restraint reduction or limitation. *Psychiatric Services* 56 (9) 1109-1114.
- Lewis M, Taylor K, Parks, J (2009) Crisis prevention management: a program to reduce the use of seclusion and restraint in an inpatient mental health setting. *Issues in Mental Health Nursing* 30 159-264.
- Putkonen A, Kuivalainen S, Louheranta O, et al. (2013) Cluster-randomised controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. *Psychiatric Services* 64 (9) 850-855.
- Smith GM, Ashbridge DM, Altenor A, et al. (2015) Relationship between seclusion and restraint reduction and assaults in Pennsylvania's forensic service centers: 2001-2010. *Psychiatric Services* 66 (12) 1326-1332.
- Wale JB, Belkin GS and Moon R (2011) Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services – improving patient-centered care. *The Permanente Journal* 15 (2) 57-62.

Appendix C – NSW seclusion and restraint indicator definitions

An occupied bed day		An occupied bed is an available bed where there is a patient physically in the bed or the bed is being retained for a patient. This excludes same-day admissions. [NSW Health HIRD]
Stay		The period of time between admission and discharge to a hospital.
NSW HIE		The "Health Information Exchange" – NSW Health's federated network of data warehouses.
Seclusion Rate	Definition	Seclusion episodes per 1000 occupied bed days
	Numerator	Number of seclusion episodes in unit/facility/LHD during the reference period
	Denominator	Number of occupied bed days in the unit/facility/LHD during the reference period
Seclusion Duration	Definition	Average Hours per seclusion episode
	Numerator	Total duration of seclusion episodes in unit/facility/ LHD
	Denominator	Number of seclusion episodes in unit/facility/LHD during the reference period
Seclusion Frequency	Definition	Percent of mental health related admitted care episodes (hospital stays) with at least one episode of seclusion
	Numerator	Number of hospital stays with at least one episode of seclusion during a hospital stay
	Denominator	Total stays in unit/facility/LHD during the period (count of unique stays from data in the NSW HIE at a unit level)

Appendix D – NSW Health annual report 2016–17, Mental health seclusion

Table 2. Rates of 28 day re-admission, seven day post discharge and seclusion rate, duration and frequency in mental health service

LOCAL HEALTH DISTRICT/NETWORK/ HOSPITAL	28 DAY READMISSION RATE 2016-17 (%)[1]	7 DAY POST-DISCHARGE COMMUNITY CARE RATE 2016-17 (%)[2]	SECLUSION RATE 2016-17[3]	SECLUSION AVERAGE DURATION 2016-17[4]	SECLUSION FREQUENCY 2016-17(%)[5]
X170 Justice Health[6]	**15.1**	**23.4**			
Forensic Hospital	5.0	40.0			
Long Bay	14.1	26.6			
Metropolitan Remand and Reception Centre	16.7	22.7			
Mulawa	13.4	19.8			
X630 Sydney Children's Hospitals Network	**20.0**	**68.5**	**3.3**	**0.6**	**2.5**
Children's Hospital at Westmead	18.2	70.3	0.8	0.2	1.1
Sydney Children's	23.2	65.3	5.8	0.6	4.8
X690 St Vincent's Health Network	**14.7**	**57.9**	**6.1**	**2.4**	**4.2**
St Joseph's	9.6	67.5			
St Vincent's	15.1	57.1	8.1	2.4	4.6
X700 Sydney Local Health District	**16.2**	**73.9**	**8.0**	**6.4**	**5.6**
Concord	15.2	73.1	9.4	7.2	7.4
Royal Prince Alfred	17.7	75.2	4.8	2.7	2.7
X710 South Western Sydney Local Health District	**14.9**	**67.3**	**9.4**	**2.9**	**6.1**
Bankstown	14.7	70.2	12.5	2.2	10.6
Bowral[7]	0	66.7			
Campbelltown	15.1	67.8	6.8	1.7	4.7
Liverpool	14.7	65.5	10.8	4.1	5.8
X720 South Eastern Sydney Local Health District	**14.8**	**83.9**	**5.7**	**2.9**	**3.8**
Prince Of Wales	12.0	78.5	6.9	3.5	4.7
St George	18.8	88.2	1.4	2.6	1.3
Sutherland	13.6	86.5	7.8	1.5	5.5
X730 Illawarra Shoalhaven Local Health District	**13.3**	**80.8**	**5.6**	**4.2**	**4.4**
Shellharbour	13.9	78.7	7.4	5.0	5.4
Wollongong	12.4	83.9	3.3	1.9	2.8
X740 Western Sydney Local Health District	**15.1**	**64.7**	**10.4**	**11.4**	**8.6**
Blacktown	15.6	63.9	14.1	7.7	7.2
Cumberland	16.1	66.4	11.2	13.6	10.9
Westmead	9.9	60.6	2.7	2.7	1.4
X750 Nepean Blue Mountain Local Health District	**16.1**	**58.8**	**5.1**	**4.0**	**3.4**
Blue Mountains	15.9	57.3	1.8	1.1	1.9
Nepean	16.2	59.2	5.8	4.3	3.7
X760 Northern Sydney Local Health District	**13.0**	**83.5**	**3.8**	**3.9**	**3.5**
Greenwich	6.6	77.0			
Hornsby	11.1	87.1	7.5	4.1	6.4
Macquarie	19.0	77.6	1.3	5.1	2.4
Manly	14.5	82.9	2.8	3.6	2.6
Royal North Shore	13.6	82.2	2.0	2.5	1.6
X770 Central Coast Local Health District	**12.8**	**79.4**	**4.8**	**2.6**	**5.1**
Gosford	15.1	77.9	4.6	1.1	4.4
Wyong	11.5	80.4	5.0	3.3	5.6
X800 Hunter New England Local Health District	**13.2**	**74.3**	**7.8**	**4.6**	**3.9**
Armidale	12.0	96.7			
Hunter New England Mater	14.9	75.6	9.8	5.5	3.9
John Hunter	10.3	88.0	6.7	0.4	4.7
Maitland	10.1	58.8	8.6	3.1	6.0
Manning	9.3	83.6	1.4	2.0	2.1

Appendix D – NSW Health annual report 2016–17, Mental health seclusion

LOCAL HEALTH DISTRICT/NETWORK/ HOSPITAL	28 DAY READMISSION RATE 2016-17 (%)[1]	7 DAY POST-DISCHARGE COMMUNITY CARE RATE 2016-17 (%)[2]	SECLUSION RATE 2016-17[3]	SECLUSION AVERAGE DURATION 2016-17[4]	SECLUSION FREQUENCY 2016-17(%)[5]
Morisset	6.1	81.8	1.6	1.9	2.1
Tamworth	14.7	64.7	7.2	2.3	4.3
X810 Northern NSW Local Health District	**15.6**	**69.7**	**8.0**	**7.7**	**6.8**
Byron Central	17.4	60.9			
Lismore	16.7	67.0	8.4	9.3	6.4
Tweed	13.9	74.1	9.6	5.7	7.9
X820 Mid North Coast Local Health District	**17.0**	**80.4**	**6.5**	**10.5**	**5.4**
Coffs Harbour	14.8	87.0	8.7	10.5	8.1
Kempsey	22.4	77.6			
Port Macquarie	17.3	69.1	6.8	10.4	4.4
X830 Southern NSW Local Health District	**13.7**	**11.4**	**1.7**	**0.9**	**1.1**
Goulburn	13.4	13.8	1.6	0.8	0.9
South East Regional	14.5	6.2	2.0	1.1	1.6
X840 Murrumbidgee Local Health District	**9.7**	**81.6**	**9.2**	**2.8**	**5.4**
Wagga Wagga	9.7	81.6	9.2	2.8	5.4
X850 Western NSW Local Health District	**11.4**	**60.2**	**6.5**	**1.2**	**4.0**
Bathurst	5.6	62.8			
Dubbo	11.6	69.5	4.4	2.2	2.8
Orange Health Service	13.8	52.4	8.7	1.0	5.3
X860 Far West Local Health District	**14.8**	**70.4**	**6.3**	**3.3**	**5.1**
Broken Hill	14.8	70.4	6.3	3.3	5.1
NSW – TOTAL	**14.4**	**70.0**	**7.0**	**5.5**	**4.9**
2015-2016	14.8	66.0	8.8	5.3	6.0
2014-2015	15.0	63.3	8.3	5.8	5.8
2013-2014	14.3	65.6	7.9	6.0	5.5
2012-2013	14.7	59.5	8.9	6.9	6.1

Definitions: 1 Overnight separations from acute psychiatric inpatient units that are followed by re-admission to the same or another acute psychiatric unit. 2 Overnight separations from acute psychiatric inpatient units for which a community mental health contact, in which the client participated, was recorded in the seven days following that separation. 3 Rate: Acute seclusion episodes per 1000 bed days. 4 Duration: Average duration of acute seclusion episodes (hours per episode). 5 Frequency: Percentage of acute mental health hospital stays where seclusion occurred. Notes: 3, 4, 5 Some facilities with acute mental health beds do not have seclusion rooms: Bowral, Greenwich (Riverglen), Kempsey, Armidale, Bathurst, Byron Central and St Joseph's. These contribute to the calculation of Local Health Districts/Specialty Health Networks and State Seclusion figures. 6 Forensic beds are not included in Acute Seclusion, NSW figures. 7 Bowral had three separations in the period with zero re-admission.

Appendix E – Terms of reference

Background

The NSW Mental Health Act (2007) and existing policy require that NSW Health staff undertake all possible measures to prevent and minimise disturbed or aggressive behaviour, and reduce the use of restrictive practices such as seclusion and restraint.

The Act requires that (s68)

- people with a mental illness or mental disorder receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, and that
- any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.

For the great majority of people with a mental illness or disorder, treatment is most appropriately provided in the community. For those whose problems are more severe and complex, treatment in a hospital inpatient unit may be indicated for a limited period of time. This is more likely where more intensive treatment is required to keep the person and those around them safe.

The existing NSW Health Policy Aggression, Seclusion and Restraint in Mental Health Facilities in NSW emphasises the role of prevention and the use of a range of therapeutic interventions in reducing seclusion and restraint.

Terms of the review

In relation to the seclusion, restraint and observation of mental health consumers in NSW Health facilities and services, this review will:

1. Consider whether existing legislation, policy, clinical governance and oversight, principles and practice standards are consistent with national standards, leading evidence and international best practice principles, and the expectations of consumers and the community
2. Examine the application of existing mental health legislation, policy, clinical governance and oversight, principles and practices, and the extent to which these have been adhered to across NSW Health facilities with acute mental health units, mental health intensive care units and declared emergency departments.
3. Taking into consideration the findings at (1) and (2), make recommendations for amendment to
   i. legislation
   ii. policy
   iii. reporting
   iv. clinical governance and oversight
   v. practice standards; and
4. Make recommendations for any system capability building required to support clinical and non-clinical staff to implement any proposed legislation, policy or practice changes.

Governance

The Review will be undertaken by an expert panel led by the NSW Chief Psychiatrist.

A review team has been appointed, comprised of:

1. Dr Murray Wright, Chief Psychiatrist
2. Ms Karen Lenihan, Principal Official Visitor
3. Dr Kevin Huckshorn, CEO, Huckshorn and Associates
4. Ms Julie Mooney, Executive Director, Nursing and Midwifery, Southern NSW LHD
5. Dr Robyn Shields, Deputy Commissioner, NSW Mental Health Commission
6. Ms Jackie Crowe, Commissioner, Australian Mental Health Commission (consumer representative)

Dr Wright will report to the Secretary, Ministry of Health.

The Secretary will report on progress and outcomes of the review to the Minister for Mental Health and the Minister for Health. The Secretary will engage with the Mental Health Commission of NSW at key points through the review process.

Appendix E – Terms of reference

Methodology

The review will:

- undertake site visits to NSW hospitals with acute mental health units, mental health intensive care units and declared emergency departments
- undertake a review of a sample of cases which involved the seclusion of a consumer with a mental illness or disorder, to determine the extent to which existing legislation, policy, clinical governance and oversight, and practice standards have been applied
- undertake review and analysis of the existing NSW policies (including revised policy on restrictive practices, and consumer observations, which are currently under review), legislation and practice, and leading evidence and international best practice
- call for written submissions, and undertake thematic analysis
- facilitate face to face consultations with key stakeholders through one-to-one meetings and consultation workshops with key stakeholders, including bodies that are representative of people with a lived experience of mental illness and their families or carers
- make a recommendation on a pathway for the reduction of seclusion and restraint practices in NSW
- provide a final report and recommendations.

Timeframe

The review will report to the Minister for Mental Health and the Minister for Health by Friday 8 December 2017.

Appendix F – Review team

Dr Murray Wright

Chief Psychiatrist,
NSW Ministry of Health

Dr Murray Wright is a graduate of the University of Sydney Medical Faculty, completed his post graduate training in Psychiatry in South Eastern Sydney, and has worked in a range of metropolitan, rural and regional centres, as a clinician and, increasingly over the last 10 years, in various leadership roles, including Director of Mental Health services and, since October 2014, NSW Chief Psychiatrist.

His clinical interests include consultation-liaison psychiatry, emergency psychiatry, psychiatric and substance misuse comorbidity, and psychiatric impairment among health professionals and police officers.

Dr Wright has had a longstanding interest in service improvement, quality and governance, and played a significant role in the introduction of the first Maintenance of Professional Standards program by the RANZCP in the early 1990s.

In addition to his public sector roles, Dr Wright has maintained a private practice since 1990, with a focus latterly on general adult psychiatry, and assessment and treatment of health professionals and police.

Dr Wright has also worked in a consultant capacity with the Medical Council of NSW in a number of roles over the last 20 years, including the provision of assessment reports as a Council Appointed Psychiatrist, participation as a Performance Assessor, and as a panellist for the Impairment Programme, Professional Standards Committees and Section 150 Hearings. He is a Peer Reviewer for the HCCC and a part-time member of the NSW Medical Tribunal.

Dr Wright was the Chair, Psychiatry State Training Committee HETI from 2007-13, and has had a number of roles with the RANZCP, including membership of the Quality Assurance Committee 1990-95, Exams Committee 1996-02, Exemptions Sub-committee 1996-05, Consultation-Liaison Working Party 1992-94, NSW Branch Rural Psychiatry Steering Group 2002-08.

Dr Wright's role as NSW Chief Psychiatrist includes an oversight of quality and safety for mental health services, investigation/ review of critical incidents associated with mental health services, and contributing to improvements in patient safety.

Appendix F – Review team

Ms Jackie Crowe

Commissioner, National Mental Health Commission

Jackie was dedicated to encouraging greater understanding, compassion and respect for people affected by mental ill health, the suicidal mind and the families, friends and carers who journey with them. Jackie had been involved in mental health and suicide prevention issues in various advocacy, advisory, public speaking, research, consultancy and commissioner roles – at the local, state, national and international levels over many years.

Jackie worked to help create a better world that values all people, social justice and ends discrimination. Her work had always been grounded in the perspectives of people affected by mental ill health and suicidal concerns. She was solution focused and had an enthusiastic vision about what is possible. She enjoyed engaging in differing opinions and views which informed her work.

Jackie combined her lived experience, understanding of the grass roots and knowledge of high level strategic policy and planning, with her familiarity with recovery and well-being to shift thinking about mental ill health and suicide.

Dr Kevin Huckshorn

Chief Executive Officer

Kevin Huckshorn is CEO of a behavioural health consulting business, Kevin Huckshorn & Associates, Inc. that she initiated in December of 2014. This consulting business has expertise in organizational analysis and development; behavioural health administration (community and hospitals); substance use disorders/addictions; meeting facilitation and organizational mediation; recovery-oriented systems of care; trauma-informed practice integration including the reduction of seclusion and restraint; peer-run program implementation; behavioural health workforce development; and ADA/Olmstead services implementation.

Dr. Huckshorn is currently serving as the Executive Director for Clinical Services at Bridgewater State Hospital, Bridgewater MA. This work is the result of a successful response to a MA Department of Correction by Correct Care Recovery Solutions [CCS, Inc.] and includes turning this infamous prison hospital into a state mental health facility.

Dr. Huckshorn served as the past Director of the Division of Substance Abuse and Mental Health (DSAMH) for the state of Delaware (2009-2014). The position oversaw the planning, program development, fiscal responsibilities, contractual obligations, contract monitoring, licensure, federal block grants, operations of the state mental health hospital, and all DSAMH community provider contractors. Dr. Huckshorn was also the lead on the DE USDOJ Settlement Agreement (signed in 2011) and, in that role, was able to lead Delaware toward substantial compliance, along with her team, with the targets in that settlement agreement by October of 2014.

Appendix F – Review team

Dr. Huckshorn is a licensed and certified mental health nurse and substance abuse clinician with practical knowledge from 38 years of professional frontline experience working in a variety of public and private behavioural health organizations and substance abuse programs. She has extensive experience in both inpatient and outpatient program development, including developing and managing peer-run projects; leading state hospital service re-design; and directing recovery-based mental health and substance abuse services. She is published on adult and youth topics including violence, treatment adherence, trauma-informed care, and workforce development. She serves on the editorial board of one U.S. peer reviewed mental health-nursing journal and consults with two others; and co-authored a book with William Anthony, PhD, titled "Principled Leadership in Mental Health Systems and Programs" (2008).

Dr. Huckshorn was the past Director of the Office of Technical Assistance for the National Association of State Mental Health Program Directors and the National Coordinating Center for Seclusion and Restraint Reduction where she led the development of an evidence-based model to prevent violence and the use of seclusion and restraint titled "Six Core Strategies" that is on the federal NREPP database of approved models (2001-2009). Dr. Huckshorn has also worked internationally in Canada, Finland, United Kingdom, United Kingdom, Ireland, New Zealand and Australia on issues related to seclusion and restraint, trauma-informed care, compliance with the ADA and Olmstead, and implementing recovery-oriented systems of care.

Ms Karen Lenihan

Principal Official Visitor

Karen Lenihan is the Principal Official Visitor for New South Wales under the NSW Mental Health Act 2007. She has held this position since February 2016.

With a background working as a clinician, educator, manager and executive, Ms Lenihan has broad working experience in health service delivery and policy. Her prior positions include Executive Director of Nursing and Midwifery for the former Greater Southern Area Health Service, Director of Alcohol, other Drugs and Corrections Health at ACT Health and Manager, Population Health in NSW Health. In these roles, the dominant focus was on service improvement and reorientation toward excellence in patient care.

Initially she trained as a general registered nurse and then a psychiatric registered nurse in the UK before moving to Australia. She then gained a social science degree (BSocSc) with majors in political science and sociology, a management master degree (MBA) with a major in human resource management and a postgraduate degree in mental health practice (GradCertMentalHealthPrac). She is also trained as a women's health nurse with specialisation in the area of domestic violence.

She recently spent several years at Charles Sturt University where she focused on organisational development and change management. Having now returned to work in Health, this experience has enhanced her knowledge base and broader her capacity to achieve effective results in reform and change environments.

Ms Lenihan's career is characterised by her work with fringe populations who experience high levels of social stigma and disadvantage. She is passionate about quality service provision, is a strong advocate for social justice and believes in equity of access to the resources available in contemporary society.

Appendix F – Review team

Ms Julie Mooney

Executive Director, Nursing and Midwifery, Southern NSW LHD

Julie Mooney has extensive experience in leadership positions and mental health service delivery. She has participated in a number of complex external clinical reviews. She originally trained as a mental health nurse in Goulburn and currently holds the position of Executive Director, Nursing and Midwifery at Southern NSW Local Health District.

Dr Robyn Shields AM

Deputy Commissioner, NSW Mental Health Commission

Growing up in the shadow of an asylum, Dr Robyn Shields' first impression of mental illness was that it was about being locked away and was not to be discussed.

"I didn't know what asylums were about until I found myself having a professional career in mental health," recalls Dr Shields of the asylum, which is now closed. " I was amazed and traumatised by seeing first hand the treatment mentally ill people were given in those days. It was awful."

Dr Shields has worked in the mental health sector for many years and is now undertaking specialist training as a psychiatry registrar.

Since her career started in mental health, Shields has concentrated on raising the status of people experiencing mental illness in the public consciousness, talking about trauma informed care and recovery, as well as developing new models of care for mentally ill people for the most disadvantaged groups, particularly Aboriginal people and forensic patients. "I'm interested in breaking the cycles and patterns of dysfunction in the mental health system."

As a proud Aboriginal woman, Dr Shields is acutely aware of the need for communities to design and control their own services, "because of distrust from a long history of disappointments and oppression from government departments and particularly in mental health," she says. "There's no easy fix, but it's essential it never gets put off the government's agenda."

Appendix G – Community consultation handout

Review of seclusion, restraint and observation – Community Consultation

We understand that sharing your experiences about seclusion and restraint can be distressing. If you need support there are a number of places you can contact:

- **NSW Mental Health Access Line 1800 011 511**
  For people in NSW this 24/7 state-wide line will connect you to a mental health professional who can provide support and referral to services in your local area.
- **Lifeline 13 11 14**
  Anyone across Australia experiencing a personal crisis or thinking about suicide can contact Lifeline for support.
- **NSW Carer Line 1800 242 636**
  If you are looking after someone with a mental illness and you need support you can contact the Carer's NSW Line (9am – 5pm, Monday to Friday).
- **Being**
  If you would like further information on mental health advocacy please contact Being at http://being.org.au/ or 9332 0200.
- **Mental Health Carers NSW**
  If you would like further information on mental health carer advocacy or support services please contact Mental Health Carers NSW Inc., at http://www.arafmi.org/ or 1300 554 660.

If you would like to make a **written submission** details about how to do this can be found on the NSW Health Website http://www.health.nsw.gov.au/patients/mentalhealth/Pages/default.aspx

If you have specific concerns about the quality of the health care provided to you or your family this should be raised directly with the Local Health District or Speciality Health Network. Alternatively you can contact the Health Care Complaints Commission https://www.hccc.nsw.gov.au/ or 1800 043 159.

NSW Ministry of Health
ABN 92 697 899 630
73 Miller St North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Tel. (02) 9391 9000 Fax. (02) 9391 9101
Website. www.health.nsw.gov.au

Appendix H – Community consultation follow-up letter

Name
Position
Organisation
Address
Suburb STATE Postcode

Our ref H17/61402

Dear

Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

Thank you for coming to the <Insert Name> community consultation for the review of seclusion, restraint and observation.

This review is looking at how the system is currently operating, what has been achieved and the barriers and enablers to further reducing seclusion and restraint. It will not be investigating particular incidents or services.

The review is gathering information in a number of ways including

- Reviewing the literature about what works and what doesn't
- Hearing from other states and countries where they have reduced seclusion and restraint while still maintaining consumer and staff safety
- Reviewing the results of a detailed audit of practice completed by all acute mental health units and declared emergency departments
- Hearing from consumers and their carers and families about their experiences at 10 community consultations across NSW
- Hearing from individuals and organisations who make a written submission
- Talking with mental health and emergency department leadership and front line staff during site visits to hospitals.

This information will be used to make recommendations to support services to reduce the use of seclusion and restraint. The final report will not identify individuals or services. The terms of reference for this review contain more information about the review and its methodology. These are available at http://www.health.nsw.gov.au/patients/mentalhealth/Pages/terms-of-reference.aspx

If you would like to make a written submission, details about how to do this can be found on the NSW Health Website http://www.health.nsw.gov.au/patients/mentalhealth/Pages/default.aspx. Written submissions will be accepted until 24 September 2017.

If you have specific concerns about the quality of the health care provided to you or your family you can contact the Local Health District or Specialty Health Network directly. <Insert Name> Local Health District can be contacted at <insert contact details>.

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Alternatively you can contact the Health Care Complaints Commission https://www.hccc.nsw.gov.au/ or 1800 043 159.

We understand that sharing your experiences about seclusion and restraint can be distressing. If you need support there are a number of places you can contact:

- **NSW Mental Health Access Line 1800 011 511**
  For people in NSW this 24/7 state-wide line will connect you to a mental health professional who can provide support and referral to services in your local area.
- **Lifeline 13 11 14**
  Anyone across Australia experiencing a personal crisis or thinking about suicide can contact Lifeline for support.
- **NSW Carer Line 1800 242 636**
  If you are looking after someone with a mental illness and you need support you can contact the Carer NSW Line (9am – 5pm, Monday to Friday).
- **Being**
  If you would like further information on mental health advocacy you can contact Being at http://being.org.au/ or 9332 0200. Being is the peak organisation for people with a lived experience of mental illness in NSW.
- **Mental Health Carers NSW**
  If you would like further information on mental health carer advocacy or support services you can contact Mental Health Carers NSW Inc., at http://www.arafmi.org/ or 1300 554 660.

Yours sincerely

Dr Murray Wright
NSW Chief Psychiatrist

[INSERT THE DATE]

Appendix I – Self-audit

Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities Self-Audit June 2017

Hospital: _____

Unit: _____

Person Completing Audit: _____

Phone Number: _____

Email: _____

I _____ Mental Health Director have reviewed and endorsed the responses in this self-audit

(Name)

_____

(Signature & Date)

Table of contents

Background

In May 2017 the Minister for Health and the Minister for Mental Health announced a review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities.

The review will:

1. Consider whether existing legislation, policy, clinical governance and oversight, principles and practice standards are consistent with national standards, leading evidence and international best practice principles, and the expectations of consumers and the community
2. Examine the application of existing mental health legislation, policy, clinical governance and oversight, principles and practices, and the extent to which these have been adhered to across NSW Health facilities within acute mental health units, mental health intensive care units and declared emergency departments
3. Taking into consideration the findings at (1) and (2), make recommendations for amendment to
   i. legislation
   ii. policy
   iii. reporting
   iv. clinical governance and oversight
   v. practice standards; and
4. Make recommendations for any system capability building required to support clinical and non-clinical staff to implement any proposed legislation, policy or practice changes.

As part of this review Local Health Districts (LHDs) and Speciality Health Networks (SHNs) are requested to complete an audit of their current practice and governance in relation to seclusion, restraint and observations for all acute mental health units, mental health intensive care units and declared emergency departments.

The terms of reference for the review can be found at http://www.health.nsw.gov.au/patients/mentalhealth/Pages/default.aspx

Completing the self-audit

Who should complete the self-audit

This self-audit should be completed by at least one member of the leadership team of the acute mental health unit/mental health intensive care unit/emergency department. This could include the Nursing Unit Manager or Clinical Director.

How to complete the tool

This tool has been designed to be completed in Microsoft Word. It should be completed at the unit/ward level not hospital level. Each unit should complete sections 1 to 9.

Emergency departments also need to complete section 10 "Emergency Departments". If there is a question that is not relevant for the unit/ward then simply write N/A.

Who should review and endorse the results

It is important that after this audit has been completed that the LHD/SHN Mental Health Director reviews and endorses the responses prior to submission to the NSW Mental Health Branch.

For multiple choice questions highlight the correct response in the "**Response**" column.

The "**Details**" column is to answer open ended questions and provide context to the response and answer the questions in italics.

The "**Evidence**" column is where all evidence to support responses needs to be listed. In Appendix 1 there is a list of possible evidence. These are suggestions and should be used as a guide not an exhaustive list. Additional sources of evidence are encouraged.

1. Governance

Ref	Question	Response	Details	Evidence
1.1	Does the unit have any local policies/ procedures/guidelines for seclusion and/or restraint?	Yes No		☐
1.2	Does the unit have any local policies/ procedures/guidelines for trauma informed care?	Yes No		☐

Where you have answered NO please provide context for this response in the details column.

Examples of evidence

When submitting the self-audit please include all relevant evidence, however if you are referring to a NSW Health document you only need to provide the document number.

In this audit we have included examples of possible evidence to support a unit's response. It is not intended to be an exhaustive list and there may be other evidence that a unit wishes to include.

At the end of this document there is a list of possible evidence that can be used like a checklist prior to submission. There is also space to add any additional evidence that is being included.

If you are including photos as evidence please ensure that there are no consumers in the photos. If any evidence has identifying information about consumers please redact the identifying information.

How to submit the audit

Once you have completed the audit and the Mental Health Director has reviewed and endorsed the response please ensure that the audit is sent back as a **word document,** if you need to PDF the document for signature then also include the Microsoft Word version.

Key definitions and **documents** can be found at the end of this document in Appendix 2 and 3.

Self-audit

Self-Audit Tool Sections

1. Governance
2. Data
3. Unit & Unit Processes
4. Seclusion
5. Seclusion Rooms/Areas/Safe Assessment Rooms
6. Restraint
7. Observations
8. Training
9. Staffing
10. Emergency Departments (only completed by Emergency Departments)

How to Complete the Tool

For multiple choice questions highlight the correct response in the "**Response**" column.

The "**Details**" column is to answer open ended questions and provide context to the response and answer the questions in italics.

The "**Evidence**" column is where all evidence to support responses needs to be listed. In Appendix I there is a list of possible evidence. These are suggestions and should be used as a guide not an exhaustive list. Additional sources of evidence are encouraged.

1. Governance

Ref	Question	Response	Details	Evidence
1.1	Does the unit have any local policies/ procedures/guidelines for seclusion and/or restraint?	Yes No		☐
1.2	Does the unit have any local policies/ procedures/guidelines for trauma informed care?	Yes No		☐

1. Governance

Ref	Question	Response	Details	Evidence
1.1	Does the unit have any local policies/ procedures/guidelines for seclusion and/or restraint?	Yes No		☐
1.2	Does the unit have any local policies/ procedures/guidelines for trauma informed care? *List the names of the documents*	Yes No		☐
1.3	Does the unit have any local policies/ procedures/guidelines regarding observations? *List the names of the documents*	Yes No		☐
1.4	Does the unit conduct incident reviews (as defined in PD2012_035)? *List the positions of all people involved*	Yes No		☐
1.5	Who facilitates the incident review? *List the position of the person*	Yes No		☐
1.6	Do peer workers participate in incident reviews? *Describe their role*	Yes No		☐
1.7	Does the unit conduct collaborative reviews (as defined in PD2012_035)? *List the positions of all people involved*	Yes No		☐
1.8	Who facilitates the collaborative review? *List the position of the person*	Yes No		☐
1.9	Do peer workers participate in collaborative reviews? *Describe their role*	Yes No		☐
1.10	Are consumers offered the opportunity to engage with a peer worker to write a post incident narrative? *Describe the process and what happens with the narrative once completed*	Yes No		☐
1.11	Are learnings from incident reviews shared with staff? *List the different ways the learnings are shared*	Yes No		☐
1.12	Is the safety plan or similar document used routinely? *Describe when during a consumer's admission the consumer completes the form and how it is communicated to staff*	Yes No		☐

1. Governance *continued*

Ref	Question	Response	Details	Evidence
1.13	Do any committees discuss the unit's seclusion and/or restraint performance? *List all committees where seclusion and/or restraint are discussed either as an adhoc or regular item*	Yes No		☐
1.14	What generates a discussion about seclusion and/or restraint performance at a committee? *For each committee describe what would initiate a discussion*	Yes No		☐
1.15	Are achievements or "wins" with seclusion and restraint reduction discussed at any committees? *Describe the process for these discussions occurring*	Yes No		☐
1.16	Are learnings from complaints used to improve practice? *Describe how you share the outcomes of complaints to improve practice*	Yes No		☐
1.17	Are learnings from incidents used to improve practice? *Describe how you share the outcomes of incidents to improve practice*	Yes No		☐
1.18	Is there a relationship between the LHD/SHN Director of Nursing and Midwifery and the unit? *Describe the reporting relationship to the LHD/SHN Director of Nursing and Midwifery. Describe what situations would be escalated to the LHD/SHN Director of Nursing and Midwifery*	Yes No		☐
1.19	Is clinical supervision offered to medical staff? *State the frequency of sessions, duration of sessions, who facilitates the sessions and what staff attend (e.g. JMOs, Registrars, Consultants, Nursing Staff, Allied Health)*	Yes No		☐
1.20	Is clinical supervision offered to nursing staff? *State the frequency of sessions, duration of sessions, who facilitates the sessions and what staff attend (e.g. RNs, EENs, CNCs, CNEs, NUM, Medical Staff, Allied Health)*	Yes No		☐

1. Governance *continued*

Ref	Question	Response	Details	Evidence
1.21	Is clinical supervision offered to allied health staff? *State the frequency of sessions, duration of sessions, who facilitates the sessions and what staff attend (e.g. OTs, SWs, DTs, Psychologists, Nursing Staff, Medical Officers)*	Yes No		☐
1.22	Is clinical supervision offered to peer workers? *State the frequency of sessions, duration of sessions, who facilitates the sessions and what staff attend (e.g. Consumer Peer Workers, Carer Peer Workers, Nursing Staff, Medical Officers, Allied Health)*	Yes No		☐
1.23	Is a member of the executive/ leadership team notified if there is a seclusion and/or restraint? *How long after the event is the person notified and what information is discussed?*	Yes No		☐
1.24	Has there been a formal review of seclusion and/or restraint in the unit? *Provide details of when and who conducted the review and any recommendations*	Yes No		☐
1.25	Has there been any quality improvement projects focused on the reduction of seclusion and/or restraint? *Provide name of project, project team, when it occurred and outcomes*	Yes No		☐
1.26	Has there been an audit of seclusion practice? *Provide details of when the audit was last conducted, how often it is conducted and any findings*	Yes No		☐
1.27	Has there been an audit of restraint practice? *Provide details of when the audit was last conducted, how often it is conducted and any findings*	Yes No		☐
1.28	Has there been an audit of observation practice? *Provide details of when the audit was last conducted, how often it is conducted and any findings*	Yes No		☐

1. Governance *continued*

Ref	Question	Response	Details	Evidence
1.29	Is there a staff recognition program to reward individual staff who have significantly contributed to reducing restrictive practices? *Describe the recognition program*	Yes No		☐
1.30	Is there a staff recognition program to reward groups of staff/teams who have significantly contributed to reducing restrictive practices? *Describe the recognition program*	Yes No		☐

Any further comments:

2. Data

Ref	Question	Response	Details	Evidence
2.1	Is seclusion and restraint recorded in one register?	Yes No		☐
2.2	Is the register/s paper? *If electronic what software is used*	Yes No		☐
2.3	Are seclusion performance reports generated locally? *State the frequency (e.g. weekly, monthly, quarterly) and the audience*	Yes No		☐
2.4	Are restraint performance reports generated locally? *State the frequency (e.g. weekly, monthly, quarterly) and the audience*	Yes No		☐
2.5	Do you have any local targets for seclusion performance? *State the targets for each indicator, describe the process for determining the target and how they are used*	Yes No		☐
2.6	Do you have any local targets for restraint performance? *State the targets for each indicator, describe the process for determining the target and how they are used*	Yes No		☐
2.7	Is seclusion data displayed for staff to see? *Describe where the data is displayed and how often it is updated*	Yes No		☐
2.8	Is restraint data displayed for staff to see? *Describe where the data is displayed and how often it is updated*	Yes No		☐
2.9	Is seclusion data displayed for consumers and their carers to see? *Describe where the data is displayed and how often it is updated*	Yes No		☐
2.10	Are consumers offered the opportunity to engage with a peer worker to write a post incident narrative? *Describe the process and what happens with the narrative once completed*	Yes No		☐
2.10	Is restraint data displayed for consumers and their carers to see? *Describe where the data is displayed and how often it is updated*	Yes No		☐

Any further comments:

3. Unit and Unit Processes

Ref	Question	Response	Details	Evidence
3.1	Does the unit have a welcome pack for consumers? *List the content covered in the pack*	Yes No		☐
3.2	Does the unit have a welcome pack for carers? *List the content covered in the pack*	Yes No		☐
3.3	Do all consumers have their own bedroom? *If no, how many beds are in a shared bedroom?*	Yes No		☐
3.4	Do consumers have access to their bedrooms at all times? *If no, describe when consumer do not have access to their rooms and why*	Yes No		☐
3.5	Is there an area in the unit consumers can use for quiet time? *Describe the area that consumers can use including what is in the area (e.g. TV, couch)*	Yes No		☐
3.6	Does the unit have a dedicated sensory room? *Describe the room including where it is located, what equipment it contains and how consumers can access it*	Yes No		☐
3.7	Does the unit have access to sensory modulation equipment? *List the equipment available, where it is stored and how consumers access it*	Yes No		☐
3.8	Is there a local protocol/procedure/ guideline for sensory modulation? *List the name of the document*	Yes No		☐
3.9	Is there a structured group program on the unit? *State how often groups run (e.g. Mon-Fri, 7 days a week), which professions run groups and what type of groups are offered, how often groups are cancelled and reasons why*	Yes No		☐
3.10	Are there uniform rules on the unit (e.g. visiting times, mandatory participation in groups, enforced wake up times)? *List the rules and the process for amending or reviewing rules*	Yes No		☐
3.11	Is a universal trauma assessment completed for all consumers on admission? *Is this a standalone assessment tool or incorporated in another assessment tool?*	Yes No		☐

Any further comments:

4. Seclusion

Ref	Question	Response	Details	Evidence
4.1	How many seclusion rooms does the unit have? *These are purpose built rooms only* *If you do not have any rooms write 0*			☐
4.2	Does/has seclusion occurred in an area/s other than a seclusion room? *Refer to the definition of seclusion in Appendix 2* *If there is more than one area note the number of areas and where each area is located*	Yes No		☐
4.3	Describe the area that seclusion has occurred (other than a dedicated seclusion room) *If seclusion does not occur anywhere other than a purpose built room write N/A*			☐
4.4	Do consumers have access to a bathroom while in seclusion? *Describe how the bathroom is accessed*	Yes No		☐
4.5	Do consumers have access to fluid while in seclusion? *Describe how a consumer can request fluid, what drinks are routinely offered (e.g. water only, hot drinks) and how often it is routinely offered*	Yes No		☐
4.6	Do consumers have access to food while in seclusion? *Describe how a consumer can request food , what food is routinely offered and how often it is routinely offered*	Yes No		☐
4.7	Does a consumer falling asleep in seclusion prompt staff to end seclusion? *If no, describe why seclusion would be continued*	Yes No		☐
4.8	Does the unit have a plan for reduction of seclusion? *If yes, is the plan just for the unit or more broad (e.g. facility, LHD)?*	Yes No		☐
4.9	Is the seclusion reduction plan endorsed by an executive sponsor? *Position title of the sponsor/s*	Yes No N/A		☐

Any further comments:

5. Seclusion Rooms/Areas/Safe Assessment Rooms

In this section please complete a new column for each seclusion room or area that is used to seclude consumers
*Please **highlight** the correct response*

Ref	Question	Room/Area 1		Room/Area 2		Room/Area 3	
5.1	Is this a purpose built seclusion room?	Yes	No	Yes	No	Yes	No
5.2	Is this a purpose built safe assessment room?	Yes	No	Yes	No	Yes	No
5.3	Is there entry to the seclusion area/room off a clinical area of the unit (that is not a corridor where only staff have access)?	Yes	No	Yes	No	Yes	No
5.4	Is there a secondary visual observation point (i.e. is there more than one window)?	Yes	No	Yes	No	Yes	No
5.5	Is there CCTV?	Yes	No	Yes	No	Yes	No
5.6	Is CCTV used for observations?	Yes	No	Yes	No	Yes	No
5.7	Intercom?	Yes	No	Yes	No	Yes	No
5.8	Bathroom?	Yes	No	Yes	No	Yes	No
5.9	Courtyard?	Yes	No	Yes	No	Yes	No
5.10	Able to see a clock?	Yes	No	Yes	No	Yes	No
5.11	Able to see a TV?	Yes	No	Yes	No	Yes	No
5.12	Window to outside?	Yes	No	Yes	No	Yes	No
5.13	Can the door remain unlocked?	Yes	No	Yes	No	Yes	No
5.14	Mattress/ Bed?	Mattress	Bed	Mattress	Bed	Mattress	Bed
5.15	Linen?	Standard	Non rip	Standard	Non rip	Standard	Non rip
5.16	Number of entry/exit points						
5.17	Distance to life saving equipment?		metres		metres		metres

Describe any other features of the seclusion room/area/safe assessment room

Room/Area 1:

Room/Area 2:

Room/Area 3:

Any further comments (if comments relate to a specific room/area please note the room/area):

6. Restraint

Ref	Question	Response	Details	Evidence
6.1	Is prone physical restraint used at any time? *Prone restraint can be referred to as face down restraint* *Describe under what circumstance a consumer would be restrained in a prone position rather than face up/ supine or in a seated position*	Yes No		☐
6.2	Is mechanical restraint used? *Refer to the definition of mechanical restraint in Appendix 2* *Describe the situations when mechanical restraint is used*	Yes No		☐
6.3	Are all mechanical restraint devices approved for use by the LHD/ Hospital Clinical Governance Committee or equivalent? *List all devices used and the name of the committee*	Yes No		☐
6.4	Do you have a Duress Response Team? *Note the positions of the staff on the team and position title of leader of the team*	Yes No N/A		☐
6.5	Are Security Officers/Health & Security Assistants involved in the physical restraint of consumers? *Describe the role of Security Officers/ Health & Security Assistants*	Yes No		☐
6.6	Does the unit have a plan for reduction of restraint? *If yes, is the plan just for the unit or more broad (e.g. facility, LHD)?*	Yes No		☐
6.7	Is the restraint reduction plan endorsed by an executive sponsor? *Position title of the sponsor/s*	Yes No N/A		☐

Any further comments:

7. Observations

Observations include formal and objective assessment of a person's condition – physical, mental and social.

Ref	Question	Response	Details	Evidence
7.1	Are alerts documented that a consumer may be at high risk of deterioration in seclusion and/or restraint in the health care record? *Describe where in the health care record these are documented*	Yes No		☐
7.2	Are observations documented in a paper health care record or eMR? *If you use a hybrid paper and eMR record indicate what observations are recorded on paper and what are recorded in eMR*	Paper eMR Hybrid		☐
7.3	What level of observation is maintained for consumers in seclusion after the first 60 minutes? *If other describe the level of observation*	Constant – visual 10 minutes 15 minutes Other N/A		☐
7.4	What level of observation is maintained for consumers in mechanical restraint after the first 60 minutes? *If other describe the level of observation*	Constant – visual Constant – arm's length 10 minutes 15 minutes Other N/A		☐
7.5	How do you facilitate verbal interactions with consumers in seclusion? *If other describe how it occurs*	Intercom Other N/A		☐
7.6	How do you document food and fluid for consumers who are in seclusion? *If other describe how it is documented*	Seclusion observation form Food and Fluid Chart Other N/A		☐
7.7	Do medical officers physically attend the unit to authorise seclusion during business hours? *If no, how is the authorisation communicated?*	Yes No		☐
7.8	Do medical officers physically attend the unit to authorise seclusion after business hours and on weekends? *If no, how is the authorisation communicated?*	Yes No		☐

7. Observations *continued*

Ref	Question	Response	Details	Evidence
7.9	Are consultant psychiatrists contacted about a seclusion episode? *Describe when consultants are contacted*	Yes No		☐
7.10	Are consultant psychiatrists contacted about a restraint episode? *Describe when consultants are contacted*	Yes No		☐
7.11	Are either Security Officers or Health & Security Assistants involved in the supervision of mental health consumers? *Describe under what circumstances*	Yes No		☐
7.12	Does the unit have a post sedation monitoring protocol? *Provide details about what physiological observations are undertaken, the frequency of observations, who completes the observations*	Yes No		☐
7.13	Does the unit monitor for nicotine withdrawal? *Provide details about any standardised assessments used and what nicotine replacement therapy consumers can access in seclusion*	Yes No		☐

Any further comments:

8. Training

Ref	Question	Response	Details	Evidence
8.1	Is seclusion and restraint reduction part of mental health orientation? *If no, how do staff access training about reduction of seclusion and restraint?*	Yes No		☐
8.2	Is trauma informed care part of mental health orientation? *If no, how do staff access training about trauma informed care?*	Yes No		☐
8.3	Do all staff receive training in seclusion and restraint reduction? *List the positions of staff that attend the training and note the rationale for staff selected*	Yes No		☐
8.4	Do all staff receive training in trauma informed care? *List the positions of staff that attend the training and note the rationale for staff selected*	Yes No		☐
8.5	Do all staff receive training in physical restraint techniques? *List the positions of staff that attend the training and note the rationale for staff selected*	Yes No		☐
8.6	Do all staff receive training in the use of mechanical restraint? *List the positions of staff that attend the training and note the rationale for staff selected*	Yes No		☐
8.7	How frequently do staff complete refresher training in reduction of seclusion and restraint? *If other state how often*	Yearly 2 yearly 5 yearly Other		☐
8.8	How frequently do staff complete refresher training in trauma informed care? *If other state how often*	Yearly 2 yearly 5 yearly Other		☐
8.9	How frequently do staff complete refresher training in physical skills for restraint? *If other state how often*	Yearly 2 yearly 5 yearly Other		☐
8.10	How frequently do staff complete refresher training in the use of mechanical restraint? *If other state how often*	Yearly 2 yearly 5 yearly Other		☐
8.11	Has the seclusion and restraint reduction training been evaluated? *Provide the year it was evaluated and any recommended changes that have been implemented as a result*	Yes No		☐

8. Training *continued*

Ref	Question	Response	Details	Evidence
8.12	Has the trauma informed care training been evaluated? *Provide the year it was evaluated and any recommended changes that have been implemented as a result*	Yes No		☐
8.13	Has the physical skills for restraint training been evaluated? *Provide the year it was evaluated and any recommended changes that have been implemented as a result*	Yes No		☐
8.14	Has the mechanical restraint training been evaluated? *Provide the year it was evaluated and any recommended changes that have been implemented as a result*	Yes No		☐
8.15	Do security staff receive training in working in mental health settings? *Is this training specific for security staff and is it mandatory?*	Yes No		☐
8.16	Do security staff receive training in seclusion and restraint reduction? *Is this training specific for security staff and is it mandatory?*	Yes No		☐
8.17	Do all staff receive Duress Responders training? *List the positions of staff that attend the training*	Yes No		☐
8.18	Is seclusion and restraint reduction part of Duress Responders training?	Yes No		☐
8.19	Who facilitates Duress Responders training? *List the position of facilitator/s*	Yes No		☐
8.20	How frequently do Duress Responders complete refresher training? *If other, state how often*	Yearly 2 yearly 5 yearly Other		☐
8.21	Has Duress Responder training been evaluated? *Provide the year it was evaluated and any recommended changes that have been implemented as a result*	Yes No		☐
8.22	Do you have a transition to mental health nursing program?	Yes No		☐
8.23	What percentage of nurses currently working on the unit have completed the transition to mental health nursing program?			☐
8.24	What percentage of nurses currently working on the unit have post graduate qualifications in mental health?			☐

Any further comments:

9. Staffing

Ref	Question	Response	Details	Evidence
9.1	Are there Registered Nurses working on the unit?	Yes No		☐
9.2	Are there Enrolled Nurses working on the unit?	Yes No		☐
9.3	Are there Assistants in Nursing working on the unit?	Yes No		☐
9.4	Are there Clinical Nurse Consultants working on the unit?	Yes No		☐
9.5	Are there Clinical Nurse Educators working on the unit?	Yes No		☐
9.6	Are there Clinical Nurse Specialists working on the unit?	Yes No		☐
9.7	Are there Occupational Therapists working on the unit?	Yes No		☐
9.8	Are there Social Workers working on the unit?	Yes No		☐
9.9	Are there Psychologists/Clinical Psychologists working on the unit?	Yes No		☐
9.10	Are there Diversional Therapists working on the unit?	Yes No		☐
9.11	Are there Staff Specialists/VMOs working on the unit?	Yes No		☐
9.12	Are there Psychiatry Registrars working on the unit?	Yes No		
9.13	Are there Career Medical Officers (CMOs) working on the unit?	Yes No		
9.14	Are there Junior Medical Officers working on the unit?	Yes No		
9.15	Are there Consumer Peer Workers working on the unit?	Yes No		
9.16	Are there Carer Peer Workers working on the unit?	Yes No		
9.17	Do allied health staff work on the unit outside of business hours or at the weekend? *State their shift pattern*	Yes No		
9.18	Are security staff employees of NSW Health? *State who they are employed by*	Yes No		

Any further comments:

10. Emergency Departments

Observations include formal and objective assessment of a person's condition – physical, mental and social.

Ref	Question	Response	Details	Evidence
10.1	Does the emergency department have a safe assessment room/s? *Note the number of rooms and whether they are used as a safe assessment room as described in Appendix 2*	Yes No		☐
10.2	When would a safe assessment room be used for a mental health consumer? *Describe when it would be used*			☐
10.3	Are safe assessment rooms ever locked from the outside? *Describe when the room would be locked*	Yes No		☐
10.4	If a safe assessment room is locked from the outside would this be recorded as seclusion?	Yes No		☐
10.5	What is the level of observation by nursing staff for a mental health consumer in a safe assessment room? *If other, describe the level of observation*	Constant – visual Constant – arm's length 10 minutes 15 minutes Other N/A		☐
10.6	Are safe assessment rooms and mechanical restraints ever used together? *Describe when, why they would be used and level of observations maintained*	Yes No		☐
10.7	Are cable ties used on consumers? *Describe when they would be used*	Yes No		☐
10.8	*Are records kept for restraint in the emergency department?* *If no, what department maintains the records?*	Yes No		☐
10.9	Is there a standard procedure for managing mental health consumers who do not want to remain in the emergency department for assessment? *Describe the procedure*	Yes No		☐

10. Emergency Departments *continued*

Ref	Question	Response	Details	Evidence
10.10	Is there a dedicated place for mental health consumers to wait following triage? *Describe the area including whether it is visible from the nursing station, access to tea/coffee/water and access to a bathroom*	Yes No		☐
10.11	Are all mental health consumers specialled (under constant observation) in the emergency department? *Describe when a consumer would require constant observation and what staff position is involved (RN, EEN, EN, AIN, Security)*	Yes No		☐

Any further comments:

Additional Comments

Are there any projects/reviews/initiatives that have not been covered in this audit that you feel would inform the review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities?

YES NO

Details of the project/review/initiative and supporting evidence

Appendix I: Possible Evidence

This list of evidence is only provided as suggestions of possible evidence and should not be used as an exhaustive list

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Local policies/procedures/guidelines for seclusion	X			X		X			
Local policies/procedures/guidelines for restraint	X				X	X			
Local policies/procedures/guidelines for mechanical restraint	X				X	X			X
Local policies/procedures/guidelines for observations	X					X			
Local policies/procedures/guidelines for trauma informed care	X								
Local policies/procedures/guidelines for incident reviews	X								
Form used to document process/ outcome of incident reviews	X								
Minutes/notes from an incident review	X								
Local policies/procedures/guidelines for collaborative reviews	X								
Form used to document process/ outcome of collaborative reviews	X								
Local policies/procedures/guidelines for post incident narratives	X								
Minutes from meeting where learnings from incident reviews are discussed	X								
Emails to team where learnings from incident reviews are shared with team	X								
Safety plan or similar document	X								

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Terms of Reference for committees that discuss seclusion and/or restraint performance	X								
Membership lists for committees that discuss seclusion and/or restraint performance	X								
Minutes from committees that discuss seclusion and/or restraint performance	X								
Copy of complaints received related to unit culture, observation, seclusion and/or restraint	X								
Examples of how practice has changed as a result of complaints	X								
RCA reports related to observation, seclusion and/or restraint	X								
Incident reports related to observation, seclusion and/or restraint	X								
Organisation Chart	X							X	
Clinical supervision schedule	X								
Staff orientation manual	X								
Any formal reviews of seclusion and/or restraint final reports	X								
Quality improvement project outlines	X								
Quality improvement project reports	X								
Seclusion audit tool	X								
Restraint audit tool	X								
Observations audit tool	X								
Examples of how practice has changed as a result of audits									
Communication with staff about recognition programs	X								

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Copy of seclusion register		X							
Copy of restraint register		X							
Recent seclusion data report		X							
Recent restraint data report		X							
Photo of where seclusion data report is displayed for staff		X							
Copy of seclusion data report displayed for staff		X							
Photo of where restraint data report is displayed for staff		X							
Copy of restraint data report displayed for staff		X							
Photo of where seclusion data report is displayed for consumers		X							
Copy of seclusion data report displayed for consumers		X							
Photo of where restraint data report is displayed for consumers		X							
Copy of restraint data report displayed for consumers		X							
Floor plan of the unit			X	X					X
List of unit rules			X						
Poster outlining unit rules			X						
Welcome pack for consumers			X						
Welcome pack for carers			X						
Local policy/procedure/guideline for sensory rooms			X						
Sensory room utilisation form/risk assessment			X						
Safe operating procedures for sensory equipment			X						
Local policy/procedure/guideline for sensory equipment			X						

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Unit group program			X						
List of groups available on the unit			X						
Copy of trauma assessment form			X						
Photo of area where seclusion occurs				X					
Seclusion reduction plan				X					
Documentation from clinical governance committee approving mechanical restraint devices					X				
Safe operating procedures for all mechanical restraint devices					X				
Local policy/procedure/guideline for duress response teams					X				
Restraint reduction plan					X				
Alerts form						X			
Screenshot of alerts in eMR						X			
Observation form/s						X			
Screenshot of observation form in eMR						X			
Seclusion observation form						X			
Mechanical restraint observation form						X			
Food and fluid chart						X			
Physical observation form						X			
Local policy/procedure/guideline for nicotine withdrawal						X			
Nicotine withdrawal form						X			
List of topics for mental health orientation							X		
Syllabus for mental health orientation reduction of seclusion and restraint training							X		
Syllabus for mental health orientation trauma informed care training							X		

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Syllabus for reduction of seclusion and restraint training							X		
Syllabus for trauma informed care training							X		
Syllabus for physical restraint training					X		X		
Syllabus for mechanical restraint training					X		X		
List of mandatory training for clinical staff							X		
Training transcripts for reduction of seclusion and restraint training							X		
Training transcripts for trauma informed care training							X		
Training transcripts for physical restraint training							X		
Training transcripts for mechanical restraint training							X		
Evaluation of reduction of seclusion and restraint training							X		
Evaluation of trauma informed care training							X		
Evaluation of physical restraint training							X		
Evaluation of mechanical restraint training							X		
Syllabus of training for security working in mental health settings							X		
Syllabus for training of security staff in reduction of seclusion and restraint							X		
List of mandatory training for security staff							X		
Syllabus for duress responders training							X		

Possible Evidence	Governance	Data	Unit & Unit Processes	Seclusion	Restraint	Observations	Training	Staffing	Emergency Departments
Training transcripts for duress responders training							X		
Evaluation of duress responders training							X		
Syllabus of transition to mental health nursing program							X		
Local policy/procedure/guideline for safe assessment rooms									X
Local policy/procedure/guideline for use of cable ties									X
Copy of restraint records maintained in the emergency department									X
Local policy/procedure/guideline for managing mental health consumers in the emergency department									X

Appendix 2: Key Definitions

Term	Definition	Source
Collaborative Review	After an aggressive incident a member of the clinical team will offer to discuss the incident with the consumer. The consumer's primary carer will be offered the opportunity to participate. The review should ideally occur within 24 to 48 hours of the incident.	PD2012_035
Consumer	A person with a lived experience of mental illness. The term patient is only used in this document where it was the term in the document being referenced.	
Declared Mental Health Facility	A premise subject to an order in force under section 109 NSW Mental Health Act 2007.	NSW Mental Health Act 2007
eMR	Electronic medical record.	eHealth
FTE	Full Time Equivalent.	
Health and Security Assistants	A person appointed as such who has the following responsibilities: • a person required to undertake limited duties associated with the care of patients such as pre-operative shaves, routine enemata, bathing of patients, general assistance in wards and cleaning duties; and/or • a person who undertakes routine clerical/administrative work (Level 1); and/or • a person who has the primary functions usually undertaken by the classification of Hospital Assistant Grade 1, 2 or 3; and/or • any other classification of staff agreed to between the employer and the Union; and in addition, undertakes securing, watching, guarding and/or protecting as directed, including response to alarm signals and attendances. Such employee is required to be appropriately licensed in accordance with the Security Industry Act, 1997.	Health Employees' (State) Award
Incident	Any unplanned event resulting in or with the potential for injury, damage or other loss. This includes a near miss.	PD2014_004
Incident Review	A process where the multidisciplinary team rigorously review aggressive incidents. It involves reviewing the documentation of the incident and reflective interviews with staff and the consumers involved in the incidents.	PD2012_035
Manual/Physical Restraint	The application of devices (including belts, harnesses, manacles, sheets and straps) on a consumer's body to restrict his or her movement. This is to prevent the consumer from harming him/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restrict the consumer's capacity to get off the furniture except where the device was solely used for the purpose of restraining a consumer's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.	PD2012_035

Appendix 2: Key Definitions

Term	Definition	Source
Observation	Observation through engagement is the purposeful gathering of information from persons receiving care to inform clinical decision making. It is the formal and objective assessment of a person's condition – physical, mental and social. Observation is not passive nor does it predominately include watching consumers from a distance. Undertaking observations requires clinicians to be person centred and engage therapeutically with consumers.	Draft Engagement and Observation in Mental Health Inpatient Units Policy (Due for release in 2017)
Peer Worker	A mental health peer worker is someone employed on the basis of their own personal lived experience of mental ill-health and recovery. This lived experience is an essential qualification for their job, in addition to other skills, training and experience required for the particular role they undertake. As part of their role, it is expected that mental health peer workers will share their recovery journey with consumers, stakeholders and colleagues to inspire hope, challenge stigma and model that recovery is possible.	NSW Mental Health Commission
Physical Restraint	The skilled hands on immobilisation or the physical restriction of a consumer to prevent the consumer from harming him/herself or endangering others or to ensure the safe provision of essential medical treatment.	PD2012_035
Root Cause Analysis (RCA)	A method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process yields recommended actions directed at the prevention of a similar occurrence.	PD2014_004
Safe Assessment Rooms	A room or area that can be used for the treatment/assessment of a patient displaying aggressive or combative behaviour that keeps them separated from other patients, staff and visitors within the emergency department.	NSW Health Emergency Department Security Review Report 2016
Seclusion	The confinement of the consumer at any time of the day or night alone in a room where free exit is prevented. Key elements: 1. The consumer is alone 2. The seclusion applies any time of the day or night 3. Duration is not relevant in determining what is or is not seclusion 4. The consumer cannot leave of their own accord.	PD2012_035
Sensory Equipment	Resources include weighted, movement, tactile, vibrating, squeeze and auditory modalities.	GL2015_001
Sensory Modulation	The ability to regulate and organise responses to sensory input in a graded and adaptive manner.	GL2015_001
Sensory Room	A sensory based therapeutic space specifically utilised to promote recovery and rehabilitation with different age groups and populations, where consumers have opportunities to manage distress and agitation using sensory modulation equipment.	GL2015_001

Appendix 3: Key Documents

This Review has been primarily based on PD2012_035 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities. The other documents listed below have also informed the audit.

PD2012_035 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW

PD2012_008 Violence Prevention & Management Training Framework for the NSW Public Health System

PD2014_004 Incident Management Policy

PD2015_001 Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach

PD2015_004 Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint

Protecting People and Property – NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies June 2015

Safety Notice 003/16 Use of Prone Restraint and Parenteral Medication in Healthcare Settings

GL2012_005 Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People

GL2015_001 Safe Use of Sensory Equipment and Sensory Rooms in NSW Mental Health Services

GL2015_007 Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments

Mental Health for Emergency Departments – A Reference Guide 2009 (Amended March 2015)

NSW Mental Health Act 2007

NSW Health Emergency Department Security Review Report 2016

Draft Engagement and Observation in Mental Health Inpatient Units Policy – Due for release in 2017.

Appendix J – Self-audit summary

Part A – Mental health units

1. Mental health units - governance

- Most mental health units reported having local policies, procedures and guidelines for seclusion and restraint. These were mostly local (district and network level) policies which were described as complimentary or aligning with NSW state policy directives.
- Most units reported that they conduct collaborative reviews. However, comments indicated a poor understanding of the definition of collaborative review (as per PD2012_035). Collaborative reviews were frequently described as occurring without consumers, through working groups, during staff meetings, at handovers, and multi-disciplinary team meetings.
- Most units reported that peer workers rarely contribute to collaborative reviews. Most mental health units do not have peer workers available.
- Most units did not report auditing their own practice of seclusion, restraint or observation. Where units described audit practices as occurring, these were commonly in reference to mandatory quarterly reporting to the Ministry of Health, or audits occurring through the Official Visitors Program.
- Less than half of mental health units reported that formal reviews of seclusion and/or restraint had occurred. However, most units reported that a quality improvement project has been undertaken. Quality improvement projects that were mentioned included the implementation of the Six Core Strategies, Safewards program and the Productive Wards programs.
- Just over half of mental health units reported using the safety plan or similar document. Where a safety plan or similar document was reported there was large variation in use. Plans reported in use include, Mental Health Safety Action Plans, Consumer Wellness Plans, Mental Health Safety Plans, Advance Care Directives, Nursing Treatment Plans, MECHS Assessment Plans, or risk assessment plans.
- The majority of units reported that nursing, allied health and medical staff have access to clinical supervision. Clinical supervision is generally provided by a one hour session per month for nursing staff. Clinical supervision of nursing staff is also often in the form of group supervision sessions during nursing transition programs, with optional supervision thereafter or upon request.

2. Mental health units - use of data

- Most units described generating local reports for seclusion and restraint. The purposes of local reports were generally for quarterly or monthly reporting to clinical governance meetings, or as a standing agenda item for nursing management meetings. Reports were also generated as required to the Ministry of Health (InforMH) and the Official Visitors program.
- Most units do not display seclusion or restraint data for staff or consumers. Where data was made available to staff this was mostly passively, through meeting minutes or data available in the seclusion register. It was infrequently reported that seclusion or restraint data is available to consumers. Where data was made available to consumers this occurred in the form of white boards, learning boards, or monitor displays.
- Less than half of mental units have local targets to reduce seclusion or restraint. Of the units that describe local targets, some units described a target of zero. Many units also described a local health district or network key performance indicator as described in performance agreements.

3. Mental health units - processes

- The majority of units reported that consumers have access to their bedrooms at all times. However, some units did report that bedrooms were locked or unavailable at certain times. This was reported as occurring during meal times, or in accordance with unit rules to encourage healthy sleep patterns. A minority of units report that consumers share a bedroom. Where rooms were shared these were dorm style accommodation.
- Most mental health units reported that there is an area in the unit that consumers can use for quiet time. In general this is a T.V room, lounge room or activities room. Some units also described gym rooms and libraries as available quiet spaces.
- Most mental health units reported that consumers have access to sensory modulation equipment. Some

units also reported that a dedicated sensory room is available. Some responses noted that staff supervision is required to access equipment, that sensory rooms were being refurbished, and that sensory modulation equipment was being purchased.

- Most units reported having a structured group program. These are facilitated mostly by nursing or allied health staff. Many units provided evidence of structured group programs.
- Most units reported having uniform/rigid rules (e.g. visiting hours). Most units also reported that flexible arrangements and special needs and requests are met. Visiting hours, enforced wake up times and group participation rules were most common.
- Most units provide a welcome pack to consumers. Many units also reported that welcome packs are in place or being developed specifically for carers. Welcome packs were sometimes described as flyers, unit guidelines, rules of the unit, fact sheets, or feedback questionnaires.

4. Mental health units - seclusion

- On average 1.2 seclusion rooms were reported for each unit. However there appears to be some double counting at the unit level due to some seclusion facilities being utilised under shared arrangements.
- Most units reported having a seclusion reduction plan. Where plans were described, these were frequently non-specific to seclusion. For example many units referenced trauma informed care initiatives, or the Productive Ward program as a 'reduction plan'.
- Where a seclusion reduction plan was reported, most mental health units stated the plan is endorsed by an executive sponsor. The executive sponsor position varied, and included the Nurse Unit Manager, Manager of Security, Director of Nursing, District Board, or Mental Health Executive Committee.
- Some units reported that a consumer falling asleep would not prompt them to end seclusion. Some units also stated they would not end seclusion when a patient is asleep as a full mental state and risk assessment cannot be conducted.

5. Mental health units - seclusion rooms

- Just under half of mental health units reported that consumers have access to a bathroom while in seclusion. Some units also reported that where seclusion rooms do not have bathrooms, consumers are escorted to facilities.
- The majority of mental health units reported that consumers are unable to see a clock when in a seclusion room.
- Only a minority of seclusion rooms reported a window to the outside.
- Mental health units did not widely report that intercoms are available.

6. Mental health units - restraint

- Most mental health units reported that prone restraint is used. Where used, mental health units reported it is used rarely, and only when indicated for severely behaviourally disturbed consumers.
- Around half of the mental health units reported having a restraint reduction plan. Where plans were described these were frequently non-specific to restraint. For example many units referenced trauma informed care Initiatives, or the Productive Ward program as a 'reduction plan'.
- Where restraint plans were reported they were generally endorsed by an executive sponsor. This person was usually the Director of Nursing, Director of Mental Health or Service Manager.

7. Mental health units - observations

- Many units reported that verbal communication is 'through' the seclusion door or that consumers are engaged 'through the window'. Information provided was unclear on how verbal interactions with consumers in seclusion would otherwise occur.
- Just over half of mental health units reported that a medical officer physically attends the unit to authorise seclusion after hours or on weekends. Most units also reported a medical officer physically attends the unit to authorise seclusion during business hours.

- Most units reported that consultant psychiatrists are contacted about seclusion and restraint episodes. Timeframes for notification were unclear in many self-audit responses. Where notification occurs this is described as 'via the registrar', 'as soon as practicable', 'during business hours' or 'at handover'.
- The majority of units reported they have a post sedation monitoring protocol. This was generally referenced in relation to a local health district or network policy. Where no policy or protocol was reported, a post sedation tool or standard was commonly described in comments.
- The majority of mental health units reported monitoring for nicotine withdrawal. Most units reported that nicotine replacement therapy is offered routinely. However there was significant variation in approaches across mental health units, in terms of withdrawal assessment and therapies.

8. Mental health units – training

- Most mental health units reported that staff are not routinely trained in trauma informed care. Many units stated that training in trauma informed care is via sexual safety training, in-service training with a clinical nurse consultant, or as requested. Trauma informed care did not appear to be compulsory training, and is not routinely part of orientation for new staff.
- The majority of mental health units reported that staff receive training in seclusion and restraint reduction, and security staff receive training in working in mental health settings, and seclusion and restraint reduction.
- It was generally reported that physical restraint technique training is provided to staff in mental health units. The majority of units reported that staff routinely completed violence prevention management training and HETI Modules.
- Refresher training in the use of physical skills for restraint, mechanical restraint and trauma informed care was unclear. Responses were not comprehensively provided. On average it appears that refresher training is offered yearly or every two years.
- Most mental health units reported that a transition to mental health nursing program is available. Many of these programs were reported as non-mandatory.

9. Mental health units - staffing

- Mental health units reported the below percentages of staff working or available in the unit. Frequently 'staff working' was interpreted as staff being available through the district or network.

Percentage of mental health units with staff working or available

Occupational Therapist	**80%**
Social Worker	**90%**
Diversional Therapist	**46%**
Consumer Peer Worker	**31%**

- Most units do not have access to allied health outside of business hours. Where this was described this was often rehabilitation assistants or diversional therapists that work on weekends.

Part B – Emergency departments

1. Emergency departments - governance

- Most emergency departments rely on NSW state policy directives as the basis for seclusion and/or restraint. Most emergency departments also referred to local (district and network level) policies that are in place and govern seclusion and restraint practices.
- Collaborative review processes were reported as occurring in emergency departments. However the self-audit reports often described reviews as occurring as part of the inpatient unit processes or did not specifically mention consumer participation.
- The majority of emergency departments do not employ peer workers, and peer workers were not generally reported as part of incident reviews, collaborative reviews, or engaged with consumers to write a post incident narrative.
- Most emergency departments did not report formal reviews of seclusion and/or restraint as occurring. These were frequently described as occurring through the Official Visitors program. A minority of emergency departments reported quality improvement projects are underway that focus specifically on the reduction of seclusion and/or restraint.

Appendix J – Self-audit summary

- Emergency departments did not often refer to specific committees that discuss seclusion and restraint performance. Where performance was discussed, this occurred through Official Visitor meetings and incident management review committees.
- The majority of emergency departments do not audit their own practice of seclusion, restraint or observation. Where units describe audit practices occurring, this was commonly in reference to audits occurring with the Official Visitors Program.
- Very few emergency departments reported using a safety plan or similar document routinely.
- Most emergency departments reported that members of the executive or leadership team are notified if there is a seclusion and or restraint episode. However the methods and executive that are notified varied. Timeframes for notification were unclear and notification generally relies on existing processes for incident management notification.

2. Emergency departments - use of data

- Few emergency departments reported that seclusion and restraint performance reports are generated at a local level. Where performance reports are generated, this is generally for reporting to the Official Visitors program or through incident reporting management processes.
- Seclusion and restraint data is not often made available to staff and almost never made available to consumers in emergency departments. Where this data is made available to staff, this is through a paper based register, which in the majority of emergency departments is the most frequent method of recording seclusion and restraint. One emergency department reported that seclusion and restraint data is made available to consumers.
- The majority of emergency departments do not have local targets for seclusion and restraint performance. Where local targets were reported, local health district and network targets were commonly referenced.

3. Emergency departments - processes

- Sensory modulation equipment was rarely reported as an available resource within emergency departments. A local protocol, procedure, or guideline for sensory modulation was also not often reported as available. Emergency departments in general did not report having dedicated sensory room facilities.
- A small minority of emergency departments described that a welcome pack is available for mental health consumers or carers.
- Most emergency departments did not report that uniform/rigid rules (e.g. visiting hours) are in place, or that a structured group program exists.

4. Emergency departments - seclusion

- Most emergency departments reported that they do not have a seclusion reduction plan in place. Where plans were described, these were plans related to transfer to Mental Health Units, or principles to reduce seclusion and restraint rather than formal plans.
- Similarly, only a small proportion of emergency departments reported that a seclusion reduction plan was endorsed by an executive sponsor.

5. Emergency departments - safe assessment rooms and seclusion rooms

- Most emergency departments did not report that consumers have access to a bathroom while in seclusion. Most reported that consumers are escorted to facilities or that bathrooms are accessible 'as required'.
- The majority of safe assessment rooms and seclusion rooms reported by emergency departments do not have a clock that is able to be seen, or a window to the outside.
- Some emergency departments reported Closed Circuit Television (CCTV) and a minority of emergency departments also described using CCTV for observations.
- Most safe assessment rooms do not have a secondary visual observation point (i.e. is there more than one window.

Appendix J – Self-audit summary

6. Emergency departments - restraint

- Most emergency departments reported that prone restraint is not used. This was generally described as used rarely, briefly, or in situations of extreme violence or aggression.
- The majority of emergency departments did not report having a restraint reduction plan. Where plans were described, these were frequently non-specific to restraint. For example references to a seclusion and restraint committee or education package around de-escalation strategies.

7. Emergency departments - observations

- In general consultant psychiatrists are not contacted about seclusion and restraint episodes within emergency departments when they occur.
- Approximately two thirds of self-audits received from emergency departments indicated they monitor for nicotine withdrawal.

8. Emergency departments - training

- Some emergency departments reported that staff receive training in seclusion and restraint reduction. However very few emergency departments reported that seclusion and restraint reduction training forms part of emergency department orientation.
- Most emergency departments reported that physical restraint technique training is provided to staff, and most emergency departments described that staff complete violence prevention management training and HETI Modules.
- Emergency departments reported that staff are not routinely provided training in trauma informed care. This is rarely provided and where provided was described as occurring through other training such as sexual safety training or violence prevention management training.
- The evaluation of seclusion and restraint reduction training generally does not occur and was very rarely reported in emergency departments.
- Refresher training in the use of physical skills for restraint, mechanical restraint and trauma informed care was unclear. Responses were not comprehensively provided from emergency departments.

9. Emergency Departments - staffing

- Emergency departments reported the below percentages of staff working or available. Many reported that staff are available through the district or network, and it was unclear if these positions are employed exclusively within the emergency department.

Percentage of emergency departments with staff working or available

Occupational Therapist	**9%**
Social Worker	**22%**
Diversional Therapist	**2%**
Consumer Peer Worker	**4%**

- The majority of emergency departments do not have access to allied health outside of business hours. Where this was described these were aged care or physio assistants, or social workers.

10. Emergency departments - specific

- Emergency departments reported that mental health consumers are not routinely specialled (under constant observation). Observation decisions were mostly described as based upon individual risk assessment, including history and observation of behaviour.
- Most emergency departments reported there is a standard procedure for managing mental health consumers who do not want to remain in the emergency department for assessment. Procedures differ, but mostly consider the patient's level of risk, legal status, and other mitigating factors, as per risk assessments undertaken.
- Some emergency departments stated that the safe assessment room is used for every mental health consumer.

Appendix J – Self-audit summary

- Most emergency departments reported that if a safe assessment room is locked from the outside this would be recorded as seclusion.
- Most emergency departments do not have dedicated place for mental health consumers to wait following triage. A minority of emergency departments reported a 'relatives room' or 'distressed parents' room', in a few instances the dedicated space to wait following triage was reported as the safe assessment room.

Appendix K – Site visit schedule

Date	Facility
8 August 2017	Orange Health Service*
9 August 2017	Dubbo Health Service*
11 August 2017	Wollongong Hospital /Shellharbour Hospital
14 August 2017	John Hunter Hospital
15 August 2017	Calvary Mater Newcastle
15 August 2017	Wyong Hospital
16 August 2017	Blacktown Hospital
17 August 2017	Liverpool Hospital
17 August 2017	Campbelltown Hospital
22 August 2017	Children's Hospital Westmead
23 August 2017	St George Hospital
31 August 2017	Cumberland Hospital
31 August 2017	Nepean Hospital
1 September 2017	St Vincent's Hospital
1 September 2017	The Forensic Hospital
4 September 2017	Concord Centre for Mental Health
4 September 2017	Bankstown Hospital
6 September 2017	Prince of Wales Hospital
6 September 2017	Royal North Shore Hospital
12 September 2017	The Tweed Hospital
13 September 2017	Lismore Base Hospital
14 September 2017	Coffs Harbour Health Campus
19 September 2017	Wagga Wagga Rural Referral Hospital
20 September 2017	Queanbeyan District Hospital
21 September 2017	Goulburn Base Hospital

* Videoconferencing to Broken Hill Base Hospital

Appendix L – Recommendations

The review team examined recommendations from 54 mental health related coronial inquests that were finalised between 2011 to mid-2017 and identified the following relevant recommendations.

Emergency departments and safe assessment room

- State level - Consideration of a statewide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments.
- District level - Develop and implement a site-specific policy relating to the use of the safe assessment room in line with the existing NSW Health Policy concerning aggression, seclusion and restraint in mental health facilities in NSW.

Coronial inquest - July 2017.

Consultation with primary carers about consumers' care and treatment

- State level – Provide hospital clinicians with appropriate reminders of all mandatory requirements under the Mental Health Act 2007 in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment.
- District level – Implement training and education systems to ensure that medical officers in mental health facilities are aware of all mandatory requirements of the Mental Health Act 2007 in relation to the notification of, and consultation with, primary carers concerning a patient's care and treatment

Coronial inquest - January 2016.

Support for families/carers and their active input in care plans

- District level - Allocate a Carer Advocate to each patient, who would contact families and be available for communication at all times
- Local service level – Immediately ensure that the input of families/carers into the assessment and development of care plans is actively facilitated, encouraged with patients and includes provision of written material.

Coronial inquest - August 2011.

Review of policy, consideration of continuous observation of consumers in seclusion and avoidance of prone restraint

- State level - A review is conducted on a statewide basis of the hospital directive "Seclusion Practices in Psychiatric Facilities" with consideration given to whether there should be a direction that continuous observation of a patient occurs once a patient is placed in seclusion.
- State level - A review be conducted on a statewide basis of the policy/practices involving the method of restraint throughout all Hospital departments, with consideration given to a direction that the prone restraint method be avoided if at all possible and that there be consequent training and retraining of staff.
- For Australasian College of Emergency Medicine and Royal Australian and New Zealand College of Psychiatrists - The findings as to the manner and potential dangers of the prone method of restraint of patients are forwarded to the Australasian College for Emergency Medicine and Royal Australian and New Zealand College for Psychiatrists for their information and consideration in the event of formulation of policy as to the preferred method of restraint.

Coronial inquest - June 2011.

Adherence to policies and protocols

- The Coroner found that there were existing policies and protocols (including PD2012_035, Aggression, Seclusion and Restraint in Mental Health Facilities in NSW) that applied to care, which had not been followed. He directed that his findings and comments be sent to the Minister for Health and the Health Care Complaints Commission for their consideration but did not make any recommendations for the district or NSW Health.

Coronial inquest - September, 2016