health

Providing a safe environment for all

Framework for reducing restrictive interventions

State Government
Victoria

Providing a safe environment for all

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Foreword

The Victorian Government is committed to reducing restrictive practices in public mental health services. The experience of consumers and carers is central to how we support people in their recovery, which is why we are implementing a range of reforms to make sure that recovery-oriented practice and trauma-informed care are core business for mental health services.
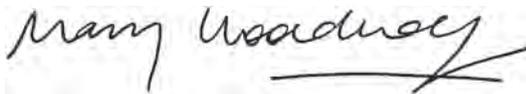
Restraint and seclusion must only be used after all other less-restrictive options have been considered and found unsuitable, and to protect the health and safety of the person involved or others.

While clinical mental health services are making significant progress in this area, we should continue to strive to do better. This is because people who use services tell us that restrictive interventions can have enduring effects such as feelings of distress, agitation and fear. It may re-traumatise people with past experiences of trauma and impede the development of trusting relationships between people receiving care and clinicians.

The evidence is clear: sustained effort will reduce the use of seclusion and restraint. To create real change health service boards, managers and clinicians, in partnership with government, must genuinely invest in improving how people experience care in an inpatient mental health unit.

Everyone working in a clinical mental health service has a responsibility to create an environment that is safe for all people, for our workforce and for the people that access our services.

I am proud of our efforts to date and look forward to your continued commitment to improving treatment and care by working to reduce restrictive practices even further.

Hon Mary Wooldridge MP
Minister for Mental Health

Contents

Acknowledgements

This framework has been developed with the support and active participation of many people. In particular, the Department of Health would like to acknowledge the valued contribution of Associate Professor Richard Newton, Chair of the Advisory Committee and Ms Cath Roper, Co-Chair of the Advisory Committee, who were instrumental in advancing this project.

Introduction

Achieving the best health and wellbeing for all Victorians is a key priority for the Victorian Government. In the public mental health service system this will be achieved through recovery-oriented practice that minimises the use and duration of compulsory treatment, safeguards the rights and dignity of people with a mental illness and enhances oversight while encouraging innovation and service improvement.

Consistent with the objectives of the reform of Victoria's *Mental Health Act 1986*, the Victorian Government and health services share a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services.

All Victorian public mental health services and all areas in a hospital that have been proclaimed as an approved mental health service (a gazetted service) when working with people who are experiencing mental illness are required to have in place local procedures and clinical practices that reduce, and where possible, eliminate the use of restrictive practices.

Professionals and workers in all disciplines who work with children, young people, adults and older people in clinical mental health services, emergency departments and other gazetted mental health settings are required to engage in this work.

Two Victorian Government initiatives – Creating Safety: Addressing Restraint and Seclusion Practices, and Reducing Restrictive Interventions – have explored ways to reduce restrictive practices without compromising safety through building key capabilities, implementing integrated, locally relevant approaches and promoting recovery-oriented practice.

These initiatives have yielded valuable insight into practical and effective approaches, and have informed this framework.

Further information about the policy context may be found in Appendix 1.

About this framework

This framework, *Providing a safe environment for all*, is central to the government's commitment to reduce restriction and provide mental health services that are safe places for all people accessing treatment and care, their support people and those who work with them.

The framework has been developed as part of the Reducing Restrictive Interventions project. It will assist health services to comply with mental health reform objectives and the *Charter of Human Rights and Responsibilities Act 2006* by providing guidance in developing a local response to reduce the use of restrictive interventions through a culture of safety and recovery.

A systematic approach that involves people with lived experience, their support people, mental health professionals, health leaders and the health workforce is required.

This framework is underpinned by a comprehensive review of the research and evidence relating to reducing restrictive interventions. *Reducing restrictive interventions: literature review and document analysis* (Department of Health 2013) is available at <www.health.vic.gov.au/mentalhealth>.

It's about recovery, because the thing about recovery is that it empowers people to make decisions and to be involved in their own care, then this enables interventions to be more collaborative. When this happens it makes the ward environment and the work you are doing so much more rewarding.

Health professional

Seclusion and restraint jeopardise people's rights, freedoms, psychological and physical safety for the sake of managing hospital environments – we have to do better.

Person with a lived experience

The work on reducing the use of seclusion and restraint has been closely followed by the board of management. They feel pleased that this work continues to be built upon, and that existing strategies are regularly monitored, reviewed and reported on.

Board of management

Elements of the framework

> The one intervention that has been almost universally missing during my own crises has been a person, any person, willing to sit down next to me, and just be there.
>
> **Person with a lived experience**

> People talk about 'debriefing' after seclusion. If that space was used to tell me 'reasons why' I 'had' to be secluded, I would be furiously angry. But if I was offered a genuine space where I could give my testimony about what the experience of seclusion had been like, how it had affected me, be deeply heard and know that the people involved were learning, I would appreciate it. Debriefing with consumers cannot be used as a space where staff justifies their actions.
>
> **Person with a lived experience**

Principles

The framework is underpinned by the following principles:

- Reducing restrictive interventions is everybody's business.
- All key stakeholders – that is, people with a lived experience, carers, health service staff, management and government – have a role in the design and implementation of safe environments.
- People with lived experience, their support networks and staff are treated with respect and dignity; their rights and responsibilities are central to promoting safety.
- The service environment is organised to ensure the safety and wellbeing of people accessing the service, their support networks and staff.
- Difficult and challenging behaviour is managed in ways that show decency, humanity and respect for individual rights while effectively managing risk.
- Restrictive interventions are used as a last resort after all other less restrictive options reasonably available have been tried or considered and found to be unsuitable in the circumstances.
- Programs of activity to reduce restrictive interventions require effective governance and ongoing monitoring of local action plans and processes to ensure effective implementation.
- Recovery-oriented practice, trauma-informed care and supported decision making inform workforce practices and are necessary to prevent ward cultures that are experienced as either coercive or conflictual.

These principles are further developed within the framework capabilities.

Capabilities

The framework describes four interconnected capabilities that support the mix of interventions that will enable a sustainable reduction in restrictive practices. These capabilities, underpinned by core practice principles, are discussed in more detail in the section entitled 'A safe environment'. They are:

- leadership and accountability
- systems
- self-determination
- workforce.

Care approaches

Three care approaches are integral to the framework. They reflect contemporary mental health practices and should assist in any efforts to improve a person's experience of care. Therefore, they are part of any program of activity that would reduce restrictive interventions. The three care approaches are discussed in more detail in the section entitled 'A safe environment'. They are:

- recovery-oriented practice
- trauma-informed care
- supported decision making.

Enablers

Within each capability there are four enablers where organisational effort should be focused. These are:

- culture and systems
- a healthy environment
- anticipating need and escalation
- review and quality assurance.

1. Culture and systems

Organisational culture and systems must align with organisational values and objectives to reduce restrictive interventions. The development of culture and systems supports practice and continuous improvement.

2. A healthy environment

A healthy environment considers the physical setting, social dynamics, and cultural and behavioural patterns that impact on the creation of a calm and safe ward environment and a therapeutic milieu. Healthy environments acknowledge people's past experiences and preferences, support open dialogue and a positive learning culture.

3. Anticipating need and managing escalation

Anticipating need and managing escalation involve the person with a lived experience, their support people and health professionals identifying and responding in a timely way to anxiety, conflict and acute arousal.

4. Review and quality assurance

Review and quality assurance contribute to continuous improvement in the reduction of restrictive interventions. Key to this is the effective use of data and feedback.

Figure 1: A framework to reduce restrictive interventions

Leadership

Supported
decision making

Recovery-oriented
practice

Systems

Safe
environments

Self-determination

Workforce

Trauma-informed care
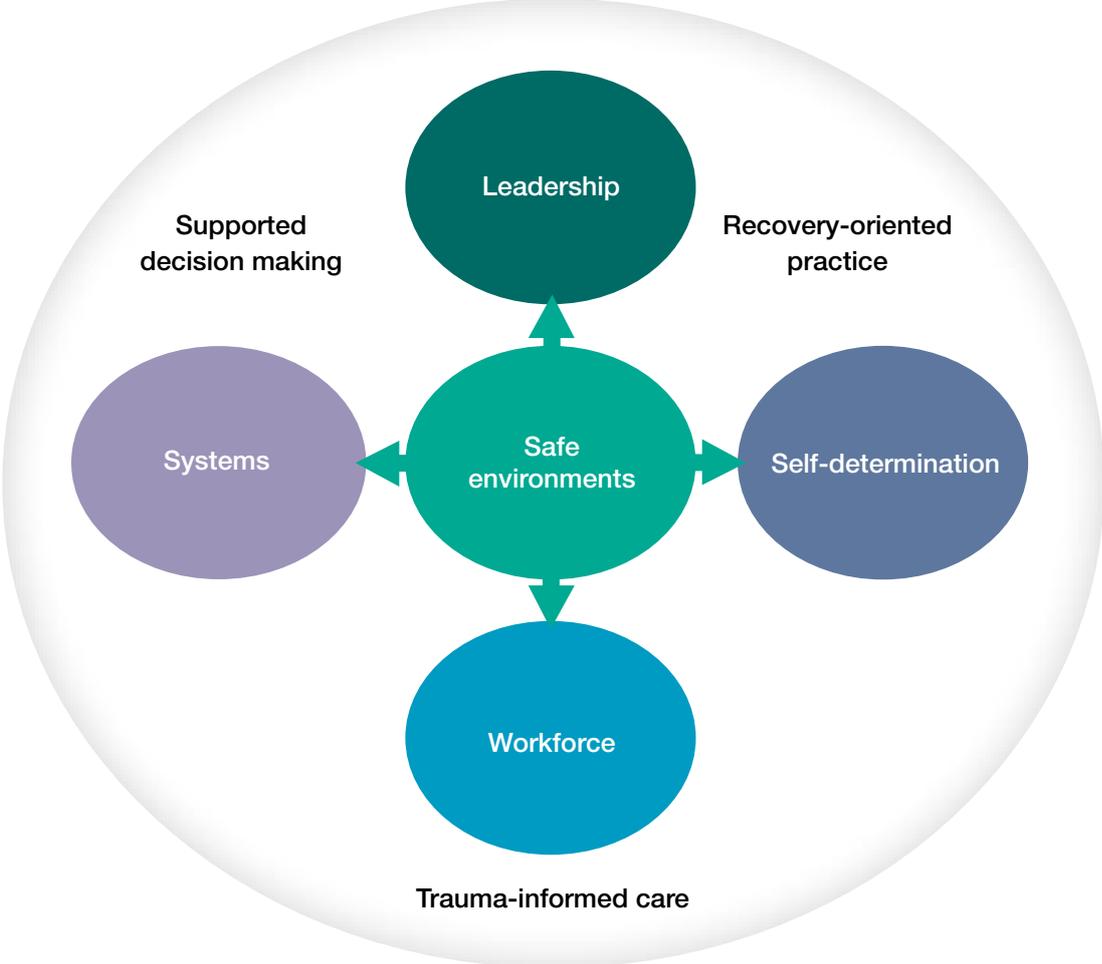
How to use this framework

> It's great to have a clear voice in the unit that says to new staff 'OK, you may have done that at another service but that's not the way we do things at our service'.
>
> **Chief nursing officer**

People with a lived experience, staff and management can use this framework to systematically and comprehensively plan and design services that reduce and, where possible, eliminate the use of restrictive interventions. The framework can also be used to provide a lens in reviewing any element of service planning, design and delivery.

Organisational effort should be focused on identifying areas of strength and weakness, enabling cultures and systems, enabling a healthy environment, anticipating need and managing escalation, and embedding review and quality assurance. This provides a comprehensive and integrated platform for critical reflection and building capabilities.

There is an increasing body of good practice and evidence available to support organisations in undertaking work to reduce restrictive practice. This framework contains 'snapshots' of good practice and links to guidelines, frameworks and resources that can be used to support planning, decision making, review and quality assurance.

The elements in this framework need to be considered alongside the actions identified in the literature review[1] as key activities that could be implemented to reduce and, where possible, eliminate restrictive interventions.

Appendix 3 provides reflection questions to assist in identifying strengths and weaknesses in, and enablers for, leadership, systems and workforce capability. The questions identify and challenge assumptions, and enable people to 'drill down' into the detail of their practice, prompting further questions. Appendix 3 also provides prompts to consider in the assessment and planning of localised responses to reducing restrictive interventions.

A note about language

There are a number of terms employed throughout international mental health policy, legislation and literature to refer to people accessing mental health services. These terms include 'consumer', 'client', 'service user' and 'patient'. In this framework, wherever possible, the terms 'person', 'individual', 'people with lived experience' and 'people accessing mental health services' are used to reflect the language of recovery. Similarly, this document uses the term 'carer'. However, the plurality of relationships of importance to people is recognised and it is acknowledged that this term encapsulates 'support person', 'family' and 'nominated person'.

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1 Reducing restrictive interventions: literature review and document analysis (Department of Health 2013) is available at <www.health.vic.gov.au/mentalhealth>.

A safe environment

People working in mental health services have the capability to influence better outcomes for people by engaging in effective interventions to support people's recovery when they are in inpatient care.

Capabilities

Services should focus their attention on the following capabilities within their organisations to reduce restrictive practices:

- **leadership and accountability** to set targets, develop methods to monitor and reflect, enable front-line accountability and support to change practices
- **systems** that support the delivery of local action plans, provide clarity of the service's vision for reducing restrictive interventions and enable structures to support practice change
- processes that support **self-determination** by respecting and facilitating a person's rights and wishes to plan their recovery and work on the issues that are important to them
- a capable **workforce** that has role clarity, understands the application of contemporary practice and has mechanisms in place to support accountability and reflection.

Care approaches

Three approaches to care are integral to these organisational capabilities. These care approaches should underpin all mental healthcare and treatment, and provide a foundation for all efforts and initiatives that aim to reduce the use of seclusion and restraint.

Recovery-oriented practice

Recovery-oriented practice is mental healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- holistically addresses factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.

A recovery approach involves promoting people's choice, agency and self-management. To that end, a degree of risk tolerance in services becomes necessary. Services can empower people – within a safe environment and within the parameters of their duty of care – to decide the level of risk they are prepared to take as part of their recovery journey (Department of Health 2011a).

> Our staff are ready and now work with patients differently.
>
> **Nurse and educator**

Trauma-informed care

Many people with a mental illness and within the mental health service workforce have experiences of trauma. The effects of these experiences can be multiple, varied, complex and enduring.

The use of seclusion and restraint, or the precursory situation, can trigger new experiences of trauma. Trauma-informed mental healthcare is sensitive to and understanding of trauma-related behaviours that serve as coping and survival mechanisms for people with a lived experience.

Trauma-informed care involves the recognition of lived experience and the empowerment of consumers in decision making (Department of Health 2011).

> I can remember within a week of starting my career in the sector, the director mentioned in a handover that we would need to become familiar with experiencing violence. I actually consider myself lucky that it took almost 10 years before I was assaulted at work. After this experience, I developed some post-traumatic stress disorder type of symptoms every time a client would start to escalate. After some counselling, I learnt to deal with this. From this point onwards, I always endeavoured to obtain a trauma history and discuss with the client what their triggers may be, and options available if they were feeling unsafe in the ward from seeing other people escalate.
>
> **Health professional**

Understanding and working with risk

Our workforce encounters complex clinical situations. There are competing demands and priorities that impact on the environment where care is provided. Comprehensive clinical risk assessment and active management of that risk requires a skilled and engaged workforce focused on providing the best care possible.

Reducing restrictive interventions requires balancing the clinical risk assessment, consumer choices and duty of care. Creating a safe environment requires staff to reconcile flexibility and responsiveness and people's unique circumstances and preferences with appropriate risk-management obligations.

This involves balancing the tension between risk and safety in practice, in clinical decision making, in clinical interaction and in governance.

Working with risk requires:

- transparency and an openness with the person about risks
- clarity about practitioner roles and associated responsibilities
- supportive teams with whom duty of care and dignity of risk can be discussed
- a safe authorising environment within the health service's governance structures, where open and non-blaming dialogue can occur on the dignity of risk, best interests and duty of care
- clear protocols and development opportunities for front-line staff to implement strategies that support de-escalation and effective engagement with a person and their carer
- supporting staff to do their job well.

The implementation of organisational responses to the factors that impact the use of restrictive practices will support health services to manage this tension without compromising safety.

Restrictive interventions are not therapeutic techniques

Restrictive interventions are management strategies and are not regarded as primary treatment techniques.

Staff should feel confident in using different methods of relating with people across all age ranges. The literature review *Reducing restrictive interventions* (Department of Health 2013) provides illustrations of the types of interventions that are therapeutic and can assist with de-escalation and the reduction of restrictive interventions. This should assist with training strategies for staff to reduce the use of seclusion and restraint.

> We were taught that containing someone who was 'out of control' was therapeutic! I guess it was simply part of the culture. However, as I tend to question things, I discovered that by actually engaging with people, getting to know what they needed and actively helping them to understand that some of what they were experiencing were symptoms of mental illness, I could teach alternative ways to manage distress and model de-escalation without having to resort to restraint. At times this takes longer; however, the time is worth the outcomes for the people I work with.
>
> **Health professional**

Chemical restraint is not considered appropriate in mental health settings in Victoria. However, acute sedation and pharmacological treatments need to be very carefully considered with clear criteria for use, and a dissemination and communication strategy that supports staff in the judicious use of medications to relieve distress. Medications must not be used as an isolated response but can be provided to reduce acute arousal and agitation.

It should be the goal of aged psychiatry to eliminate, as far as practicable, restrictive practices such as seclusion and mechanical restraint from all inpatient settings. These practices are profoundly traumatic for consumers (and their carers) often disorientated by mental illness or cognitive impairment. They offer little therapeutic value, and given the age, fragility and physical comorbidities experienced by this group, this generally increases levels of risk for consumers rather than reducing them!

Operations manager, aged persons mental health service

He was only nine years old when he was physically restrained numerous times in one admission. He still has nightmares about it and wakes up frightened and crying. It is the screaming that I cannot get out of my head … horrendous, intense and primal, while they were holding him down on the floor. The whole experience was just so dehumanising and just so wrong. Both of our minds have been psychologically damaged by the experience … I don't think we will ever forget it or get over it.

Parent

A few years after I started mental health nursing, the hospitals started to build seclusion rooms and place an emphasis on restraint techniques. Over the years, higher levels of physical restraint and/or seclusion were used. This was certainly not what I envisaged I would be doing when I decided to become a mental health nurse, and I have never in my 20 years heard any colleague describe this technique as 'rewarding'. I hope that by genuinely focusing on reducing restrictive interventions, we might now be supported to actually spend therapeutic time with clients. It is only then that we will truly be able to use our specialist qualifications and skills to help people on their recovery journey.

Health professional

Recommendations for reducing restrictive interventions

Research and policy relating to reducing restrictive practices have identified the following elements of successful approaches:

- recognition of the influence on the practices of healthcare providers of legislation, policy, and support of people with a lived experience and carer and consumer workers
- a broad range of initiatives such as psychosocial models of care, treatment plans and assessment tools
- a knowledgeable workforce with competencies in the aetiology of aggression, preventing aggression, and assessment, and interventions to manage escalation of behaviours that result in the application of restrictive interventions
- implementation practices that use cycles of preparation, organising structures and workforce, monitoring and feedback.

In order to progress *Providing a safe environment for all* the recommendations below should be followed as part of a program of activity to reduce restrictive interventions.

1. Organisational assessment

Undertake an organisational assessment to:

- confirm the three approaches to care are present
- identify the effectiveness of current or previous initiatives in reducing restrictive interventions
- establish a suitable and sustainable change management process in line with this framework, including identifying targets and objectives.

2. Workforce plan

Develop a workforce plan:

- to support front-line accountability and engagement
- that includes alternative strategies for front-line staff to ensure de-escalation and effective management of aggression
- to ensure leaders at all levels are aware of their responsibilities and have clear actions to engage and support others in this initiative.

3. Review data

Review the way data is used to inform practice and monitor progress.

4. Review governance structures

Review governance structures to provide:

- clarity around roles and responsibilities in relation to oversight of activities to reduce restrictive practices
- a culture of learning and enquiry.

5. Develop a program

Develop a program of activity to reduce restrictive practices and engage consumers and carers at all levels to ensure activities are grounded in the real experience of those who have received care.

6. Adapt processes and policies

Update and amend processes and policies to embed reflective practice and critical review of incidents as they arise. This should include the three care approaches – recovery-oriented practice, trauma-informed care and supported decision making – and strategies for the four interconnected capabilities of leadership, organising structures, self-determination and workforce.

Snapshot: Peace in Mind

Peace in Mind – a whole-of-system response to reducing seclusion

An investigation into very high seclusion rates identified that seclusion was a reactionary response by individual clinicians rather than the result of multidisciplinary clinical decision making. There was limited prevention work occurring, for example, looking at triggers, safety needs or the environment.

Who led the work?

Steering committee: director of clinical services, area manager, consultants, unit managers, clinical nurse educator, heads of disciplines, consumer and carer representatives

Working groups: education and training, medication, therapy and environment, policy, seclusion review, patient safety plan

What did you do?

We looked at the whole system. Together, consumers, staff and management:

- identified practice issues at staff forums
- obtained consumers' and carers' input through interviews
- reviewed the literature and investigated good practice at other services
- undertook a 'reduction readiness audit' to identify practice and governance gaps
- changed authorisation and governance around seclusion
- determined baseline (acceptable) seclusion and assault rates
- reviewed and introduced a new medication matrix for acute agitation
- implemented training for all staff (including administration and hospital service staff) in:
  - o prevention with safety plans developed for consumers (for example, looking at triggers)
  - o de-escalation approaches (for example, sensory, relaxation, talking to the person)
- changed the environment to make it feel 'warmer'
- implemented a primary nurse role
- introduced strict policies that cover what has to be done if seclusion is used, for example:
  - o undertake a clinical review as soon as possible
  - o articulate all the preventative actions taken
  - o document all decisions and actions relating to seclusion
  - o do a consumer review
  - o discuss the instance of seclusion at handover.

How have things changed?

- Staff members talk with and get to know people.
- Seclusion rates have significantly decreased.
- 'Maintaining and sustaining' the change is now seen as core practice for all staff.

Leadership

Facilitating self-determination

Workforce

System

Capability 1: Leadership and accountability

Leaders have an important role in inspiring and influencing others to understand and work towards the vision of reduced use of restrictive practice. Creating an organisational environment that supports staff to work towards the change is paramount and leaders must advocate, facilitate and manage the change process so that objectives may be met.

Core to any leadership role is accountability. Accountability means that leaders have clear responsibility in working towards objectives to reduce restrictive interventions, and governance structures within the organisation hold leaders to account in all efforts.

Leadership can be clinical, managerial or cultural. Leadership is not just the responsibility of management nor is it position bound. Leadership is dispersed across the organisation and will come from people with a lived experience, carers, from staff on the wards and from management.

Core practice principles

- People with a lived experience, carers, health professionals and management all have a role in influencing initiatives to reduce restrictive interventions.
- Leaders empower and focus on people's strengths, resources, skills and assets.
- Leaders are aspirational and work towards a culture that is supportive of the least restrictive practices.
- Leadership is demonstrated through language and behaviour, and by modelling the culture and practices the organisation is trying to achieve.

Enablers

The roles and responsibilities of effective leadership should be clear and understood when developing and implementing strategies to reduce restrictive interventions. The following enablers should be considered.

Culture and systems	- Develop, implement and monitor strategies to reduce restrictive interventions. - Support all people in the organisation to understand and embrace the vision for reducing restrictive practices. - Provide role clarity so that all people understand their contribution to a culture that supports the least restrictive practice. - Invest in the time and resources needed for transformation. - Address systems, policies, practices, service delivery and human resource models and environments in integrated responses. - Identify and celebrate success.

A healthy environment	• Bring together people with a lived experience, carers, clinicians and management to design and deliver initiatives. • Encourage development of service models that create a therapeutic and responsive environment, where reduction in stress and agitation for all is a goal. • Ensure the physical environment is conducive to an effective model of care.
Anticipating need and managing escalation	• Support the development of service models that anticipate need and have an early intervention focus. • Recognise that different situations require different responses and implement a broad range of initiatives. • Foster a culture in the service that promotes participation by people with a lived experience, health professionals and leadership in the review of incidents of aggression, and develop strategies to improve clinical practice.
Review and quality assurance	• Review processes and use data and information to inform the prevention, reduction and elimination of restrictive practices. • Establish a working knowledge of the factors that reinforce the use of restrictive interventions and address them. • Ensure that data collection, analysis and review processes are in place to identify and address issues raised by people with a lived experience, carers and staff. • Implement a quality assurance methodology such as Plan, Do, Study, Act cycles.

Snapshot: Consumer leadership

Leadership

Systems

Workforce

Facilitating self-determination

Consumer leadership in the design and delivery of the Reducing Seclusion and Restraint project

The consumer consultant has been integral to the design and implementation of the Reducing Seclusion and Restraint program.

The consumer consultant was a member of the leadership team that also included the clinical director, nurse unit manager, assistant nurse unit managers and unit consultant. This team was consistent and gave the same strong messages for a number of years.

What did the consumer consultant do?

- She was involved in the development of the seclusion pathway.
- She worked full time as part of the adult acute ward team and participated fully in unit processes such as clinical handovers.
- She spent time with clients in the unit discussing what the service was trying to achieve and obtaining feedback.
- She sat with staff who had a high level of anxiety at that time and was able to guide them from a consumer perspective to see the benefits of what we were trying to achieve.
- If there was a seclusion she would:
  - sit with the team to explore what they did well and what they could improve on
  - talk with the clients, hear their experiences and give them support.

How have things changed?

Consumers used to talk about seclusion a lot. The consumer consultant recently remarked, 'The clients aren't even talking about being secluded anymore'.

Capability 2: Facilitating self-determination

The rights of a person with a lived experience to make the decisions they are capable of making at that time, and their experience of care, are central to reducing restrictive interventions. An environment that values lived experience and acknowledges past trauma supports people to express their needs. Capability in facilitating self-determination, embedded across all levels of the health service, is required for this right to be achieved.

Core practice principles

- Recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting and self-management.[2]
- Practice is oriented towards supported decision making and working with people's expressed wishes and could include advance statements, enabling the person to retain legal capacity regardless of the level of support required.
- A presumption of capacity is the foundation of supported decision making and people's capacity is supported and developed.
- People are provided with the information and support they need to make decisions or participate in decision making as much as possible.
- Services are aware of, and promptly respond to, people's needs in a timely manner.

Enablers

Collaborative practice in which people with a lived experience, carers and staff work together to develop strategies to reduce the use of restrictive practices is embedded in both individual practice and in service design.

Culture and systems	• Invest in an organisational culture that recognises the rights and values of people.
	• Invest in culture change processes that improve understanding of the role and position of people with lived experience and carers in the development of initiatives and personal plans.
	• Recognise, elicit and act on lived experience and expertise in all service design and decision-making processes.
	• Work alongside people with a lived experience of seclusion and restraint to explore and document their experiences and integrate these into organisational systems and workforce strategies.
	• Review policies and practices to incorporate collaborative practice.
	• Review processes and practices to enable supported decision making.
	• Identify and promote best practice that focuses on the views and experiences of people with a lived experience.
	• Celebrate and acknowledge successes.

2   Department of Health (2011), Framework for recovery-oriented practice, State Government of Victoria, Melbourne.

A healthy environment	• Develop recovery-oriented and trauma-informed practice models that align with the principles of the new mental health legislation and enable self-determination and supported decision making. • Provide post-event debriefing for all to emphasise the importance of a no-blame culture. • Use data to inform and change practice, and practise reflection to support change and acknowledge progress. • Change the physical environment to help people feel safe and contained without the need for restriction.
Anticipating need and managing escalation	• Ensure that all consumers and carers are given the opportunity to develop advance statements that identify their preference for how to manage their distress or agitation at various levels of severity. • Use admission procedures that provide for compiling a history of expressions of distress. • Provide opportunities for clinicians to further develop their skills in assessment and effective interventions in agitation and challenging behaviours.
Review and quality assurance	• Seek feedback on experiences of restrictive interventions from people with lived experience and carers, and incorporate it into quality assurance processes. • Ensure that self-determination and supported decision making permeates all aspects of the therapeutic milieu through the development of local performance indicators through the safety and quality meeting matrix.

Snapshot: Pharmacology guidelines

Development of guidelines for the pharmacological management of distress, arousal and agitation

It was apparent to senior staff of the adult psychiatric unit that a frequent precursor to aggressive behaviour was increasing distress, agitation and arousal. Aggressive behaviour was routinely managed through the use of seclusion, and the unit's seclusion rates were high.

The medical director of the mental health clinical service unit led a range of initiatives under the banner of the Creating Safety project to address the high seclusion rates and to create a safe environment for patients and staff.

One key initiative was the development of guidelines for the pharmacological management of distress, agitation and arousal.

Prior to the development of the guidelines there was inconsistent practice in the use and prescription of psychopharmacological medication to manage agitated behaviour.

Many people said that they would much prefer to use medication to manage their distress and agitation rather than this escalating and resulting in seclusion.

What did you do?
- We listened to staff and patients. We engaged staff from all disciplines – medical staff, nurses, allied health practitioners, people with lived experience, and carers.
- We developed guidelines that were embedded into a broader approach to manage agitation and arousal.
- We provided training in the use of the guidelines.

What were the outcomes?

Pre-initiative

David was already known to the service. In a previous admission he was elevated, aggressive and highly threatening towards staff. This ended in a code black and police being called in to assist. Due to his level of aggression he spent 48 hours in seclusion.

Post-initiative

David was admitted with a similar presentation. The staff were concerned that this might lead to similar outcome. David arrived on unit with his pet parrot. He was greeted at the front door by the nurse unit manager, who allowed the parrot to be placed on his shoulder **[engagement and getting to know the person before things escalated]**. The nurse unit manager identified that David needed medication quickly as per the acute arousal guidelines … offered David medication, which required intramuscular administration … David agreed only if his parrot could come in while he was getting same … this was agreed to. The next time he was to get medication he asked for his partner to hold his hand while getting this … this was agreed to. This was repeated on a weekend day when the nurse unit manager was not on duty **[changed culture and empowering nursing staff]**. Outcome: David was discharged within three weeks and did not go into seclusion – what a success!

Leadership

Workforce

Systems

Facilitating self-determination

Capability 3: Workforce

A capable and skilled workforce is central to creating a culture where restrictive interventions are a last resort. Investment in the workforce must support the least restrictive practices, and all people in the organisation must understand and work towards the mandate of reducing restrictive practices.

Recognising that the workforce is interdisciplinary and includes health professionals, people with a lived experience and carers is important in building organisational capabilities towards a positive learning culture. Through a partnership approach staff will be clear on the complex mix of accountability, responsibility and flexibility while supporting self-determination.

Staff must be well supported, especially if they experience aggression in their front-line role.

Core practice principles

- Reducing restrictive interventions requires an interdisciplinary partnership committed to sustained effort.
- Healthy teams are built on individual and collective skill sets.
- A skilled workforce is resourced anda supported.
- Competence in, and commitment to, recovery-oriented practice and a focus on supported decision making and self-determination are key features of the interdisciplinary team.
- Roles are clear and accountable.
- There is recognition of trauma and its impact on people with a lived experience, carers and staff.
- The health service is a safe environment where governance arrangements support and enable open dialogue on the dignity of risk, best interests and duty of care.
- The environment values learning and authorises and fosters open disclosure.
- The organisation is commited to continuous learning and quality improvement.

Enablers

Strategies to reduce restrictive interventions must consider how the following enablers support and acknowledge the important role the workforce plays in service delivery that minimises restrictive practices.

Culture and systems	• Establish a team to oversee implementation and to provide support at various levels of the organisation. • Provide leadership that challenges people to grow. • Provide the workforce with the mandate, authorising environment, systems, structures, policies and procedures to enable recovery-oriented practice and supported decision making. • Develop the capacity of the workforce to promote and enable supported decision making. • Provide an environment that supports open disclosure. • Ensure that staff across all disciplines, as well as peer workers, carers and consumer consultants have appropriate competencies in reducing restrictive interventions.

Culture and systems (cont.)	• Develop the capacity of the workforce to work effectively with peers, families and carers. • Foster a learning environment and chances for staff to identify barriers to good practice and opportunities for improvement. • Support the workforce to participate in learning and development programs. • Manage the workforce and staffing models to best support a safe environment. • Establish a policy for managing arousal, distress and acute intoxication. • Ensure that staff understand one another's roles. • Support the workforce to recognise the impact of trauma on people with lived experience, carers, themselves and their practice. • Ensure there are structures and opportunities to embed principles of best practice in this area, for example, through induction and orientation.
A healthy environment	• Develop strategies for creating a sense of security and safety from the first contact the person has with the service, admission staff or nurse. • Look after the environment to create a therapeutic milieu. Be alert to the context, dynamics and flow occurring on the ward. Develop skills in interventions that create an effective and calm treatment environment. • Be aware of where the safe places are in the therapeutic milieu.
Anticipating need and managing escalation	• Offer programs that respond to people's needs for timeliness, attachment and belonging. • Support the workforce to develop and maintain knowledge and skills in advance statements, managing distress, agitation, arousal and trauma. • Support the workforce to learn and use trauma-informed practice approaches, sensory approaches and pharmacotherapy. • Provide clarity to the workforce about appropriate treatment strategies. For example, chemical restraint is not considered acceptable to people with a lived experience and carers, whereas managing acute agitation and the judicious use of medicines is an appropriate pharmacotherapy intervention.
Review and quality assurance	• Establish measures and targets to report, monitor and track recovery-oriented practice. • Monitor and provide data and feedback regularly to the workforce on restrictive interventions. • Use active monitoring, practice review, clinical supervision and practice supervision.

Snapshot: Forensicare

Reducing restrictive interventions for people in a forensic service

Forensicare was one of the 2009 National Beacon Demonstration Sites that produced data highlighting the impact of implementing best practice in reducing seclusion and restraint. Since 2009 Forensicare has continued to incrementally change practice, resulting in decreased use of restrictive interventions.

What did you do?

- Staff and patients worked together to develop shared unit rules.
- Patient personal safety plans were implemented.
- Since the beginning of Beacon three seclusion rooms have been removed completely.
- Every unit now has a dedicated calming or quiet room.
- The occupational therapists have assisted in developing sensory modulation strategies and there has been training for staff on the use of sensory modulation.
- The seclusion areas on the acute units now have a dedicated area for de-escalation which often prevents the use of seclusion and restraint. Patients receive training in understanding and implementing their safety plans.
- Forensicare staff have developed The Model of Inpatient Aggression to assist in understanding inpatient aggression. This model is being embedded in review processes (including seclusion reviews and case conferences) and staff have received some training. This model encourages staff to reflect on their own practice and that of the team, and consider personal and contextual factors.
- Trauma-informed care is being piloted in one of the male acute units at present. The steering committee includes two patients in the service.

What was achieved?

- Admission procedures have changed.
- Sensory approaches are used and have been well received by patients.
- Documentation of incidents has improved, with staff more clearly outlining the interventions and strategies used.
- Staff are keen to reduce the use of restrictive interventions.
- Every seclusion episode is reviewed in a supported environment.
- The trauma-informed care pilot has received a lot of support from patients, staff and the Forensicare executive. It is hoped that this project will be embedded across all Forensicare units.
- Training in management of aggression has been enhanced with a focus on early intervention and prevention, assessing and understanding aggression, de-escalation techniques, trauma-informed care and sensory approaches.

Workforce

Systems

Facilitating self-determination

Leadership

Capability 4: Systems

Health service systems comprise the organisation of people, processes and resources to deliver care. This includes policies, models of care, internal and external environments as well as the interrelation among all the components to govern service delivery. To create a sustainable change in practice, health service systems must align with the vision to reduce and eliminate restrictive interventions.

Core practice principles

- Policies and procedures provide clear guidance and direction to prevent and manage escalation, and enable people with a lived experience, their support people and staff to work together.
- Systems are informed by best practice and are responsive to the local service environment.
- Models of care and therapeutic interventions are collaboratively designed with consumers and carers.
- Systems reflect the organisation's core values, including openness and reflective practice to reduce restrictive interventions.
- Reporting, monitoring and evaluation are core components of health service systems and contribute to building the knowledge base of effective strategies that reduce restrictive interventions.
- Physical environments promote safety and comfort, and minimise distress, and can support the therapeutic milieu.

Enablers

Strategies to reduce restrictive interventions should involve the review of service system components. The following enablers focus on system components that have a direct impact on restrictive interventions.

Culture and systems	• Review and, where required, develop policies and guidelines that are based on evidence and best practice. • Develop systems that are based on the principles of trauma-informed care. • Engage with people to establish strategies that create safe environments and minimise distress. • Identify and manage formal and informal structures that inhibit the least restrictive practices.
A healthy environment	• Develop treatment environments that reduce stress, anxiety and conflict and enable the early identification of issues. • Develop strategies that support consumers to stay informed. • Address environmental factors that impact restrictive interventions. This may include providing space and privacy for people. • Celebrate individual and team success and achievement.

A healthy environment (cont.)	• Support people to develop daily routines and self-expression, and to voice their personal preferences. • Create opportunities and set expectations for reflective practice.
Anticipating need and managing escalation	• Intake procedures include talking with people about their stress triggers, warning signs, calming strategies, and restraint and seclusion history. • Develop a clinical seclusion pathway with threshold standards that is built on knowledge and best practice. • Develop and use processes to give people with a lived experience a chance to give testimony or debrief following an incident of restraint or seclusion. These processes are not used to explain workers' rationale for restriction or to blame the person's behaviour but an opportunity offered to the person to give an uninterrupted account back to practitioners about the consequences of the intervention for them. • Provide those who have witnessed an incident of seclusion or restraint an opportunity to give testimony or debrief.
Review and quality assurance	• Use data to inform practice and develop processes for its monitoring and use. • Use data to keep consumers, carers and staff informed of performance. • Identify data that reflects local circumstances and measures performance against desired outcomes. Develop processes for ensuring data quality, monitoring and use. • Continually consider new evidence that supports reducing restrictive interventions.

Snapshot: Behavioural support plans

Using a behavioural support plan to manage anxiety, agitation and aggression in an autistic adolescent boy

An adolescent boy was admitted to the psychiatric unit under Section 9 of the Mental Health Act. He presented in an extremely agitated and distressed state. Time spent in the emergency department and being in an unfamiliar environment contributed to his agitation and distress. He was placed in seclusion and provided with a nurse who worked with him one-on-one.

The boy's family had been struggling to manage him safely.

It wasn't until the following day that staff discovered the boy had a behavioural support plan (BSP) used by his family and by staff at his school.

What did you do?

- The occupational therapist, speech pathologist and nursing team met to replicate the BSP in the context of the ward environment and to educate staff on how to implement it.
- Because of the boy's disability, aspects of the plan had to be communicated to him in written and pictorial form.
- The boy's educational support aid and principal visited the unit to aid in consistency of the boy's management. The school also offered ongoing phone support to the unit staff if needed.
- The hospital's neurological development team were included in the implementation of the BSP and they provided on-site support and advice to staff.
- All staff were briefed and supported on how to successfully implement the BSP. This included clear instructions on strictly adhering to the boy's normal routine, completing his activities of daily living, exercise routine, learning activities, relaxation techniques, rewards plan and positive reinforcement techniques. This established a safe and structured environment where the boy could be cared for without the need for restrictive interventions.

What was achieved?

Disability services were contacted and the hospital staff initiated re-engagement with a case manager. Further support was put in place before the boy was discharged back home to his mother.

The unit's multidisciplinary team learnt that BSPs are essential in providing consistent care for young people with autism spectrum disorder and intellectual disability. Links were forged with the neurological development team and all members of the team are now advised to request BSPs on admission for similar presentations. There were frequent case conferences and representation from health, disability, education and the boy's family. A care team was established at the suggestion of the hospital, and discharge planning occurred with multiagency input.

Facilitating self-determination

Leadership

Workforce

Systems

Appendix 1: Background

Understanding the policy context

Reducing and, where possible, eliminating restrictive practices is a priority for the Victorian Government.

Reform of Victoria's Mental Health Act

Central to the reform of the Act are recovery-oriented practice, supported decision making, minimising the duration of compulsory treatment, safeguarding the rights and dignity of people with mental illness and enhancing oversight while encouraging innovation and service improvement. The new set of legislative principles reflects the Charter of Human Rights and Responsibilities Act, the *United Nations convention on the rights of persons with disabilities* and the *United Nations convention on the rights of the child*. Legal mechanisms to enable supported decision making will be included in the legislation. These include a presumption of capacity, advance statements and nominated persons.

The new mental health legislation will specify that restrictive interventions must only be used after all other less restrictive options reasonably available have been tried and considered and found unsuitable in the circumstances.

The legislation seeks improvement to safety and accountability requirements relating to the use of restrictive interventions (bodily restraint and seclusion) through regulation of physical restraint in addition to the existing regulation of mechanical restraint and seclusion. It will also seek to improve the safety of restraint and seclusion by increasing oversight and accountability.

The Reducing Restrictive Interventions project

The Reducing Restrictive Interventions project is a critical component of the reform of Victoria's Mental Health Act.

Consistent with reform objectives, this project aims to reduce and, where possible, eliminate restrictive interventions in mental health services and emergency departments across Victoria. This framework supports health services in this task.

National standards for mental health services 2010

The *National standards for mental health services 2010* require that the activities and environment of mental health services are safe for consumers, carers, families, visitors, staff and the community.

Reducing and, where possible, eliminating the use of restraint and seclusion within all mental health service settings is required in the implementation of this standard.

National Mental Health Commission – National Seclusion and Restraint Project

The Commission is leading a national project to look at best practice in reducing and eliminating the seclusion and restraint of people with mental health issues and to help identify good-practice approaches.

Australian Health Ministers' Advisory Council, Mental Health Standing Committee – National Seclusion and Restraint Reduction Initiatives

The Committee has an ongoing national focus on seclusion and restraint reduction. Annual national forums highlight best practice and showcase progress on the implementation of initiatives to reduce seclusion and restraint in public mental health services.

Victoria's Chief Psychiatrist in partnership with the Victorian Quality Council – Creating Safety: Addressing Restraint and Seclusion Practices project

This project demonstrated that the following elements can reduce the use of restraint and seclusion: organisational and clinical leadership, workforce education, enhancing the physical and therapeutic environment, monitoring and data analysis of restraint and seclusion, active involvement of consumers as partners in care, and using alternative approaches.

Literature review

The Department of Health undertook a review of contemporary literature and Victorian, national and international service policies. *Reducing restrictive intervention: a literature review and document analysis* (Department of Health 2013) focused on research and evidence relating to reducing and eliminating restrictive interventions. It incorporated information on the aetiology of aggression, and preventing and managing aggression (including de-escalation, observation, sensory approaches, maintaining safe therapeutic environments, specialised teams, recognising and responding to clinical deterioration, and pro re nata medication).

Consultation

An advisory committee comprising people with a lived experience, carers, health professionals, union and health service representatives was established to provide ongoing guidance towards the development of this framework. Members of the committee had expertise across many different areas of mental healthcare for all age ranges across different settings, including emergency departments.

Appendix 2: Definitions

Shared definitions will enhance the capacity of health services, staff, people with a lived experience and carers to talk and work together to reduce restrictive interventions.

The following definitions are drawn from Victoria's Mental Health Act, the *National standards for mental health services 2010*, the National Seclusion and Restraint project and Victoria's *Framework for recovery-oriented practice*. The new mental health legislation will include definitions of restrictive interventions.

Authorising environment

The authorising environment includes people and policies with the prestige, authority and control over resources to legitimise the agenda.

Dignity of risk

The concept 'dignity of risk' recognises that taking risks is part of life. When people have the opportunity to make mistakes, they also have the opportunity to learn from those mistakes. Through making informed choices and taking calculated risks people learn how to manage their mental illness.

Recovery, which is owned by and unique to each individual, encompasses notions of self-determination, self-management, personal growth, empowerment and choice. Dignity of risk is aligned with recovery.

Environment

Surroundings or influences affecting one or more people. Elements of the environment include physical settings, social dynamics, culture and behavioural patterns.

Family-inclusive practice

Valuing the role of families, carers and significant others in supporting people with a lived experience is central to family-inclusive practice. Family-centred practice works effectively and inclusively with people's support networks using evidence-based practices.

Family-inclusive practice requires policies and protocols to clarify the information that services are permitted to share with families and significant others.

Interdisciplinary teams

Teams of health professionals and consumer and carer workers working collaboratively.

Mechanical restraint

The application of devices (including belts, harnesses, manacles, sheets and straps) on a consumer's body to restrict their movement. This is to prevent the consumer from harming themselves 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 restricts the consumer's movement, except where the devices are used solely for the purpose of restraint. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Multidisciplinary teams

Teams utilise the skills and experience of individuals from different disciplines, with each discipline approaching the consumer from their own perspective.

Physical restraint

The skilled, hands-on immobilisation or physical restriction of a person to prevent them from harming themselves or endangering others, or to ensure the provision of essential medical treatment.

Practices

Methods or techniques that are used consistently.

Processes

A series of actions or steps in order to achieve a particular end.

Protocols

Systems or rules that govern care and treatment.

Recovery-orientated practice

Recovery-oriented practice is understood as encapsulating mental healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship (Department of Health 2011a, *Framework for recovery-orientated practice*).

Restraint

The restriction of an individual's freedom of movement by physical or mechanical means. This applies to consumers receiving specialist mental healthcare regardless of the setting.

Restrictive interventions

Mechanical and physical restraint and seclusion.

Risk

The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood.

Risk assessment and management

The process of identification, analysis, control, evaluation and management of a risk.

Seclusion

The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of time out, where a patient is asked to seek voluntary social isolation for a period of time.

Supported decision making

A presumption of capacity is the foundation of supported decision making. All people receiving mental health treatment are presumed to be able to make decisions about their treatment.

People's capacity to make particular decisions can change over time. A person may not be able to make a decision about a particular treatment at a particular point in time, but may regain capacity to make that decision at another point in time.

People should be provided with information and support to make decisions about their treatment, or to participate in decision making as far as possible. Systems and structures are required to facilitate supported decision making.

People with a lived experience may make decisions with the assistance of carers or other networks (family, friends or support workers). Collaborative practice – in which people with a lived experience, their support people and staff work together to develop strategies to reduce the use of restrictive practices – is embedded in both individual practice and in service design.

Systems

People, organisations and resources working together to achieve particular needs.

Trauma-informed care

Trauma-informed care involves practitioners individually, and services systematically, ensuring that care is sensitive to trauma-related issues. People can experience admission to mental health facilities as intimidating and alienating. Services should take care to avoid practices and behaviours that may trigger previous experiences of trauma. For example, practices of seclusion and restraint may trigger experiences of isolation, abandonment, confinement or powerlessness associated with abuse that exacerbate the impact of trauma and compound a person's distress (Department of Health 2011a, *Framework for recovery-oriented practice*).

Appendix 3: Reflective questions

Culture and systems

People with a lived experience

- How are people with a lived experience and carers involved in developing systems?
- How are people supported to share their experience of seclusion and restraint, and is this learning incorporated into staff training and current practice?
- How do we seek people's views on factors that contribute to creating a safe environment?

Workforce

- How are people at all levels of the organisation supported to understand and work towards a vision for reducing restrictive practices?
- Are clinicians clear on their role and responsibility to reduce restrictive interventions, and how is individual accountability monitored and supported?
- Are strategies in place, and effective, in enabling skill development in de-escalation and managing complex dynamics within a ward environment?
- How are clinicians supported to facilitate self-determination and develop skills to better understand the lived experience?
- How is the cultural vision developed and communicated to all people in the organisation?
- Is there a clear workforce plan that outlines roles and responsibilities of all the positions in the organisation, from the chief executive officer to ward staff? Does the plan ensure that staff have the tools they require to reduce restrictive interventions?

Management

- Are managers clear about the organisation's commitment to reducing restrictive interventions? How are they held accountable for modelling the vision and supporting a learning culture?
- Are there systems in place that are effective in enabling supported decision making?
- Do our systems effectively enable our workforce to meet objectives in reducing restrictive interventions? How are they reviewed to ensure they are contemporary and align with our vision?
- To what extent do our systems support or hinder the least restrictive practices?
- To what extent are systems based on evidence-based best practice?

A healthy environment

People with a lived experience

- How are people supported to contribute their expertise to designing models of care that support calm, safe and welcoming environments?
- Do we effectively discuss with people their experience, needs and preferences? If so, do we use this information to align our practice to recovery principles?
- How is the physical fabric of the ward managed to be welcoming and respectful?

Workforce

- How is the workforce supported to effectively work with consumers and carers using prevention and early intervention models?
- How do systems support clinicians to reflect on and enhance their practice?
- To what extent are clinicians held accountable for practising in ways that reflect the organisation's vision for reducing restrictive practices?
- Are workforce strategies and systems aligned with recovery-oriented practice and trauma-informed principles? Do people understand how these approaches lead to a reduction in restrictive practices?
- How is the workforce supported to contribute to a positive and open culture? Are all people in our organisation clear about their responsibilities in fulfilling this cultural vision?
- Do we effectively engage with our workforce to create safe environments for all people and how do we review this?

Management

- Are leaders at all levels clear about their role and responsibility in reducing restrictive interventions, and do our systems hold them accountable?
- To what extent do systems enable people with a lived experience and carers to contribute to initiatives that reduce restrictive interventions?
- How do we align our systems with the principles of recovery-oriented practice and trauma-informed care? Are we clear about how these principles contribute to create a safe and healthy environment?
- How do workforce strategies encourage reflection and learning to contribute to a healthy environment?

Anticipating need and managing escalation

People with a lived experience

- How do we engage with consumers and carers to seek their views on systems that support a prevention and early intervention focus?
- Are people with a lived experience and carers involved in initiatives to reduce restrictive interventions and how do we seek their views in reviewing incidences of aggression?
- How are people supported to provide their views and debrief following an incident of restraint or seclusion?
- How do we work with people to develop care and treatment plans that identify people's triggers, calming strategies and history, and include interventions that maximise people's choices?

Workforce

- How is the workforce supported to anticipate people's needs, and reduce stress and agitation? Do systems enable or hinder this?
- How does reflective practice support individuals and teams to understand, recognise and respond to agitation or aggression?
- Are clinicians clear on what it means to practise in a way that balances responsibility and risk, and how do our systems facilitate this?
- To what extent do our practice and systems align with the principles of trauma-informed care? Would people with a lived experience and carers agree with our assessment?
- Do workforce development strategies and systems allow adequate opportunities to incorporate sensory approaches to care?

Management

- To what extent do practice models and other systems facilitate an early intervention focus? Do we provide opportunities for our staff, people with a lived experience and carers to make positive changes?
- How effective are our strategies in anticipating need and managing escalation? How is data used to inform practice and monitor the effectiveness of these strategies?

Review and quality assurance

People with a lived experience

- Are there opportunities for people with a lived experience and carers to provide feedback on systems or the use of restrictive interventions? How is the feedback encouraged and considered?
- To what extent do strategies and systems provide opportunities for people to contribute their experiences and preferences? Is this done in a formal way that informs practice?

Workforce

- Are there opportunities for the staff to be involved in the collection, analysis and review of data? How does this contribute to reflective practice?
- How does data inform individual and collective practice?
- Is this data available and used effectively to provide learning and development to staff?

Management

- How is data used to inform service and environmental design?
- To what extent are we using data to monitor our progress in reducing restrictive interventions? Is progress being monitored against targets and is this being communicated across the organisation?
- How is data used to improve our systems and the way we work with consumers and carers? Do we inform people of our progress in reducing restrictive interventions?

Appendix 4: Useful resources

Creating Safety: Addressing Restraint and Seclusion Practices project report
Department of Health, Victoria, 2009
www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/index.htm

Creating violence free and coercion free mental health treatment environments for the reduction of seclusion and restraint
Chief Psychiatrist, Victoria, 2009
www.health.vic.gov.au/chiefpsychiatrist/creatingsafety

Framework for recovery-oriented practice
Department of Health, Victoria, 2011
www.health.vic.gov.au/search.htm?q=recovery+orientated+practice

Medical leadership competency framework, 3rd edition
NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010
www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf

Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
Queensland Health, 2008
www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf

Recovery-oriented practice: literature review
Department of Health, Victoria, 2011
docs.health.vic.gov.au/docs/doc/Recovery-oriented-practice---literature-review

Reducing restrictive interventions: a literature review and document analysis
Department of Health, Victoria, 2013
www.health.vic.gov.au/mentalhealth

Seclusion in approved mental health services
Chief Psychiatrist, Victoria, 2011
www.health.vic.gov.au/mentalhealth/cpg/seclusion-cpg-1103001.pdf

Six core strategies for reducing seclusion and restraint use
National Association of State Mental Health Program Directors, Alexandria, Virginia, 2006
www.nasmhpd.org/docs/NCTIC/Consolidated_Six_Core_Strategies_Document.pdf>

Supported decision-making: background and discussion paper
Office of the Public Advocate, Victoria, 2009
www.publicadvocate.vic.gov.au/file/file/Research/Discussion/2009/0909_Supported_Decision_Making.pdf

What is happening at the Seclusion Review that makes a difference? A consumer led research study Bradley Foxlewin, 2012
www.cmhdaresearchnetwork.com.au/data/files/02/00/00/00/Bradley%20Consumer-Led%20Research.pdf

References

Department of Health 2011a, *Framework for recovery-oriented practice*, Department of Health, State Government of Victoria, Melbourne.

Department of Health 2011b, *Recovery-oriented practice: literature review,* Department of Health, State Government of Victoria, Melbourne.

Department of Health 2012, *A new Mental Health Act for Victoria: summary of proposed reforms*, Department of Health, State Government of Victoria, Melbourne.

Department of Health 2013, *Reducing restrictive interventions: literature and document analysis*, Department of Health, State Government of Victoria, Melbourne.

Department of Health and Ageing 2010, *National standards for mental health services 2010*, Commonwealth Department of Health and Ageing, Canberra.

National Mental Health Strategy 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra.

NSW Health 2012, Aggression, seclusion & restraint: preventing, minimising and managing disturbed behaviour in mental health facilities in NSW, New South Wales Government, Sydney, <www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_035.pdf>.