



**Minimum training standards: Preventing and managing clinical aggression including the use of physical restraint**

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# Introduction

Clinical aggression is increasingly being recognised as an area of concern. In Victoria, health services are each responsible for ensuring workforce development strategies are in place for the prevention and management of clinical aggression and that staff are aware of these strategies and skilled in their application. The Department of Health and Human Services (DHHS) is undertaking a project to standardise approaches to training in the prevention and management of clinical aggression in mental health services (including emergency departments) in Victoria. This document is a step toward this intent by developing minimum training standards for preventing and managing clinical aggression including a practice model for physical restraint.

This document integrates five literature reviews and a Chief Psychiatrist’s guideline related to the prevention and management of clinical aggression published by the Victorian Government. These documents are:

* Livingstone, A. (2007). *Seclusion practice: a literature review.* Melbourne: Department of Health.
* Department of Health (2013), *Reducing restrictive interventions: literature review and document analysis.*  Melbourne: Department of Health.
* McKenna, B., Furness, T. & Maguire, T. (2014). *A Literature Review and Policy Analysis on the Practice of Restrictive Interventions.* Melbourne: Department of Health and Human Services
* McKenna, B., Daffern, M., Maguire, T. & Roberton, T. (2016). *A literature review and policy analysis on the management of clinical aggression in Victoria.* Melbourne: Department of Health and Human Services.
* McKenna, B., Daffern, M., Maguire, T. & Roberton, T. (2016). *A literature review and policy analysis on the use of physical restraint in Victoria.* Melbourne: Department of Health and Human Services.
* Department of Heath and Human Services(2014). *Chief Psychiatrist’s guideline: Restrictive interventions in designated mental health services*. Melbourne: Department of Health and Human Services.

Three important over-arching principles relating to the prevention and management of clinical aggression emerged from these literature reviews:

* Utilise a range of strategies, including *primary* (minimising the risk of violence before violence develops), *secondary* (used when violence is perceived to be imminent) and *tertiary* (controlling or reducing a violent incident that is already underway) strategies.
* Consistently adopt policies at an organisation level (encouraging cultural change), rather than at a ward or individual level. This aligns with the intent of these guidelines, which is to standardise the approach of training in the prevention and management of clinical aggression across Victoria.
* Take a recovery-oriented, person-centred, trauma-informed approach in the prevention and management of clinical aggression. This is associated with more successful outcomes in preventing and managing aggression and is consistent with reducing restrictive interventions.

#  Minimum training standards for the prevention and management of clinical aggression

## Training as part of a model of care.

The training for the prevention and management of clinical aggression should be located within a recovery-oriented, person-centred, family/carer inclusive, trauma-informed model of care. As such, the focus is on the least restrictive strategies, yet cognisant of the need to maintain the safety of consumers and staff. The model of care should be included in the training. Such models of care may include, but are not limited to, the following:

* Safewards

Safewards is a model that has been established to guide the way people understand and respond to conflict and containment on mental health wards (Bowers, 2014). Safewards identifies a range of originating factors that give rise to specific flashpoints that can trigger a range of conflict events (e.g. aggression, self-harm, absconding). The model also identifies methods of containment (e.g. p.r.n. medication, seclusion, physical restraint), noting that containment is often in a ‘dynamic reciprocal relationship’ with conflict events. While providing a framework for understanding how conflict and containment events come about, the Safewards model also aims to guide the reduction of instances of both conflict and containment through addressing staff modifiers and, in some cases, the originating factors (such as the staff team or physical environment).

* Six core strategies

The ‘six core strategies’ for reducing the use of seclusion and restraint are based on trauma-informed and strength-based care (Huckshorn & LeBel, 2009). This is a systemic response to reducing restrictive interventions through targeting leadership toward organisational change; the use of data to inform practice; workforce development; the use of seclusion/restraint prevention tools; the development of consumer roles in inpatient settings; and the use of debriefing techniques post the use of restrictive interventions.

* Recovery - orientated care

Recovery-oriented care is the policy directed and preferred mode of mental health service delivery in Victoria. Recovery is a broad empirical and philosophical paradigm that emphasises an individual’s journey to a full and productive life, with or in the absence of episodes of mental illness. Recovery-oriented service delivery aims to adapt to the needs and aspirations of each consumer and assist with each person’s unique journey. The onus is on health professionals to care within the domains of recovery-oriented practice - to promote a culture of hope; to promote autonomy, and self-determination through holistic and personalised care; to establish collaborative partnerships and meaningful engagement; to focus on consumers’ strengths; to include families and carers; and to encourage community participation and citizenship (Department of Health, 2011). These guidelines also advocate for the reduction of restrictive interventions such as restraint and seclusion.

* Trauma-informed care

The use of a trauma-informed care approach is thought to be particularly important, given that exposure to trauma (particularly in childhood) is associated with a higher likelihood of aggressive behaviour in forensic mental health consumers (Podubinski, Lee, Hollander, & Daffern, 2015). A trauma-informed approach acknowledges the central role that trauma has played in the consumer’s life and recognises the presence of trauma symptoms in the consumer’s display of aggressive behaviours. Services that are trauma-informed will i) accommodate the vulnerabilities of trauma survivors, ii) make efforts to avoid re-traumatisation, and iii) facilitate healing.

## Standards for the training of primary strategies:

* Staff training programs

There is research evidence that staff training in the prevention and management of clinical aggression increases staff confidence, by improving staff knowledge and skill competencies. Therefore, all staff across the multi-disciplinary team should receive such training with annual up-dates. This training should be provided by trained educators.

The training should be based on adult learning principles that participants offer experiences that contribute to the learning of others. Thus learning is emphasised as a collaborative endeavour. A variety of modes of presentation should be adopted in the training to accommodate the differing learning styles of participants including slide show presentations, video viewing, group discussion, e-learning and interactive learning including role plays. It is also important that learning is reinforced with the opportunity to reflect on its application in the clinical setting, to assist in the translation of the learning into practice. Mentors in the form of ‘best practice champions’ (Ploeg, Skelly, Rowan, et al., 2010) might be helpful in this regard. Training can also be enhanced through the co-facilitation of the training with people with lived experience of mental illness to assist in the critical reflection on what is being taught by the participants.

It is vital that there is systemic oversight by the clinical governance structure or service quality oversight committee of the quality of the training in preventing and managing clinical aggression. This oversight should coincide with the monthly review of statistics related to the use of restrictive interventions. There is also value in the service regularly (every 6-12 months) considering the training in relation to the potential impact it has on staff attitudes to the management of aggression and the unit social environment more generally. Two validated measures, the Essen Climate Evaluation Schema (EssenCES: Schalast, Collins, Stacey & Howells, 2008) and the Management of Aggression and Violence Attitude Scale (MAVAS: Duxbury et al., 2008) might assist in this regard.

* Legal and policy parameters

The training should alert participants to the legislative processes that guide strategies such as the legal requirements in the Mental Health Act 2014 (see Department of Heath and Human Services, 2014).

All Victorian designated mental health services are required to have in place local policies, procedures and clinical practices that reduce, and where possible, eliminate the use of restrictive practices. Such processes should align with associated legislation including the Victorian Occupational Health and Safety Act 2004. Local policies and procedures are required to consider the particular service setting, populations served and any other relevant local factors. Those being trained must be informed about these.

* Maintaining a safe therapeutic environment

The training should emphasise the importance of maintaining an appropriate ward culture conducive to reducing instances of aggression and maintaining safety. A responsive ward culture is one that is consumer centred (respecting consumers as people; caring and connecting with consumers; observing, being aware of, and responding to behaviours, thoughts, emotions, and motivations; being fully present in the ebb and flow of daily life in the unit; and facilitating the needs of individual consumers and the therapeutic milieu (Department of Health, 2013).

Creating a safe environment for consumers, visitors and staff is essential to building and maintaining a positive experience of care. It is important to recognise that whilst physical security measures have a part to play in supporting the delivery of a safe service; this is only part of the picture. The environment has a key role in encouraging consumers to participate in life on the ward and actively engage with staff and in treatment. Importantly, the environment also has a part to play in minimising risk and maintaining motivated, confident staff. The intent is to achieve ‘therapeutic security’ by managing risk to provide a safe working and living environment. A safe and secure environment is maintained through ‘physical security’ associated with the structure and design of buildings, and manual and electronic containment systems; ‘procedural security’ which relates to the methods used to manage people including policies and procedures, information systems, reception and screening processes, search practices and responses to aggression; and ‘relational security’ which is the use of communication skills by well-motivated and trained staff who use these skills to contain behaviour.

Recognising and responding to clinical deterioration

Train staff in the use of a short-term violence risk assessment instrument and ensure this is systematically used and integrated into routine care; such an approach is important to assist recognition of clinical deterioration/increasing aggression propensity. Several risk assessment instruments exist though we recommend the Dynamic Appraisal of Situational Aggression (DASA; Ogloff & Daffern, 2006), which was develped in an Australian context. This assessment rates the presence or absence of certain behaviours that commonly precede acts of aggression in an effort to determine whether the consumer is likely to be aggressive in the next 24-hour period. Such instruments contribute to efforts to reduce aggression by allowing early recognition of emerging signs of imminent aggression and enhancing objectivity in clinical decision making.

* Observations through engagement

Train staff in the importance of observations though engagement, which are potentially less restrictive strategies for preventing and managing aggression. Observation is not passive surveillance. It involves gathering both objective and subjective information about the person from direct contact with the person, to inform decision making (Department of Health, 2013b). Observations within this context might involve detailed physical health assessment, mental health status assessment or risk assessment; more frequent observations; or reporting of findings to a medical practitioner, authorised psychiatrist or delegate. The detail of what is required during purposeful observations should be outlined in the consumer’s care plan. The use of observations may also flow over into a secondary intervention in the form of continuous observations, which can involve two approaches.

1. Constant (visual) observations, which occur with the person being within the vision of a registered nurse or registered medical practitioner at all times.
2. Constant (arm’s length) observations, which occur with the person being in arm’s length of a registered nurse or registered medical practitioner at all times.

The use of observations also provides opportunity for person-centred engagement and can assist staff in gaining an understanding of the issues of concern for the consumer (Department of Health, 2013b).

## Standards for the training of secondary strategies:

* Train all staff in de-escalation skills.

Training must equip staff in the skilled use of de-escalation to be used ahead of restrictive measures when managing clinical aggression. A literature review commissioned by the Department of Health and Human Services identified seven themes of effective de-escalation (Department of Health, 2013a). Three themes relate to staff skills (de-escalation style; personal control; verbal and non-verbal skills) and four themes relate to the process of de-escalation (engaging with the consumer; deciding when to intervene; ensuring safe conditions for de-escalation; and strategies for de-escalation).

A model by Bowers (2014) involves three stages of de-escalation: i) delimit: make the immediate situation safe for yourself and others, ii) clarify: find out why the consumer is angry or agitated by asking open questions and checking your understanding of the situation with the consumer, and iii) resolve: try to find a way of dealing with the complaint that will satisfy the consumer. Bowers also notes that in order to be successful, these process need to be carried out by a de-escalator who is able to control their own emotions and act in a respectful and empathic manner.

In the literature that does exist on de-escalation, a different set of relevant components emerges. This represents one of the challenges of de-escalation training – definitions of de-escalation vary widely with a perception that staff ‘just know’ what de-escalation is. Each service will need to make a decision about what specific approach from the evidence base to use and have staff consistently trained in the approach throughout the service.

* Train all staff in the use of appropriate limit setting skills.

Training must equip staff in the effective use of respectful, empathic, yet appropriately directive styles of communication, which are the most important element of limit setting (Department of Health, 2013a). A recent study has identified five principles for limit setting: helping consumers understand why limits are being set; listening to and understanding the consumer’s perspective; treating consumers fairly and respectfully; knowing the consumer and engaging them in the process; and setting limits in a consistent manner (Maguire, Daffern, & Martin, 2014).

* Train all staff in the use of sensory modulation techniques to assist people in self-regulating aggression

All nursing staff and occupational therapy staff must be trained in the use of sensory modulation, given that sensory approaches may be effective in reducing distress and provide an afferent response to arousal or aggression (Sutton et al., 2013). Sensory modulation aims to shift attention away from negative cognitive scripts or distressing symptoms, refocussing attention on the consumer’s body or immediate environment. This might occur in a designated space equipped with a range of materials for sensory input or rely on taking the materials preferred by the consumer to them.

## 2.4 Standards for the training of tertiary strategies:

* Create an awareness in staff of the guidelines for the use of pharmacological approaches in managing aggression including the use of PRN medication.

In a previous review it was noted that there is a paucity of evidence to support the practice of using pharmacological approaches to provide a calming effect intended to prevent or manage aggression (Department of Health, 2013a). This practice, including *pro re nata* (PRN) medication and rapid tranquilisation, is often based upon clinical experience rather than scientific evidence. The review highlighted the possible dangers associated with using *pro re nata* (PRN) medication and noted calls for best-practice guidelines to be developed. Research indicates that there is some low-level evidence that not only is there a lack of consensus in guideline documents, but that staff may not always follow the guidelines that are available with respect to administering PRN medications.

Against a background of growing concern over the use of PRN medications in the absence of empirical evidence, this is some initial evidence that reducing the use of PRN medications is not necessarily associated with an increase in aggressive behaviours.

* The training should dispel the myth that reducing the use of seclusion and restraint is associated with an increase in clinical aggression.

In the past, there has been some concern that a reduction in restrictive measures will lead to an increase in clinical aggression. However, Smith et al. (2015) retrospectively explored data in mental health hospitals and found a weak but significant association between the declining use of restrictive measures (including physical restraint, mechanical restraint, and seclusion) and lower rates of assaults (both consumer-to-consumer and consumer-to-staff). No conclusions on causation can be made, of course, however this evidence does support the idea that a reduction in restrictive measures is not necessarily associated by an increase in clinical aggression.

* The use of restrictive intervention as last resort measure.

The training must be based on the use of restrictive interventions as a last resort in response to behaviour that suggests a ‘serious and imminent risk of harm’ to self or others. The determination of ‘serious and imminent harm’ is based on clinical judgment, clinical knowledge and the assessment of a person and their behaviour using evidenced based assessment instruments. Clinical staff must assess and document that there is a high probability that the person will (or within the near future will) seriously harm themselves or another person and cite their rationale for this judgement.

In a matter of urgency, restrictive interventions may be applied to any person receiving services in a designated mental health service, regardless of legal status, under duty of care. In such circumstances, the principles for reducing restrictive interventions still apply.

* Train staff in the policies and procedures regarding the use of seclusion.

This training needs to reflect the Chief Psychiatrists’ guidelines (see Department of Heath and Human Services, 2014) and local service policies and procedures.

* Train staff in the policies and procedures for the use of physical restraint.

This training needs to reflect the Chief Psychiatrists’ guidelines (see Department of Heath and Human Services, 2014) and local service policies and procedures. The detail of the evidenced-based techniques reflected in point 3 below need to be incorporated into the training.

* Train staff in the policies and procedures for the use of mechanical restraint.

This training needs to reflect the Chief Psychiatrists’ guidelines (see Department of Heath and Human Services, 2014) and local service policies and procedures.

* Applicable to the use of all restrictive interventions (seclusion, physical restraint and mechanical restraint).

The training in the use of restrictive interventions must be modified to the population-specific characteristics of service users in the organisation. The training must incorporate (Department of Health and Human Services, 2014):

1. Gender specific care

Sensitivity to gender-specific needs is crucial. Consumers may have different preferences about the gender of staff involved in prevention and early intervention, as well as the use of a restrictive intervention. The consumer’s preferences should be sought and responded to. Arrangements for clothing, searches for dangerous objects, toileting and review should also be undertaken in regard to gender sensitivity. Consideration should also be given to the possibility of pregnancy in female consumers and the implications of this, especially if medications contraindicated during pregnancy are being considered. It is important to remember a key component of providing gender sensitive care is to understand trauma and how it manifests in people when they are in acute distress.

1. Intellectual disability or acquired brain injury

Where a person has an intellectual disability or acquired brain injury, his or her behaviour may be the principal means of communication, particularly where his or her ability to communicate may also be impaired by mental illness. Problematic behaviour, where possible, should be assessed for meaning before making decisions to use a restrictive intervention.

It should be anticipated that it is not uncommon for these consumers to demonstrate a low frustration tolerance and at times poor impulse control. People with cognitive impairment often have difficulty in understanding the rationale for the use of a restrictive intervention and may react with an escalation in agitation during this process. Carers’ views should be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained at a level the person is able to comprehend. All the above points should be outlined in a detailed care plan.

1. Older persons

Consideration should be given to the ramifications of the use of a restrictive intervention for this age group. There is a marked increase of bone fractures and loss of skin integrity when applying and maintaining a restrictive intervention for older persons, as well as exacerbation of underlying confusion and agitation. Special consideration should be given to the assessment for underlying or emerging medical conditions impacting on the person’s mental state and behaviour.

Carers views should also be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events. Wherever possible, older adults should receive one-to-one nursing care in preference to using a restrictive intervention. All the above points should be outlined in a detailed care plan.

1. Children and adolescents

The developmental status of a young person should be a consideration in any decision to use a restrictive intervention. The use of a restrictive intervention with children under the age of 12 years should be avoided. Restrictive interventions must be used with caution when they involve adolescents because in most cases their musculoskeletal systems are immature, which elevates the risk of injury.

The carer, of a young person must be informed of the use of a restrictive intervention as soon as practicable. A decision to involve a carer, or other relevant third parties in the debriefing process must take into account the young person’s capacity to consent to their involvement.

1. Aboriginal consumers

Aboriginal consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences of colonisation.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Cultural advisors should be used, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

1. Culturally and linguistically diverse (CALD) consumers

Restrictive interventions may be more traumatic and potentially more dangerous for people who are unable to understand what is happening or unable to communicate their questions or concerns. Consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences such as being a refugee or being a survivor of abuse or torture.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Interpreters should be used (telephone or face-face) or cultural advisors, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

1. Consumers with sensory impairment

The use of a restrictive intervention may also be more traumatic and potentially more dangerous for people who are unable to fully understand what is happening or unable to communicate their questions or concerns due to sensory impairment. Specific interventions, such as the physical restraint of an auditory impaired person’s hands, may also prevent effective communication.

Special care must be taken in these situations to achieve effective communication. The use of carers who are familiar with the communication needs of the consumer should be considered in these situations.

1. **Best practice model for physical restraint**

In Victoria, the use of physical restraint has only recently been regulated by the *Mental Health Act 2014*. Physical restraint involves the ‘skilled, hands-on immobilisation or physical restriction of a person’ (Department of Health, 2014, p. 8). At the current time, health services are each responsible for the type of physical restraint techniques used and for ensuring that staff have the appropriate skills and knowledge to manage this safely. The Department of Health and Human Services (DHHS) in Victoria is now undertaking a project to develop a standardised approach to the use of physical restraint in health services. The literature on physical restraint techniques locates the application of physical restraint techniques in a process commencing before the application of the techniques, through to the application of the techniques and through to approaches required following their use.

*Before a physical restraint episode:*

* Emphasis needs to be placed on early intervention and the prevention of aggression (see reference to primary and secondary strategies in this document).
* Recovery-oriented, person-centred and trauma-informed care reduces the use of physical restraint (see reference to ‘Training as part of a model of care’ in this document).
* Consumers, carers, and relevant third parties must be informed of the reason for physical restraint as soon as possible.
* Physical restraint should be a component of a holistic training package for staff, which includes training in early intervention and prevention, de-escalation, physical monitoring, and relevant local service policy (see reference in 2. Above).
* Physical restraint should be undertaken by a trained team who work closely together, understand each other’s roles and have a clearly defined lead.
* Training needs to be updated on a regular basis.
* Staff need to be trained in basic life support.

*Staff safety during assault scenarios.*

* Training needs to be given on techniques for staff to defend themselves from assault (‘break away techniques’). However, consideration needs to be given to the number of techniques that are taught in order to ensure they are remembered.
* The UK standardisation process advocates for teaching four ‘breakaway techniques’ - Fix and move; Bowling; Lever principles; Close proximity techniques.

*During a physical restraint episode:*

* If physical restraint is used, it should only be used as a last resort.
* The level of force applied during physical restraint must be justifiable, appropriate, reasonable, and proportionate to the situation.
* Standing holds (escort, support and secure) are the least restrictive alternative
* Such holds are accepted in a sitting position
* There is no physical restraint position that is absolutely safe.
* Staff must monitor and manage the risks, whatever restraint position is used.

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|  A person on whom a physical restraint is used must be under continuous observation by a registered nurse or registered medical practitioner (Mental Health Act 2014, s. 116(2)). This level of observation reflects the seriousness of the intervention and the potential for injury and death. The focus of attention during observation must be on the person's safety, dignity and any change in the person's physical, risk or mental health status (see Department of Health and Human Services, 2014). |

* Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area.
* Physical restraint should not be used in a way that interferes with the consumer’s ability to communicate.
* The minimum team number is two staff and three if the person physically resists.
* Physical restraint requires physical and psychological monitoring and a physical health review after the episode.
* There is no safe time limit for physical restraint. Do not routinely use physical restraint for more than 10 minutes.
* The use of wrist locks which induce pain are used as a last resort for short periods of time in some jurisdictions. However, this has not a practice in Victoria (including in forensic mental health). Therefore, pain-inducing techniques should not be used.
* Controlled exiting from a seclusion room is required when a person is restrained for the purpose of seclusion.
* Wherever possible, restraining consumers on the floor should be avoided. If the floor is used, this should be for the shortest period of time and for the central reason of gaining control of the situation.
* The prone position (lying on the floor face down) and the flexion of the head or trunk toward the knees restrict the ability of the person to breath and should be avoided.
* Where the prone position is unavoidable, the Supported Prone Position may have fewer physiological and psychological risks for adults than Unsupported Prone Positions (wrists or ankles must not be restrained behind the back) (See Figure 1).
* People are not to be taken to the floor in the supine position. They should be taken to the floor by a controlled prone technique and then transferred to the supine position.
* If legs are required to be restrained when the person is supine or prone a 4th person is required (weight must not be placed on the person’s body).
* In some clinical situations (e.g. emergency departments) bed restraint maybe an alternative to taking someone to the floor.

*After the physical restraint episode:*

* A physical review of the consumer is required.
* Debriefing with consumers and staff is important.
* There must be a rigorous review of the event conducted with all key stakeholders.

 

***Figure 1.*** *Three different prone positions. (a) Position I, (b) Position 2, (c) Position 3 “supported prone position” (*Barnett et al., 2016).

**Recommendation:**

A standardised approach to the use of physical restraint techniques is rapidly progressing internationally. This is specifically evident in three jurisdictions – New South Wales, New Zealand and the United Kingdom. However, the manualised versions of the techniques in each jurisdiction are still being refined, but should be available by the end of the year. There is commonality across the jurisdictions and some nuances specific to each jurisdiction.

1. We recommend discussions with the following to obtain a finalised version of their manuals on physical restraint:
* The Health Education and Training Institute in New South Walesa.
* The National Directors of Mental Health Nursing in New Zealand.
* The manager of training at Rampton Hospital in the United Kingdom.
* Director of Mental Health Nursing at Forensicare, Victoria.
1. We recommend the development of a state-wide Victorian resource (manual or video) on evidence-based physical restraint techniques, by a small group of expert trainers in the prevention and management of physical aggression.
2. We recommend a review and development of best practice guidelines for de-escalation and limit setting, so that we don’t see a range of invalid approaches emerge throughout Victoria.
3. We recommend that the following document is revised in accordance with these evidence-based standards:-

Department of Health and Human Services (2014). *Chief Psychiatrist’s guideline: Restrictive interventions in designated mental health services.* Melbourne: Department of Health and Human Services.

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