

National Mental Health Seclusion and Restraint Project (NMHSRP)

National Documentation Outputs

Executive Summary

The National Mental Health Seclusion and Restraint Project was a collaborative initiative between the Australian Government and State and Territory Governments. In line with the *National Safety Priorities in Mental Health: a National Plan for Reducing Harm*, the project aimed to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services.

Commencing in the second half of 2007, the project comprised three parts:

1. The National Documentation project. This part supported, expedited and expanded the work already started by the Safety and Quality in Mental Health Partnership Subcommittee Seclusion and Restraint Working Party (SRWP) through the establishment of a Community of Practice (CoP), and by developing and piloting data standards and performance indicators.
2. Beacon demonstration sites. Eleven national sites, with relevant jurisdiction support, worked to develop and implement best practice. They aimed to become centers of excellence in relation to the reduction and, where possible, the elimination of seclusion and restraint.
3. Scholarships to undertake a study tour of the United States of America. The scholarships aimed to identify evidenced-based practice occurring in the USA and enable adaptation of this to Australian conditions.

The Safety and Quality Partnership Subcommittee (SQPS), a subgroup of the Mental Health Standing Committee (MHSC), had governance over the project. The SQPS had previously established a Seclusion and Restraint Working Party (SRWP) to develop standard national definitions for seclusion and restraint, key underpinning principles, procedural guidelines and audit tools and this work continued in parallel with the NMHSRP.

A major learning from the project was that the successful reduction of seclusion and restraint relies on the complex interaction of a number of factors that, in turn, impact more broadly on service delivery. This includes the need to address the broader system of care including leadership at all levels, organisational culture and values, culturally informed consumer centred care embracing recovery principles, training and education, quality improvement processes and the inpatient environment. At the completion of the project in June 2009 the outcomes were positive, with significant changes achieved at all participating sites; not just in the rates of seclusion, but in the culture, knowledge and attitude of staff as well as increased consumer and carer involvement.

The SQPS will continue to have a watchful brief in this national safety and quality priority area as much remains to be done to ensure that the focus and momentum achieved during the project continues and is extended more widely to all services across Australia. There is also considerable potential for the strategies piloted by this project to be applied in health service settings outside of mental health as well as the private health sector.

The suite of national documentation which follows is one of the outputs of the project. The documents were developed over a period of two years, drawing of the combined learnings of participating organisations and the work of the SRWP. At its meeting in September 2009, the Mental Health Standing Committee endorsed the suite of documents for use by Australian mental health services.

NATIONAL DOCUMENTATION RELATING TO SECLUSION AND RESTRAINT REDUCTION

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Seclusion and Restraint Working Party
Preface to Report

It is an established principle that in all aspects of mental health service provision consumers and carers must be involved to the fullest extent possible and this is reflected in this report. In this report the term carer or carers means the person or persons identified as such by the consumer or in the absence of such identification can include parents, partners, brothers, sisters, friends or children of any age. A carer can also be a State and Territory Guardianship Board or Tribunal appointed guardian or administrator.

Release of information to an identified carer or carers will be subject to the relevant jurisdictional legislation which may include legislation that supports the involvement of carer(s) including release of information to a carer and/or limiting legislation that restricts the release of personal information to support the consumer's right to privacy and confidentiality. The principle that carers must be involved to the maximum extent possible is to be implemented in practice but this must occur within the respect for privacy and confidentiality and associated legislative requirements.

Wherever in this report "where appropriate*" appears it is to be interpreted on the basis of identification of the carer(s) compliance with any jurisdictional legislative requirements, such as obligatory consent for release of personal information, but at all times maximizing the opportunities for involvement of the carer(s) in all aspects of the consumer's care including general discussion and relevant information to enable the carer's understanding and involvement.

Seclusion – Definition

The confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.

Key elements:

1. The consumer is alone.
2. The seclusion applies at any time of the day or night.
3. Duration is not relevant in determining what is or is not seclusion.
4. The consumer cannot leave of their own accord.

Implications:

1. The intended purpose of the confinement is not relevant in determining what is or is not seclusion.
2. Seclusion applies even if the consumer agrees or requests the confinement.
3. The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion.
4. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area e.g. courtyard.
5. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition.

Exceptions:

Any exceptions that are specified in relevant jurisdictional legislation.

Restraint – Definition

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

The clinical interventions of pharmacological treatments to sedate a consumer or reduce agitation or distress are not included in these guidelines as an acceptable form of restraint and should not be applied as an equivalent to restraint practice. Such pharmacological treatments require clear separation from any practice of restraint and appropriate guidelines should be developed and applied to support and clarify this separation.

Physical restraint is defined as the skilled hands-on immobilisation or the physical restriction of a consumer to prevent the consumer from harming him/herself or endangering others or to ensure the provision of essential medical treatment.

Mechanical restraint is defined as the application of devices (including belts, harnesses, manacles, sheets and straps) on a consumer's body to restrict his or her movement. This is to prevent the consumer from harming him/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the consumer's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a consumer's freedom of movement.¹ The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Key elements:

1. The safety of the consumer and others is paramount.
2. The restraint is used for urgent intervention only where all other interventions have been tried, or considered and excluded.
3. Restraint is used for the shortest period necessary.
4. Minimal amount of force necessary is used.

Implications:

1. Staff participating in the use of restraint are trained in safe restraint practices that have been endorsed by the appropriate clinical governance body of the specialist mental health service.
2. Services have a range of interventions/strategies for managing acutely disturbed behaviour prior to considering the use of restraint.
3. Physical restraint for the purpose of administering medication and/or electro convulsive therapy is to be regarded as restraint.
4. It is expected that all episodes of restraint will be recorded and reported for review and audit.

Exceptions:

Any exceptions that are specified in relevant jurisdictional legislation.

¹ Victorian Mental Health Act

KEY PRINCIPLES FOR SECLUSION PRACTICE

Principle 1: Protection of fundamental human rights

- A sensitive assessment of the needs and risks for the consumer is undertaken at the time of admission, identifying and implementing strategies that ensure seclusion is only used where absolutely necessary and as a last resort.
- Wherever possible, consumers and their carers should be involved in collaborative decision-making about the options for the management of disturbed/violent behaviour.
- Seclusion is intended to prevent harm to the consumer, staff or others.
- The clinical decision to use seclusion should only be taken when all other less restrictive options have been tried, or considered and excluded.
- Seclusion should not be used as a punishment or threat, as part of an individual treatment and care plan, or because of staff shortages.
- Seclusion should be used for the shortest possible time and must adhere to the principle of care in the least restrictive manner.

Principle 2: Protection against inhumane or degrading treatment

- During seclusion, there should be continuing attention to the consumer's dignity, privacy and self-respect.
- During seclusion, the individual needs of the consumer are recognised, including sensitivity to cultural, spiritual, language and gender concerns.

Principle 3: Right to highest attainable standards of care

- The physical and emotional safety of consumers is maintained throughout the seclusion process through competent, timely and appropriate observation and monitoring.
- Staff caring for consumers in seclusion must have undergone appropriate training and have a sound knowledge of relevant legislation and preventative consumer care interventions including de-escalation and/or conflict resolution.
- Policies and procedures on seclusion practices are available and accessed by all staff who may potentially be involved in the seclusion of a consumer.
- Education and training is provided to update the knowledge and practice skills of all staff who may potentially be involved in the use of seclusion, including risk assessment and alternative interventions.

Principle 4: Right to medical examination

- During all episodes of seclusion, the consumer must be examined by a medical practitioner at least every four hours and any adverse outcome, such as physical

injury or emotional trauma, sustained as a result of the seclusion, must be appropriately treated, recorded and reported.

Principle 5: Documentation and notification

- All episodes of seclusion must be documented in the consumer's clinical record and, where appropriate*, the carer must be notified as soon as possible of the reason for the seclusion and of any adverse outcome, such as any injury that may have been sustained.

Principle 6: Right to appropriate review mechanisms

- The consumer is provided with the opportunity for debriefing with a psychiatrist or senior mental health clinician at the earliest possible time.
- A timely review of every episode of seclusion is required to determine the appropriateness of the intervention and its application, and to identify alternative interventions. The consumer's perspective must form part of the review process. The outcomes of the review must inform the individual treatment and care plan for the consumer.
- All services should periodically review the rate of seclusion, the practice of seclusion and any adverse events that may have occurred during seclusion.
- Services should ensure that aggregated seclusion reports are provided to the quality and safety oversight committee (e.g. clinical governance committee) for the service or area health service on a regular basis in order to advise the service and clinicians on conclusions or recommendations.

Principle 7: Compliance with legislation and regulations

- Seclusion policies, procedures and protocols must comply with the jurisdictional legislation, regulations and reporting requirements.

* Refer to Preface

KEY PRINCIPLES FOR RESTRAINT PRACTICE

Principle 1: Protection of fundamental human rights

- A sensitive assessment of the needs and risks for the consumer is undertaken at the time of admission, identifying and implementing strategies that ensure restraint is only used where absolutely necessary and as a last resort.
- Wherever possible, consumers and their carers should be involved in collaborative decision-making about the options for the management of disturbed/violent behaviour.
- Restraint is intended to prevent harm to the consumer, staff or others.
- The clinical decision to apply restraint should only be taken when all other less restrictive options have been tried, or considered and excluded.
- Restraint should not be used as a punishment or threat, as part of an individual treatment and care plan, or because of staff shortages.
- Restraint should be used for the shortest possible time and must adhere to the principle of care in the least restrictive manner.

Principle 2: Protection against inhumane or degrading treatment

- During restraint there should be continuing attention to the consumer's dignity, privacy and self-respect.
- During restraint the individual needs of the consumer are recognised, including sensitivity to cultural, spiritual, language and gender concerns.

Principle 3: Right to highest attainable standards of care

- The physical and emotional safety of consumers is maintained throughout the restraint process through competent, timely and appropriate observation and monitoring.
- Appropriate training and have a sound knowledge of relevant legislation and preventative consumer care interventions including de-escalation and/or conflict resolution.
- Policies and procedures on restraint practices are available and accessed by all staff who may potentially be involved in the restraint of a consumer.
- Education and training is provided to update the knowledge and practice skills of all staff who may potentially be involved in the use of restraint, including risk assessment and alternative interventions.

Principle 4: Right to medical examination

- Following all episodes of restraint, the consumer must be examined by a medical practitioner and any adverse outcome, such as physical injury or emotional trauma sustained as a result of the restraint, must be appropriately treated, recorded and reported.

Principle 5: Documentation and notification

- All episodes of restraint must be documented in the consumer's clinical record and, where appropriate *, the carer must be notified as soon as possible of the reason for the restraint and of any adverse outcome, such as any injury that may have been sustained.

Principle 6: Right to appropriate review mechanisms

- The consumer is provided with the opportunity for debriefing with a psychiatrist or senior mental health clinician at the earliest possible time.
- A timely review of every episode of restraint is required to determine the appropriateness of the intervention and its application, and to identify alternative interventions. The consumer's perspective must form part of the review process. The outcomes of the review must inform the individual treatment and care plan for the consumer.
- All services should periodically review the rate of restraint, the practice of restraint and any adverse events that may have occurred during restraint.
- Services should ensure that aggregated restraint reports are provided to the quality and safety oversight committee (e.g. clinical governance committee) for the service or area health service on a regular basis in order to advise the service and clinicians on conclusions or recommendations.

Principle 7: Compliance with legislation and regulations

- Restraint policies, procedures and protocols must comply with the jurisdictional legislation, regulations and reporting requirements.

* Refer to Preface

GUIDELINES FOR MANAGING EPISODES OF SECLUSION

These guidelines have the contextual principle that the clinician must be continuously responsive to any requirement of clinical care for the individual patient, particularly where a more immediate intervention is required or is appropriate.

On Admission

- The admission assessment identifies any history and risk of acutely disturbed behaviour and records strategies for managing the potential for such behaviour in the individual treatment and care plan.

- Consumers and their carers are informed about unit routines and expectations, including the unit policy on seclusion.

Authorisation of an Episode of Seclusion

- Authorisation of the use of seclusion must comply with the legislation of the relevant jurisdiction.
- The authorisation must be documented.

Individual Treatment and Care Plan

- The individual treatment and care plan should be reviewed and updated following each episode of seclusion.

Communicating the Seclusion Process to the Consumer

- While a seclusion event is in progress, every effort should be made to explain the process to the consumer in order to reduce distress.

Maintaining Dignity and Self Respect

- During an episode of seclusion there should be continuing attention to the particular concerns of the consumer including self respect, history of trauma, gender, culture and language.
- A consumer in seclusion should retain their own clothing unless this compromises their safety and the safety of others. Appropriate alternative clothing will be provided, as necessary, to maintain the consumer's dignity.
- No person should be placed naked into seclusion. In the event that the consumer removes their clothing while in seclusion, staff should make all attempts to maintain the dignity of the consumer by appropriate means.
- A consumer in seclusion should be allowed to keep personal items, including those of religious or cultural significance (such as some items of jewellery) as long as it does not compromise their safety or the safety of others.

Physical and Behavioural Observations

- Visual observations should preferably be continuous or as frequent as necessary to ensure the safety of the consumer and to comply with relevant jurisdictional legislation.
- Staff involved in the episode of seclusion must ensure that observations include that the consumer's breathing is unobstructed, their position is posturally appropriate to ensure their safety, and their level of consciousness and distress is closely monitored.
- If staff cannot be certain via visual observations alone that the consumer is breathing, appropriate physical examination must be undertaken without delay.

Initial Medical Review

- Medical review should occur as soon as practicable, preferably within one hour after the initiation of any episode of seclusion and should be documented in the consumer's clinical record.

Ongoing Medical Review

- Regular attempts should be made to enter the seclusion room unless there are documented reasons, approved by the authorised practitioner, not to do so.
- An assessment of physical and mental state should be made at this time.
- An assessment of the ongoing need for seclusion should be conducted by two staff (wherever possible, one of whom was not involved in the decision to seclude). This review should take place no later than two hours after the commencement of seclusion, every two hours thereafter, and the reasoning for the decision should be documented.
- The consumer must be examined by a medical practitioner at intervals of not more than four hours. Any adverse outcome, such as physical injury or emotional trauma sustained as a result of the seclusion, must be appropriately treated, recorded and reported to the treating psychiatrist.
- Where appropriate*, the carer must be notified as soon as possible, of any adverse outcomes, such as physical injury, that may have been sustained.

Prolonged or Multiple Episodes of Seclusion

- Comprehensive reassessment by the treating team should be conducted if the cumulative hours of seclusion exceed 24 hours in a one week period.
- A revised individual treatment and care plan that stipulates the rationale for continuation of seclusion, if necessary, and the expected path of treatment should be developed and alternative options actively identified and implemented where possible.

* Refer to Preface

- An independent psychiatrist's opinion should be obtained if further seclusion occurs beyond the review by the treating team.

Ceasing Seclusion

- Seclusion must be ceased when the consumer is no longer an acute risk to themselves or others. When a consumer falls asleep whilst secluded, staff should assess whether it is appropriate to cease seclusion.
- On ceasing seclusion, the senior registered nurse on duty must ensure that the risk assessment is completed and the individual treatment and care plan reviewed.
- Following seclusion, the consumer should be sensitively reintegrated to the ward.

Review of an Episode of Seclusion with the Consumer

- A debriefing with the consumer should be facilitated as soon as appropriate. The debriefing should be clearly documented in the consumer's clinical record.
- This debriefing will include a discussion with the consumer, and carer/s where appropriate*, to inform any necessary amendments to the consumer's individual treatment and care plan.

Recording the Use of Seclusion

- Recording of seclusion should start as soon as an episode of seclusion has been initiated.
- The record must comply with the relevant legislative requirements for the jurisdiction.

Reporting Seclusion

- Jurisdictions should review and revise existing arrangements for the reporting of seclusion episodes and ensure that reporting requirements include the time of commencement and cessation of each episode, the authorisation and the observation and examination standards articulated in this document.

Documentation

- All episodes of seclusion must be documented in the consumer's clinical record and, where appropriate*, the carer must be notified as soon as possible of the reason for the seclusion and of any adverse outcome, such as physical injury, that may have been sustained.
- Documentation should be as complete as possible, refer to all areas outlined above and include clear documentation of any adverse events relating to the episode of seclusion.

* Refer to Preface

- Documentation indicates alternative strategies attempted or considered and confirmation that seclusion was used as a last resort.

Clinical and Operational Review

- A timely review of each episode of seclusion must occur to determine the appropriateness of its use, ensure attention to safety issues and identify alternative interventions and opportunities for clinical care improvement. This review should involve a psychiatrist and senior nurse, or other personnel as appropriate. The consumer and carer, where appropriate*, should be offered the opportunity to participate and learning from the debriefing should be incorporated into the review.
- The outcomes of the episode review should inform the individual treatment and care plan for the consumer in particular, and service delivery in general.
- Services should undergo a process of regular review (no less than six monthly) of the aggregated seclusion reports by the clinical governance/clinical quality committee or equivalent. The review should include a consumer and carer representative and one clinician external to the service. Feedback should be provided to the clinical staff on any conclusions and recommendations of that committee in relation to the use of seclusion.

Compliance with Legislation

- All seclusion episodes must comply with relevant jurisdictional legislation.

* Refer to Preface

GUIDELINES FOR MANAGING EPISODES OF RESTRAINT

These guidelines have the contextual principle that the clinician must be continuously responsive to any requirement of clinical care for the individual patient, particularly where a more immediate intervention is required or is appropriate. These guidelines apply equally to physical and mechanical restraint.

On Admission

- The admission assessment identifies any history and risk of acutely disturbed behaviours and records strategies for managing the potential for such behaviour in an individual treatment and care plan.
- Consumers and their carers are informed of unit routines and expectations of reasonable behaviour.

Authorisation of an Episode of Restraint

- Authorisation of the use of restraint must comply with the legislation of the relevant jurisdiction.
- The authorisation must be documented.

Individual Treatment and Care Plan

- The individual treatment and care plan should be reviewed and updated following each episode of restraint.

Communicating the Restraint Process to the Consumer

- While a consumer is being restrained, every effort should be made to explain the process to the consumer in order to reduce distress.

Maintaining Dignity and Self Respect

- During an episode of restraint there should be continuing attention to the particular concerns of the consumer including self respect, history of trauma, gender, culture and language.

Physical and Behavioural Observations

- Visual observations should be continuous or as frequent as necessary to ensure the safety of the consumer and to comply with relevant jurisdictional legislation.
- Staff involved in the episode of restraint must ensure that observations include that the consumer's breathing is unobstructed, their position is posturally appropriate to ensure their safety, and their level of consciousness and distress is closely monitored.

- In assessing consumer safety, the medical history and any recent sedation should be considered and monitored.

Initial Medical Review

- Review by a medical practitioner should occur forthwith after the initiation of any restraint episode and should be documented in the consumer's clinical record.

Ongoing Medical Review

- The consumer must be examined by a medical practitioner at intervals of not more than one hour, or as determined by relevant jurisdictional legislation. Any adverse outcome, such as physical injury or emotional trauma sustained as a result of the restraint, must be appropriately treated, recorded and reported to the treating psychiatrist.
- Where appropriate*, the carer must be notified, as soon as possible, of any adverse outcomes, such as physical injury, that may have been sustained.

Prolonged or Multiple Episodes of Restraint

- Comprehensive reassessment by the treating team should be conducted if the cumulative hours of episodes of restraint exceed two hours in a one week period.
- A revised individual treatment and care plan that stipulates the rationale for further use of restraint, where necessary, and the expected path of treatment should be developed and alternative options actively identified and implemented where possible.
- An independent psychiatrist's opinion should be obtained if further restraint occurs beyond the review by the treating team.

Ceasing Restraint

- Restraint must be ceased when the consumer is no longer an acute risk to themselves or others.
- The need for continuing an episode of restraint should be assessed frequently as long as the consumer remains restrained. This assessment should be undertaken by two staff, one of whom was not involved in the initial decision to restrain and the reasoning for the continued restraint should be documented at least every 15 minutes.
- On ceasing restraint, the senior registered nurse on duty must ensure that the risk assessment is completed and the individual treatment and care plan reviewed.
- The consumer should be sensitively resettled to the ward as soon as the restraint is ceased.

Review of an Episode of Restraint with the Consumer

* Refer to Preface

- A debriefing with the consumer should be facilitated as soon as appropriate. The debriefing should be clearly documented in the consumer's clinical record.
- This debriefing will include a discussion with the consumer, and carers where appropriate*, to inform any necessary amendments to the consumer's individual treatment and care plan.

Recording the Use of Restraint

- Recording of restraint should start as soon as an episode of restraint has been initiated.
- The record must comply with the relevant legislative requirements of the jurisdiction.

Reporting Restraint

- Jurisdictions should review and revise existing arrangements for the reporting of restraint episodes and ensure that reporting requirements include the time of commencement and cessation of each episode, the authorisation and the observation and examination standards articulated in this document.

Documentation

- All episodes of restraint must be documented in the consumer's clinical record and, where appropriate*, the carer must be notified as soon as possible of the reason for the restraint and of any adverse outcome, such as physical injury, that may have been sustained.
- Documentation should be as complete as possible, refer to all areas outlined above and include clear documentation of any adverse events relating to the episode of restraint.
- Documentation indicates alternative strategies attempted or considered and confirmation that restraint was used as a last resort.

Clinical and Operational Review

- A timely review of each episode of restraint must occur to determine the appropriateness of its use, ensure attention to safety issues and identify alternative interventions and opportunities for clinical care improvement. This review should involve a psychiatrist and senior nurse or other personnel as appropriate. The consumer and carer, where appropriate*, should be offered the opportunity to participate and learning from the debriefing should be incorporated into the review.
- The outcomes of the episode review should inform the individual treatment and care plan for the consumer in particular, and service delivery in general.
- Services should undergo a process of regular review (no less than six monthly) of the aggregated restraint reports (the rate of restraint, the

* Refer to Preface

practice of restraint and any adverse events that may have occurred in relation to the use of restraint) by the clinical governance/clinical quality committee or equivalent. The review should include a consumer and carer representative and one clinician external to the service. Feedback should be provided to the clinical staff on any conclusions and recommendations of that committee in relation to the use of restraint.

Compliance with Legislation

- All restraint episodes must comply with relevant jurisdictional legislation.

SECLUSION PRACTICES: AUDIT TOOL

DOMAIN: INDIVIDUAL CLINICAL CARE Standard 1: Consumers are provided with high quality care <i>(Document source: Retrospective clinical record review)</i>	Yes	No	Partial	Comments
1.1 The admission assessment identifies any history of acutely disturbed behaviours and records strategies for managing the potential for such behaviour.				
1.2 There is evidence that a multidisciplinary assessment and corresponding care plan is developed in partnership with the consumer and their carer that documents how risk factors for seclusion will be addressed.				
1.3 The clinical record documents that the provision of care is sensitive to the particular concerns of the consumer e.g. history of trauma, gender, culture and language.				
1.4 The clinical record documents consideration and use of alternative strategies to reduce the likelihood of seclusion; there is evidence that seclusion has been used only as an intervention of last resort.				
1.5 There is evidence in the clinical record that all relevant statutory forms are completed to ensure legislative requirements are met and appropriate clinical observations and monitoring occurred.				
1.6 There is evidence in the record that the consumer has appropriate access to bedding, food and fluids, and that personal hygiene needs are met.				

1.7 There is evidence in the record that the consumer is provided with post seclusion debriefing.				
1.8 There is evidence in the record that an independent psychiatrist's opinion is obtained if further seclusion occurs beyond the review by the treating team.				

DOMAIN: CLINICAL SUPPORT SYSTEMS Standard 2: The mental health service demonstrates its commitment to continuous quality improvement and improving and supporting good standards of consumer care (Source: staff survey/interview, clinical support systems and evidence of continuous quality improvement, risk management systems)	Yes	No	Partial	Comments
2.1 There is a system in place to ensure all seclusion episodes are reviewed for appropriateness and standards of care; each episode of seclusion results in a treating team review to identify opportunities for improvement of care.				
2.2 Clinical supervision is available to support staff in providing high standards of care; staff debriefings are utilized to discuss issues of safety and provide incident review.				
2.3 There is evidence that seclusion data and related data information systems are used to support and improve care delivery.				
2.4 Aggregated data is presented for review at the clinical governance/clinical quality committee or equivalent on a regular basis.				
2.5 Unit routines and expectations are documented and available and are explained to consumers and carers at orientation.				

DOMAIN: ORGANISATIONAL SUPPORT Standard 3: The organisation ensures that formal structures and delegation practices are in place to support safe, quality care. (Source: evidence of policies and procedures and strategic operational planning and directions)	Yes	No	Partial	Comments
3.1 Separate quiet areas are available for use by consumers as needed.				
3.2 Seclusion specific policies and procedures are available and consistent with national seclusion guidelines (principles and procedures).				
3.3 The organisation has a seclusion reduction plan outlining goals and actions; there is evidence that the plan is regularly evaluated.				
3.4 There is evidence of addressing seclusion practices that includes: <ul style="list-style-type: none"> • practice and systems change required to reduce the use of seclusion • individual and/or group clinical supervision for staff to ensure opportunities for learning • training and education program in relation to seclusion • staff sensitivity to consumer experiences and concerns • education on post seclusion debriefing of consumers and where appropriate*, carers • legal and compliance requirements for seclusion use 				
3.5 Mandatory training is provided to staff on seclusion reduction systems of care.				
3.6 There is evidence of orientation and training for new employees specific to seclusion practices.				

* Refer to Preface

RESTRAINT PRACTICES: AUDIT TOOL

DOMAIN: INDIVIDUAL CLINICAL CARE Standard 1: Consumers are provided with high quality care <i>(Document source: Retrospective clinical record review)</i>	Yes	No	Partial	Comments
1.1 The admission assessment identifies any history of acutely disturbed behaviours and records strategies for managing the potential for such behaviour.				
1.2 There is evidence that a multidisciplinary assessment and corresponding care plan is developed in partnership with the consumer and their carer that documents how risk factors for restraint will be addressed.				
1.3 The clinical record documents that the provision of care is sensitive to the particular concerns of the consumer e.g. history of trauma, gender, culture and language.				
1.4 The clinical record documents consideration and use of alternative strategies to reduce the likelihood of restraint; there is evidence that restraint has been used only as an intervention of last resort.				
1.5 There is evidence in the clinical record that all relevant statutory forms are completed to ensure legislative requirements are met and appropriate clinical observations and monitoring occurred.				

1.6 There is evidence in the record that the consumer has appropriate access to bedding, food and fluids, and that personal hygiene needs are met.				
1.7 There is evidence in the record that the consumer is provided with post restraint debriefing.				
1.8 There is evidence in the record that an independent psychiatrist's opinion is obtained if further restraint occurs beyond the review by the treating team.				

DOMAIN: CLINICAL SUPPORT SYSTEMS Standard 2: The mental health service demonstrates its commitment to continuous quality improvement and improving and supporting good standards of consumer care (Source: staff survey/interview, clinical support systems and evidence of continuous quality improvement, risk management systems)	Yes	No	Partial	Comments
2.1 There is a system in place to ensure all restraint episodes are reviewed for appropriateness and standards of care; each episode of restraint results in a treating team review to identify opportunities for improvement of care.				
2.2 Clinical supervision is available to support staff in providing high standards of care; staff debriefings are utilized to discuss issues of safety and provide incident review.				
2.3 There is evidence that restraint data and related data information systems are used to support and improve care delivery.				
2.4 Aggregated data is presented for review at the clinical governance/clinical quality committee or equivalent on a regular basis.				
2.5 Unit routines and expectations are documented and available, and are explained to consumers and carers at orientation.				

DOMAIN: ORGANISATIONAL SUPPORT Standard 3: The organisation ensures that formal structures and delegation practices are in place to support safe, quality care. (Source: evidence of policies and procedures and strategic operational planning and directions)	Yes	No	Partial	Comments
3.1 Separate quiet areas are available for use by consumers as needed.				
3.2 Restraint specific policies and procedures are available and consistent with national restraint guidelines (principles and procedures).				
3.3 The organisation has a restraint reduction plan outlining goals and actions; there is evidence that the plan is regularly evaluated.				
3.4 There is evidence of addressing restraint practices that includes; <ul style="list-style-type: none"> • practice and systems change required to reduce the use of restraint • individual and/or group clinical supervision for staff to ensure opportunities for learning • training and education program in relation to restraint • staff sensitivity to consumer experiences and concerns • education on post restraint debriefing of consumers and where appropriate*, carers • legal and compliance requirements for restraint use 				
3.5 Mandatory training is provided to staff on restraint reduction systems of care.				
3.6 There is evidence of orientation and training for new employees specific to restraint practices.				

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National Mental Health Seclusion and Restraint Project

CORE TRAINING AND EDUCATION PRINCIPLES & PRIORITIES FOR THE REDUCTION OF SECLUSION AND RESTRAINT

PREAMBLE

The concept of 'primum non nocere' ('first, do no harm') is a fundamental tenet for all clinicians, and it is with this obligation to consumers in mind that the practices of seclusion and restraint are currently being examined. The rationale for using seclusion and restraint has been many and varied; some of which are well-intentioned, but many of which are misunderstood, misinterpreted or even misused. Seclusion and restraint should not be used as a substitute for interpersonal and therapeutic engagement with consumers.

The use of (or reliance on) seclusion and restraint may be an indirect result of a range of factors, including organisational leadership, poor unit design, a lack of suitable alternative management options, the skill level of staff and lack of appropriate staff training and education.

Training and education that uses a prevention and early intervention model is a core component of a restraint and seclusion reduction strategy. It is also a component of a broader workforce development strategy that includes orientation of new staff to the principles and policies of restraint and seclusion reduction; availability of regular clinical supervision and support for staff, and ongoing opportunities for related training e.g. post incident consumer debriefing.

The following outlines the key principles and priorities for staff education and training, which the Core Training and Education Working Group have identified as providing the necessary foundation for services (and their staff) engaged in the reduction of seclusion and restraint within inpatient settings.

KEY PRINCIPLES

1. Consumer and carer perspectives will be central to the planning, development, delivery and evaluation of all training and education programs.
2. The organisation is responsible for ensuring that all staff have access to initial and ongoing seclusion and restraint reduction training and education.
3. The content of the training and education program will support least restrictive interventions at all stages of the consumer journey.
4. Training and education will reflect best practice principles and evidence where available.
5. Training and education will be in line with the legislative requirements of each jurisdiction and appropriate to local policies and protocols.
6. The training and education will be developed considering flexible delivery options with opportunity for appropriate delivery to all levels of staff in the organisation.
7. Training and education needs to be provided by credible people that have familiarity with, and a demonstrated commitment to, the strategies and components of the core training and education priorities for the reduction of seclusion and restraint.

CORE TRAINING AND EDUCATION PRIORITIES

Introduction

The table below lists the strategies and accompanying components that are critical for a restraint and seclusion reduction strategy. Some of these components may already be offered in existing mental health services training programs. Not all components will be provided through a formal training program. Other educational modes such as clinical supervision, organisational meeting forums, and staff development opportunities may also include some of these components. The table is intended as a checklist.

Some of these concepts can be further explored through the references and website links which immediately follow this table.

STRATEGY	COMPONENTS
<p>1. An Organisational Approach to Reducing Seclusion & Restraint</p> <p>For initiatives such as reducing seclusion and restraint to be successful, a systematic methodology that involves staff, carers and consumers at all levels is required and needs to be communicated through training and education.</p> <p>Integrating the initiative into existing organisational structures and processes ensures sustainability of the initiative and must be supported by ongoing training and education.</p>	<ul style="list-style-type: none"> 1.1. Organisational Readiness 1.2. Leadership (at all levels: medical, nursing/allied health, admin) 1.3. Change Management 1.4. Identifying enablers & barriers 1.5. Strategic Plan, Vision Statement 1.6. Communication Strategy 1.7. Use of Data 1.8. Consumer & Carer involvement 1.9. Multidisciplinary (team approach) 1.10. Orientation for staff
<p>2. Consumer, Carer & Staff Perspectives</p> <p>As in all mental health training and education activities there is an expectation that consumer, carer and staff perspectives will inform practice.</p> <p>It provides an opportunity to explore and appreciate other perspectives which at times may be very opposing.</p>	
<p>2.1. Consumer Perspective</p>	<ul style="list-style-type: none"> 2.1.1. Trauma Informed Care 2.1.2. Lived (consumer) experience 2.1.3. Recovery 2.1.4. Person centred care 2.1.5. Cultural respect, sensitivity and safety

<p>2.2. Carer Perspective</p>	<ul style="list-style-type: none"> 2.2.1. Trauma Informed Care 2.2.2. Lived (carer) experience 2.2.3. Recovery 2.2.4. Person centred care 2.2.5. Cultural respect, sensitivity and safety 2.2.6. Communication (timely information)
<p>2.3. Staff Perspective</p>	<ul style="list-style-type: none"> 2.3.1. Personal experiences 2.3.2. Reflective practice (including fear and apprehension) 2.3.3. Clinical supervision 2.3.4. Support options 2.3.5. Anticipating and planning care 2.3.6. Trauma Informed Care
<p>3. Therapeutic Workplace Culture</p> <p>Every organisation has a kind of personality - the culture. The culture determines how the organisation performs and how the staff interpret and respond to their experience within the organisation.</p> <p>Moulding a therapeutic culture is the responsibility of all staff and creating and maintaining a therapeutic workplace culture does not just happen - it involves considerable thought and planning.</p> <p>Training and education to facilitate the reduction of seclusion and restraint must provide staff with opportunities to examine their workplace culture and how it influences practice.</p>	<ul style="list-style-type: none"> 3.1. Definition of “workplace culture” 3.2. Understand the impact of workplace culture 3.3. Explore aspects of a therapeutic culture 3.4. Compare coercive and custodial culture with therapeutic culture 3.5. Apply understanding of “therapeutic culture” to the experience of aggression and reducing seclusion
<p>4. Understanding Aggression and Other Challenging Behaviours</p> <p>Staff require understanding of the nature of aggression/ violence and other challenging behaviours and critical events to be able to assess the client and circumstances, to address the factors related to the behaviours and events, and also to deliver the relevant, least restrictive intervention in the event of crisis.</p>	<ul style="list-style-type: none"> 4.1. Theories of aggression/violence and other challenging behaviours 4.2. Antecedents of aggression/violence and other challenging behaviours 4.3. Dynamic constructs of inpatient aggression/violence and other challenging behaviours

<p>5. Risk Assessment and Management</p> <p>Training and education can assist staff to make informed and transparent risk assessments that can suggest early intervention and prevent escalation to crisis.</p>	<p>5.1. Principles of risk assessment and management</p> <p>5.2. Risk assessment/predictive tools</p> <p>5.3. Personal Safety/transition Plans</p>
<p>6. Legal & Ethical Aspects of Seclusion & Restraint</p> <p>Full understanding of the restrictive and traumatic nature of seclusion and restraint practices can only be developed in the context of understanding the various ethico-legal and moral positions associated with these practices.</p> <p>Establishing an ethical approach to practice is an á priori focus of professional development associated with this aspect of mental health work.</p>	<p>6.1. Civil and criminal implications of assault</p> <p>6.2. Negligence</p> <p>6.3. Principles of the Mental Health Act (with attention given to seclusion and relevant sections)</p> <p>6.4. Effective Documentation</p> <p>6.5. Providing ethical care to clients and carers</p> <p>6.6. Post incident debriefing</p>
<p>7. Therapeutic Strategies</p> <p>The most pertinent question to ask in the intent to reduce seclusion and restraint is “how to engage clients in a manner that is both respectful and meaningful in terms of their recovery?” as this changes the focus into one where staff become pro-active.</p> <p>Of necessity all elements related to client recovery should come under scrutiny, this includes ways to divert client attention and tension as well as ways to engage them in their own recovery processes.</p> <p>Offering clients the means to establish hope and meaning, take control and make choices is highly assisted if staff are familiar with and able to suggest a range of therapeutic and purposeful strategies.</p>	<p>7.1. Orientation & information processes for consumers/carers</p> <p>7.2. Every day interactions with clients and carers</p> <p>7.3. Therapeutic engagement with clients and carers</p> <p>7.4. The Structured Day and meaningful activities (e.g. psycho/social interventions, physical activity)</p> <p>7.5. Sensory modulation</p> <p>7.6. Safe places/comfort rooms</p> <p>7.7. Post incident debriefing/support</p> <p>7.8. Appropriate use of pharmacological interventions</p> <p>7.9. Appropriate inclusion of Therapeutic strategies in planned care</p>
<p>8. Therapeutic Communication</p> <p>Within mental health our primary work is delivered through the medium of communication. Skill in communication across age, gender and culture is something that ought not be assumed or taken for granted but rather constantly explored and refined.</p>	<p>8.1. Principles of communication</p> <p>8.2. Core interpersonal skills</p> <p>8.3. Principles and techniques of verbal de-escalation</p> <p>8.4. Responding to criticism</p> <p>8.5. Conflict resolution</p> <p>8.6. Cultural appropriateness and use of interpreters in therapeutic encounters</p>

<p>9. Emergency Response</p> <p>While education and training to reduce seclusion and restraint have a focus on early and least restrictive intervention in consultation with the client and carer, attention must also be given to safe, humane and ethical emergency intervention for those times when restraint and seclusion are required.</p>	<ul style="list-style-type: none">9.1. Risks associated with emergency intervention9.2. Emergency use and risks of medication9.3. Break away9.4. Team restraint9.5. Safe seclusion practices
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A Snapshot of Six Core Strategies© for the Reduction of Seclusion and Restraint

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http://www.nasmhpd.org/general_files/publications/ntac_pubs/SR%20Core%20Strategies%20Snapshot%2011-2006%20src%20edits.pdf

Draft Six Core Strategies for the Reduction of Seclusion and Restraint in Australian Mental Health Facilities

Draft Document resulting from the learning of the Australian National Mental Health Seclusion and Restraint Project.

Sensory Modulation:

Sensory Connection Program

Karen Moore –

Strategies, handbooks, education

<http://www.sensoryconnectionprogram.com/index.php>

Occupational Therapy Innovations

Tina Champagne –

Seclusion and Restraint Reduction Initiatives

<http://ot-innovations.com/>

Using Comfort, Communication and the Arts to Minimise Conflict

Gayle Bluebird, Bluebird Consultants

<http://www.bluebirdconsultants.com/index.htm>

The Sensory Project

Aims to promote the use of sensory and movement approaches to enhance health, learning and wellbeing for all.

<http://www.sensoryproject.com/>

Comfort Rooms that Work

New York State Office of Mental Health

"Comfort Rooms: A Preventative Tool Used to Reduce the Use of Restraint and Seclusion in Facilities that Serve Individuals with Mental Illness"

http://www.omh.state.ny.us/omhweb/resources/publications/comfort_room

Tina Champagne MEd, OTR/L and Nan Stromberg, MSN, RN, CL
Sensory Approaches in Inpatient Psychiatric Settings
Innovative Alternatives to Seclusion & Restraint
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http://www.mass.gov/Eeohhs2/docs/dmh/rsri/sensory_article.pdf

Trauma Informed Care

Responding to Childhood Trauma: the Promise and Practice of Trauma Informed Care.

Gordon R. Hodas MD

Statewide Child Psychiatric Consultant,

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February 2006

http://www.nasmhpd.org/general_files/publications/ntac_pubs/Responding%20to%20Childhood%20Trauma%20-%20Hodas.pdf

National Association of State Mental Health Program Directors

Presentations and handouts from Jan 2008 Seclusion and Restraint Reduction Kick Off Meeting

– Various presentations on USA S&R reduction initiatives including Trauma Informed Care, Sensory Modulation

<http://www.nasmhpd.org/SRkickoff.cfm>

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SIX CORE STRATEGIES

for the Reduction of Seclusion and Restraint in Australian Public Mental Health Facilities

Overview

The following Six Core Strategies have been developed as an outcome of the *National Mental Health Seclusion and Restraint Project* (NMHSRP): a collaborative initiative between the Australian Government and State and Territory Governments with the primary aim to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health facilities. This is in line with the *National Safety Priorities in Mental Health; a National Plan for Reducing Harm*.

Much of the work of the NMHSRP was based on the USA *Six Core Strategies for the reduction of Seclusion and Restraint*¹ framework and acknowledgement is given to Kevin Ann Huckshorn and the National Technical Assistance Centre (NTAC): National Association of State Mental Health Program Directors (NASMHPD) for endorsement to utilise the model.

The Strategies build on the suite of National Documentation developed by the Seclusion and Restraint Working Party (SRWP): Safety and Quality Partnership Subcommittee (SQPS) as a national framework for the reduction of seclusion and restraint in Australian public mental health facilities.

The SQPS has a continuing role in monitoring progress of the seclusion and restraint reduction in mental health services and it is intended that the strategies will be continually updated as new information and research emerges.

¹ Kevin Ann Huckshorn – Office of Technical Assistance (OTA) (formerly NTAC): National Association of State Mental Health Program Directors (NASMHPD)

Six Core Strategies for the Reduction of Seclusion and Restrain in Australian Public Mental Health Facilities

A Snapshot Summary

1. Leadership towards Organisational Change

This core strategy is considered essential in the implementation of seclusion and restraint reduction initiatives. It involves ensuring that an organisation is adequately prepared and demonstrates committed leadership at all levels to implement change.

This strategy includes:

- an organisational lead who provides strategic direction
- mission statement, vision, values and philosophy of care encompass individual consumer focus and principles of recovery
- formation of a seclusion and restraint reduction governance committee
- development of a unit work plan (performance improvement plan) involving multidisciplinary team approach. The plan to be accessible to all staff
- development and review of relevant policies, procedures and guidelines with a broad consultation process
- formation of Working Groups/Reference Groups as required
- seclusion and restraint included as standard item on various key committees meetings ranging from the service unit through to the Executive/Council
- review of every seclusion and restraint event
- weekly team review meeting which analyses every seclusion and restraint event
- regular audit of documents and accountability
- communication strategy
- utilising data to inform service reform
- monitoring and improving workforce development issues
- appropriate staff training in leadership and management

2. Use of Data to Inform Practice

This strategy involves the collection and use of data by an organisation at the individual unit level.

The strategy includes:

- development of a data tool (with clear instructions) to collect relevant event information on seclusion and restraint including unit information (unit name, day, shift, staff members involved in the event), consumer information (demographics, medication) and event details and tracking of injuries related to the event in both consumers and staff
- the collection of data to identify the unit seclusion and restraint use baseline
- the continuous collection of data relating to the event (including validation, analysis and reporting)
- setting flags in the data collection system at milestones (for example, the introduction of a new initiative)
- setting realistic improvement targets
- development of performance indicators
- monitoring incidents and trends/changes over time and making that information available
- undertaking benchmarking activities across unit/organisation as appropriate
- education of staff on the interpretation and use of data as a quality improvement tool

3. Workforce Development

This strategy involves the development and delivery of intensive and ongoing staff training and education activities relating to the seclusion and restraint reduction strategies. To emphasise the importance of this strategy, training/education activities have been included under each of the six core strategies.

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The strategy includes the use of the 7 Key Principles and 9 Core Training and Education Priorities to reduce seclusion and restraint developed by the Core Training and Education and Working Group of the NMHSRP.

The 9 Core Training and Education Priority areas are:

- organisational approach to reducing seclusion and restraint
- consumer, carer and staff perspectives
- therapeutic workplace culture
- understanding aggression and challenging behaviours
- risk assessment and management
- legal and ethical aspects of seclusion and restraint
- therapeutic strategies
- therapeutic communication
- emergency responses

4. Use of Seclusion and Restraint Prevention Tools

This strategy reduces the use of seclusion and restraint through the use of a variety of tools and assessment that are integrated into the facility policies and procedures and each individual consumers care/management plan. The strategy relies heavily on the concept of individualised treatment and recovery model as well as prevention and early intervention.

It includes the development and use of assessment tools to:

- identify risk of violence and seclusion and restraint history
- identify high risk factors for injury (self and others)
- identify history of trauma

In addition it includes the use of

- de-escalation/safety plan (identify triggers and preferred de-escalation options)
- first person, non discriminatory language in speech
- comfort and sensory rooms stocked with appropriate/suitable equipment
- other environmental changes including décor, artworks etc
- meaningful structured treatment activities designed to teach people self management skills

It also requires the development and delivery of staff training on the appropriate use of S&R prevention tools and interventions.

5. Consumer Roles in Inpatient Settings

This strategy involves the meaningful inclusion of consumers, carers, family and advocates in various roles within the organisation to assist in the reduction of seclusion and restraint.

This strategy includes:

- involvement in individual care/management/safety plans
- involvement in debriefing activities post seclusion or restraint events
- involvement in the event oversight, monitoring and review processes

- involvement in the development of policies, procedures, strategies and training associated with seclusion and restraint reduction
- consumer and carer perspective elements within the staff training program

Additionally it includes:

- use of peers in positions of support, companionship and/or advocacy
- representation on various working/reference groups and committees
- employment within the organisation/unit with clear roles and responsibilities, and the support and oversight at executive level

It also includes the development and delivery of training to consumers and carers.

6. Debriefing Techniques

This strategy involves the thorough analysis of every seclusion and restraint² event recognising that the knowledge gained from the review activity is used to update the care/management/safety plan for the individual as well as to inform policy, procedures and practices to avoid repeats in the future. The strategy is also intended to attempt to mitigate the adverse and potentially traumatising effects of a seclusion or restraint event for the involved staff, consumer and all witnesses.

The strategy involves:

1. An initial “post-event” debriefing (*immediately after or shortly after – needs to be determined due to differing views*) led by the senior supervisor, to:
 - ensure that everyone is safe
 - consult with staff, consumers and witnesses to capture sufficient information to assist with later analysis/review
 - ensure that appropriate protocols/procedures are in place for continued monitoring
 - assist in returning the unit milieu to the pre event status
 - identify potential needs for policy and procedure review
2. A therapeutic intervention or “talk session” with the consumer at a time considered appropriate (determined with due consideration of the consumer and the event). This is intended to:
 - provide information to the consumer about the event (assisting in understanding)
 - provide emotional support and validate the consumers feelings associated with the event
 - discuss alternatives to prevent a similar event in the future and use the outcome to update the consumers care/management/safety plan
 - repair or improve the rapport
 - identification of issues which may require specialised interventions
3. A formal debriefing which occurs one to several days following the event which is attended (as far as possible) by the staff involved and the treatment team, including the attending doctor. This is intended to enable a rigorous problem solving process to identify what went wrong, what knowledge was unknown or missed, what could have been done differently and how to avoid seclusion/restraint in future

Note: The organisation is to ensure that staff involved with, and witnesses to, the event are also provided with appropriate debriefing processes.

The strategy also requires the development and delivery of staff training on the appropriate use of S&R debriefing techniques.

² Consider extending this to apply to all (major) events where there is violence or aggression, not just S&R.