Assisting mental health services to reduce restrictive practices

A case study about the role of the Victorian Department of Health and Human Services
The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices

A case study
Acknowledgments

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Background

The use of restrictive practices (seclusion and bodily restraint) has a long history in mental health services internationally. There is marked variation in their use across jurisdictions. In some countries, certain practices are not used at all, while specific practices are more pronounced in some countries than in others. Social attitudes and clinical traditions are attributed as accounting for such variations (Raboch et al. 2010).

Restrictive practices in mental health service delivery are coercive violations of human rights (Drew et al. 2011), and reducing and eliminating their use has been a constant focus for mental health services (Bergk et al. 2011). However, restrictive practices continue to be used as a last resort in managing risk of harm to self and others (Wieman et al. 2014).

Restrictive practices are used in mental health services throughout Australia. Again, there is variation in their use across states and territories, the extent of which has been difficult to determine until recent standardisation in the way such practices are recorded (Australian Institute of Health and Welfare 2018). There are also national initiatives to reduce their use. Reducing restrictive interventions was identified as one of four safety priorities for mental health services by the Commonwealth Government in 2005 (National Mental Health Working Group 2005). Mental health services must be safe for consumers, carers, families, visitors, staff and the community by reducing and, where possible, eliminating the use of restraint and seclusion (Commonwealth Government of Australia 2010). The Australian Health Ministers’ Advisory Council (2016) has projected a stronger shift towards eliminating these practices. The council, through its key mental health committees (the Safety and Quality Partnership Standing Committee and the Mental Health, Drug and Alcohol Principal Committee), supports the goal now shifting to supporting eliminating restrictive practices in mental health services.

In Victoria, seclusion, physical restraint and mechanical restraint practices are mandated under the Mental Health Act 2014 (the Act), which enables their use as a last resort and for the briefest duration after all other less restrictive options have been tried or considered and found to be unsuitable (Chief Psychiatrist 2014).

Section 3 of the Act defines restrictive practices as the use of ‘bodily restraint and seclusion’ (Chief Psychiatrist 2014, p. 12). It defines bodily restraint as ‘a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms)’ (Chief Psychiatrist 2014, p. 3). Physical restraint involves the ‘skilled, hands-on immobilisation or physical restriction of a person’ (Chief Psychiatrist 2014, p. 3). Mechanical restraint involves the ‘application of devices (including belts, harnesses, manacles, sheets, and straps) on a consumer’s body to restrict their movement’ (Chief Psychiatrist 2014, p. 3). Section 3 of the Act defines seclusion as ‘the sole confinement of a person to a room or any other enclosed space, from which it is not within the control of the person confined to leave’ (Chief Psychiatrist 2014, p. 3). ‘Chemical restraint’ is not recognised under the Act.

In Victoria there has been an ongoing commitment to reducing the use of restrictive interventions, starting with implementing the Creating Safety: Addressing Restraint and Seclusion Practices project in 2006. The Mental Health Act strengthens state government policy and initiatives to reduce the use of restrictive interventions by regulating the practice of restrictive interventions and increasing oversight and accountability.

The role of the Chief Psychiatrist under the Victoria’s Mental Health Act includes providing clinical leadership and expert clinical advice to public mental health services, promoting the quality and safety of mental health services, and promoting the rights of people receiving mental health treatment from public mental health services (Department of Health and Human Services 2018b). The Office of the Chief Mental Health Nurse is part of the Office of the Chief Psychiatrist within the Department of Health and
Human Services. This office similarly supports the implementation of the Act and Victorian Government priorities for safety in mental health services and works towards eliminating restrictive practices (Department of Health and Human Services 2018a).

In Massachusetts, in the United States, a systems-wide approach to reducing the use of seclusion resulted in a reduction in the rates of seclusion in 70 child and adolescent inpatient services (LeBel et al. 2004). This was achieved primarily through an external authority monitoring visits, assisting staff to change workplace cultures to align with reducing restrictive practices, and assisting staff to introduce evidence-based reduction practices. This reduction was achieved through a ‘working with’ approach, rather than by changing policies and regulations (Gaskin, Elsom & Happell 2007). This external authority to mental health services is similar to the position held by the department in relation to working towards eliminating restrictive practices in Victoria. However, little is understood about the precise mechanisms by which this approach has been implemented, the uptake of this support by mental health services, or its perceived impact.

Aim and objectives

Given this limited understanding, the aim of this research was to provide a case study of the department’s approach to eliminating restrictive practices by focusing on the following objectives:

• Outline the strategies and mechanisms the department has engaged to reduce the use of restrictive practices.
• Describe the uptake by mental health services of the department’s strategies.
• Outline the perceived impact of the department’s approach.
• Compare the approach taken by the department with other national and international jurisdictions.

Method

Research to meet these objectives involved an illustrative case study of the development, implementation and perceived impact of the department’s efforts towards eliminating restrictive practices in mental health services. In general, a case study aims to investigate a complex intervention or approach within the real-life context in which it has occurred (Yin 2003). Illustrative case studies are primarily descriptive studies that typically use one or two instances of an event to illustrate an intervention or approach, with a focus on the contextual elements of the case. Case studies characteristically combine mixed methods of data collection involving both quantitative and qualitative approaches. A case study methodology was chosen for this research because current international knowledge about systems-wide approaches to reducing the use of restrictive practices in mental health services is sparse.

This study does not claim to establish the efficacy of the department’s approach. There is value, however, in understanding how the approach was implemented, how it has been embraced by the mental health services and the perceived impact on reducing the use of restrictive practices.

The qualitative and quantitative approaches used to address each of the objectives are outlined below.

Objective 1: Outline the strategies and mechanisms the department has engaged to reduce the use of restrictive practices.

The approaches undertaken to achieve this objective involved:

• a comprehensive literature review of the leadership approaches to reducing restrictive practices
• a document and website analysis of key reports and strategic documents developed by the department towards eliminating restrictive practices
• interviews with key leaders in the department to explore the strategies used to assist services in eliminating restrictive practices; the Victorian policy context within which these strategies developed;
and the contextual drivers and sector needs, which have facilitated the emphasis towards eliminating restrictive practices.

Objective 2: Describe the uptake by mental health services of the department’s strategies.

The approaches undertaken to achieve this objective involved:

- three service case studies involving collaborative work between the department and a specific mental health service
- a national and international scan of the literature, which determined references to departmental resources in the literature.

Objective 3: Outline the perceived impact of the department’s approach.

The approaches undertaken to achieve this objective involved:

- interviews with the person primarily responsible for reducing restrictive practices in each of the area mental health services and the statewide forensic mental health service
- discussion of statistical trends in the frequency, duration and multiple use of restrictive practices for non-forensic consumers between the ages of 18 and 64 over the reporting years 2007–08 to 2016–17.

Objective 4: Compare the approach taken by the department with other national and international jurisdictions.

The approach undertaken to achieve this objective involved:

- a website analysis of strategies used towards eliminating restrictive practices comparing that of the department with other health departments or equivalent websites from each of the states and territories of Australia and three international jurisdictions.

Data analysis

A qualitative thematic analysis of the interviews and documentation was undertaken. This approach enables defensible analysis of qualitative data that may initially be varied in the raw text, allowing it to be condensed into brief summaries (Thomas 2006). The coding of interviews and documentation was developed through continuous independent reading and agreement among the researchers. Colour-coding was used to organise the data. As necessary during analysis, codes were either collapsed or split into pre-existing or different categories until central relationships began to emerge (Patton 2002). Each pattern was examined for supporting quotes from the data. Rigor was further enhanced by collective agreement among the research team on the categorical analytic framework, emergent patterns and supporting evidence (Guba & Lincoln 2005; Mays & Pope 1995).

Quantitative data were aggregated, presented as graphs, and described.

Ethics

Ethics approval for this project was obtained from the Swinburne University of Technology Human Research Ethics Committee (Approval: 2017/127).
Results: Objective 1

Objective 1: Outline the strategies and mechanisms the department has engaged to reduce the use of restrictive interventions.

Literature review

Summary
A comprehensive literature review of leadership approaches to reducing restrictive practices was undertaken. The review highlighted that:

- Strong leadership is a critical component in the drive towards eliminating restrictive practices.
- Leadership qualities such as vision and commitment are necessary for culture shift.
- An emphasis on quality improvement through continuous assessment, planning, implementation, and evaluation is essential.
- ‘Coal face’ leadership, service-wide leadership, and wider bureaucratic leadership must align.

Introduction

Coercive practices in mental health service delivery have a long and contentious history that are known to be traumatising for both consumers and staff. Restrictive practices are used to prevent consumers from harming themselves or others as a last resort, when less restrictive measures have failed (Valenkamp, Delaney & Verheij 2014). However, using seclusion, physical restraint and mechanical restraint (restrictive practices) threatens consumers' human rights to liberty, together with their rights of freedom from cruel and unusual punishment involving the use of force (Recupero et al. 2011). In the United States, Weiss et al. (1998) reported that 50–150 individuals die each year as a result of restrictive practices in mental health facilities and many more are injured or psychologically traumatised. The use of restrictive practices may also traumatised staff and damage the interpersonal relationships between staff and consumers (LeBel, Huckshorn & Caldwell 2010).

In the United States, outrage following reports of the excessive use of restrictive practices (Weiss et al. 1998) elevated an awareness of such practices from relative obscurity to a national health policy priority (Huckshorn 2004). Following the publication of the exposé (Weiss et al. 1998), the National Association of State Mental Health Program Directors identified core strategies to reduce the use of restrictive practices. This led to the publication of the Six Core Strategies for reducing restrictive practices in mental health settings (Huckshorn 2004). The six strategies are:

1. Leadership toward organisational change
2. Use of data to inform practice
3. Workforce development
4. Use of restraint and seclusion reduction tools
5. Consumers’ roles in inpatient settings
6. Vigorous debriefing techniques.

There is evidence that the Six Core Strategies are effective in reducing the use of restrictive practices (Wieman et al. 2014). However, this success has been dependent, in the United States, on leadership driven by nation-wide bodies such as the American Psychiatric Nurses Association, the American Nurses Association (Haber 2001; LeBel et al. 2004; Sivakumaran, George & Pfukwa 2011) and local bodies such as the New York City Health and Hospitals Corporation (Wale, Belkin & Moon 2011). The aim of...
this literature review was to determine the leadership requirements needed in reducing the use of restrictive practices.

**Method**

A literature search was undertaken using a variety of computerised bibliographic databases including Web of Science, PubMed/Medline, Scopus, CINAHL, EBSCO, ProQuest and Nursing & Allied Health Database. Additional papers were identified by manually searching the bibliographies of articles retrieved from the electronic search. The keywords/phrases used in the search, singly or in combination, were: seclusion, restraint, Six Core Strategies, reduction, coercion and leadership. The number of papers identified in each search are detailed in Figure 1, which shows a flow of inclusion and exclusion information through the different phases of assessing the collected papers.

**Figure 1: Inclusion and exclusion strategy for papers relating to leadership towards eliminating restrictive practices**

- **Identification**
  - Records identified through database searching \(n = 798\)
  - Additional records identified through other sources (reference lists and prospective searching) \(n = 23\)

- **Screening**
  - Records after titles screened \(n = 639\)
  - Abstracts screened \(n = 157\)
  - Full-text articles excluded \(n = 123\)

- **Eligibility**
  - Full-text articles assessed for eligibility \(n = 34\)
  - Reasons for exclusion:
    - Not available \(n = 6\)
    - Foreign \(n = 2\)
    - Not relevant \(n = 115\)

- **Included**
  - Studies included in systematic review relating to leadership and elimination of restrictive practices \(n = 18\)
Results

Eliminating restrictive practices requires a substantive paradigm shift away from coercive and punitive methods of control towards a more caring, person-centred approach involving collaboration with consumers. O’Hagan, Divis and Long (2008) suggest that restrictive practice reform appears on a continuum stretching from compliance with national regulations and appropriate use (Donat 2002; Fisher 2003; Schreiner, Crafton & Sevin 2004) to eliminating restrictive practices, which is philosophically aligned with a recovery-oriented approach to service delivery by being person-centred and working alongside people (Curie 2005; Huckshorn 2004; Sullivan et al. 2005). Following the revelation of restrictive practice abuse (Weiss et al. 1998) and the reforms that were undertaken in the United States, there has been variable reform elsewhere.

In Victoria a guideline has been established through the Office of the Chief Psychiatrist outlining the legal and best practice requirements in the use of restrictive practices (Chief Psychiatrist 2014). The guideline broadly sets out the requirements for assessment, planning, implementation and evaluation before, during and after using restrictive practices to minimise future use.

This systematic approach of assessment, planning, implementation and evaluation also constituted themes in the literature review (see Figure 2). This framework outlines the processes involved in developing a strategy towards eliminating restrictive practices in mental health service delivery, which is driven by leadership. O’Hagan et al. (2008) suggest that active, committed leadership must be present at all stages of organisational change. Each stage in the framework is discussed below in terms of the leadership qualities and approaches required.

Figure 2: Framework of processes towards eliminating restrictive practices

Assessment

A central component in initiating any change in practice culture is the careful, comprehensive assessment of the consumer population and the context of service provision. An effective assessment must take into account the special characteristics and needs of each consumer based on individual needs assessments (O’Hagan et al. 2008). Leadership towards eliminating restrictive practices should advocate for clinical assessments tailored to each individual, recognising the context in which the
behaviour has been occurring. This assessment should include considering a broad range of planned responses using preventative procedures to avoid using restrictive practices.

Leadership also needs to focus on the needs of staff. A person-centred assessment must also be used to determine these needs. The appropriateness of staff attitudes, staff burnout and the ward culture and environment should all be assessed and interventions planned to minimise their impact on using restrictive practices (Bowers et al. 2011). This may include assessing the professional development needs of staff, as poorly trained staff are at risk of reverting to restrictive practices. Therefore, mental health services must continuously monitor training needs to ensure they are consistent with best practices, meet regulatory guidelines and accommodate internal policies and procedures (Reed et al. 2013).

**Planning**

Huckshorn (2004) suggests that the values that underlie the culture change towards eliminating restrictive practices must shift from one that is institutional, impersonal, rule-based and possibly coercive, to one that is person-centred, respectful, not shame-based and endeavours to avoid homogenous approaches and generalities. Although this cultural change may be imposed through institutional policies devolved from government requirements, introducing action plans towards change requires a shared organisational vision led by management and owned by key stakeholders. This shared vision should be developed collaboratively from the outset by management, with consumers, carers and staff. Effective leadership requires the motivation of key stakeholders around a shared vision (Anthony 2004). Therefore, a paradigm shift away from restrictive practices requires organisational leadership that promotes creative thinking, collaborative problem solving and the exploration of new ideas backed by the support of all involved (Allen, de Nesnera & Souther 2009).

When implementing change, it is crucial that leaders create opportunities for stakeholders to have input and discussion on issues that are derived from their perspectives. Leaders should be able to creatively support staff without undermining their judgement. They should promote and incorporate sound problem solving and innovative ideas in managing difficult and challenging behaviour (Blair & Moulton-Adelman 2015).

Organisational change requires key stakeholder involvement at all levels, and transformational leadership is seen as a vehicle through which these groups can be empowered to make decisions based on agreed protocols that creatively support and promote sound problem solving and innovative ideas (Blair & Moulton-Adelman 2015). Transformational leadership promotes inspiration, intellectual dialogue, and participative decision making (Bowers et al. 2011). It attempts to inspire and motivate staff through the expression of the value and importance of shared goals (Aarons 2006).

Clear organisational vision statements should then be included in a plan in order to motivate staff towards a common goal: creating non-violent and non-coercive healthcare services (Huckshorn 2004). To be effective, shared vision statements must provide a sense of purpose and meaning to staff, consumers, carers and the community (Huckshorn 2004). Therefore, a specific plan must be developed that includes: (a) introducing directives that restrictive practices be eliminated; (b) mandating a timeline for elimination (Hellerstein, Staub & Lequesne 2007); (c) introducing targets or benchmarks for reducing restrictive practices (Singh et al. 1999); and (d) considering pragmatic means for initiating elimination, such as removing seclusion rooms (Lehane & Rees 1996; Scanlan 2010).

At this point, there is value in integrating the aforementioned transformative leadership style with transactional leadership, which values goal setting, feedback and reinforcement strategies, in order to meet specific targets or objectives. Both styles of management are not mutually exclusive, and good leaders effectively combine both (Aarons 2006; Bowers et al. 2011), role-modelling respectful and proactive engagement with the stakeholders involved (Huckshorn, Stromberg & LeBel 2004). Any action plan to reduce restrictive practices must be linked to the organisation’s philosophy of care. It must be
clear and unambiguous and hold all members of the organisation accountable for their actions (Allen et al. 2009).

A number of reviews have highlighted that leadership in decision-making is all too often inconsistent, reactionary, and subjective (Holzworth & Wills 1999; Mohr, Petti & Mohr 2003). Leaders should be proactive not reactive, adding value and taking ownership of the paradigm shift away from use of restrictive practices to a preventative approach; an approach that recommends using primary, secondary, and tertiary prevention interventions to mitigate risk of harm (Huckshorn 2004; National Executive Training Institute 2005), so that the practices are eventually eliminated. This must be communicated in the plan for change.

The ownership of organisational changes is crucial to the success of new ideas. Transformational leadership must empower staff to make decisions based upon agreed protocols that creatively support and promote sound problem solving and innovative ideas (Blair & Moulton-Adelman 2015), all of which are part of participative decision making (Bowers et al. 2011). Interestingly, Bowers et al. (2011) suggest that the establishment and maintenance of structure and procedural transparency for consumers is determined by teamwork. Good leadership and teamwork are key to the success of organisational changes to reduce restrictive practices (Huckshorn, Lebel & Jacobs 2014). The Six Core Strategies provide a prevention-based framework to anticipate behavioural challenges. Such management strategies allow early intervention and the analysis of the factors that contribute to the continuance of violence if restrictive practices are used (Huckshorn et al. 2014). In support of the role of leadership, Godfrey, McGill, Jones, Oxley and Carr (2014) reported that committed leadership was essential for developing and implementing new policies to reduce using restrictive practices, which is in concordance with other researchers (Ashcraft & Anthony 2008; Curie 2005; Donat 2005; Murphy & Bennington-Davis 2005). Strong recovery-oriented leaders were champions for the success of implementing policy changes (Godfrey et al. 2014).

Implementation

Leaders should be actively involved in implementing a plan towards eliminating restrictive practices. Allen et al. (2009) suggest that leaders who witness restrictive practices are best able to evaluate current responses, consider proposals for change, reduce organisational barriers and provide the essential resources to facilitate change. Problem solving in implementing the plan should involve all stakeholders including organisation leaders. Leaders should volunteer themselves as resources rather than merely be decision-makers. Blair and Moulton-Adelman (2015) suggest that staff are more likely to take ownership for the success of any system changes if such an approach is taken. Staff need to feel empowered with respect to decision making through encouragement from leaders.

Therefore, the implementation plan towards eliminating restrictive practices requires teamwork facilitated by proactive inter-stakeholder communication (Bowers et al. 2011). Leadership needs to enhance staff relationships through providing information, support and the resources to implement the plan of eliminating restrictive practices. This encourages staff to ‘engage in connected, empowering relationships with [consumers]’ (Chandler 2012, p. 35). In implementing the plan, leaders create the environment that develops and empowers staff (Huckshorn 2004). Leadership support and appropriate resourcing improves trust, connection and awareness of the consumer’s needs (Chandler 2012).

Policies and procedures need to be developed and implemented to support the plan. These need to have a degree of flexibility and should be values-based, not rule-based. Practices should be flexible enough to allow individualisation and be person-centred and responsive to consumers’ needs rather than business-centred (Ashcraft & Anthony 2008). Committed leadership is essential for developing and implementing new policies towards eliminating restrictive interventions (Ashcraft & Anthony 2008; Curie 2005; Donat 2005; Murphy & Bennington-Davis 2005).
Evaluation

Oversight of restrictive practice incidents allows leaders to drive change. The objective analysis of incident data helps set realistic goals and the tracking of multiple variables (for example, age, gender, and ethnicity) and patterns of staff involvement. Collected data helps monitor progress and the emergence of best practice. Data assists leaders to identify staff who require further training (Huckshorn 2004). The dissemination of information gathered assists leaders to inform staff of the progress made and the pitfalls that led to using restrictive practices.

The commitment to gather a historical record assists staff to recognise patterns that may be modified to move towards eliminating restrictive practices. Such data enables leaders to recognise best practices and reward staff who are able to avoid confrontation that leads to restrictive practices. The records allow the transference of knowledge so best practice is sustained. The analysis of recorded outcomes is of vital importance to identifying risk factors and the effectiveness of protocols towards eliminating restrictive practices (Guzman-Parra et al. 2016).

A culture of continuous quality improvement should be developed where leadership is sensitive to the inevitable mistakes in implementing a plan and transforms mistakes into avoidance practices that ensure they are not repeated. Leaders should create a no-blame environment where staff are not fearful of repercussions but are equipped with preventative techniques and the skill and confidence to use them. Evaluating training is essential in this regard (Reed et al. 2013).

A cohesive team approach to continuous quality improvement that is orchestrated by effective leadership is recommended. LeBel et al. (2014) suggest that consumers, carers and clinicians critically review problems, rules and practices so that clinicians can receive regularly updated information on preventative methods together with the risks and trauma associated with using restrictive practices. Assistance can also be given to clinicians regarding developing individualised prevention strategies with alternatives to restrictive practices. Romijn and Frederiks (2012) view using restrictive practices as a treatment failure and suggest leadership initiated reviews are applied to every incident involving restrictive practices.

It is suggested that formal debriefing is a critical element towards eliminating restrictive practices. This involves the active engagement of strong leadership and staff commitment (Sutton, Webster & Wilson 2014). Sutton et al. (2014) suggest there are three key elements to structured debriefing: (a) consumer debriefing; (b) staff debriefing; and (c) psychological debriefing for those experiencing trauma through using restrictive practices. There is evidence indicating consumers debriefing with those unconnected to the incident and formal team review reduce using restrictive practices (Donat 2002; Lewis, Taylor & Parks 2009). Huckshorn et al. (2004) suggest that staff debriefing should be in three tiers: (a) an immediate post-incident analysis; (b) a more formal process, a few days later, which includes a rigorous analysis; and (c) an executive level and external review to provide expertise in managing particular consumers.

Conclusion

Sound leadership is a critical component in the drive towards eliminating restrictive practices. Leaders must orchestrate organisational changes that make eliminating restrictive practices a priority (Schreiner et al. 2004). Leaders need to facilitate staff ownership of restrictive practice elimination policies and set expectations of staff to eliminate restrictive practices (Sullivan et al. 2005). Leaders need to provide staff with the necessary resources that enable eliminating restrictive practices (for example, training; Schreiner et al. 2004). Success requires leaders to establish quality evaluation processes that gather data regarding each restrictive practice incident (Taxis 2002). Debriefing and regular feedback to staff are also key to successfully eliminating restrictive practices (Godfrey et al. 2014)

However, such mechanisms can only occur if leaders have an accurate perception of the transition from a redundant culture of restrictive practices to an aspirational culture of moving towards eliminating restrictive practices. The literature does mention the leadership qualities necessary for this culture shift
but focuses more on the systematic process of quality improvement through continuous assessment, planning, implementation and evaluation.

Leadership not only involves frontline management but also hospital executives and government bureaucratic officials (Scanlan 2010). The success of any organisational change towards eliminating restrictive practices does not require large reservoirs of expenditure or increases in the number of clinical staff, but rather quality leadership, commitment, vision and desire (Bills & Bloom 1998).

**An analysis of the department’s key reports and strategic documents**

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<td>A document analysis of key reports and strategic documents completed by the department over 10 years was undertaken, which found:</td>
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<td>• a strong emphasis on reducing occupational violence from 2005 to 2011 (this emphasis occurs throughout the health sector and not just within mental health services)</td>
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<td>• an emphasis on mental health-specific documentation alongside the emphasis on occupational violence from 2012 to 2017</td>
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<td>• an initial emphasis in the mental health-specific documentation on using the Six Core Strategies, which has been maintained through developing sensory modulation and trauma-informed care training</td>
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<td>• a more recent expression of eliminating restrictive practices through implementing Safewards.</td>
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**Introduction**

The department exists at a bureaucratic level, external to the context of everyday mental health service delivery. However, the Office of the Chief Psychiatrist’s mandate under the Mental Health Act is to have oversight and monitoring roles concerning using restrictive practices, which automatically puts them in a leadership position. Given this external leadership role, one strategy for influencing cultural change is through developing resources to guide mental health services in reducing restrictive practices. This strategy is levelled at leadership in area mental health services but also has the potential to influence those directly working face to face with consumers ‘at the coal face’. The intent of this analysis of the department-written resources was to determine the extent to which these documents systematically addressed the themes arising from the literature review, to determine the audience to which the resources were directed, and to determine the means by which the resources were disseminated.

**Method**

The researchers extracted documents on reducing restrictive practices from the department's website <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/reducing-restrictive-interventions>. The researchers sent an itinerary of these documents to the Office of the Chief Mental Health Nurse to seek confirmation that the documentation was sufficient to complete the document analysis adequately. The list was subsequently confirmed and the documents retrieved in July 2017.

Each document was briefly described (see Appendix). It quickly became evident that the documents either related to generic occupational violence in the health sector or were specific to mental health. The documents were coded as either occupational violence or mental health specific before overriding themes in each code were determined. The predetermined codes from the literature review were applied to each document (whether the document was intended to assist assessment, planning, implementation, evaluation, or a combination). The audience was determined (for example, service leaders, staff, consumers, family or other external agencies), as was the primary point of dissemination (for example, the world-wide web, print in various forms or a PowerPoint presentation). The citation of each document was not added to the reference list, given that these documents existed on the website and were in a variety of different forms. The documents were viewed in chronological order and the results of the analysis tabulated in order to discuss any possible variations in the documents produced over time.
Results

In total, 74 documents were retrieved for review. Six documents were excluded from the analysis because they were not specifically focused on reducing restrictive practices. The documents were divided into two, reflecting a natural division in the subject nature of the documents. Of the 68 analysed documents, 28 were dated from 2005 to 2011 (see Table 1), though seven documents were undated but the subject matter indicated placement within this time period. During this period, there was a strong emphasis on occupational violence. In the second period (2012–2017) there was a stronger emphasis on mental health-specific documentation alongside the emphasis on occupational violence. During this period, 40 documents were analysed (see Table 2). This included three undated documents where the subject matter indicated placement within this time period and four documents that were undated but whose subject matter gave no indication in which time period they should be placed. There appears to be a consistent rate of the number of documents disseminated on the reduction of restrictive practices throughout the 11-year period, especially from 2011 onwards.

Table 1 outlines a summary of the analysis of the documents from 2005 to 2011 (n = 28). The documents overwhelmingly focused on the occupational violence experienced by staff (n = 25). Of these, four related specifically to occupational violence in emergency departments. There were three documents that focused specifically on the issue of managing aggression within mental health services. One, at the beginning of the time period, concerned developing the Creating Safety training resource developed to assist Victoria’s mental health services to reduce and, where possible, to eliminate restrictive practices. Within the training modules, there was a strong emphasis on the Six Core Strategies (Huckshorn 2004). The second document related specifically to guidelines in undertaking searches in mental health services, while the third was an overarching policy document on the recovery framework, within which eliminating using restrictive practices is a natural fit.

Table 2 outlines a summary of the analysis of the documents from 2012 and 2017 (n = 40). An emphasis on occupational violence remained (n = 19), with one specific to emergency departments. In this timeframe, there was a marked shift in emphasis with the majority of the documents focused on mental health (n = 21). Many of these documents focused on general statements regarding reducing, if not eliminating, of restrictive practices (n = 13). Of the remaining, three documents focused specifically on reducing physical restraint, three on using Safewards to reduce restrictive practices, one on using sensory modulation and trauma-informed care, and the last on creating an understanding of the variance data collected by the department on the prolonged duration of using restrictive practices.

In relating the documents to the themes detected in the literature review, the documents were overwhelmingly directed at assisting services to plan and implement strategies to reduce either occupational violence in health services generally or using restrictive practices in mental health services. Information to assist services in assessing the need to focus on these issues was integrated alongside a planning and intervention focus in some documents. Documents primarily focusing on evaluation were more recent, including an evaluation of sensory modulation and trauma-informed care training, an evaluation of the piloting of the implementation of Safewards, and the evaluation of the variance data already discussed.

The written resources were overwhelmingly directed towards service leaders and staff, which is not surprising given the department’s role in monitoring and oversight of services and their practices. Finally, the resources were primarily distributed via the department’s website as reports that can be downloaded in electronic or paper versions.
Table 1: Summary of documents 2005–2011

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Notes: ED = emergency department; MH = mental health; OV = occupational violence; RRP = reducing restrictive practices. Citations identified as ‘Year?’ (such as 2011?) were reasoned to be in this time period, though no date was provided. The light blue shaded columns (columns 5–8) refer to the type of document; the darker blue columns (9–13) show the intended audience.
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Table 2: Summary of documents 2012–2017

Notes: MH = mental health; n.d. = no date with no indication of time period from the content; OV = occupational violence; PR = physical restraint; RRP = reducing restrictive practices; SM & TIC = sensory modulation and trauma-informed care.

Citations identified as “Year?” (such as 2016?) were reasoned to be in this time period, though no date was provided.

The light blue shaded columns (columns 5–8) refer to the type of document; the darker blue columns (9–13) show the intended audience.

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Discussion

A crucial mechanism used by the department to help reduce restrictive interventions has been developing written resources. These are mainly in the form of position or policy papers and progress reports on the department meeting its objectives, which are articulated in this documentation. However, an emphasis on reducing using restrictive practices in mental health services has been late to emerge.

Reducing occupational violence in the health sector more generally has been emphasised by the Department. In 2004 the Victorian Taskforce on Violence in Nursing recommendations aimed at addressing the problem of violence against nurses in a more consistent and coordinated manner. In particular, the work highlighted the need for a framework to address occupational violence in health services generally. The framework provides the policy principles to assist health services to implement occupational violence prevention and management programs at the local level. Many of the documents analysed in this study were based on progress reporting of the efforts of services in this regard, in meeting the policy directives of the department.

In 2011 the Department of Health published *Preventing occupational violence: a policy framework including principles for managing weapons in Victorian health services* (Department of Health 2011b). This is the overarching policy framework for preventing and managing workplace violence and bullying within Victorian public health services. In 2012 the department commissioned *The good practice guide to performance management for nurses and midwives in Victorian public health services* (Shaw & Blewett 2013). This guide identified the features of best practice performance management and how it relates to preventing bullying in the workplace. This provided an ongoing emphasis on the focus on occupational violence. More recently, this emphasis has been sustained by the focus of the department on safety arising from the cluster of perinatal deaths at Djerriwarrh Health Services revealed in 2016 (Duckett 2016).

With this sustained emphasis, reducing restrictive practices within the department sits alongside a policy emphasis on occupational violence throughout the health sector, not just within mental health services. Regarding the reduction of restrictive practices, there was an initial emphasis on using the Six Core Strategies that was somewhat maintained through developing sensory modulation and trauma-informed care training, as well as the growth in using data. However, the documentation reveals a more recent energy arising in moves towards eliminating restrictive practices through implementing Safewards.

**Interviews with key leaders in the department**

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<tr>
<td>Interviews with key department leaders involved in reducing restrictive practices enabled an outline of the department’s mechanisms used over time to reduce seclusion and restraint use:</td>
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<tr>
<td>• The work of the department began in earnest in 2007 out of the Office of the Chief Psychiatrist, with an emphasis on reducing seclusion. This was called the Creating Safety project.</td>
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<td>• The intent of the approach was to ‘raise the consciousness’ of leadership and staff in mental health services to prioritise the reduction of seclusion. A staff teaching resource for services was developed based on the Six Core Strategies.</td>
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<td>• A fresh momentum occurred with the portfolio for reducing restrictive practices under nursing leadership. This leadership change aligned with key policy shifts in the department including developing a person-centred, recovery-based framework for mental health service delivery and the introduction of the new Mental Health Act in 2014, which focused on reducing all forms of restrictive practice.</td>
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<td>• Specific strategies to reduce restrictive practices were implemented, including the Reducing Restrictive Interventions Project (a multidisciplinary team response to assist individual services in reducing restrictive practices) and using data to create a greater understanding of restrictive practice use across the state.</td>
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<td>• Recently, a further momentum towards eliminating restrictive practices has occurred through the joint...</td>
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Introduction and method

Another way of outlining the mechanisms by which the department has engaged in reducing restrictive practices was to interview key departmental leaders about the process.

The Office of the Chief Mental Health Nurse sent a list of potential interviewees to the research lead. The researcher then sent potential participants a flyer informing them of the project and requesting further contact if the person was willing to enter into the informed consent process. Everyone who entered into the informed consent process agreed to participate.

In all, 10 people were interviewed. Of these, four were working in the Office of the Chief Mental Health Nurse or the Office of the Chief Psychiatrist. In the data presented in the analysis, membership of this group is referred to as Group 1. Of the 10 interviewed, four had other key roles in the department, three of whom had been directly involved in the Office of the Chief Psychiatrist in the past in reducing restrictive practices activity. In the data presented in the analysis, membership of this group is referred to as Group 2. The other two people interviewed had direct involvement in the past with reducing restrictive interventions activity in the department but were currently employed externally to the department. In the data presented in the analysis, membership of this group is referred to as Group 3.

All those interviewed had been employed by the department for no less than three years, with some participants having been employed since the start of efforts to reduce restrictive practices in 2007.

Qualitative data collection involved 30–45 minute, one-to-one interviews, the majority of which were conducted by telephone. An experienced member of the research team conducted all interviews.

The interview schedule consisted of the following items:

- Outline the department’s vision and plan in reducing using restrictive practices.
- Describe the implementation of the plan.
- Discuss how the impact of the plan is monitored/evaluated.
- Ask whether any specific subgroups of consumers were targeted in relation to reducing restrictive practices.
- Discuss what has been particularly good about the department’s focus on reducing restrictive practices.
- Discuss what they thought were some of the limitations of what has been done.

The interview schedule was standard across all interviews for all participants. All interviews were recorded on a digital audio-recorder (Sony ICD-PX333M) and transcribed verbatim. Data were collected from June to September 2017. Confidentiality and anonymity were protected throughout the transcribing, analysis and reporting process.

The interviews were thematically analysed using the process previously described (see ‘Data analysis’).
Results/themes

Consciousness raising

The active involvement of the department in reducing using restrictive practices and eventually moving towards eliminating such practices began with an emphasis on reducing seclusion. The impetus came from the Office of the Chief Psychiatrist in 2007 through a number of approaches. One was a forum initiated every quarter for inpatient unit managers. Another was via the Chief Psychiatrist’s clinical directors’ forums. In both, the response to reducing using seclusion was described as ‘lukewarm’:

The initial reaction was very interesting, it was ‘what’s it got to do with us, that’s nursing practice’. (Group 3)

Another approach was a focus on the Six Core Strategies (Huckshorn 2004). The authors of the strategies were brought from the United States to run a two-day workshop for area mental health services.

The Office of the Chief Psychiatrist made an approach to the Victorian Quality Council for funding to run projects on reducing using seclusion in mental health services. Change management consultants were employed to assist identified leaders in four services with seclusion reduction initiatives. This was called the Creating Safety project. This project ran concurrently to the national Beacon Project, which supported and showcased seclusion reduction initiatives nationally. In Victoria, Forensicare and Peninsula Health were designated sites for the Beacon Project.

Yet another approach was developing a one-day training program on reducing restrictive interventions for the whole sector based on the Six Core Strategies. The training program focused on exploring practices, thinking about why they were used and considering alternative approaches:

We had 585 inpatient staff attend and one of the things that they all remarked on was how good it was to hear each other’s stories. (Group 3)

All of these initiatives collectively constituted formative activity in establishing a commitment from the department to eliminate restrictive practices. The initial two years from 2007 to 2009 were described as a ‘consciousness/awareness raising’ phase:

Well it commenced with consciousness raising. A lot of that work at that time was about awareness raising and getting people to start really looking at what was happening for clients and actually thinking about seclusion. (Group 2)

Lessons were also learnt from implementing these approaches that were carried over into future developments. Within the Office of the Chief Psychiatrist, there was a realisation of the limited human resource to drive this activity. Within some services, it was difficult to determine the leadership structure responsible for driving seclusion reduction:

It was very difficult to actually get the same group identified as the leadership group. (Group 2)

In other cases, there were interdisciplinary tensions, which made progress difficult:

I remember speaking to one clinical director. He said when I talk to the nurses they say, ‘you know, you don’t tell us how to do our jobs’. So I think those sorts of raw attitudes are not helpful at all, not respectful of each other. (Group 2)

Yet, there was a positive realisation that progress would only be made through active, sustained, committed engagement with services by the statutory authority with oversight of restrictive practices:

So the skill lies in being able to connect with people so they don’t just see you as this person that comes in and tells you what you’ve done wrong. But there’s this person that actually also comes in and tries to help you, who understands some of the challenges and tries to help. (Group 3)
The evolving momentum

From 2009, there appeared to be a hiatus in the efforts to reduce restrictive practices:

Following Creating Safety, things dropped off the radar and if there’s one lesson I would have to say is you have to keep talking about this stuff. (Group 3)

Efforts were revitalised by internal changes in the department. A change of leadership instigated questions about how this work should be managed, and specific activities arose.

Internal structural change

An interdisciplinary tension in mental health services as to who should drive seclusion reduction was mirrored in tensions within the department. As stated, the projects mentioned sat in the Office of the Chief Psychiatrist, though there were thoughts that given the role of nursing in carrying out restrictive practices, the practice change might be more fitting to be under the umbrella of nursing leadership, which was developing in the department at that time. There was eventually a decision that this should be the case:

Nurses were making those decisions and therefore, in order for them to feel empowered to actually do something different, they had to be in charge of their own work and their own work practices. (Group 2)

The leadership of reducing seclusion was therefore placed with the nurse lead role, which at that time had an advisory capacity to the Office of the Chief Psychiatrist. A number of significant occurrences influencing restrictive practices either corresponded to this change or were initiated by it.

The frameworks

The Framework for recovery-oriented practice (Department of Health 2011a) saw active consumer and carer co-design in a person-centred approach to service delivery:

The Framework for recovery-oriented practice was actually a piece of co-design, so there were consumers there, there were family members there, there was psychiatrists there. There were allied health and nurses. (Group 2)

This momentum towards a person-centred approach paved the way for a similar approach in creating a framework for reducing restrictive practices (Department of Health 2013a). At the heart of this framework was the Six Core Strategies, though they were rebranded:

So what we did do was provide a different way of thinking about the Six Core Strategies. (Group 2)

The Mental Health Act: shift in emphasis

A focus on a consumer perspective and consumers’ rights was given further impetus through the new Mental Health Act in 2014. The Act gave a stronger focus to restrictive interventions as opposed to just seclusion by requiring the mandatory reporting of bodily restraint (physical and mechanical restraint) and not just seclusion. This enabled the department through the Office of the Chief Psychiatrist to:

… incorporate bodily restraint as part of their program of performance meetings. (Group 1)

The Reducing Restrictive Interventions Project

This project occurred in the lead-up to implementing the Mental Health Act. It was directly aligned with the shifting philosophy of the Act to become more focused on consumer accord including reducing restrictive practices. At this time, the reducing restrictive framework had not been developed and released, but the direction of the Reducing Restrictive Interventions (RRI) project became informed by the framework once released.
A multidisciplinary team including consumer involvement implemented the project. Building on earlier lessons learnt, the focus was on proactive and empowering communication with mental health services. There was a regionalised approach to implementation, with the team members responding to different parts of the state. However, there was also a coming together:

… to allow the state to hear about what others were doing, share those initiatives and actually take them and implement them in their own service, which some of them did. (Group 3)

Engagement with individual area mental health services involved a conversation about what reducing restrictive interventions might look like. Each of these services was assisted by the RRI team to develop a local action plan (LAP) to reduce restrictive practices. The LAPs were individual responses for each area mental health service that, once approved, were resourced to implement.

The project was heavily underpinned by the Six Core Strategies:

I think the RRI framework takes the Six Core Strategies and builds on it and provides more depth around things. (Group 3)

The project was also extended into emergency departments, which interface with acute mental health services and have a substantial impact on whether restrictive practices are used or not. However, the resources for the project were limited and there was a feeling that at the end of the project the gains made were not sustainable:

When resources finished, so did a lot of those interventions … it’s thinking about what’s sustainable and how we encourage services into the future. (Group 1)

### Variance reporting

As stated, during this phase of gathering momentum in reducing restrictive practices, links to the Office of the Chief Psychiatrist were not completely severed, despite the shift of responsibility for reduction to nursing leadership. A focus on bodily restraint was achieved through the legal requirement of the Office to oversee it. Under the Act, using bodily restraint was now being reported. A focus on frequency of use of restrictive practices was extended to an analysis of the duration of use of restrictive practices (McKenna et al. 2015). The intent of this project was to understand the extent of prolonged use and the reasons why this was occurring in order to drive interventions to decrease long duration.

### Changing the narrative

Such joint initiatives were an early indication of a need to re-centre efforts to reduce restrictive practices as a joint responsibility between the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist. There was a growing belief that the separation of the two offices provided:

Structural imperatives … kept the work isolated. So there was the RRI project and the framework that the Office of the Chief Mental Health Nurse led. And there were restrictive interventions monitoring and regulatory functions as far as reviewing registers and other things in the Office of the Chief Psychiatrist. And the work across those offices didn’t hold hands. (Group 1)

Subsequently, the Office of the Chief Mental Health Nurse was incorporated into the Office of the Chief Psychiatrist, though the Chief Mental Health Nurse held the portfolio on reducing restrictive practices. From this amalgamation, two high-level committees were developed to consider monthly data on area mental health services' use of restrictive practices:

We had to seriously think about the governance of the restrictive interventions here internally. (Group 1)

Under the Mental Health Act, registers on using restrictive practices come in each month. Traditionally there was an ad hoc review of this data. A data review working group was developed to consider the rates and duration of seclusion and restraint. This group analyses the data to determine a sense of the
patterns happening on a monthly basis and any individual cases that require follow-up. Other staff from
the department’s mental health branch are included in the process to collaborate in this endeavour:

So, we’re increasing the kind of literacy around that. (Group 1)

Then, the analysis goes to a statutory practice review meeting, which includes the Chief Psychiatrist and
the Chief Mental Health Nurse. Following endorsement of the issues, an action plan is developed about
how to communicate and work with the service concerned. Following the development of this plan, the
emphasis is placed on how to work with the service on the issues highlighted. In the past, the onus was
put back on services to address what were perceived as service-related needs:

You’ve got this problem, now you go away and fix it. (Group 1)

The new approach was to have direct conversations with the services around particular individuals and
concerns through face-to-face visits:

You really see how things are going and how we can support people. So when we find a service that
might be struggling, we actually don’t just do the big stick approach, we will talk about their concerns
and what we’re expecting. So we sort of partner with them and see how can we actually help. So we
sort of own the problem with them. (Group 1)

There was a sense that the department needed to be working with services about what was actually
happening in the sector and what resources there were to support initiatives in order to bring the sector
along with them. This required getting to know the service, the staff and the leadership so the service
could be assisted to find their own internal solutions:

From a department perspective, not being a person in the office who just sends out an email or a
memo. Actually being visibly present and working with them. That’s really the essence of what we’re
doing. (Group 1)

This requires transparency from all involved in order for a trusting relationship to be developed despite:

… a lot of concern that we were coming in with a different agenda than the one we actually said we
were coming in with. (Group 1)

It was this process of communication and engagement that was referred to as ‘changing the narrative’.
This approach was reinforced by review recommendations arising from the Djerriwarrh deaths in the
maternity hospital at Bacchus Marsh, which talked about shortcomings in the department standing back
from services and not having a stewardship role that was close enough to the services (Duckett 2016).
Therefore, the collaborative approach undertaken by the Office of the Chief Mental Health Nurse and the
Office of the Chief Psychiatrist department structurally aligns with the current departmental vision of
partnering with services to get improved outcomes for people:

We got the imprimatur to do the work that we were going to do. (Group 1)

In conclusion, it was stated:

I think we’ve seen some really good results in some of our engagement with some services. And for
us to have a better understanding and we’re developing relationships with services in how we work
with restrictive interventions rather than it always being a stick. (Group 1)

Current emphases

Emergency departments

The department appears to have a whole-of-systems response to initiatives occurring in one particular
sector of the health system. For some time, the department has considered reducing restrictive practices
in not only mental health services but also those services that interface with mental health. Primarily this
involves emergency departments, in which people in mental health distress are assessed and from which
they are admitted into acute mental health inpatient services.
An example of this emphasis is restrictions on using Behavioural Assessment Rooms (BAR) in emergency departments. BAR are standalone areas designated for use in managing the behavioural challenges associated with psychological distress. They provide a quiet space away from busy activities in emergency departments to manage such distress. However, in some hospitals, BAR were being used as proxy seclusion rooms with no legal mandate for such use. The department has been instrumental in averting such practices:

So sometimes we’ve found behaviours in the emergency department being managed by the use of seclusion. You can’t seclude anyone in the emergency department. We have sent out a directive to emergency departments basically saying that BAR in the emergency departments are never to be locked. (Group 1)

More recently, reducing restrictive practices has been considered more widely in the whole of the health sector. This broadening of the approaches initially focused in mental health services is viewed positively by the Office of the Chief Mental Health Nurse as an acknowledgement of the proactive work in this space that has been done by the office:

We [the Office of the Chief Mental Health Nurse] are looking right across health. We’re actually being heard about that and it’s only a positive. I think the whole moving right across health and not just sitting looking at inpatient units is where we’re seeing ourselves going. (Group 1)

**Movement to physical restraint**

There has also been an increased emphasis within the department on reducing the use of restraint. This began in approximately 2011 in response to international evidence highlighting deaths associated with using the prone position during episodes of physical restraint (Duxbury, Aiken & Dale 2011):

We had a whole lot of data from Australia and New Zealand and internationally about the risks of patients dying from the use of prone restraint. (Group 3)

The response of the Office of the Chief Psychiatrist was to send out a practice directive to services that the duration of prone physical restraint was not to exceed three minutes. In hindsight, this directive lacked an emphasis on what could be done to prevent this practice:

What we did was perhaps the cart before the horse. We gave an alert, but we’re still in the process of trying to work out what’s the best training to give staff if they’re not using prone restraint; what preventative strategies should look like and what a best practice physical restraint would be. (Group 1)

**Safewards**

An evidence-based model of care called Safewards has gained traction internationally to assist in reducing restrictive practices (Bowers 2014). The model aims to explore the relationship between conflict and containment, and to identify opportunities for staff to intervene to prevent conflict and containment through improved communication and proactive engagement (Bowers 2014). A statewide approach to introducing Safewards to all acute mental health inpatient services in Victoria has been developed.

This emphasis arose from the RRI project. During the project, a number of services indicated that they wished to use Safewards as part of their LAPs in reducing restrictive practices. The author of Safewards, Professor Len Bowers, was brought to Victoria to help promote the model of care. The implementation of the model has grown to be a pivotal component in reducing restrictive practices:

I see Safewards as being an important element of the work that we’re doing in Victoria. We wanted some consistency around the model of care across the state. This is one consistent way that everybody should be working with. (Group 2)

Its benefit was seen in its approach, which is person-centred and gives nurses pragmatic means to engage with consumers in a therapeutic manner that aligns with best practice:
I think that Safewards also gives us stuff to do, for nurses who want to create a better experience for clients. It's how you create a culture of practice that says that the clients are at the centre and you're not going to use coercive practices in order to engage. (Group 2)

It is seen as providing the building blocks upon which other reducing restrictive practices can be added:

Safewards is not the end, it's actually the foundation of where other things can go from. From that base, it can actually grow, you know, trauma-informed care, other therapeutic engagements. (Group 1)

The engagement processes articulated in Safewards are mirrored in the current approach used by the department to engage with mental health services in a collaborative manner:

The Safewards principles are actually embedded into everything that we [the staff of the Office of the Chief Mental Health Nurse] do. The way that we talk about things has actually been using the language of Safewards. (Group 1)

**Sustained consumer and carer involvement**

Although the involvement of consumer and carer expertise has traditionally been part of the department commitment to reducing restrictive interventions, it has not occurred in a consolidated manner. This is despite the fact that such expertise was acknowledged as crucial in reducing restrictive practices:

The single most effective way of making these changes is having consumers partnering with us with this. (Group 13)

Current efforts in the department have focused on consolidating this involvement. In talking about the Offices of the Chief Mental Health Nurse and the Chief Psychiatrist, it was stated:

So there's a consumer project officer in our Safewards team in the Office of the Chief Mental Health Nurse, and we're currently recruiting to two positions, so [a] consumer expert and a carer expert into the Office of the Chief Psychiatrist. (Group 1)

**Indigeneity and ethnicity**

In discussing current emphases, those interviewed identified foci that were only in the very early stages of development. This included the need to focus on subgroups of vulnerable consumers. The most discussed area in this regard was the need to focus on reducing restrictive practices with Aboriginal people:

An emerging area that we need to start thinking about is actually the Aboriginal group, because I think we’ve not given them enough attention. And recently looking at the data, they certainly are a significant group who do end up being secluded. And we need to think about what that means culturally for them. (Group 1)

Closely aligned with the focus on Aboriginal needs was an acknowledgment of the need to focus on reducing restrictive practices with vulnerable ethic minority groups, including recent immigrants:

We’ve also got new communities who have been subject to trauma and torture and refugee groups. I think there's a new requirement for us to get more culturally competent in the new communities that we're serving across mental health and become more competent in trauma-informed care, which the Office of the Chief Mental Health Nurse has produced funding for. (Group 1)

**Discussion**

Interviews with key leaders involved in the department's initiatives to reduce restrictive practices enabled an outline of the mechanisms used over time to reduce restrictive practices. The work of the department began in earnest in 2007 out of the Office of the Chief Psychiatrist with an emphasis on reducing seclusion. Initially, the intent of the approach was to ‘raise the consciousness’ of leadership and staff in
mental health services to prioritise reducing seclusion. Strategies in this regard included developing a staff teaching resource based on the Six Core Strategies (Huckshorn 2004).

Collectively these tentative steps were referred to as the Creating Safety project, but by 2009, the impetus had begun to wane. A fresh momentum was revitalised by internal changes in the department, with the portfolio for reducing restrictive practices coming under nursing leadership. This leadership change aligned with key policy shifts in the department including developing a person-centred, collaborative recovery-based framework for mental health service delivery and a move towards the new Mental Health Act, which focused on the consumer perspective, consumers’ rights and reducing restrictive practices more generally (not just seclusion).

Aligning with leadership change and the policy shift were specific strategies to drive the reduction of restrictive practices. These included developing a framework to reduce restrictive practices (Department of Health 2013a), the RRI project (a multidisciplinary team response to assist individual services to reduce restrictive practices), and using data to create a greater understanding of restrictive practice use across the state.

More recently, a further momentum towards eliminating restrictive practices has occurred through the joint efforts of the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist. This effort has led to a strengthening of the approach adopted by the department in working with services through face-to-face meetings to collaborate with them. This strategy has required getting to know the services, the staff and the leadership so the department can assist mental health services to find unique internal solutions to reducing restrictive practices.

This collaborative approach has allowed the department to consider some of the most challenging issues faced in reducing restrictive practices. This includes reducing restrictive practices in emergency departments; a focus on staff developing the skills to prevent restrictive practices; standardising physical restraint techniques; and developing a core model of care (Safewards) across the state. Recent considerations also include the more active involvement of consumer and carer expertise in reducing restrictive practices and developing strategies to focus on subgroups of vulnerable consumers, including Aboriginal and ethnic minority groups, such as recent immigrants.
Results: Objective 2

Objective 2: Describe the uptake by mental health services of the department’s strategies.

Case studies of three area mental health services

Summary
Mental health services' uptake of the department efforts was described through three case studies in area mental health services (AMHS), which were identified as making advances in reducing restrictive practices. Each case study involved interviews with key stakeholders in the AMHS concerned and a document analysis of AMHS reports outlining initiatives to reduce restrictive practices.

• All three case studies demonstrated a commitment to a journey in reducing restrictive practices.
• All conceded that this journey required a cultural transformation in the services over time. The steps towards this change in culture loosely modelled the Six Core Strategies.
• Services consistently used data to inform their efforts in reducing restrictive practices.
• Using sensory modulation and, to some extent, trauma-informed care were evident in all three case studies.
• Developing a peer support workforce was mentioned, as was debriefing, though these strategies were embryonic. There was a strong indication that the adoption of both could have a demonstrable impact on future progress towards reducing restrictive practices.
• Leadership was consistently discussed in-depth as being central to the reducing restrictive practices and changing the culture to enable this to happen.
• All services expressed the value of the Safewards model of care in progressing towards reducing restrictive practices.
• Future challenges were highlighted, foremost among them being managing people admitted to mental health services experiencing methamphetamine-induced psychosis.

Introduction and method
One way of describing the uptake of the department’s efforts to reduce restrictive practices was to consider in-depth illustrative case studies of area mental health services (AMHS) that had been innovative and/or systematic in embracing reducing restrictive practices. A case study gives the opportunity to profile developing activities to reduce restrictive practices and determine future directions towards eliminating such practices. It also enables the exploration of what has worked well and what is still work in progress.

An illustrative case study methodology was used to describe efforts to reduce restrictive practices in the mental health services of three AMHS. The Office of the Chief Mental Health Nurse negotiated the involvement of each AMHS. The researchers made all attempts to protect the confidentiality of each AMHS, with the caveat that as there are only 21 adult AMHS statewide. Therefore, the confidentiality of any given AMHS could not be guaranteed.

The first case study was undertaken in a large metropolitan AMHS with two acute inpatient units, which could potentially use restrictive practices. The second case study was undertaken in a rural AMHS also with two acute inpatient units and a mental health unit for older people. The third case study was undertaken in a metropolitan AMHS, which has an adult mental health unit, a secure extended care mental health unit, a youth mental health unit and a child mental health unit for children under 13. This latter case study related to the adult, youth and child units at the request of the AMHS.

Each case study was designed to involve interviews with at least the staff member responsible for leading the reduction of restrictive practices, clinical or managerial leads, the consumer advisor in the
service, and the carer advisor. However, each AMHS had the choice to determine who would be interviewed. The participants in the interviews are outlined at the beginning of each case study.

Mixed methods of data collection were used. Qualitative methods involved 30–45 minute, one-to-one, semi-structured interviews. An experienced member of the research team conducted all interviews. In one case study, interviews were undertaken by phone, while the others involved site visits and face-to-face interviews. Potential participants were initially approached by the Director of Mental Health Nursing to gauge their willingness to be approached for informed consent process by the researchers. Everyone who entered into the informed consent process agreed to participate.

The interview schedule consisted of the following items:

- Outline what your AMHS has done in mental health services to reduce restrictive practices.
- Outline what has worked well in your plan.
- Discuss what has not worked as well and requires refining.
- Outline your future plans for reducing restrictive practices.
- Have you any documents that we could have access to in order to create clarity?

The interview schedule was standard across all interviews. All interviews were recorded on a digital audio-recorder (Sony ICD-PX333M) and transcribed verbatim. Data were collected from June to November 2017. Confidentiality and anonymity were protected throughout the transcribing, analysis and reporting process. Written documents on reducing restrictive practices were submitted at the discretion of the participants. These included minutes of meetings, surveys, project briefs, project reports, unit policies, memos, service-wide policies or protocols and presentations.

De-identified, quantitative data on the progress of each AMHS in reducing restrictive practices were obtained from the department’s data analysis area. The Client Management Interface/Operational Data Store (CMI/ODS) is the Victorian public mental health system database and is used to store a range of core reporting requirements including caseload analysis, consumer outcome measurements and all client service-level information. Information on using restrictive practices, including the frequency and duration of use, are recorded in this dataset.

The CMI/ODS was interrogated to consider trends in the frequency of restrictive practices, the duration of use, and multiple use on individuals during a single episode of admission for each of the case studies. These data were aggregated over the reporting years 2007–08 to 2016–17. In the first two case studies, this included only consumers between the ages of 18 and 64 admitted to adult AMHS excluding secure extended care units (SECU). In the third case study, the same considerations were extended to youth and children in separate analyses. The aggregate data received from the department did not contain any identifiable data.

Although trend analyses were possible regarding seclusion, trend analyses for bodily restraint (physical restraint and mechanical restraint) was complicated and unachievable. This was primarily due to the short period of time in the reporting of physical restraint since the mandatory reporting requirements set in the Mental Health Act, as well as the blurring of a distinction in the types of bodily restraint in the reported data.

For an outline of the research design see ‘Method’ and for an outline of the data analysis see ‘Data analysis’.

**Results: Case study 1**

**Data description**

In this case study, six individuals were chosen to represent the mental health service and participate in one-to-one interviews. Two participants, who had nursing leadership positions (a Creating Safety nurse and nurse practitioner), worked primarily in the psychiatric inpatient unit and had been in their roles for
approximately seven and four years respectively. The four remaining participants worked across both units holding the roles of clinical nurse educator, program manager, Safewards coordinator and consumer consultant, with experience in their roles ranging from approximately eight months to five years.

Table 3 outlines the documents included in the analysis.

**Table 3: List of documents analysed in case study 1**

<table>
<thead>
<tr>
<th>List of documents</th>
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<tbody>
<tr>
<td>Mental health nurse practitioner prescribing practice</td>
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<tr>
<td>Acute adult inpatient mental health nurse practitioner model 2017</td>
</tr>
<tr>
<td>Use of Restrictive Interventions Guideline</td>
</tr>
<tr>
<td>Pharmacological Management of Acute Arousal</td>
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**Themes**

**Leadership**

Efforts to reduce restrictive practices first began with a drive from leadership to review the service’s historical use of seclusion, in order to determine *‘What do we need to do to improve this practice?’* (Creating Safety nurse). This led to reviewing and revising practice guidelines to ensure they were consistently and coherently applied. This is a process that has been ongoing:

> There were a lot of restrictions and that was just causing a lot of conflict, and sometimes the inconsistent application of rules was causing conflict. (Creating Safety nurse)

This review resulted in new guidelines and policies, such as those concerning the management of acute agitation (both pharmacological and non-pharmacological). It also led to a focus on early intervention and preventative strategies aligned with the service’s Management of Clinical Aggression training. Additional guidelines were also provided to ensure staff documented using restrictive practices in line with the service’s procedures, and to aid staff participation in seclusion reviews.

These guidelines were combined with a multifaceted suite of processes aimed at ensuring using restrictive practices was thoroughly monitored:

> We review all episodes of restrictive interventions every week and we provide feedback directly to the staff involved. We have developed management plans for those patients at risk of restrictive interventions, or those who have had three episodes of seclusion. Then, on our ward, medical review must occur within the first hour of an episode so that we can review whether that episode needs to continue or it can be ceased. And then for anything over eight hours, the director of clinical services must be notified. (Nurse practitioner)

In 2014 the service began to introduce Safewards to the unit with funding from the department, which included creating the Safewards coordinator role to oversee implementation. With this rollout came training and education for management and staff as well as some resources including sensory modulation tools and ‘calm down boxes’:

> So Safewards was fantastic when we had the funding, because even staff morale was evident in improving. (Safewards coordinator)

However, despite initial success, implementation slowed or plateaued as funding stopped and the leadership driving the approach ceased. The interventions lost some momentum:
The challenge then came when the funding stopped and then my role ceased. Then everything started trickling down. We still have some interventions which are still going, but there’s not as many. (Safewards coordinator)

Leadership was hopeful that a recent influx in funding for Safewards would help to revive the momentum. Overall, strong leadership and accountability were seen as ‘key to being successful’ (Creating Safety nurse) in reducing restrictive practices. Indeed, engagement from individuals such as the nurse unit manager spurred a culture shift among staff, as discussed further below. Such individuals were involved on the floor and drove review and reflection on restrictive practice episodes:

It was good leadership by example, and a good agenda encouraging, pushing, which then kind of forced everyone to think about let’s see what we can do beforehand, even in a quite tricky situation. (Clinical nurse educator)

The depth of this leadership was especially exemplified in the role of the nurse practitioner. Part of her role focused on assisting staff to manage aggression during acute admission to the intensive care area. The nurse practitioner has prescribing rights, which can facilitate the proactive use of medication if this is deemed as an appropriate approach in preventing using restrictive practices. Again, the on-the-floor nature of this role, working alongside clinical staff and consumers, was articulated as being crucial to the success of reducing restrictive practices.

The leadership structures within the units provided continued engagement with the multidisciplinary team, which also helped in early intervention by creating a supportive environment:

There’s a lot of keen discussion goes on. The structure here is if there’s any concerns about escalation occurring then the whole team actually get together. So our allied health staff join in with the nursing staff and they’ll allow nursing staff to engage in the clinical practice of trying to de-escalate. Then they’ll monitor the rest of the ward. It’s a fair sharing of a supportive process. (Program manager)

Another structural aspect of the leadership discussed was the creation of dedicated roles and/or portfolios focused on safety and quality issues, such as the Creating Safety and Safewards roles, as well as the involvement of the nurse practitioner. This has created staff capability and resources to dedicate efforts to reduce restrictive practices. Additional support provided by individuals such as the senior social worker, senior psychologist and senior occupational therapist in reviewing safety tools and reviewing management plans, were also noted as supportive elements:

They have a strong passion and concern about safety for everybody on the unit. And so, you know, that’s probably a little bit unique too. I reckon you don’t always get that. (Program manager)

In the future, those interviewed indicated intending to continue refining the review processes – expanding them to consider using mechanical restraint. This latter focus was aimed at responding, in part, to the specific challenges managing the population of methamphetamine users, as well as forensic mental health related consumers, in the least restrictive way. Another area noted as requiring future consideration was using restrictive practices in the emergency department, as many consumers reach the inpatient units having already experienced such practices within the emergency department.

The role of effective leadership was highlighted throughout all the interviews and is backed by the development and resourcing of dedicated clinical roles to lead restrictive practice reduction:

The whole leadership accountability, the governance that sits behind it, is what has led to the changes on our ward. (Nurse practitioner)
Use of data

Using data has played a vital role in shaping both practice guidelines and fostering staff understanding and buy-in regarding reducing restrictive practices. Weekly reviews were conducted to review seclusion events in the previous week:

- We look at clinical issues for the consumers, but we also look at any systemic issues [using the data] or feedback for staff. (Creating Safety nurse)

Monthly summaries were also emailed to all staff to track episodes of restrictive practice events, detailing the number and lengths of such events, per unit and shift:

- So it kind of gives people a bit of a breakdown as to what went on this month in terms of the numbers. (Creating Safety nurse)

These data are seen as helping to maintain staff motivation and commitment to reducing restrictive practices, while providing a morale boost for staff:

- So it’s quite a powerful thing to be able to say to them, look back in 2011 these were our statistics and this is what we’re looking at now. That sort of positive feedback is really quite helpful for those nurses who are working on the floor. However, being able to give that feedback, despite all the challenges, can indicate we’re still tracking really well. (Creating Safety nurse)

Workforce development

A key focus of staff development has been fostering a ‘change in the culture over time’ (Creating Safety nurse) concerning using restrictive practices. The first step in this process was educating staff on the high rate of use of such practices compared with other services across the state, and equipping the staff with alternate skills such as de-escalation:

- The first thing they did quite well was to get all staff on board. I know there was a lot of training, education, a lot of discussion with all staff, not just nursing staff, but the whole multidisciplinary team. (Program manager)

This change was driven by leaders who encouraged staff to reflect upon and revise their practice. This included using reviews as a tool for staff discussion on future preventative measures to avoid using restrictive practices:

- That required a number of staff to think about how they do their job, and what their role is in engaging patients as well. Their role in reducing restrictive interventions. (Clinical nurse educator)

While some staff initially felt challenged by efforts to change the culture as a workforce development initiative, over time staff attitudes and buy-in have improved considerably, leading to a widespread shift in practice. Creating a supportive environment for staff acted as a catalyst for this culture change:

- Just remembering how challenging it was on their practice, and how much resistance there was, and how much that’s changed. Now it’s just a part of everyday practice that people go to big efforts to avoid the use. (Creating Safety nurse)

It was noted, however, that while considerable progress has been made, maintaining this culture change through workforce development requires ongoing efforts from both leadership and staff to communicate and reflect upon their practice:

- Sustainability is always a big thing. Trying to sustain many of the practices that go on the ward. You have to have everybody involved in doing it. It’s always those little bits of extras, I believe, that will make a difference in moving that forward successfully. (Program manager)
Evidence-based interventions

In the past few years the service has begun to incorporate evidence-based interventions to support reducing restrictive practices, providing, for example, training and resources for sensory modulation and trauma-informed care. However, participants noted that implementing these practices was still a work in progress and resources were limited. While there has been the idea to turn one seclusion room into a sensory modulation for some time, action has yet to be taken:

The sensory safety tools, we can still do a lot of work on the ward with getting more [consumers] involved in that … We need to embed them a bit better on the ward. (Nurse practitioner)

In relation to trauma-informed practice, the Creating Safety nurse explained:

Seclusion or restraint can definitely trigger someone who may have had previous trauma. So I think there’s still a bit of work to do, in that we kind of recognise the trauma of the incident itself, but I think we’ve got to do a bit more work to do in acknowledging retriggering trauma.

Most recently, as part of a focus on the creation of new trauma-informed care guidelines, the service has adopted a focus on gender sensitive practice, which has included developing mixed-gender spaces in the wards.

Moving into the future, recommendations were made to focus on developing activities programs for consumers, as well as to implement evidence-based interventions more consistently and with more resources.

Peer support

Peer support workers were identified as playing a crucial role in efforts to reduce restrictive practices, offering support and guidance within the inpatient units, across the service and in the community. Also discussed was the key aspect of peer support work in providing lived experience insight into the experience of restrictive practices, so that staff can better understand and revise their practice:

They bring a lot in terms of helping staff understand the consumer perspective. And also helping [consumers] on the ward understand the organisation and the system, and why staff operate the way we do. (Program manager)

The services offered by peer support workers and consumer consultants were wide ranging, including participating in debriefing and reviews of restrictive practices, developing policy/recommendations and helping to identify and provide support for ‘high-risk’ consumers and their carers (such as those identified as likely to be readmitted in a 28-day period). It was stated that peer support workers had good relationships with clinical staff and were viewed as ‘part of the team’:

I know for both myself and my colleague, when we have raised concerns, the clinicians are always open. They’ll always discuss why reasons were made. And we also have the capacity to say, look, well in this case I disagree with this decision, and that is of course taken seriously and internalised. (Consumer consultant)

It was noted that developing the peer support or consumer workforce had not reached full fruition and was in the process of being expanded. Increased staff allocation within the units (having more peer support available on the floor) to provide ongoing support and facilitate debriefing, as well as increasing the resources for peer support engagement in the community, were identified as goals for the future:

So the next phase for these guys who are working those peer support worker roles is to engage in activities on the floor as well. Identifying the patients who may need their support when they are in here, and also get transferred out to the community and discharged. (Program manager)
Trends in reducing seclusion

Figure 3 indicates a sustained reduction in the rates of seclusion in the AMHS from the beginning of the trend analysis in the 2007–08 reporting year (rate = over 30+ episodes per 1,000 occupied bed days) to a completion of the trend analysis in the 2016–17 reporting year (rate = 10+ episodes per 1,000 occupied bed days).

Figure 3: Seclusion episodes per 1,000 occupied bed days

A similar downward slide was detected in the trend analysis of the average duration of seclusion episodes (see Figure 4) from the beginning of the trend analysis in the 2007–08 reporting year (duration = 7–8 hours) to the completion of the analysis in the 2016–17 reporting year (duration = 5 hours).

Figure 4: Average duration in hours per seclusion episode

A reduction was also detected in the trend analysis of the number of events experienced by a secluded person during the time of their admission (see Figure 5). However, this was not as marked from the beginning of the trend analysis in the 2007–08 reporting year (just over two events per person) to the completion of the analysis in the 2016–17 reporting year (just under two events per person).
Results: Case study 2

Data description
In this case study, four individuals in leadership roles were chosen to represent the mental health service and participate in one-to-one interviews. The individuals held the positions of workforce discipline senior (consumer advisor), clinical director, executive director of nursing and midwifery, and education service manager. This service had been involved previously in Commonwealth initiatives to reduce seclusion and much of the participants’ experience in reducing restrictive interventions began during this time. There was variation in the time spent in their current roles, which ranged from one month to 14 years. All individuals had considerable experience in the mental health sector (17+ years) and had held previous roles including consumer consultant, social worker, nurse educator for mental health services and associate nurse unit manager. Table 4 outlines the documents included in the analysis.

Table 4: List of documents analysed in case study 2

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<tr>
<td>The seclusion clinical pathway</td>
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<tr>
<td>The risk identification, safety, communication, environment (RiSCE) guideline</td>
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<tr>
<td>Seclusion and restraint in mental health services (PowerPoint)</td>
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Themes

Leadership
Leadership first began to be involved in efforts to reduce restrictive interventions when the service was chosen to be part of a Commonwealth initiative to reduce using seclusion in 2007. Involvement in the project brought considerable funding to the service focused on implementing the Six Core Strategies (Huckshorn 2004), though the strategies were addressed to varying degrees and the leadership was generally not familiar with the framework.

Prior to this time, leadership reported that there was a ‘real culture of seclusion on the inpatient unit’ (Workforce discipline senior), and staff were not equipped with the knowledge, tools or training to avoid using seclusion.

In the decade following the abovementioned initiative, the service has been very successful in reducing restrictive practices (see Figures 6–8). Indeed, the service’s efforts have been so successful that it has
changed the environment and experience of the consumers to that of a recovery and person-centred approach:

There’s two things. One is that we had in a number of years, the lowest seclusion rate in the state, in comparison to any other service. But the best thing I can tell you is that there are clients that ask me what seclusion is. They don’t know what seclusion is. (Workforce discipline senior)

It was stated that this reduction in restrictive practices has also corresponded to a reduction in staff assaults.

Key to this success has been the engagement of leadership in both a top-down and ground-up approach. From the top-down, leaders established a strong clinical governance structure as a team, which focused on key performance indicators including rates of restrictive practices, as well as creating a clinical pathway and clinical practice guidelines to reduce these practices:

We had strong medical leadership. We had strong nursing leadership, across all of the nurse unit manager structure. They were absolutely on board with making changes, cultural changes and obviously in turn that led to practice changes. (Executive director of nursing and midwifery)

This began with the realisation that things could change. In describing an early incident where a consumer had assaulted a staff member, the clinical director explained:

[The] operation manager, not a clinician at that time, just came in, took charge and said, ‘Actually, we’re all gonna get hurt’. And he said this aloud and said this to the man. ‘I didn’t come here to get hurt today, we need to look after the person that you’ve just hit. He’s obviously injured. Would you mind going over there, please?’ And the guy did. The guy came back after two minutes and said, ‘How is he? Is he okay? I’m so sorry’. You know, complete sea change. So that was my realisation that actually all of this stuff can change. (Clinical director)

This realisation led to the systematic adoption of new processes and guidelines, particularly focused around reviews:

And so we said that every seclusion had to be subject to an incident review using incident review methodology. So then we could identify what the opportunities were for alternate behaviours.

(Clinical director)

These systems adopted a multidisciplinary and supportive approach, intending to create a sense of ‘shared organisational risk and responsibility’ (Executive director of nursing and midwifery).

At the ‘on-the-floor level’, leaders were engaged in everyday practice and served as role models for staff:

Leadership absolutely had to lead from the front and send a really strong message to the staff that clients that come into our services are getting re-traumatised from these events. And we needed to make sure staff really understood that impact of restrictive interventions. (Executive director of nursing and midwifery)

This helped to support a shift in staff attitudes, particularly those who met the new changes with hesitance or resistance:

People actually felt very scrutinised and uncomfortable with that initially until they kind of got that it wasn’t about them, it was about opportunities. (Clinical director)

As discussed further below, targeted workforce development as well as the involvement of peer support workers and consumer feedback also helped to shift staff culture.

In recent times, the service has noticed a slow increase in their restrictive practice statistics, which has been partially accredited to the surge of methamphetamine use. Consistent to other services, leadership reported that consumers with drug-induced psychosis and other mental health issues typically presented with considerable aggression and were harder to manage without using restrictive practices. They also
tended to experience restrictive practices earlier in their pathway due to the involvement of police or admission via the emergency department:

When I was working on [the unit] and I saw six policemen going upstairs, I was just devastated. Because the person involved was so unwell and the assaults were going up, and seclusions were going up. And it was just horrendous. Some people argue that the client group has changed. (Workforce discipline senior)

**Use of data**

While participants tended to discuss data use more indirectly than other topics, it was clear that data played a strong role in the service’s approach. Data were mentioned primarily in terms of seclusion and staff assaults, which served as an indicator or benchmark of how the service was tracking and informed policy development:

That again gives us an opportunity to look at what’s happening, because now there’s concern that things weren’t in the position that they were before. So we really need to understand the direction the service is going in and make some changes. (Executive director of nursing and midwifery)

As stated above, there was a correlation between reducing seclusion and a decrease in staff assaults. This information was used to foster staff buy-in and understanding of the benefits of reducing restrictive practices.

A second aspect of data was collecting detailed information following a restrictive practice episode during the review process, which was then reported to leadership. This information was used to provide feedback to staff and facilitate staff learning around how things could be done differently in the future:

We have structured almost research process around data collection, staff surveys and reporting back to staff. There is a really big emphasis on reporting, so we had to absolutely make sure our systems were robust to have that reporting consistent. (Executive director of nursing and midwifery)

Leadership was also involved in presenting data at national and international conferences and meetings, which provided an opportunity for information sharing regarding best practices in reducing restrictive practices.

**Workforce development**

As stated previously, a central focus of reducing restrictive practices was workforce development and education to help staff realise seclusion, escalation and restrictive practices were all ‘dangerous for both staff and clients’ (Education service manager), and then equip staff with the tools to prevent using restrictive practices:

[We] essentially just began with … increasing awareness, having the discussions, engaging nursing staff, giving them an opportunity to reflect on different opportunities. (Clinical director)

This led to the wide culture shift noted by the leadership. However, some also noted that increased leadership engagement and implementation of detailed review processes had created the feeling for some staff, especially younger staff, that they were not allowed to use seclusion, or that they may get in trouble if they did:

Both of them [clinical leaders] were very hands on, and they would come and they’d speak to staff. For some staff, their presence indicated that ‘we’re in trouble again’. (Workforce discipline senior)

This may highlight a potential area for future workforce development. To ensure that staff choose not to seclude based on a legislative, human rights-based and clinical rationale, as opposed to fear of reprimand.

In addition to the education initiatives linked to changing staff culture, training was also provided on de-escalation as well as various evidence-based interventions such as sensory modulation and trauma-
informed care. It was noted that training and education should be ongoing for all staff, including new staff and recent graduate health professionals:

It’s that continual learning really, and refreshing, and updating what we do, because as soon as you rest on your laurels something’s going to come and challenge you again. (Executive director of nursing and midwifery)

Evidence-based interventions

Two main evidence-based interventions were discussed, albeit briefly. Regarding sensory modulation, a sensory room was set up in one of the acute management areas, which was equipped with various sensory tools (for example, weighted blanket, scents).

Using trauma-informed care was also identified, which helped to underpin the service’s approach and was included in staff training initiatives. It was also used to emphasise to staff the traumatising nature of restrictive interventions for all involved:

For me trauma-informed care actually translates into relationships, so it’s about having a respect for a relationship with somebody that respects their experience and needs. (Clinical director)

The participants did not indicate to what extent these interventions were being used.

Peer support workforce

In this case study, the peer support workforce has been highly involved in efforts to reduce restrictive practices, from policy development to staff training, to debriefing (including what was referred to as ‘reflective practice’). It was viewed as ‘central’ and ‘pivotal’ to reducing restrictive practices and indeed pivotal to ‘almost all important reform initiatives at the clinical point of care … in the last 15 years’ (Clinical director).

Peer support workers were valued as serving as a sounding board for staff reflections on their use of restrictive practice:

That role was encouraged to speak to staff individually and say, listen, what is it about seclusion that you’re frightened to take away, but what are you frightened of, what is it, you know, what are the concerns? (Service discipline senior)

Similarly, consumers were also used to foster staff reflection on practice. The service discipline senior described an example of this involvement:

We brought in a separate consumer who’d been exposed to seclusion and she presented this amazing story about what her experiences had been like … The other thing we did was, we had butcher’s paper, and we asked clients to list what they hate about seclusion, what it’s like to be secluded. And they listed all these individual words and we covered those up and we asked the staff to talk about their experiences when they’re physically manhandling someone to get them into seclusion, what does that feel like for you. And they listed their words and then we took the thing off.

It was powerful. And you could actually see people’s light bulbs going off. That was really powerful.

This helped to break down staff barriers or resistance to reducing restrictive practices and contributed to the shift in staff culture. The involvement of the peer support workforce was also noted as fostering transparency and providing support particularly for consumers who experienced difficulties engaging with clinical staff.

Environment

The service had experienced challenges, particularly relating to its physical environment. This resulted in the refurbishment of one ward to make it more ‘spacious, well designed, [and] fit for purpose’ (Clinical director), which included changing the layout of the nurses station to make it more visible, putting in more comfortable and colourful furniture, and creating a sensory room. This was combined with broad changes
to the social or cultural environment noted above, including the shift towards person-centred and recovery-oriented practice. However, it was noted that the environmental aspects in reducing restrictive practices required further attention from both the department and the service:

Maybe we need to make a recommendation to [the department] to look at the environment. I don’t think the inpatient unit, where it is located upstairs, is an ideal space at all. You need space for these clients and they are in that block where there’s no decent courtyard or anything. (Education service manager)

Trends in reducing seclusion

Figure 6 indicates a sustained reduction in the rates of seclusion in the AMHS from the beginning of the trend analysis in the 2007–08 reporting year (rate = 9 episodes per 1,000 occupied bed days) to a completion of the trend analysis in the 2016–17 reporting year (rate = 2+ episodes per 1,000 occupied bed days). Notably, in the reporting year 2015–16 a rate of 0.2 episodes per 1,000 occupied bed days was achieved.

Figure 6: Seclusion episodes per 1,000 occupied bed days

A similar downward slide was detected in the trend analysis of the average duration of seclusion episodes (see Figure 7). The highest average duration of time in seclusion per episode was 40+ hours. At the completion of the trend analysis, the duration was 8.7 hours.

Figure 7: Average duration in hours per seclusion episode

A reduction was also detected in the trend analysis of the number of events experienced by the secluded person during the time of their admission (see Figure 8). This was from the beginning of the trend analysis in the 2007–08 reporting year (2.4 events per person) to the completion of the analysis in the
2016–17 reporting year (1.8 events per person). Notably, the desired goal of one event per person was achieved in the reporting year 2015-16.

**Figure 8: Average number of seclusion episodes per secluded consumer**

![Graph showing average number of seclusion episodes per secluded consumer from FY07/08 to FY15/16]

**Results: Case study 3**

**Data description**

In this case study, interviews were held with six representatives from the service representing the adult, youth and children’s units as well as the peer support workforce. More specifically, four participants were interviewed in groups of two and held the roles of: (a) unit manager and associate nursing manager for the acute adult unit; and (b) carer and consumer participation coordinator and consumer consultant. The other three participated in one-on-one interviews. One represented the role of associate nursing manager, whose duties concerning restrictive intervention reduction ranged across the service, and the other two served as acting unit manager of the youth and children's mental health units, respectively. Time in roles ranged from eight months to seven years, with previous experience in mental health up to 12+ years in roles ranging from nurse, to associate nurse unit manager, to allied health clinician.

Table 5 outlines the documents included in the analysis.

**Table 5: List of documents analysed in case study 3**

<table>
<thead>
<tr>
<th>List of documents</th>
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<tbody>
<tr>
<td>Aggression Prevention Initiative</td>
</tr>
<tr>
<td>Getting to zero: reducing restrictive interventions (PowerPoint presentation)</td>
</tr>
<tr>
<td>Seclusions APU report</td>
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**Themes**

Like the other case studies, there was a theme on the centrality of leadership. There was also some albeit limited reference to the other Six Core Strategies. However, in contrast with the other two case studies, this service’s efforts focused primarily on establishing an environment conducive to reducing restrictive practices. This included both changing the staff culture through a focus on the model of care, as well as attending to the physical environment of the units themselves. Key to this focus was the development and implementation of sensory modulation spaces and tools, which were used in all three units, as discussed below. Consequently, less detailed discussion occurred in the interviews on aspects of reducing restrictive practices such as use of data and workforce development. The themes below primarily focus on leadership and aspects of the clinical and physical environment.
Leadership

It was noted that seclusion statistics played an important role in identifying the service’s success and needs for improvement. Leadership reported that the service held the second lowest seclusion rate in the state (for detail see Figures 10–12). Over a 10-year period of reduction, the leadership interviewed spoke about an increasing focus on reducing restrictive practices, which coincided with a more proactive management approach to the need.

Like the other services, leadership in collaboration with peer support workers were involved with reshaping the clinical environment through a re-examination of policies and guidelines around using restrictive interventions. For example, this included reviewing Code Grey policies to make them more ‘clinically led as opposed to letting security take over’ (Adult unit manager), and to empower nurse leaders to take charge of the process.

A key strategy to reduce restrictive practices involved creating a thorough review process to examine each seclusion event. Data were used to inform the process and feedback the outcome to nursing staff. The data were then compared with statistics concerning staff assaults/injury. The data were also used to identify ‘hotspots’ or times of the day at which consumers were most at risk of experiencing restrictive practices, which were then used to inform management plans and staffing levels. Leaders, including peer support workers, were highly engaged and involved in the review processes, both on the floor and within leadership and monitoring groups such as the Health and Safety Quality Improvement Group and the Health, Safety, Quality and Risk Committee.

These efforts have broadly led to a culture shift within the service as a whole, which has influenced how staff respond to consumer arousal:

I think on the floor, a lot of it is up to the associate nurse unit managers to decide what to do, because sometimes the staff do feel scared. I think that the culture shift is that previously, if people became agitated, they would go straight to seclusion. Now, I think we understand why the people have moments of being agitated, but we don’t just move straight to that point. (Adult unit manager)

For example, leaders in all units reported staff spent considerable amounts of time building therapeutic relationships with consumers, including eating with them. In the youth and children’s units, for example, staff and peer support workers spent time playing games, writing music and cooking with consumers:

So, it’s just engaging them, yeah, and just normalising, I suppose. (Peer support staff)

The clinical environment – recovery-oriented care

The emphasis in the clinical environment was on developing a person-centred, recovery-oriented model of care. For instance, peer support workers helped to facilitate a culture shift by providing insight into consumer experience, which helped staff to move towards recovery-oriented practice:

I think what is really well valued is recovery-oriented practice … Knowing that the hope and recovery can occur. (Peer support staff)

Indeed, all units emphasised the therapeutic nature of their environment and approach to care:

We have a lot of nursing staff that are really invested in not using restrictive interventions. And having that therapeutic space there, and the rapport that nurses build, makes it on an individual level. (Adolescent unit manager)

Moving into the future, leadership reported that staff were in the process of receiving Safewards training, a model that they hoped to adopt service-wide. Leaders were optimistic Safewards would help to further emphasise relationship building between staff and consumers, and therefore a recovery-oriented approach:
And collapsing the boundaries between clinicians and [consumers] … just making it more approachable. Like some of the nurses here have great rapport … It's just knowing how to use that approach with all the consumers in general. (Peer support staff)

**Physical environment**

The focus on the environment was viewed as part of the overall strategy for proactive prevention in consumer care. Discussion about using sensory modulation in all three units dominated the interviews. Sensory modulation implementation was widespread, consistent and a feature of care. Staff were broadly trained to be competent and 'sensory aware' (Adult unit manager). Significant efforts had gone into redesigning the physical environment to accommodate for and maximise the impact of sensory spaces. In all units, for example, each consumer completed a sensory profile prior to or upon admission, which fed into their management plan:

The sensory profile really gives us a better idea of what sensory modulation tools would be useful when [people] are hyper aroused, and we will go through that, usually with the young person and their family. And that gives us sort of alternatives to medication when they're becoming agitated. But also gives them a bit more independence in managing their arousal levels. (Adolescent unit manager)

Consumers have access to a sensory room and tools both in the room and on the units more broadly, such as a guitar, iPads, sensory books, stress balls, fidget toys and kinetic sands. In the children’s unit, for example, efforts had been made to make the environment more therapeutic:

We’re in a 100-year-old building. It’s not purpose-built … So, we had a very bare observation room and we’ve turned that into a sensory space. So it’s got a light tunnel in here, you can project onto the back screen, you’ve got these P pods which are hugging, so the child sits in there, you know, without the aid of anyone else. They can just go and sit in there and feel comfortable. So, this is about creating a space which is preventative in nature. (Children’s unit manager)

The ‘time out space’ had been similarly transformed into a ‘lizard lounge’ (see Figure 9) with wood flooring, soundproofing panels and TV units, where patients could go when in crisis, engage in individual therapy, or spend time with their families.
The adult unit was also in the process of decommissioning a seclusion room and turning it into a second sensory modulation room:

The high impact will be some soft or padded walls for want of a better word, but the stuff that you get halfway up the wall, so it’s a soft play sort of area. And there’ll be a rocking chair, an adult-sized rocking chair for the sensory stuff. But if they want to go in and scream and yell, and push, and take it out on the walls, they can. But at the same time, we’re going to have quite rough carpet on the floor, so that they can walk on it and touch it. We’re also going to have a data projector projecting onto a wall. [Consumers] can choose the music, they can use the set, the scenery, or they can see seascapes, landscapes, that sort of stuff. (Adult unit manager)

Attention was also paid in the adult unit to ensuring gender-sensitive practice and safety, which led to creating male-only and female-only corridors.

Leaders expressed a desire for continued changes to the physical environment, including a larger indoor and outdoor space for the adult intensive care unit. Leaders also noted the financial constraints that influenced their ability to modify the environment, but appeared to proactively accommodate this.

Trends in reducing seclusion

Adults

Figure 10 indicates a sustained reduction in the rates of seclusion in the adult mental health unit of this AMHS from the beginning of the trend analysis in the 2007–08 reporting year (rate = 25 episodes per 1,000 occupied bed days) to a completion of the trend analysis in the 2016–17 reporting year (rate = 5 episodes per 1,000 occupied bed days).
The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices

The trend analysis of the average duration of seclusion episodes (see Figure 11) over the 10-year trend reflects very little variation, with the average duration of the episodes remaining around 10 hours.

Figure 11: Average duration in hours per seclusion episode

A reduction was detected in the trend analysis of the number of events experienced by the secluded person during the time of their admission (see Figure 12). This reduced from three episodes per person secluded in the 2007–08 reporting year to 1.4 episodes in the 2016–17 reporting year.

Figure 12: Average number of seclusion episodes per secluded consumer
Youth

Figure 13 indicates a sustained increase in the rates of seclusion in the youth mental health unit in the AMHS. At the beginning of the trend analysis in the 2007–08 reporting year the rate was 0 episodes per 1,000 occupied bed days. At the completion of the trend analysis in the 2016–17 reporting year the rate was 14 episodes per 1,000 occupied bed days.

Figure 13: Seclusion episodes per 1,000 occupied bed days

The trend analysis of the average duration of episodes is broken, indicating missing data for some of the reporting years. Therefore, a trend analysis was not undertaken. However, consideration of what data exists indicates low duration from 2.6 hours in the reporting years 2009–10 to as low at 0.7 hours in the reporting years 2016–17.

The trend analysis of the number of events experienced by the secluded person during the time of their admission was also broken, indicating missing data for some of the reporting years. However, there is a marked difference between one event per person in the 2008–09 reporting year to an average of 7.6 events per person in the 2016–17 reporting year. Therefore, it seems that more seclusion for certain individuals is being used for less time. The reasons for this were not explained by any data collected.

Children

The data for the trend analysis on using seclusion in the children’s mental health unit was largely missing and no trend analysis was carried out.

Discussion

All three case studies demonstrated a commitment to a journey in reducing restrictive practices. All conceded that this journey required a cultural transformation of the service over time. The themes that arose in each of the three case studies indicated that steps towards this change in culture loosely modelled the Six Core Strategies (Huckshorn 2004), yet direct acknowledgment of the role of this approach was not made.

Services were consistently using data to inform their work in reducing restrictive practices. Using data was seen as playing a vital role in shaping both practice guidelines and fostering staff understanding regarding reducing restrictive practice. The implementation of evidence-based tools, especially using sensory modulation and, to some extent, trauma-informed care, were evident in all three case studies. Corresponding to sensory modulation was an emphasis on creating the right physical space to enable such modulation to occur.

Developing a peer support workforce was mentioned, as was debriefing, though it was often couched in the review of incidents, rather than direct targeting of consumers and staff to assist them to make sense out of what had happened and to prevent future occurrences of restrictive practices. There was a strong
indication that systematic adoption of both a peer support workforce and debriefing could have a
demonstrable impact on future progress towards reducing restrictive practices.

Of the Six Core Strategies, leadership was consistently discussed in-depth as being central to reducing
restrictive practices and changing the culture of the service to enable this to happen. Strong leadership
requires both a top-down and ground-up approach. From the top-down, leaders established strong
clinical governance structures to hold the services accountable for reducing restrictive practices. On the
ground, strong leadership drove the changes required to influence practice.

Only one of the services in the case studies had experienced the implementation of Safewards, while the
other two were anticipating its introduction. All services expressed value in this model of care in
progressing other steps taken towards reducing restrictive practices. The importance of the correct
model of care, which corresponds with restrictive practice reduction, was exemplified in one particular
service, which had a person-centred, recovery-oriented model of care, which naturally aligned to
reducing restrictive practices.

Trend analyses of the frequency, duration and multiple use of seclusion in the case studies consistently
indicated a quantifiable reduction over time that coincided with reducing restrictive practices. The one
exception was in the youth mental health unit in one service, where the pattern over time appeared to
indicate more use of seclusion for short periods with some youth. The reasons for this were not
explained by the data collected. Irrespective of the gains made, the mental health services in the case
studies were not complacent. Future challenges were highlighted; foremost among them was managing
people admitted to mental health services experiencing methamphetamine-induced psychosis. It was
stated that the level of aggression exhibited by these consumers was difficult to manage without using
restrictive practices.

Document citation record for the department

**Summary**

An international scan of the academic literature was undertaken to determine references to
departmental resources to consider the national and international impact of the work undertaken. This
found:

- Only a small number of the department’s reports were cited in the international research literature.
- More recently, departmental research reports have been converted into peer-reviewed academic
  journal articles. Three articles were detected.
- This appears to be a good strategy to allow wider international dissemination of the projects and
  research undertaken by the department.

**Introduction and method**

The comprehensive documentation undertaken by the department in reducing restrictive practices has
been disseminated statewide and throughout the country. Consideration was given as to the uptake of
these resources in the international literature on reducing restrictive practices as an indication of its wider
impact. The objective was to determine the number of peer-reviewed publications in the international
literature that have cited the reports published by the department.

Literature searches for the documents outlined as reports that were included in the document analysis
(see Appendix for a complete list) were undertaken. These searches were completed in September
2017. The search engines used in the searches were Web of Science, PubMed/Medline, Scopus,
CINAHL, EBSCO, ProQuest and Google Scholar.

**Results**

All of the documents indicated in the Appendix \(n = 74\) were included in the search. Only two reports
were cited; one was cited three times and the other six times. It is interesting to note that both cited
reports were on occupational violence, with no mental health-specific resources being cited. The reports and their associated citations are listed below in Table 6.

Table 6: Reports cited and associated citations

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<tr>
<th>Report</th>
<th>Citations</th>
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Of note was an indication of the publication of journal articles arising from research done as part of department reports. Three such journal articles were detected (see Table 7).

Table 7: Peer-reviewed journal articles from department reports

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<th>Peer-reviewed journal articles</th>
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These three articles were then searched in the same method described above in January 2018 to see if these publications had been cited in the academic literature. Given that they have only recently been published, none was cited in the academic literature.

**Summary**

The department has written a number of reports to disseminate information to assist in reducing restrictive practices. Many of these reports constitute research, either as literature reviews or as outcomes of research projects. These reports have been published on the department’s website. The reports are often peer-reviewed prior to dissemination but not in a manner acceptable to the academic community. The reports are therefore referred to as ‘grey literature’, which may or may not be detected in further academic research published on reducing restrictive practices. None of the department’s reports on managing clinical aggression in mental health services was cited in the international research literature, indicating that this strategy does not impact greatly on the academic research progressing understanding about reducing restrictive practices.

More recently, attempts have been made to convert research reports into peer-reviewed academic journal articles. Three articles were detected in this regard. However, it is too soon to determine the extent to which this is a good strategy to allow wider international dissemination of the research undertaken by the department. A focus on this type of dissemination into the future will allow a more comprehensive determination as to the extent to which the research undertaken by the department influences the international understanding of reducing restrictive practices.
Results: Objective 3

Objective 3: Outline the perceived impact of the department’s approach.

Interviews with key AMHS leads on reducing restrictive practices

Summary
Interviews with the person primarily responsible for reducing restrictive practices were undertaken in 18 AMHS, two child and/or youth area services, and the statewide forensic mental health service (n = 21). Items in the interview schedule focused on challenges to reducing restrictive practices and the perceived value of the department’s efforts to support reduction. The results found that:

- The activities outlined in the mental health services in Victoria to reduce using restrictive practices reflected the Six Core Strategies.
- Services endorsed developing leadership (clinical, managerial, service user and carer expertise) to bring about a shift of culture towards coercion-free environments.
- Such leaders served as champions or advocates that motivated other management and staff to create and implement new policies/guidelines around reducing restrictive practices.
- Leaders engaged regularly in review panels and committees, staff training and on-the-floor activity including creating clinical support plans, monitoring consumers and debriefing following incidents.
- Using data to inform the progress in reduction was widely used. Many services had ongoing processes to collect, monitor, analyse and act on data relating to restrictive practices.
- A range of initiatives were indicated in relation to workforce development to reduce restrictive practices, especially training initiatives.
- The benefit of implementing the Safewards model of care in helping to reduce restrictive practices was positively discussed. The role of the department in driving this initiative was acknowledged.
- The need to focus on reducing restrictive interventions with vulnerable groups of consumers was highlighted as a current need. This was especially related to consumers experiencing drug-induced psychosis and the specific needs of Aboriginal people, given their ‘trauma background’.
- The overall efforts of the department in assisting services to reduce restrictive practices were positively acknowledged. Specific value was seen in the collaborative approach with services undertaken by the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist.

Introduction
One means of determining the impact of department efforts in reducing restrictive practices was to interview the person primarily responsible for reducing such practices in the AMHS (n = 21). The researchers were sent a list of contacts for 18 AMHS, two statewide child and/or youth area services and the statewide forensic mental health service. The person to be interviewed in each of these services was determined by the director of mental health nursing or the equivalent role.

Items in the interview schedule focused on approaches to reducing restrictive practices and the department’s assistance in these activities. The interview schedule consisted of the following items:

- Outline what your AMHS has done in mental health services to reduce restrictive practices.
- Outline departmental resources that have assisted.
- Outline contact with the department that has assisted.
- Outline any targeted vulnerable groups in your service and strategies put in place to reduce restrictive practices with them.
- What has been particularly good about the overall focus of the department in reducing restrictive practice?
- What are some of the limitations in the department’s approach to assisting seclusion reduction?
The role of the Victorian Department of Health and Human Services in assisting mental health services to reduce restrictive practices

• How important do you see the department’s role in the future in assisting with reducing restrictive practices?

The interview schedule was standard across all interviews for all participants. All interviews were recorded on a digital audio-recorder (Sony ICD-PX333M) and transcribed verbatim. Data were collected from June to November 2017. Confidentiality and anonymity were protected throughout the transcribing, analysis and reporting process.

For an outline of the research design, see ‘Method’ and data analysis see ‘Data analysis’.

Participant summary

Twenty-one interviews were completed as indicated above. The majority of participants held various positions of leadership in mental health services, with roles including (but not limited to) operations manager, nurse unit manager, director of nursing, director and associate director of mental health, clinical nurse educator, nurse consultant, senior psychiatric nurse and quality coordinator. Duration in the participants’ current roles ranged from five weeks to nine or more years, with the average being two to three years. To varying degrees, the participants were responsible for the oversight, implementation, monitoring, evaluation and training relating to reducing restrictive practices and often worked across clinical and administrative levels in doing so. Some participants noted a key part of their role was ensuring compliance and accountability to the Mental Health Act, as well as organisational and local health service expectations and initiatives to reduce restrictive practices. Male and female leaders were similarly represented. No other demographic data (for example, ethnicity, age) were solicited from participants.

Findings

Reducing restrictive interventions in services

Legislation and policy

Many of the participants noted the importance of legislation and policy (national, statewide, service-level) in driving efforts to reduce restrictive practices. The main legalisation cited was the introduction of the Mental Health Act:

The Mental Health Act of 2014 … is very focused on and orientated towards reducing practice and use of restrictive interventions. So there was a lot of education involvement that went out to the workforce around that. (Rural service)

National priorities were cited as instigating initial discussions around reducing restrictive practices. Policy was discussed both in terms of statewide health policy and organisational policy pertaining to using seclusion and restraint, sedation and/or restrictive practice reduction. Many of the leaders had been involved directly in reviewing and revising policies and guidelines around the reduction within their services, and policy change was seen as a necessary component of reducing restrictive intervention efforts. Some participants noted the need for additional or ongoing policy development, as well as staff education around such policy:

The statewide-led agenda I think gave the whole service permission. It kind of changed the tone that we actually do need to do something. It’s a National Bill of Health Safety priority; they’re going to support health services to reduce it. (Metropolitan service)

Leadership

The participants generally noted their vision was a reduction in restrictive practices, moving towards the complete elimination of restrictive practices. Such efforts began with the Creating Safety and Beacon
Project initiatives from 2007 to 2009, in which some services were involved, and more recently included the statewide rollout of Safewards.

Central to these efforts has been the integral role of leaders such as the chief executive officer, clinical director and director of nursing/mental health nursing, as well as key staff involved in reducing restrictive practice initiatives. These individuals served as champions or advocates that motivated other management and on-the-floor staff, and helped to create and implement new policies/guidelines around reducing restrictive practices:

So we put some good governance and structures and systems in place to underpin the management of aggression but also demystify that for people. Because you were secluded last time you were here, don’t expect to be secluded the next time. (Rural service)

While the involvement of leadership varied, increased engagement of leaders was linked with more effective reducing restrictive interventions efforts. Many of these leaders engaged regularly by participating in review panels and committees, getting involved in staff training and on-the-floor activity including creating clinical and support plans, monitoring consumers’ condition and debriefing following incidents. This involvement was seen as essential in ensuring staff had a clear understanding of the vision of the service and target goals:

When I started, I did a review meeting and started hearing people’s stories from both sides. I started to realise that people wanted leadership. (Rural service)

Oversight or governance groups had various names including the Psychiatric Behaviours of Concern (PsyBOC) Committee, Creating Safety Committee, Quality and Safety Group, Reducing Restrictive Interventions Committee and the Clinical Risk meeting. Such groups tended to meet fortnightly or monthly to review incidents and formulate recommendations, with additional reporting to unit leaders occurring daily and/or post-incident. It was noted that a multidisciplinary team was required to address restrictive practices effectively from both the top-down and ground-up, especially when it comes to prevention and early intervention:

I think you’ve got to have that governance, which this committee is. But you’ve also got to involve people who are actually on the floor, who could also give you suggestions, ideas of how things can be done differently. (Statewide service)

Leadership was also signalled for a particular focus on prevention or early intervention in order to reduce restrictive practices. Participants highlighted that increased staff education was necessary to identify patients at risk and offer pre-intervention before reaching ‘Code Grey’ or requiring using restrictive practices. While some specific strategies were being adopted to facilitate early intervention, it was still identified as a focus requiring additional policies/strategy/information:

We want staff to actually think way earlier in the trajectory of deterioration and escalate things a whole lot earlier than what they currently do. (Metropolitan service)

**Use of data**

All participants discussed, to varying degrees, the role data played in their efforts to reduce restrictive practices. Many services had ongoing processes (both internally and externally driven) to collect, monitor, analyse and act upon data relating to seclusion statistics and restraint incidents, identifying trends over time:

There are various different ways we monitor. We look at the data that we send in to the department monthly. We’ve identified there’s been some other not-good practice or slippage in practice that we’ve now started to monitor and that’s around medical reviews whilst in seclusion. We’re also reporting to the department any patient who has been in seclusion longer than seven days. (Statewide service)
These data were reviewed at various committee meetings and audits and were used to inform the creation of new policies, plans and initiatives. As stated above, these processes were, in many cases, new initiatives instigated by key leaders:

So I gathered data on where we were and where we had to go and what was out there, what the Restrictive Intervention team vision was … I provided a template to share the data of each separate inpatient unit. We also realised we weren’t reviewing or what it meant for staff to be involved in restrictive practices. So in that regard I started seclusion and restraint review meetings and each different unit had different requirements for that. (Rural service)

Some leaders found the results of the initial reviews they conducted to take stock of their service surprising, which drove their passion to reduce more:

In my review I was horrified to discover that we were having very high occasions of seclusion, anything from 230 to 300 a year, so I was really passionate about improving the experience for people coming through the door and changing the culture. (Rural service)

Also important was sharing the data with staff to foster staff buy-in and understanding:

Absolutely data drives everything. And knowing it really well has helped, but I think conveying it to staff on the ground in a way that’s meaningful is a key consideration. (Metropolitan service)

**Peer support workforce**

Some of the participants discussed the need for a peer support workforce to help reduce restrictive practices. Participants identified the highly beneficial role of peer support workers, carers or consumer consultants in assisting with reduction efforts, changing staff culture and obtaining feedback from consumers:

We did employ a consumer and a carer peer in one of our acute units which had the highest rates of seclusion and restraint. And they worked, between them, worked full-time on the inpatient unit, and worked directly with staff and with consumers and carers around what’s most helpful for them, and provided a different type of support to people really. And we saw the rates of restrictive interventions plummet within weeks … It was probably the most potent thing that we’ve done. Because it was what they brought to the team that really made a massive difference. (Metropolitan service)

**Workforce development**

Many participants discussed the need for workforce development and ongoing staff education and training to gain momentum in reducing restrictive practices. A specific focus of training initially centred on ensuring staff understood the vision and need to reduce restrictive practices along with where the service currently stood, in order to foster staff buy-in:

I would say the first thing that was put in place is education. So after the vision was shared, people [discussed] what they wanted and how to achieve it. (Metropolitan service)

Subsequent training included programs relating to changes in the Mental Health Act, Safewards, using PRN medication, gender sensitivity, the collaborative recovery model or recovery-oriented practice, aggression management and specific interventions including sensory modulation and trauma-informed care.

This workforce development was seen, overall, as a means to change the ‘culture’ around using restrictive practices:

The work that went into establishing the culture has meant that it actually is an expectation that before restrictive interventions, we do everything else we can to avoid it. And then also that once if we do use restrictive interventions, there’s a very clear and robust review once they’ve happened. (Rural service)
However, it was noted that having adequate resources to release staff to do training was a challenge.

**Evidence-based interventions**

Many participants discussed their increased use of specific interventions that aided in reducing restrictive interventions, namely sensory modulation and trauma-informed care. In many cases, funding relating to initiatives such as Safewards was a catalyst to increasing the resources pertaining to the subsequent use of these interventions:

> Every ward’s got a dedicated sensory room, but we also have dedicated sensory boxes in our intensive care areas. They are quite well utilised by the staff in there. And most of our well-known consumers now come in and on admission they’ll say can I please have the wombat, or can I please have the weighted blanket. (Metropolitan service)

Some participants noted that challenges relating to ‘red tape’ or funding/allocation of resources, as well as care/maintenance of resources and staff buy-in, affected their ability to use interventions such as sensory modulation. These challenges led to the intervention not being as ‘embedded’ in practice as desired. As such, this was an area seen by some services as a work in progress:

> We have a fair bit of [sensory modulation] equipment on the ward, but in terms of training it’s started to happen a bit more but it’s not quite there. We don’t have an actual modulation room set aside but we’re hoping we might be able to do that in the near future but that’s not there yet. (Statewide service)

**Debriefing**

While most participants noted they had review processes in place for staff to discuss and analyse episodes of using restrictive practices, few participants specifically discussed debriefing as a strategy to reduce restrictive practices or involved consumers in post-incident discussions. Those who did employ debriefing noted it as a beneficial process in helping both staff and consumers to understand why the restrictive practice had occurred. One participant noted debriefing particularly as an area warranting further attention and staff training:

> If we do have an episode of a restrictive intervention we have a formal debrief that we go through with the [consumer] and the carer, again, if applicable. It is a voluntary process for the [consumer], but for those that do participate in that, they do find it of value. (Rural service)

**Safewards**

The services were at various stages of implementing Safewards. Some had been involved in the pilot rollout of the program, while most others’ adoption of Safewards was in its infancy. The funding pertaining to Safewards provided by the department was noted by multiple participants as being valuable and desirable. Some participants noted that while initial enthusiasm and adoption of Safewards was high, their implementation efforts had slowed or plateaued over time. In this way, Safewards adoption was also widely viewed as a work in progress:

> I’m a big fan of Safewards and a lot of our staff are too. We’ve seen some shift already, just with the first three interventions that were implemented in the wards, and we’re doing the next one, which is ‘bad news mitigation’, which for me is also a fairly big one. (Metropolitan service)

**Environment**

A number of participants noted that the constraints of the physical environment (for example, layout, age, condition, location and resources of the building/site) affected their ability to reduce restrictive practices or create spaces conducive to reduction such as sensory modulation rooms. Some of the participants were engaged in redesigns that would help to improve the suitability of the environment for their goals:
We’ve been trying for a few years to look at our model of care, but it has been restricted by the environment that we’ve had … It was actually built to be a private facility, not a public facility, so the seclusion rooms were a bit of an afterthought. (Rural service)

In a separate but related aspect, participants also noted the constraints of access via the emergency department. This highlights the need for a focus on using restrictive practices in the health system more generally:

One of the issues we come up against is trying to convince our acute colleagues that the Mental Health Act applies over here as well. If someone is on an assessment order in our [emergency department], then all the same requirements should be applied. They push back at that, so that’s been a real battle for us getting them to understand. (Rural service)

**Special populations**

**Drug use**
The majority of participants noted the particular challenges posed by consumers with drug-induced psychosis, particularly those using methamphetamine and ‘synthetic cannabis’. Many of these consumers exhibit aggressive behaviour and, as such, were perceived as harder to manage. They also tend to come through to the services via the emergency departments, and many have already experienced mechanical restraint and/or seclusion by the time they enter mental health services. Some participants noted the extra security and training required to manage this population:

What staff see are the people that come in who are ice-intoxicated. And we would get two of those every week in each of our adult wards, and that is really difficult to give a sufficient amount of medication to manage their aggression to be honest. (Metropolitan service)

**Intellectual disability**
Some participants identified the intellectual disability population as posing particular challenges and having a high rate of exposure to restrictive practices. One participant felt there was a lack of education, understanding and engagement around this issue:

When we have someone who is presenting with a particularly autism, we’re ill-equipped with education and understanding and how to engage. And a likely outcome of someone that is presenting like that is that the be placed in a restrictive intervention. (Rural service)

**Ethnicity and culture**
Two participants identified Aboriginal groups as requiring special consideration when it comes to using restrictive practices, noting that their ‘trauma background’ was a factor in their experience. However, most others who discussed their Aboriginal consumer population did not consider cultural considerations or specific interventions for this group, and many admitted not considering the topic at all, or felt they did not have data on this issue. Some felt that Aboriginal groups were not overrepresented in the statistics. Few participants noted having Aboriginal staff workers or liaisons, and only one discussed cultural training for staff:

Indigenous populations that come in crisis – they have all the trauma background and we’re very mindful as far as using seclusion and restraint. (Rural service)

One participant further identified a high proportion of Russian, Greek and Italian descendants in their consumer patient population. Another noted the service had some female clients who had English language barriers, which posed communication problems.

**Age**
Age did not appear to be a significant factor in using restrictive practices. One participant discussed the elderly population, noting that they had zero seclusions/restraints in the unit for many years. The lack of use was attributed to leadership decisions. A second participant noted having child and youth beds but did not specify any issues relating to using restrictive practices. A third noted that most of their youth
consumers came from diverse backgrounds and had a trauma background, which required an emphasis on trauma-informed care.

**Gender**

One participant noted the different considerations in reducing restrictive practices among specific genders. Another noted they had particular challenges with young males who had not yet received mental health treatment, and females with personality disorders. A third also noted that males aged 20–30 were the population who most experienced restrictive practices. Multiple services were currently engaged in gender-sensitive practice training or initiatives:

> For our males, it’s episodes. For our males, there’s a pattern now of coming in and going straight into seclusion. But that is partly because they’re untreated. (Statewide service)

**The role of the department in reducing restrictive interventions**

**Guidance, training and support**

Over half of participants noted they had had (or were going to be having) direct contact with the department either through site visits from the Chief Mental Health Nurse or the Chief Psychiatrist, or as part of the process of having their reporting/data audited or reviewed. These site visits included receiving guidance on how to improve their site in keeping with the department’s recommendations. Contact with the Office of the Chief Psychiatrist was noted as being the most frequent contact that occurred both formally and informally (in person and via phone):

> Just having that direct line and being able to access them, I think, yeah, it’s what’s valuable. The face-to-face or even phone call. It’s having that capacity to talk it through at a level where you’ve got a really good level of experience and understanding of the framework. (Rural service)

Training was the most common department resource used by participants, particularly training on trauma-informed care, sensory modulation and Safewards, as well the ability to have input into ‘train the trainer’ programs. Several participants further reported having engaged with the department through other seminars and workshops, or at various meetings (for example, senior nurse meetings). The department was thus seen in a broad, supportive role by the services:

> The ongoing support from the department is amazing, [their] commitment to reducing restrictive interventions. And I think it’s around improving experiences for staff and consumers and visitors coming in, and making the environments more welcoming. (Rural service)

**Resources and funding**

Most of the resources employed by the participants pertained to the Creating Safety and Safewards initiatives. Participants had mixed views as to the utility of these resources, with some finding them highly useful and others less so. One participant noted that the department had made available useful literature, such as a resource booklet on methamphetamine abuse. Others noted the resources and videos distributed via the Safewards webpage and on reducing restrictive practices generally were also helpful.

> Probably the best thing the departments done for us is make literature available which exposes just exactly what sort of behaviours are expected or are seen with people who are affected by substances and particularly methamphetamine. (Rural service)

An additional set of participants further noted using the restrictive interventions framework/guidelines in their service. One explained it provided a baseline or standard to adhere to:

> The guidelines that have come out around the restrictive interventions have been valuable. You know, to do our protocols and guidelines for the staff at a service level. (Rural service)

The department funding relating to Safewards appeared the most valuable of the resources received. One service reported they received substantial funds to purchase equipment; another used funds to
purchase sensory modulation trolleys. The second also reported they recently received ‘calm down boxes’ as well, as did a third. Another service reported substantial funding from the department for Safewards:

Once a service engages with the Safewards program, then the department provides [financial support] to support the implementation process. So that is to support buying additional items such as sensory modulation type equipment and items that might be bought in order to commit to Safewards. (Rural service)

**Strengths, limitations and recommendations**

**Leadership and networking**

Participants reported the department had been helpful in raising awareness within the health system across the state and in creating a unified response, which resulted in a culture shift towards reducing restrictive practices:

I think investment in the Safewards program by the state and by the department is probably one of the best things that have happened in the last couple of years. And the roll out of that across the state. So it’s essentially, you know, steering the whole state in one direction of reducing restrictive interventions. (Rural service)

Some participants noted that the department had played a strong leadership role and provided consistent, hands-on engagement and guidance for the services. Increased visibility and accessibility were seen as strengths:

I would say the hands-on involvement that’s been shown, and the ongoing support that they provide has been great. (Metropolitan service)

Indeed, several participants underscored the importance and need for ongoing support and leadership from the department to keep services moving in a unified and coherent direction and to make the services accountable:

I see it as going from strength to strength, with a continued push to reduce restrictive interventions and the contact that we get from the Office of the Chief Psychiatrist. Like getting that tap on the shoulder and being made accountable. If that dropped off I would have a legitimate concern that we would fall back on old practices. (Rural service)

Some participants further noted that it was helpful to have the forums provided by the department, such as the Chief Psychiatrist’s Quarterly Restrictive Intervention Committee, to act as a sounding board to receive and share information, discuss challenges and conduct planning:

When services were asked and invited to provide ideas and plans of how they were going about it, and then those services were able to share that … that was good because then all of that, those ideas and strategies and different ways that people were addressing things, came together. And people could have a look at different ways of doing things. (Statewide service)

However, some participants wanted more practice advice for implementing initiatives to reduce restrictive practices. One participant particularly sought guidelines around increasing consumer participation in reducing and reviewing restrictive practices:

Sometimes it’s tricky to actually get clear information [from the department] about what you require. Often there’s recommendations that you could do differently or you could rethink this, but not always necessarily practical advice about how to do that. (Rural service)

Others felt that the lines of communication with the department could be improved both within and across the services in order for the department to have a greater understanding of the local context:

I think one thing the department could do, could be to be a little more reciprocal and venture out to understand what the challenges are in the service system. (Rural service)
**Limitations in the approach to reducing restrictive interventions**

Participants had varying critique of the department's approach to reducing restrictive practices. One participant felt that the target goals were not realistic and recommended reducing the key performance indicators for seclusion to a lower target, such as 10 episodes per 1,000 occupied bed days. Another felt that the dominance of Safewards led other potentially beneficial solutions to reducing restrictive practices to be overshadowed or omitted, such as debriefing:

> Anytime anything’s mentioned, Safewards is thought to be the solution, but I do think that there are still areas we haven’t really done a lot of work in. (Statewide service)

Similarly, other participants recommended that, moving into the future, the department should consider strategies to reduce other forms of restrictive practices (for example, mechanical and pharmacological restraint), as well as how to improve environmental aspects that contribute to using such practices. Finally, some participants noted the differences in how the services were interpreting the restrictive practices frameworks or guidelines and advocated for a more standardised approach:

> I really feel like we need a standardised approach to how we’re managing the use of restraint and breakaway techniques. The reason being that this is something that we all do and each of the different programs are doing different things. (Metropolitan service)

**Resources and support**

As stated above, many participants noted the resources/materials, training, funding and support provided by the department, particularly around Safewards, have been useful. It was noted that increased marketing might be useful to increase the dissemination of such materials. Increased use of technology for communication such as videoconferencing was suggested.

There was some criticism surrounding the way funding has been allocated. One participant noted that they were in a constant ‘queue’ for funding and felt like the ‘poor cousins’ being a small regional facility, in comparison with the large urban facilities. Achieving funding for development was perceived to be a challenge. A second participant felt that the department could be ‘less prescriptive’ around how funding is allocated. A third participant felt that the funding process could be more transparent. A fourth participant noted limitations around funding for staffing and staffing requirements and desired more funding to train graduates:

> Being a regional facility I think from that point of view we’re the poor cousins. We certainly don’t have the resources that they do in the city with access to allied health in the unit. And yeah, my facility is very old and run down and not purpose-built, so I’m constantly putting in for submissions for funding, and you know, you’ve got to be in that queue all the time. (Rural service)

**Discussion**

Although the Six Core Strategies (Huckshorn 2004) were not formally mentioned in the interviews, the activities outlined by the AMHS in Victoria reflected this systemic means to addressing the reduction in restrictive practices. This is not surprising given that the early policy direction of the then Victorian Department of Health endorsed using the Six Core Strategies in seclusion reduction, as did national policy, which the Victorian policy reflected. There was a noticeable indication of the benefits of such policy documents in shaping local initiatives to reduce seclusion, which rolled over into a focus on restrictive practices in the momentum towards the new Mental Health Act in 2014.

Some of the Six Core Strategies appeared to be universally endorsed across the services. Primarily this related to developing leadership (clinical, managerial, service user and carer expertise) to bring about a shift of culture towards coercive free environments. Such leaders served as champions or advocates that motivated other management and on-the-floor staff, and helped to create and implement new policies/guidelines around reducing restrictive practices. Participatory leadership was described, which saw leaders engaged regularly in review panels and committees, involved in staff training and involved in
on-the-floor activity including planning, monitoring consumers and debriefing following incidents. This involvement was seen as essential in ensuring staff had a clear understanding of the vision of the service and target goals.

Another Six Core Strategy, which appeared to be widely endorsed, was using data to influence clinical practice. All participants discussed, to varying degrees, the role data played in their efforts to reduce restrictive practices. Many services had ongoing processes (both internally and externally driven) to collect, monitor, analyse, and act upon data relating to restrictive practices. A range of initiatives were also indicated in relation to workforce development to reduce restrictive practices, which is another of the Six Core Strategies. A variety of training initiatives were described including programs relating to changes in the Mental Health Act, using PRN medication, gender sensitivity, recovery-oriented practice, aggression management and specific interventions including sensory modulation and trauma-informed care. These later two interventions are part of the evidence-based tools signalled in the Six Core Strategies and many of the people interviewed discussed the implementation of sensory modulation and trauma-informed care in their services.

The last of the Six Core Strategies, debriefing and a consumer workforce, were described as 'work in progress'. The need for a peer support workforce to help reduce restrictive practices was highlighted and a few participants specifically discussed the need to improve debriefing as a strategy to reduce restrictive practices.

The participants in the study indicated the implementation of the Safewards model of care was a uniform baseline from which to launch a variety of initiatives to assist in reducing restrictive practices. Although services were at various stages of implementation of Safewards, most fully endorsed the funding and support efforts of the Office of the Chief Mental Health nurse towards its implementation in all inpatient mental health services throughout Victoria.

The majority of participants noted the need to focus on reducing restrictive interventions with vulnerable groups of consumers. Two specific groups were named in this regard. The first was the need to reduce restrictive interventions when managing challenges posed by consumers experiencing drug-induced psychosis (especially from methamphetamine and ‘synthetic cannabis’ use). The second group related to the specific needs of Aboriginal people, who required a unique response given the impact of inter-generational trauma on their experiences in general.

The department's overall efforts in assisting services to reduce restrictive practices was positively acknowledged. Specific value was seen in the direct collaborative approach undertaken by the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist. Over half of participants noted they had had (or were going to have) direct contact with the department, either through site visits or as part of the process of having their reporting/data audited or reviewed. Participants reported that the department had been helpful in raising awareness within the mental health services regarding reducing restrictive practices and creating a unified response involving a cultural shift across the sector towards reduction. This was increasingly achieved through direct lines of collaboration with all AMHS. Given that strengthening in this approach is relatively recent, it is understandable that a small number of services expressed the need to strengthen communication in the collaborative approach undertaken by the department.

Services were equally supportive of the resources and funding from the department to support the reduction of restrictive practices. Training was commonly identified as the means by which the department supported services to reduce restrictive practices, particularly training on trauma-informed care, sensory modulation and Safewards. However, the support most identified was the department funding to implement Safewards, which was widely endorsed, though some services felt the emphasis on Safewards stifled other viable initiatives to reduce restrictive practices.
Statistical analysis of national trends of seclusion use

Summary
Statistical data provided by the department’s data analysts were also used to consider the impact of the department’s efforts in reducing restrictive practices. This data revealed that:

- Since the department’s involvement in assisting services to reduce seclusion from 2006, there has been a corresponding reduction in the rates of seclusion in mental health services.
- A similar reduction has not been reflected in either the duration of using seclusion or the multiple use of the practice on individuals.
- Marked variations in using seclusion between specialty services also highlights the need to create an understanding of why this is the case.
- Although the reduction in the rates of using seclusion is laudable, there is still significant progress that needs to be made to realise the policy goal of seclusion elimination.
- The introduction of the Mental Health Act has resulted in the mandatory reporting of bodily restraint (physical and mechanical restraint). Given the short timeframe since introducing this reporting, trend analyses of this data were not possible.

Introduction
In Victoria there has been an ongoing commitment to reducing using restrictive interventions, starting with implementing the Creating Safety: Addressing Restraint and Seclusion Practices project in 2006 (Department of Health 2013a). The 2014 Mental Health Act strengthened state government policy and initiatives to reduce using restrictive practices by regulating the practice of restrictive practices and increasing oversight and accountability. The 1986 Mental Health Act required mandatory reporting of using seclusion, while the 2014 Mental Health Act requires the mandatory reporting of all restrictive practices (seclusion, physical restraint and mechanical restraint). Therefore, statistical analyses were undertaken to determine if trends in the rates and duration of reducing restrictive practices correlated with the department’s involvement in reducing such practices.

Method
Data were collected across Victoria’s 21 state-funded adult AHMS. Each of the 21 AMHS have acute mental health inpatient services attached to a general hospital for managing people with significant psychosocial disturbance and disability until they have recovered sufficiently to be managed in the community (Department of Health 2011c).

The Client Management Interface/Operational Data Store (CMI/ODS) is the Victorian public mental health system database and is used to store a range of core reporting requirements including caseload analysis, consumer outcome measurements and all client service-level information. Information on using restrictive practices, including the frequency and duration of use, are recorded in this dataset.

The CMI/ODS was interrogated to consider trends in the frequency of restrictive practices, the duration of use and multiple use on individuals during a single episode of admission. This data was aggregated over the reporting years 2007–08 to 2016–17.

The focus of the analysis was on consumers aged 18–64 admitted to adult AMHS including SECU. However, data exists on child and youth mental health services (CYMHS), mental health services for older persons (MHSOP), forensic mental health services (FMHS) and specialist units (such as mother/baby, eating disorder and veterans units). Marked variation in the general trends in using restrictive practices in relation to service types are highlighted. The aggregate data, which was received from the department, did not contain any identifiable data.
Results

Seclusion

The data supplied by the department indicated that the rates of seclusion episodes per 1,000 occupied bed days fell markedly from 26.6 per 1,000 occupied bed days in the 2007–08 reporting year, to 11.2 per 1,000 occupied bed days in 2016–17 (see Figure 14). Although the 2016–17 number is a slight increase on the lowest rate of 10.3 per 1,000 occupied bed days in 2014–15, there is a steady trend in the downward rate that correlates with department involvement in actively assisting in reducing restrictive practices since 2006.

Figure 14: Seclusion episodes per 1,000 occupied bed days

This downward trend in rates of seclusion episodes per 1,000 occupied bed days is also evident in CYMHS, MHSOP and specialist units. However, in each, the current rates for the 2016–17 reporting year are less than half that of adult services (CYMHS = 5.4 episodes per 1,000 occupied bed days; MHSOP = 1.8 episodes per 1,000 occupied bed days; specialist units = 3.1 per 1,000 occupied bed days). The notable exception to this downward trend is in FMHS, with an upward trend over time from 12.8 episodes per 1,000 occupied bed days in the 2007–08 reporting year, to 28.7 per 1,000 occupied bed days in 2016–17 (see Figure 15).
This general downward trend in the rates of seclusion is not similarly reflected in the average duration of seclusion over the same period (see Figure 15). Over the 10-year period, there was no year in which the average duration was more than 10 hours per episode. However, the average duration of 7.1 hours was at its lowest at the beginning of the period in 2007–08 and at 9.5 hours in 2016–17. This reflects a slight upward trend.

A more marked upward trend is evident in both FMHS and specialist units. In both the average duration is measured in days rather than hours. In FMHS the average duration per episode was 23.5 hours in 2007–08 and at 52.2 hours in 2016–17. In specialist units the average duration of 21.0 hours in 2007–08 and at 94.6 hours in 2016–17.

In CYMHS and MHSOPS the trends have plateaued over time, with average duration of seclusion episodes between 2.9 hours and five hours in MHSOP, and at the lowest in CYMHS between 1.2 and 2.3 hours.

In considering the average number of episodes of seclusion per person, the slight upward trend in Figure 15 was reversed to a slight downward trend in Figure 17. The average number of seclusion episodes was highest at the beginning of the time period at 2.9 episodes per person in 2007–08 and down to 2.2 episodes in 2016–17, with the lowest average of 2.0 being achieved in the 2014–15 reporting year.
This trend in adult services is very similar to that in CYMHS, MHSOP and FMHS, though the average episodes per secluded person spiked in FMHS in the 2016–17 reporting year, at 6.8 events per person. The exception in service types relates to specialist units where marked variability in the average number of episodes per person exists over time, rising as high as 14.4 in the 2013–14 reporting year (see Figure 18). However, a slight trend in service type will exist over time.

**Bodily restraint**

The total number of yearly bodily restraints (mechanical and physical restraints) in adult services showed a marked increase since the low of 0.6 episodes per 1,000 occupied bed days in the reporting year 2007–08 to 8.3 episodes per 1,000 occupied bed days in 2016–17 (see Figure 18). This increase coincided with the mandatory reporting of bodily restraint under the Mental Health Act, whereby the 2014–15 reporting year reflected the maximum rate of 10 episodes per 1,000 occupied bed days. There has been a gradual reduction since this time, and the crucial indicator will be whether this downward trend is sustained in the years to come. At this time, it is also too early to compare trends that are happening in specialty services.

Conversely, the average duration of an episode has decreased markedly from 5.7 hours in 2007–08 to 1.2 hours in 2016–17 (see Figure 19). However, again this reflects reporting of bodily restraint physical, which occurred with the Mental Health Act. Physical restraint is liable to be for a short duration of time,
while mechanical restraint is liable to be for considerably longer. When physical restraint is combined with mechanical restraint, this explains the reduction in average time, as before 2014 it was only mechanical restraint that was notifiable.

**Figure 19: Average duration of bodily restraint episodes (hours)**

![Figure 19](image)

Of interest is that the average number of bodily restraint episodes per person has not changed over time and is reflected in the flat trend, from an average of two episodes per person in 2007–08 to the same in 2016–17 (see Figure 20).

**Figure 20: Average number of bodily restraint episodes per people restrained**

![Figure 20](image)

**Discussion**

The analyses indicate that since the department’s involvement in assisting services to reduce seclusion from 2006, there has generally been a corresponding reduction in seclusion in mental health services. Although this correlation cannot be considered a cause-and-effect relationship from these analyses, since the department became involved there has been a reduction in the rates of people in mental health services being secluded. A marked impact has not been reflected in either the duration of using seclusion or the multiple use of the practice on individuals. Marked variations in using seclusion between specialty services also highlights the need to create an understanding of why this is the case. Although the reduction in using seclusion is laudable, there is still significant progress that needs to be made to realise the policy goal of seclusion elimination. This will require a continued emphasis on the support provided by the department to maintain the momentum made.
Up until 2014, of the bodily restraint processes, only mechanical restraint was notifiable. The introduction of the Mental Health Act saw the mandatory reporting of physical restraint added to the bodily restraint figures. Therefore, this data can only be reliably considered since 2014, which is not long enough for trends to be detected. There is an increased emphasis by the department on assisting mental health services to reduce bodily restraint. It is important that these efforts be monitored through assessing the trends in the use and duration of bodily restraint on an ongoing basis into the future.
Results: Objective 4

Objective 4: Compare the approach taken by the department with other national and international jurisdictions.

Website analysis

Summary
This section of the project focuses on comparing the information on reducing restrictive interventions contained on the department’s website with other state and territory jurisdictions in Australia and three international jurisdictions (Ireland, the state of Massachusetts in the United States, and New Zealand) to compare the approaches taken.

- The department’s webpage on reducing restrictive practices is clear, concise and well organised.
- The department’s webpage appears innovative in conveying to mental health services and the wider audience the extent of its efforts towards eliminating restrictive interventions. This is especially evident in comparison with other jurisdictions within Australia. Only one other jurisdiction (South Australia) had a standalone webpage on reducing restrictive practices.
- The international jurisdictions were more directly comparable to the web presence of the department in Victoria.
- Each website focused on a strategic plan towards eliminating restrictive practices. All had plans directed at a systemic response towards elimination. All had resources available to assist services to implement their approach.
- The sites of Massachusetts and New Zealand demonstrated an overt indication of consumer and carer involvement towards eliminating restrictive practices. This was missing from the Victorian site.

Introduction

The general point of communication and interface with the public and the mental health sector regarding departmental initiatives towards eliminating restrictive practices is via the internet. This section of the project focuses on comparing the information contained in the department’s website with other state and territory jurisdictions in Australia and three international jurisdictions. The aim of this analysis is to compare the approach taken by the department with other national and international jurisdictions.

Method

The approach undertaken to achieve this objective involved an analysis of the department’s website and a comparison of this site with the websites of other authorities with oversight of reducing restrictive practices in other jurisdictions in Australia and internationally. The international jurisdictions focused on locations perceived as advanced in their efforts towards eliminating restrictive practices by the mental health community. The selection of these locations was negotiated with the Victorian Office of the Chief Mental Health Nurse. It was agreed that the comparison should focus on Ireland, the state of Massachusetts in the United States, and New Zealand.

All websites of the appropriate authorities in the states of Victoria, New South Wales, South Australia, Queensland, Tasmania and Western Australia were accessed, as were the Northern Territory and the Australian Capital Territory. Similarly, the appropriate websites were accessed for Ireland, the state of Massachusetts in the United States, and New Zealand.

A qualitative thematic analysis of all websites was undertaken. This approach enabled defensible analysis of qualitative raw text and allowed the data to be condensed into brief summaries (Thomas 2006). Publications on the websites are mentioned, but not referenced, because this is a web analysis as opposed to a document analysis. For details of the analysis strategy, see ‘Data analysis’.
Results

Victoria

The department has developed a standalone webpage, *Reducing restrictive interventions* <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/reducing-restrictive-interventions>. This page webpage is divided into four categories, which automatically categorises the content and determines four specific themes, discussed below.

**Strategic planning**

One theme is titled ‘Framework for reduction’. This link places the strategic plan *Providing a safe environment for all* (Department of Health 2013a) at the centre of the intention to work towards eliminating restrictive practices. This theme has a link to this framework and also a link to the evidence for developing the framework. The latter is in the form of a comprehensive literature review (Department of Health 2013b). The literature review was organised into the following sections:

- literature in relation to the reduction or elimination of seclusion and restraint
- literature in relation to the aetiology of aggression
- literature in relation to preventing and managing aggression
- an analysis of Victorian public mental health service guidelines and policies.

The framework itself is a systemic response towards eliminating restrictive practices. Three care approaches are integral to the framework. These are recovery-oriented practice, trauma-informed care and supported decision making. To embed these care approaches, four enablers are highlighted: developing a culture and systems that support practice and continuous improvement; a healthy workplace environment; staff anticipating need and managing escalation; and review and quality assurance processes, which contribute to continuous improvement in reducing restrictive interventions.

**Safety training resources**

Training resources are also contained in a specific menu in the ‘Reducing restrictive interventions’ section of the website titled ‘Safety training resources’. These resources were referred to as the Creating Safety training program. They constitute a comprehensive training package developed to assist Victoria’s mental health services to reduce and, where possible, eliminate using restraint and seclusion in adult acute mental health inpatient units.

Creating Safety training modules can be used as an entire training program or individually to help managers and staff move towards recovery-oriented systems of care based on negotiation, empowerment and individual respect. There are 10 main modules that reflect the Six Core Strategies for reducing restrictive practices (Huckshorn 2004). All modules can be downloaded from the site as PowerPoint presentations.

**Quality improvement**

There is also a heading on the website highlighting a section called ‘Assessment of services’. This is a quality improvement initiative, whereby services can focus on developing the systems and services to support reducing using restrictive practices. This section includes a self-assessment tool for services in relation to 15 areas of potential service improvement. There is a link to the self-assessment tool, which has the title ‘Chief Psychiatrist’s Investigation of Inpatient Deaths 2008–2010 – responses to report recommendations – self-assessment tool for mental health services’. Recommendations are listed with indicators to assist services in the internal self-assessment and quality monitoring of their practices. Quality improvement areas focus on such issues as staff skill mix, the physical environment and policies/procedures.
**Focus on evidence-based interventions**

The last heading on the webpage is titled ‘Safewards – reducing conflict’. This highlights the department’s pivotal strategy of rolling out the evidence-based model of care Safewards throughout mental health inpatient services in Victoria to move towards eliminating restrictive interventions. A brief introduction to the model is given, though it is somewhat outdated. It is noted that although the trialling of Safewards was indicated, there was no link to the evaluation of the trial and/or the associated peer-reviewed journal on the evaluation (Fletcher et al. 2017).

**Conclusion**

The department’s website is a clear, concise and well-organised webpage on reducing using seclusion and restraint. There are four clearly identified themes that relate to this reduction. There is a link to a small number of documents, which are informative without bombarding the reader perusing the webpage.

**South Australia**

The State Government of South Australian’s ‘SA Health’ website has a single page that captures ‘restraint and seclusion in mental health’. The webpage is clear and succinct and has a central focus on a ‘Policy guideline’. Two themes were clear from a review of the 11 documents attached to this website.

**Strategic planning**

The strategic plan for seclusion and restraint reduction is outlined in a single policy document (Office of the Chief Psychiatrist 2015). This document outlines legislative requirements in using restrictive practices and articulates guidelines for services to develop restrictive practice reduction programs based on the best current evidence at the time, with an emphasis on prevention. Key principles in using restrictive practices are outlined and a variety of preventative strategies highlighted. Included in the document is an outline for the need for culturally-specific and age-specific considerations regarding using restrictive practices.

**Resources**

Eight fact sheets are linked to the webpage, seven of which are directed at assisting services to focus on preventing restrictive practices. Five of these relate directly to processes put in place to prevent restrictive practices. These processes are activity programs to engage people as a means of preventing aggression; using an agitation scale (the Agitated Behaviour Scale) to assist staff to identify aggression and intervene early to prevent aggression; using effective limit setting; the use and value of personal prevention planning; and using sensory modulation. Another two fact sheets focus on using reviews and debriefing to make sense of what has occurred and to enable reflection on the means of preventing similar events in the future. One fact sheet focuses on mandatory reporting, and this is reinforced by two ‘standards’ documents, one outlining the compliance required in mandatory reporting and the other on mandatory observation requirements when restrictive practices are being used.

**Conclusion**

The SA Health webpage on seclusion and restraint reduction directly focuses on clinical practice initiatives to reduce restrictive practices, rather than focusing on systemic approach, which supports reducing restrictive practices (such as leadership and the effective use of data to inform practice).

**New South Wales**

An analysis was undertaken of the New South Wales (NSW) Government’s ‘Health’ website. The homepage of the site highlights ‘Current reviews,’ one being the ‘Review of Seclusion, Restraint and Observation of Consumers With a Mental Illness in
NSW Health Facilities' (NSW Health 2017), which was the basis of the analysis below. There is no identifiable specific web presence on seclusion and restraint reduction. Placing ‘seclusion and restraint reduction’ in the search menu of the website revealed 135 linked documents (25 with exactly the words searched and the rest with part of the phase). As this was a web-based analysis and not a document analysis, no further investigation of the documents took place.

**Strategic planning**

The review (NSW Health 2017) was in response to disturbing events involving using restrictive practices captured on CCTV in a particular service. The review involved an internal audit of mental health services in NSW, a comprehensive review of the literature, and a wide consultation process on the recommendations for improving practice towards eliminating seclusion and restraint.

The review indicated strategic planning for services that involved a systemic approach to reducing restrictive practices. It advocated the strengthening of the culture in services through effective leadership, a focus on consumer safety, a strengthening of the lines of accountability and governance in mental health services, workforce development initiatives focused on best practice, better consumer and carer mechanisms of engagement, and improvements to the physical and therapeutic environment.

**Conclusion**

The web-based analysis revealed little beyond a recent review that advocated for a strategic plan towards eliminating restrictive practices. There was no indication of resources to assist in the implementation of this planning.

**Western Australia**

A detailed search was undertaken of the Government of Western Australia’s Department of Health website <http://www.health.wa.gov.au>. Use of the search menu with the phrases ‘seclusion and restraint reduction’, ‘restrictive intervention reduction’ and ‘seclusion and restraint’ resulted in no uptakes specifically related to these topics.

On the website, an external webpage of the Office of the Chief Psychiatrist <https://www.chiefpsychiatrist.wa.gov.au> was detected where the same search strategy was implemented. No documents specific to reducing restrictive interventions were detected. The only peripheral topics revealed were:

- a comment on the Health Team Excellence Award achieved by a service that had focused on reducing restrictive practices
- information on the statutory reporting of using restrictive practices to the Office of the Chief Psychiatrist
- links to two national guidelines – Principles for communicating about restrictive practices with consumers and carers and Principles to support the goal of eliminating mechanical and physical restraint in mental health services.

The same search was undertaken on the Mental Health Commission of Western Australia <http://www.mhc.wa.gov.au>, with no results. Given the lack of Western Australian specific material on the websites, no further analysis was undertaken.

**Queensland**

A detailed search was undertaken of the Queensland Government’s ‘Queensland Health’ website <http://www.health.qld.gov.au>. On this site, a separate page was located with a number of supporting documents including three fact sheets; a ‘video’ (which was only an audio clip); three Chief Psychiatrist’s guidelines on seclusion, mechanical restraint and physical restraint; four Chief Psychiatrist policies, one on each restrictive practice and a fourth on the ‘clinical need for medication policy’; and eight forms.
A search was also undertaken of Queensland’s Mental Health Commission website <http://www.health.qld.gov.au> using the terms ‘seclusion and restraint reduction’. No links of relevance were detected.

**Reduction and elimination plans**

A review of the documents on the Queensland Health website indicated a link to reducing and if possible eliminating restrictive interventions but with a focus on individual clinical practice and not on a systemic response to reducing restrictive practices. In regard to clinical practice, an emphasis was placed on clinicians developing a ‘reduction and elimination plan’. The intent of this plan is to outline the strategies to be taken to reduce or eliminate restrictive practice through accountability and monitoring to ensure that the least restrictive interventions are used.

**Conclusion**

No systemic response to reducing restrictive practices was detected in the analysis of Queensland Health’s webpage. Instead, the emphasis was on clinical accountability and the monitoring thereof by the Office of the Chief Psychiatrist.

**Tasmania**

A detailed search was undertaken of the Tasmanian Government’s Department of Health and Human Services website <http://www.dhhs.tas.gov.au>. There was no specific reduction of restrictive practices webpage on this website. Placing the phrases ‘seclusion and restraint/reduction’ in the search menu retrieved a single document. This was an information sheet for consumers on their rights if subjected to seclusion or restraint under Tasmania’s Mental Health Act 2013. There was also a PowerPoint for clinicians informing them of the legalities required when using restrictive practices under the legislation.

Entering the words ‘restrictive interventions/practices/reduction’ into the search menu on the site revealed a fact sheet about using restrictive practices as therapeutic interventions following a court case in Tasmania; and guideline and policy documents on restrictive interventions for people with disability, which were not mental health specific.

The Department of Health and Human Services website does have a specific webpage for the Chief Psychiatrist, but there is information for staff about applying restrictive practices and approval processes under the Mental Health Act. A Google search for a mental health commission website in Tasmania resulted in no findings.

Given there was no specific focus on reducing restrictive practices in Tasmania in any of the websites accessed, no further analysis was undertaken.

**Northern Territory**

A detailed search was undertaken of the Northern Territory Government’s Department of Health website <http://www.health.nt.gov.au>. There is no specific reduction of restrictive practices webpage on this website. Placing the phrases ‘seclusion and restraint/reduction’ in the search menu had no hits, nor did the phrases ‘restrictive interventions/practices/reduction’. A specific webpage was identified with the title ‘Mental Health information for Health Professions’, though there was nothing specific on restrictive interventions or their reduction.

The Department of Health website does not have a specific webpage for the Chief Psychiatrist. A Google search for a mental health commission in the Northern Territory resulted in no findings. Given the lack of data, no analysis was undertaken.
Australian Capital Territory

A detailed search was undertaken of the Australian Capital Territory Government’s ‘ACT Health’ website <http://www.health.act.gov.au>. There is no specific reduction of restrictive practices webpage on this website. Entering the phrases ‘seclusion and restraint/reduction’ in the search menu had limited hits, as did the phrases ‘restrictive interventions/practices/reduction’.

An obscure statement was found on the ‘Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services’ webpage under the subtitle ‘Achievement’ <http://www.health.act.gov.au/datapublications//annual-reports/2013-2014-annual-report/section-b-performance-reporting>. This stated that the ACT ‘continues to be a national leader in reducing seclusion and restraint’. However, no specific detail was given including documentation in the Chief Psychiatrist’s Annual report 2015–2016. A policy statement on using restraint directed at informing clinicians was also located. However, no information was detected on how reductions in using restrictive practices were achieved.

A Google search for a mental health commission in the ACT resulted in no findings. Given the paucity of data, no further analysis was undertaken.

Ireland

The Mental Health Commission (MHC) in Ireland is an independent body that was set up in 2002. Its functions are set out in the Mental Health Act 2001 to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of consumers who are involuntarily admitted. They have a number of responsibilities, which are set out in the legislation including regulating using specific practices such as seclusion and mechanical restraint. The MHC is committed to reducing both the frequency and duration of seclusion and restraint, and to completely eliminating the use of mechanical restraint.

The strategy adopted by the MHC is based on the Six Core Strategies (Huckshorn 2004). The strategies are restructured into eight key approaches: leadership, engagement, education, debriefing, data, environment, regulation and staffing. The expectation is that all services will demonstrate the implementation of the strategy and have a viable and time-specific plan for reduction. However, the impact of the strategy on the use of restrictive practices is hard to determine. The most recent statistics on the website indicate a reduction of the rates of seclusion from 62.3 episodes per 100,000 population in 2008 to 30.6 in 2012 (Mental Health Commission of Ireland 2014, p. 18). However, the same document indicates a trend up in the use of physical restraint from 50 episodes per 100,000 population in 2008 to 66.8 in 2012 (Mental Health Commission of Ireland 2014, p. 40). The reasons for these changes are not explained.

The MHC website <http://www.mhcirl.ie> is divided into two sections: ‘For the Public’ and ‘For Health Professionals’.

Public information

The ‘For the Public’ section consists of a drop-down box, one of the headings being ‘Information on ECT, Seclusion and Restraint’. The MHC has developed rules (legislative requirements) and codes of practice (best-evidence practice) on using restrictive practices (seclusion, mechanical restraint and physical restraint). On these matters, the MHC has developed three user-friendly informative leaflets for the public, which can be downloaded:

- What you need to know about the rules of seclusion
- What you need to know about the Code of Practice of Physical Restraint
- What you need to know about the rules of mechanical restraint.
**Practice guides**

The ‘For Health Professionals’ drop-down box on the webpage contains two documents as guides to clinical practice directed at using restrictive practices. These are:

- **Rules governing the use of seclusion and mechanical means of bodily restraint (2009)**, which covers definitions, using mechanical means of bodily restraint for immediate threat of serious harm to self/others, and using mechanical means of bodily restraint for enduring risk of harm to self/others
- **Code of practice on the use of physical restraint in approved centres (2009)**, which aims to guide practice.

**Strategic planning**

Given there was no discernible indication of the reduction/elimination strategies of these practices, the words ‘seclusion and restraint reduction’ were typed into the search menu. The outcome was the highlighting of 71 articles, which were categorised (see Table 8).

**Table 8: Categories of strategic planning documentation in Ireland**

<table>
<thead>
<tr>
<th>Article category</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports on issues in specific services</td>
<td>35</td>
</tr>
<tr>
<td>Activity reports on the reduction of restrictive practices</td>
<td>19</td>
</tr>
<tr>
<td>Generic articles (reduction subsumed within)</td>
<td>9</td>
</tr>
<tr>
<td>Meeting minutes</td>
<td>2</td>
</tr>
<tr>
<td>Lead in documents to the strategic plan</td>
<td>2</td>
</tr>
<tr>
<td>Relevant articles</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the four relevant articles, two are described above under practice guides and the another is a review of these two documents. Only one is of direct relevance to reducing restrictive practices and this is the **Seclusion and restraint reduction strategy (2014)**.

The MHC is committed to reducing both the frequency and duration of seclusion and restraint episodes and to completely eliminating mechanical restraint. The MHC acknowledges that this requires a process of change, which fits comfortably with efforts to develop a culture of collaboration and recovery within services. The MHC initially undertook a review of the literature related to seclusion and restraint reduction, from which a ‘knowledge review’ was developed that summarised current international evidence-based best practice. Through consultation with the sector, the eight key interventions already discussed in the introduction were integrated into the strategy.

**Conclusion**

The Irish MHC website focuses on using restrictive interventions rather than reducing their use. It is conveniently organised into information for clinical staff and information for the general public. Information about reducing restrictive practices requires detailed searching and only relates to detail of the actual the strategy, not how this should be implemented (such as training).

**Massachusetts**

In November 2000 the Massachusetts Department of Mental Health (DMH) embarked on an initiative to reduce and ultimately eliminate restraint and seclusion in all child and adolescent inpatient and intensive residential treatment facilities in the state. There was well-documented success in this regard on their reducing restrictive practices-specific website <https://www.mass.gov/service-details/restraint-seclusion-reduction-initiative-rsri>.
In 2004 the DMH was one of eight states selected by the Substance Abuse and Mental Health Services Administration, a branch of the United States Department of Health and Human Services, to receive funding to develop alternatives to restraint and seclusion. These efforts began in 2005.

Since then, Massachusetts has adopted the Six Core Strategies (Huckshorn 2004). However, the total impact of the approach on the mental health services of the state over time are not accessible on the website. On the website, 19 documents are linked, which can be categorised into the following four themes.

**Strategic and operational planning**

The emphasis on the Six Core Strategies is clearly articulated in the DMH’s strategic planning documents linked on the website \( n = 6 \). A further two documents focus on implementing the vision. This strategic planning occurred across adult, adolescent and children’s mental health services and even included an interagency vision encouraging state agency partners, schools and residential service providers to embark on organisational cultural change to reduce the use of restrictive practices using the Six Core Strategies (Massachusetts Department of Mental Health 2010).

The vision’s strategic positioning was also enhanced by an economic analysis of reducing restraint (LeBel & Goldstein 2005). A restraint reduction initiative was associated with a reduction in the use of restraint, staff time devoted to restraint and staff-related costs.

**Role modelling using the Six Core Strategies**

One of the Six Core Strategies is using data to inform practice. The website includes two documents where using this strategy was role-modelled. Data was presented on progress in reducing both staff and consumers’ injuries related to using restrictive practices.

**Stakeholder position papers**

Introducing the Six Core Strategies involved extensive consultation with key stakeholders. The website presented three position papers on the need to emphasise the prevention of restrictive practices penned by three stakeholder groups. One was related to youth, one to adult consumers, and one to families.

**Resources**

A number of resource documents are linked on the reducing restrictive practise webpage \( n = 6 \). Four relate to ‘safety tools’ in three age-related service configurations and a residential treatment program. Safety tools are personalised intervention plans that help people avoid or mitigate crisis by considering preventative strategies to avoid using restrictive practices. Another resource is specific to using sensory modulation, and the other constitutes a generic ‘resource guide.’

**Conclusion**

The DMH has a considerable history of focusing on the systemic approach to reducing using restrictive interventions centred on using the evidence-based Six Core Strategies. This initially started with a focus on child and adolescent services but soon gained traction in adult mental health services. Standard planning processes are outlined on its website, as are resources to assist. What is unique about this website is an expression of the views of key stakeholders (consumers and families) and the presentation of data that supports the efforts made. The web presence covers just over two pages and is succinct and relatively uncluttered in the use of supporting links.

**New Zealand**

In Aotearoa New Zealand, Te Pou o te Whakaaro Nui (Te Pou; the national centre for evidence-based workforce development in the mental health, addiction and disabilities sectors) has been contracted by the Ministry of Health to help reduce restrictive practices. Te Pou has adopted an evidence-based,
systems-wide response (the Six Core Strategies; Huckshorn 2004) to support mental health services to reduce seclusion and restraint. Since Te Pou became involved in helping services to reduce seclusion, there has been a reduction in seclusion in mental health services. Although this correlation cannot be considered a cause-and-effect relationship from these analyses, there has been a reduction in the total number of people in mental health services being secluded by 25 per cent from 2009 to 2016. There has also been a reduction in the total number of seclusion hours (by 92 per cent from 2009 to 2016) (Ministry of Health 2017).

The Te Pou website [https://www.tepou.co.nz] was analysed. A separate webpage under ‘Initiaives’ called ‘Reducing seclusion and restraint’ categorises the Te Pou-developed material into drop-down boxes, which assist in the process of thematic analysis. From this analysis, the following themes were determined.

**Co-production**

The co-production emphasis is at the forefront of the ‘Reducing seclusion and restraint’ webpage. The co-producers (one being a Te Pou consumer lead and the other a clinical advisor to Te Pou) are introduced and there is a video by the consumer lead that talks about the essence of co-production and its use in developing Te Pou’s approach.

The importance of collaboration is also reinforced by ‘Stories’ (n = 6) of work at the ‘coal face’ in reducing the use of restrictive practices. There is also a video that reinforces the consumer perspective on eliminating seclusion. The video is called *Opening doors: From the Practice of Fear to the Practice of Compassion*.

**Strategic planning**

The central use of the evidence-based Six Core Strategies in reducing seclusion is positioned from the onset. There are four documents linked to profile this work:

- Te Pou o te Whakaaro Nui 2008, *Action plan: Developing alternatives to the use of seclusion and restraint in New Zealand mental health settings; Seclusion: Time for change*, Te Pou, Auckland
- Te Pou o te Whakaaro Nui 2008, *Survey of seclusion reduction initiatives in New Zealand acute mental health services*, Te Pou, Auckland
- Te Pou o te Whakaaro Nui 2012, *De-escalation and restraint training for clinicians: a literature review*, Te Pou, Auckland.

In the drop-down box titled ‘Toward restraint free mental health services’, the emphasis on the Six Core Strategies was also highlighted in reducing restraint. The Six Core Strategies workforce development strategy is highlighted through mention of the nationally-endorsed Safe Practice Effective Communication training. This training is supported with a variety of resources the reader can link to, some of which are easy to align with restraint reduction and some of which are not. A crucial document to support this emphasis is linked to a resource cited as:


**Resources**

Service development and training resources were scattered in a variety of places throughout the website, not always attached to easily discernible themes. One specific drop-down box highlighted a variety of training resources under the heading ‘Seclusion prevention and reduction’. A noticeable resource was about developing a self-assessment checklist to assist services in determining their action plans around implementing the Six Core Strategies. The latest version of this resource is:
Specific areas of focus

A major theme of the Te Pou website is a focus on either specific areas of the Six Core Strategies or areas of practice that require adapting the approach. The two core areas of focus on the website are the evidence-based tools in the Six Core Strategies: sensory modulation and trauma-informed care. The former is by far the most developed approach, with a number of resources attached to the website to assist in its implementation. The emphasis on trauma-informed care is less developed, with only a single clarification document attached to the brief discussion.

The Six Core Strategies do not overtly address the importance of the influence of the environment in setting the climate for reducing restrictive practices. There is a specific emphasis on environment through its own drop-down box with evidence attached, which supported best practice. Finally, the over-representation of Māori in the seclusion statistics is emphasised, as are resources to assist in reducing restrictive practices in working in partnership with Māori consumers.

Conclusion

The Te Pou website is very comprehensive in outlining the approach of the workforce development centre towards eliminating restrictive interventions. An obvious strength is the positioning of co-production in the approach based on the Six Core Strategies. There is a strong emphasis on developing resources to assist in implementation and also evidence on the website of some evaluation of the work done to date, sometimes adapted to the unique context of New Zealand. One limitation is the busy nature of the website. There are a number of attached documents sometimes rather obscurely attached to the topic under discussion.

Discussion

The point of communication and interface with the public and the mental health sector regarding initiatives to eliminate restrictive practices is via the internet. This section of the project focused on comparing the information contained on the department’s website with other state and territory jurisdictions in Australia and three international jurisdictions.

The department’s separate webpage on reducing restrictive practices is clear, concise and well organised. There are clearly identified themes that relate to this reduction. There are links to a small number of documents that are informative without overwhelming the reader perusing the webpage. The Victorian department webpage appears innovative in conveying to mental health services and the wider audience the extent of its efforts towards eliminating restrictive interventions. This is especially evident in comparison with other jurisdictions within Australia.

In Australia, only one other jurisdiction (South Australia) has a standalone webpage on reducing restrictive practices. Both territories and two states (Western Australia and Tasmania) have no easily retrievable information about efforts towards eliminating restrictive practices. Three other states (NSW, South Australia and Queensland) demonstrate planning regarding reduction, but only NSW has a systemic approach similar to that indicated by Victoria. The other two jurisdictions have planning levelled at improvements in clinical practice only. Finally, only South Australia, like Victoria, has links to resources to assist mental health services in their efforts towards eliminating restrictive practices.

The international jurisdictions are more directly comparable to the department’s web presence. However, information via a government department only occurs in Massachusetts. The responsibility to reduce restrictive practices lies with the Mental Health Commission in Ireland and a national workforce development centre (Te Pou o Te Whakaaro Nui) in New Zealand. Like Victoria, all webpages specific to reducing restrictive practices are easy to detect, although Ireland does not have a standalone page. The website designs are generally user-friendly and uncluttered except in New Zealand, where a large number of documents are often linked to themes that are not always easily relatable to the topic at hand.
Each website has a focus on the strategic plan towards eliminating restrictive practices. All have plans directed at a systemic response towards elimination. In the Irish, Massachusetts and New Zealand cases, a clear focus in the vision is the Six Core Strategies (Huckshorn 2004). Although this emphasis is overtly evident in some earlier training resources on the Victorian website, its emphasis is largely superseded by that of an emphasis on the Safewards model of care. All websites have resources attached to help services implement restrictive intervention reduction efforts.

One point of departure from the Victoria site is demonstrated in the sites of Massachusetts and New Zealand. In Massachusetts, consumer and carer perspectives towards eliminating restrictive interventions is demonstrated through posting position papers. In New Zealand, the active involvement of consumers in the process towards elimination is demonstrated through the co-production of the initiatives projected. An overt indication of consumer and carer involvement towards eliminating restrictive practices would be a welcome addition to the Victorian department’s website. New Zealand is also unique in highlighting adaptations of its approach to its specific context. This is expressed in a focus on improvements in the physical environment of mental health services and the need to address the unique cultural needs of Māori people. Other sites do not overtly demonstrate local contextual challenges.

Despite these suggestions for improvement, the Victorian department’s website on reducing the use of restrictive practices exceeds the quality demonstrated in other jurisdictions in Australia. It is also at a standard comparable with other international sites considered to be at the forefront of demonstrating best practice in this regard.
Conclusion

This research project is an illustrative case study of the Department of Health and Human Services’ efforts to reduce the use of restrictive practices in Victorian mental health services. This study does not claim to establish the efficacy of the department’s approach. There is value, however, in understanding how the approach was implemented, how it has been embraced, the impact it has had, and how the approach compares with other jurisdictions.

Illustrative case studies characteristically combine mixed methods of data collection and analysis, involving both quantitative and qualitative approaches. Multiple research approaches allow diverse means of shedding light on the topic of interest. From the diverse research approaches incorporated in this study, certain themes emerged.

Strong leadership was identified as a critical component in the drive towards eliminating restrictive practices. The shift in culture required to move services from custodial paradigms of care towards eliminating restrictive practices requires a systematic approach to quality improvement through continuous assessment, planning, implementation and evaluation. The success of organisational change towards eliminating restrictive practices requires aligning ‘coal face’ leadership, hospital-wide leadership and wider bureaucratic leadership.

The leadership shown by the department has been crucial in maintaining a momentum towards eliminating restrictive practices in Victoria. The department has used an evidence-based, systemic response (the Six Core Strategies; Huckshorn 2004) to support mental health services to reduce seclusion. However, this has not always been overt. More recently, the emphasis on reducing restrictive practices has focused on implementing Safewards, an evidence-based model of care (Bowers 2014). In implementing these initiatives, the department has strengthened a collaborative approach of supporting services through face-to-face meetings. Mental health services widely endorse this approach.

Mental health services’ positive uptake of the department’s efforts was demonstrated in this project through case studies of three AMHS. The case studies highlighted the advantage of services adopting a recovery-oriented model of care, which has a natural synergy with initiatives to reduce restrictive practices. The services indicated the positive impact of the department’s efforts, though improvements were suggested to support the significant momentum already attained. The main suggestions are captured in the recommendations below.

Finally, there is the potential for the department’s approaches to influence other jurisdictions facing similar challenges in reducing restrictive practices. One suggested means of enabling such assistance would be to convert the department’s evaluation reports into peer-reviewed, published academic literature. Another suggestion is to expand the department’s current website content to discuss the involvement of consumers and carers in the planning, implementation and evaluation of initiatives to reduce restrictive practices.

From the findings of this case study research, the following recommendations are made.

- **Co-production and co-design**: The role of co-production and co-design is developed in future work towards eliminating restrictive practices as undertaken by the Office of the Chief Psychiatrist and the Office of the Chief Mental Health Nurse (OCMHN).
- **Review the Statement of Priorities agreement between area mental health services and the Department of Health and Human Services**: Such statements should include measuring and reducing mechanical restraint and chemical restraint.
- **Physical restraint**: The Office of the Chief Psychiatrist and the OCMHN lead a project to develop standardised training in managing aggression and using physical restraint techniques, including reviewing the use of restraint holds.
• **Eliminating restrictive practices**: A strategic plan is developed for eliminating restrictive practices. This includes managing aggression with vulnerable populations including consumers with substance abuse issues (such as methamphetamine and ‘synthetic cannabis’), Indigenous people and ethnic minorities including recent immigrants.

• **Focus of future initiatives**: Planning is undertaken by the Office of the Chief Psychiatrist and the OCMHN to determine the barriers created by legislation, workforce culture and service demands that influence efforts towards eliminating restrictive practices and that they support systems to address these barriers.

• **Variation between service types**: That the Office of the Chief Psychiatrist and OCMHN create an understanding of what accounts for variation in using restrictive practices between service types and assist such services in their unique challenges towards eliminating restrictive practices.

• **Policy shift**: The Office of the Chief Psychiatrist and the OCMHN consider strategies to address the policy tension between occupational violence and eliminating restrictive practices.

• **Strategic reform to assist with elimination**: The Office of the Chief Psychiatrist and the OCMHN review and enhance the workforce capacity and competency related to alternatives to restrictive practices, including approaches such as mental health intensive care.

• **Learning culture**: The Office of the Chief Psychiatrist and the OCMHN develop a service self-assessment matrix of the clinical governance of restrictive practices in the light of national reviews in South Australia and New South Wales.

• **Learning culture**: The Office of the Chief Psychiatrist and the OCMHN facilitate all research findings from project evaluations towards eliminating restrictive practices to be published in the academic, peer-reviewed literature.
## Appendix: Description of document analysis items

<table>
<thead>
<tr>
<th>No.</th>
<th>Year</th>
<th>Document title</th>
<th>Summary</th>
<th>Document type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2005</td>
<td>Safety training resources to reduce restrictive interventions</td>
<td>Creating Safety is a comprehensive training program developed to assist Victoria’s mental health services to reduce and, where possible, eliminate using restraint and seclusion interventions in adult acute mental health inpatient units. Creating Safety training modules can be used as an entire training program or individually to help managers and staff move away from coercion and control to recovery-oriented systems of care based on negotiation, empowerment and individual respect. The 10 main modules are outlined. There is a strong component of the Six Core Strategies (Huckshorn 2004) in this training resource.</td>
<td>PowerPoints Training program</td>
</tr>
<tr>
<td>2.</td>
<td>2005</td>
<td>Victorian Taskforce on Violence in Nursing: final report</td>
<td>The aim of the taskforce was to establish mechanisms that promote: (a) consistent reporting; (b) measurement; (c) monitoring and evaluating; and (d) prevention and reduction of workplace violence. The report lists a number of themes to facilitate the prevention and management of violence and bullying in the nursing workplace.</td>
<td>Report</td>
</tr>
<tr>
<td>3.</td>
<td>2005</td>
<td>Victorian Taskforce on Violence in nursing</td>
<td>Healthcare professionals who are involved in direct clinical care experience incidents of occupational violence and bullying. The taskforce proposed that a well-developed plan of action fully endorsed by senior management is necessary to achieve a cultural shift within Victorian healthcare services from one that accepts violence and bullying as ‘part of the job’ to one of zero tolerance of such behaviours.</td>
<td>Policy document</td>
</tr>
<tr>
<td>4.</td>
<td>2007</td>
<td>Criteria for searches to maintain safety in an inpatient unit – for consumers, visitors and staff</td>
<td>Mental health inpatient services are required to provide and maintain a safe therapeutic environment that promotes the safety, wellbeing and recovery of consumers. This guideline aims to describe search processes that are permissible by law and can ensure clinical safety while respecting consumers’ rights. Services should develop local policies and procedures consistent with this guideline to promote safety for consumers, visitors and staff in mental health inpatient units.</td>
<td>Guideline (Chief Psychiatrist)</td>
</tr>
<tr>
<td>5.</td>
<td>2007</td>
<td>Preventing occupational violence in Victorian health services: a policy framework and resource</td>
<td>In 2004 the Victorian Taskforce on Violence in Nursing made recommendations aimed at addressing the problem of violence against nurses. In particular, the work highlighted the need for a framework to effectively address occupational violence in health services. The framework provides the policy principles to assist health services to implement occupational violence</td>
<td>Policy document</td>
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<tr>
<td>No.</td>
<td>Year</td>
<td>Document title</td>
<td>Summary</td>
<td>Document type</td>
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<tr>
<td>6.</td>
<td>2007</td>
<td>Nurse Safe posters 1–2: A workplace free of violence</td>
<td>Two Nurse Safe posters carrying the message, ‘A workplace free of violence and bullying is a better place to care for you and your family’ have been developed. Not included in further analysis.</td>
<td>Posters</td>
</tr>
<tr>
<td>7.</td>
<td>2007</td>
<td>Nurse Safe poster 3: A workplace free of violence</td>
<td>A Nurse Safe poster carrying the message, ‘A workplace free of violence and bullying. A better place for work. A better place for care.’ Not included in further analysis.</td>
<td>Poster</td>
</tr>
<tr>
<td>8.</td>
<td>2007</td>
<td>Nurse Safe posters 4–5: A workplace free of violence</td>
<td>Two Nurse Safe posters carrying the message, ‘A workplace free of violence and bullying. Everyone has the right to be safe.’ Not included in further analysis.</td>
<td>Poster</td>
</tr>
<tr>
<td>9.</td>
<td>2007</td>
<td>Nurse Safe poster 6: A workplace free of violence</td>
<td>A Nurse Safe poster carrying the message, ‘A workplace free of violence and bullying. Everyone has the right to be safe here.’ Not included in further analysis.</td>
<td>Poster</td>
</tr>
<tr>
<td>10.</td>
<td>2008</td>
<td>Victorian Taskforce on Violence in Nursing: Implementation of recommendations – update on Occupational Violence Prevention Fund 2008–2011, round 1 (June 2008)</td>
<td>In April 2008 public health services were invited to submit applications for the first year of funding of the Occupational Violence Prevention Fund to address the highest priority occupational violence risks in their organisations. Thirty-nine public health services were successful in 2008. The works include improvements to emergency department security systems, duress systems, safe environments for managing behaviours of concern, alarm systems for community mental health teams, audits, improvements to reception areas to improve safety and observation, and police health service partnership committees to better manage occupational violence.</td>
<td>Report</td>
</tr>
<tr>
<td>11.</td>
<td>2008</td>
<td>Victorian Taskforce on Violence in Nursing: Implementation of recommendations – update on Occupational Violence Prevention Fund 2008–2011, rounds 1 and 2 (November 2008)</td>
<td>In June 2008, 39 public health services were funded in the year 1 (2008) round to undertake 51 remediation projects. Round 2 of the fund was opened to public health services in 2008. Forty-three health services were successful in round 2 to undertake 62 remediation works across a range of settings.</td>
<td>Report</td>
</tr>
<tr>
<td>12.</td>
<td>2009</td>
<td>A workplace free of</td>
<td>A campaign was developed to increase awareness among police, healthcare workers and the</td>
<td>Guideline</td>
</tr>
<tr>
<td>No.</td>
<td>Year</td>
<td>Document title</td>
<td>Summary</td>
<td>Document type</td>
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<tr>
<td>13.</td>
<td>2010</td>
<td>Victorian Taskforce on Violence in Nursing implementation of recommendations status report 2/2010</td>
<td>This document is a status report on the implementation of the 29 taskforce recommendations (2005) to reduce the incidence of occupational violence implemented by the then Department of Health, employers and other agencies.</td>
<td>Report</td>
</tr>
<tr>
<td>14.</td>
<td>2010</td>
<td>Update on Occupational Violence Prevention Fund 2008–2011, round 3</td>
<td>In 2009 public health services were invited to apply for funds in round 3 of the fund. In round 3 (2010) 24 projects or initiatives were funded and a combined report of all three rounds by health service demonstrated the success of the fund with over 75 per cent of the public health services successfully accessing the fund to remediate highest priority risks within their organisation.</td>
<td>Report</td>
</tr>
<tr>
<td>15.</td>
<td>2011</td>
<td>New weapons legislation: implications for Victorian health services</td>
<td>There were implications for health services with amendments to the Firearms Act 1996 and the Control of Weapons Act 1990 in 2010. This factsheet highlights what health services should consider when implementing these legislative changes.</td>
<td>Factsheet</td>
</tr>
<tr>
<td>16.</td>
<td>2011</td>
<td>Deter, detect and manage: a guide to better management of weapons in health services</td>
<td>Using weapons and dangerous articles is prevalent in society, permeating health services and leading to a potential for exposure to occupational violence. There is an ongoing need to be aware of the rights and responsibilities in relation to weapons management within health services and to ensure local policies are developed and implemented. This guide aims to assist public health services regarding weapons and uses a principle-based approach, underpinned by legislation and an occupational health and safety framework.</td>
<td>Guideline</td>
</tr>
<tr>
<td>17.</td>
<td>2011</td>
<td>Preventing occupational violence: a policy framework including principles for managing weapons in Victorian health services</td>
<td>A systematic occupational health and safety hazard management is the foundation of this policy framework. This proactive approach includes health services having the ability to deter, detect and manage weapons. This document explains the overarching policy framework for preventing and managing occupational violence and bullying within Victorian public health services.</td>
<td>Policy document</td>
</tr>
<tr>
<td>18.</td>
<td>2011</td>
<td>Preventing occupational violence in Victorian health services: a policy</td>
<td>The policy framework explains the overarching policy framework for preventing and managing occupational violence and bullying within Victorian public health services. It contains the guiding framework and rationale for health services to ensure that safe, healthy and productive</td>
<td>Policy document and resources (update)</td>
</tr>
<tr>
<td>No.</td>
<td>Year</td>
<td>Document title</td>
<td>Summary</td>
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<tr>
<td>19.</td>
<td>2011</td>
<td>The management of clinical aggression: rapid emergency department intervention</td>
<td>Education is an effective strategy for improving health professionals’ levels of confidence in dealing with violence. Attitudes regarding the causes of patient violence influences the way staff work to prevent and manage it. Feedback to staff and the delivery of education sessions have been found to be useful in reducing the incidence of violence. Following the introduction of the Management of Clinical Aggression-Rapid Emergency Department Intervention (MOCA-REDI) training, staff were interviewed and findings presented.</td>
<td>PowerPoint</td>
</tr>
<tr>
<td>20.</td>
<td>2011</td>
<td>Occupational violence prevention (OVP) including OVP in the design process</td>
<td>In an emergency department, violent tendencies often present with the patient when they arrive as a result of alcohol, drugs, mental distress or a combination of all three. This document focuses on improvements in the design of the environment.</td>
<td>Report</td>
</tr>
<tr>
<td>21.</td>
<td>2011</td>
<td>Occupational violence forum: One size doesn’t fit all! Using a risk calculator to assess training needs</td>
<td>Following an audit of occupational violence within Western Health, a number of concerns were highlighted. A ‘risk calculator’ was developed based on both the risk data and anecdotal reports. Once the data were analysed, the risk calculator was applied and tested across the organisation within the areas deemed to be of higher risk for occupational violence.</td>
<td>PowerPoint</td>
</tr>
<tr>
<td>22.</td>
<td>2011</td>
<td>St Vincent’s emergency response: a strategy for ensuring the safety and wellbeing of our people</td>
<td>Following an incident where staff incurred serious injury, the hospital executive, human resources, corporate counsel, medical and nursing directors researched and developed training modules. The outcome of this process is profiled in this presentation.</td>
<td>PowerPoint</td>
</tr>
<tr>
<td>23.</td>
<td>2011</td>
<td>Victorian Taskforce on Violence in Nursing implementation of recommendations status report 2011</td>
<td>This document is a status report on the implementation of the 29 taskforce recommendations (2005) to reduce the incidence of occupational violence.</td>
<td>Report</td>
</tr>
<tr>
<td>24.</td>
<td>2011</td>
<td>Victorian Taskforce on Violence in Nursing implementation of recommendations: responsibility for</td>
<td>This document establishes the responsibility for completing the implementation of the 29 taskforce recommendations (2005) to reduce the incidence of occupational violence implemented by the then Department of Health, employers and other agencies.</td>
<td>Report</td>
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<tr>
<td>25.</td>
<td>2011</td>
<td>Taskforce and implementation reference group: representation from a rural perspective</td>
<td>Following the work of the Victorian Taskforce on Violence in Nursing, the taskforce was asked to: (a) define occupational violence and bullying against nurses; (b) develop approaches to the prevention and management of occupational violence; and (c) consider factors that impact on the provision and management of a safe environment. This document articulates the need for clear guidelines that apply to both metropolitan and rural areas.</td>
<td>Policy document</td>
</tr>
<tr>
<td>26.</td>
<td>2011</td>
<td>Update on Occupational Violence Prevention Fund 2008–2011, round 3 summary</td>
<td>In 2009 public health services were invited to apply for funds in round 3 of the Occupational Violence Prevention Fund. This report summarises the successful applications.</td>
<td>Report</td>
</tr>
<tr>
<td>27.</td>
<td>2011</td>
<td>Building better partnerships to report occupational violence (Western Health)</td>
<td>In establishing data on incidents of occupational violence at Western Health, it became evident that there was a culture of under-reporting. As a result, procedures were updated to define near misses and clearly articulate reporting requirements.</td>
<td>PowerPoint</td>
</tr>
<tr>
<td>28.</td>
<td>2011</td>
<td>Building better partnerships: a focus on absconding patients</td>
<td>Following concern of the issues surrounding absconding patients in a particular service, the focus of this report is that of post-incident management rather than an early intervention and prevention model.</td>
<td>Report</td>
</tr>
<tr>
<td>29.</td>
<td>2011</td>
<td>Building better partnerships: fulfilling Strategy 3 – ‘Enhancing the justice interface’</td>
<td>This is a progress report on addressing key outcomes towards preventing occupational violence outlined in the ‘enhancing the justice interface’ strategy.</td>
<td>Report</td>
</tr>
<tr>
<td>30.</td>
<td>2011</td>
<td>Building better partnerships: Deterring, detecting and managing weapons – Southern Health’s experience</td>
<td>This is a documented joint local agreement between agencies regarding processes for best practice weapons management.</td>
<td>Report</td>
</tr>
<tr>
<td>31.</td>
<td>2011</td>
<td>Building better partnerships: promoting</td>
<td>This is an example at Werribee Mercy where partnerships were developed between the</td>
<td>Report</td>
</tr>
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<td>No.</td>
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<tr>
<td>32.</td>
<td>2011</td>
<td>Framework for recovery-oriented practice</td>
<td>The framework for recovery-oriented practice explicitly identifies the principles, capabilities, practices and leadership that should underpin the work of the Victorian specialist mental health workforce. It is intended to provide broad guidance to individual practitioners and service leaders from different practice settings and age ranges throughout the mental health service system. This sets the context within which reducing restrictive practices should occur.</td>
<td>Report</td>
</tr>
<tr>
<td>33.</td>
<td>2012</td>
<td>Progress on occupational violence prevention in Victorian health services including a snapshot of the work arising from the Taskforce on Violence in Nursing</td>
<td>The Victorian Taskforce on Violence in Nursing was asked to identify and review existing systems, procedures and policies in place in Victorian health services and recommend strategies to reduce the incidence of violence. The taskforce provided 29 recommendations. This report contains results from the project.</td>
<td>Report</td>
</tr>
<tr>
<td>34.</td>
<td>2012</td>
<td>Preventing and managing occupational violence in Victoria</td>
<td>The Taskforce on Violence in Nursing was asked to identify and review existing systems, procedures and policies in place in Victorian health services and made 29 recommendations to reduce the incidence of violence, to be implemented by the department, employers and other agencies. The implementation approach hinged upon five strategies: setting the framework, raising awareness, enhancing the justice interface, education and training, and reporting and monitoring.</td>
<td>Policy document</td>
</tr>
<tr>
<td>35.</td>
<td>2012</td>
<td>Strategy 1: Setting the framework</td>
<td>This provides guidance and direction to all public health services regarding preventing and managing occupational violence in Victorian healthcare settings. The purpose of framework is to ensure the maintenance of safe, healthy and productive work environments. It is hoped that health services will develop specific operational policies/procedures for managing and preventing occupational violence that give effect to the principles outlined in the framework.</td>
<td>Policy document</td>
</tr>
<tr>
<td>36.</td>
<td>2012</td>
<td>Strategy 2: Raising awareness</td>
<td>A booklet A workplace free of violence and bullying: how to deliver the message was developed to assist health services develop an effective communication plan to support their occupational violence prevention and management programs.</td>
<td>Policy document</td>
</tr>
<tr>
<td>37.</td>
<td>2012</td>
<td>Strategy 3: Enhancing the</td>
<td>This document incorporated recommendations that involved education and awareness</td>
<td>Policy document</td>
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<tr>
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<td>38.</td>
<td>2012</td>
<td>Strategy 4: Supporting education and training</td>
<td>Guidelines for occupational violence prevention training were included in the Preventing occupational violence in Victorian health services: a policy framework and resource kit.</td>
<td>Policy document</td>
</tr>
<tr>
<td>39.</td>
<td>2012</td>
<td>Strategy 5: Effective reporting and monitoring</td>
<td>This incorporated recommendations regarding the monitoring of bullying and occupational violence experienced by staff. It also recommended collecting data about occupational violence and bullying within Victorian health services on a biannual basis.</td>
<td>Policy document</td>
</tr>
<tr>
<td>40.</td>
<td>2012</td>
<td>Chief Psychiatrist’s investigation of inpatient deaths 2008–2010: responses to report recommendations</td>
<td>A self-assessment tool was developed to assist mental health services evaluate their response to the recommendations made in the Chief Psychiatrist’s investigation of inpatient deaths 2008–2010. The recommendations are listed with indicators to assist services in the internal self-assessment and quality monitoring of their practices following the death of an inpatient. This is not related to restrictive practices and was removed from further analysis.</td>
<td>Report</td>
</tr>
<tr>
<td>41.</td>
<td>2013</td>
<td>Workplace violence action checklist</td>
<td>The Workplace violence action checklist is a comprehensive guide to the protocols that should be followed in reporting an incident of occupational violence in healthcare services across Victoria.</td>
<td>Checklist</td>
</tr>
<tr>
<td>42.</td>
<td>2013</td>
<td>Practice of prone restraint: Chief Psychiatrist clinical practice advisory notice</td>
<td>This clinical practice advisory notice is to support clinical services in developing procedures to ensure the appropriate care and treatment of people being physically restrained in mental health services. Of particular concern is the practice of prone restraint, which is to be avoided. If in the course of a restraint a person is put in a prone position then this must cease as soon as practical and is not to exceed three minutes.</td>
<td>Practice advisory notice</td>
</tr>
<tr>
<td>43.</td>
<td>2013</td>
<td>Occupational violence incident response: Managing incidents in public health services</td>
<td>This resource kit has been developed to promote a statewide, consistent and integrated approach to reporting and responding to occupational violence in Victorian public healthcare settings.</td>
<td>Guideline/resource</td>
</tr>
<tr>
<td>44.</td>
<td>2013</td>
<td>Restrictive interventions in designated mental health services</td>
<td>Using restrictive interventions (practices) must follow the legal requirements of the Mental Health Act and best practice requirements. The guideline considers practice prior to using a restrictive intervention, during the actual use, and following the use of the practices. These guidelines set out the expectations of what services are to consider when establishing policies</td>
<td>Guideline</td>
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<td>No.</td>
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<tr>
<td>45.</td>
<td>2013</td>
<td>Reducing restrictive interventions: literature review and document analysis</td>
<td>The aim of this literature review and document analysis was to provide an overview of literature relating to restrictive interventions in Australian and international healthcare settings. The literature review was organised into the following sections: (a) literature in relation to the reduction or elimination of seclusion and restraint; (b) literature in relation to the aetiology of aggression; (c) literature in relation to preventing and managing aggression; and (d) an analysis of Victorian public mental health service guidelines and policies.</td>
<td>Report (literature review and policy analysis)</td>
</tr>
<tr>
<td>46.</td>
<td>2013</td>
<td>Providing a safe environment for all: framework for reducing restrictive interventions</td>
<td>This framework is central to the government’s commitment to reducing restrictive interventions and providing mental health services that are safe places for all people accessing treatment and care, their support people and staff. The framework was developed to assist health services comply with mental health reforms and the Charter of Human Rights and Responsibilities Act 2006 by providing guidance in developing a local response to reduce restrictive practices. The document outlines principles to this policy, the care approaches to be used, and enablers for systemic change.</td>
<td>Report (literature review and recommendations)</td>
</tr>
<tr>
<td>47.</td>
<td>2014</td>
<td>A literature review and policy analysis on the practice of restrictive interventions</td>
<td>This literature review proceeded developing guidelines from the Chief Psychiatrist on using restrictive interventions to support mental health services in implementing the new Mental Health Act. The guidelines address the practice of bodily restraint (including mechanical and physical restraint) and seclusion. This review builds on comprehensive literature reviews on seclusion practices (Livingstone 2007) and reducing the use of bodily restraint and seclusion through preventive approaches (Department of Health 2013b).</td>
<td>Report (literature review)</td>
</tr>
<tr>
<td>48.</td>
<td>2014</td>
<td>Indicator 3: Use of physical restraint</td>
<td>This document is intended for residential aged care facilities. The aim of this indicator is to monitor the use of physical restraints and trends in the aged. Physical restraint is often used to manage behavioural and psychological symptoms of dementia and prevent falls. However, the evidence indicates restraint does not prevent falls or fall-related injuries and is likely to exacerbate behaviours and adverse outcomes that its use was attempting to address.</td>
<td>Guideline</td>
</tr>
<tr>
<td>49.</td>
<td>2014</td>
<td>MHA 142 Restrictive interventions observations form</td>
<td>This form sets out the type of restrictive intervention used (seclusion, mechanical and physical restraint), its duration and who authorised its use.</td>
<td>Form</td>
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<tr>
<td>50.</td>
<td>2014</td>
<td>Reducing Restrictive</td>
<td>This presentation by Dr Rosemary Charleston outlined the accomplishments of the Reducing Restrictive Interventions (RRI) project. This presentation reported the outcomes of ongoing</td>
<td>PowerPoint</td>
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<td>51.</td>
<td>2014</td>
<td>Mental health directions: reducing restrictive interventions</td>
<td>This document outlines integrating, consolidating and building a focus on individual needs, which is the heart of the mental health directions in Victoria. It outlines the mental health statewide initiatives of RRI, sensory modulation and Safewards. The initiative includes a literature and document analysis, developing Providing a safe environment for all: framework for reducing restrictive interventions, and the establishment of a statewide RRI project team with developing local action plans. The RRI project team developed and delivered training for trauma-informed care and sensory modulation.</td>
<td>Report</td>
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<tr>
<td>52.</td>
<td>2015</td>
<td>The evaluation of sensory modulation and trauma informed care training</td>
<td>This is an evaluation of ‘train the trainer’ resources developed and delivered as part of the RRI project. The purpose of the evaluation was to inform decisions regarding the future of the training and the implementation of sensory modulation and trauma-informed care within Victorian mental health services.</td>
<td>Report (evaluation)</td>
</tr>
<tr>
<td>53.</td>
<td>2015</td>
<td>The restrictive intervention variance pilot evaluation</td>
<td>This is an evaluation of data related to variance in using restrictive intervention collected by the Office of the Chief Psychiatrist in Victoria in 2014. The term variance relates to the prolonged use of restrictive interventions beyond specified time benchmarks. The outcomes of the evaluation include: (a) recommendations for an improved variance reporting process; (b) strategies to encourage the uptake of variance reporting; (c) new restrictive intervention benchmarks; (d) minimum standards guidelines for services for review, monitoring and providing feedback; and (e) development of a template for a benchmark report form to be completed by service clinical directors on a monthly basis.</td>
<td>Report (evaluation)</td>
</tr>
<tr>
<td>54.</td>
<td>2015</td>
<td>Violence prevention and management: standards for development of training and organisational responses in Victorian health services</td>
<td>This project was commissioned to review current and best practice for: (a) staff training programs that address prevention and management of aggression and violence in Victoria’s hospitals; and (b) organisation-wide responses to patient aggression and violence. Barriers and enablers to the implementation and sustainability of training in healthcare settings were also considered.</td>
<td>Report (literature review and recommendations)</td>
</tr>
<tr>
<td>55.</td>
<td>2016</td>
<td>Chief Psychiatrist’s annual report 2015–16</td>
<td>During the reporting period (2015–16), the Office of the Chief Psychiatrist continued overseeing and monitoring the implementation of the Mental Health Act. The Chief Mental Health Nurse</td>
<td>Report</td>
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and her staff made significant contributions to systems improvements focusing on safety through such programs as piloting Safewards and the work of the Reducing Restrictive Interventions Committee.

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<tr>
<td>56.</td>
<td>2016</td>
<td>Report of the review of hospital safety and quality assurance in Victoria executive summary: Targeting zero, supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care</td>
<td>Following a cluster of perinatal deaths at Djerriwarrh Health Services, an expert review found that seven of the deaths were avoidable or potentially avoidable, with many of them involving common and recurring deficiencies in care. The review identified that the health service had inadequate clinical governance and was not monitoring and responding to adverse clinical outcomes in a timely manner. Following a request by the Minister for Health, the department commissioned a review. The panel was asked to review the department’s current systems for governance and assurance of quality and safety in hospitals. Where systems were found to be inadequate, the panel provides recommendations for improvement. This has an impact on the initiatives established by the department to reduce the use of restrictive practices.</td>
<td>Report</td>
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<tr>
<td>57.</td>
<td>2016</td>
<td>Better, safer care: Delivering a world-leading healthcare system</td>
<td>This review highlights the need to elevate safety and quality in the Victorian hospital system, to ensure the care that patients receive is consistently world-class, continuously improving and supported to achieve the best outcomes for patients. The review finds that the department must take a stronger role as system leader and system manager.</td>
<td>Report</td>
</tr>
<tr>
<td>58.</td>
<td>2016</td>
<td>Reducing occupational violence in Victorian hospitals: summary</td>
<td>This infographic summary charts the challenge of reducing violence in Victorian hospitals by linking the various stakeholders (patients, health service staff, management and board, system manager and regulator) through a cultural change process towards the desired outcomes. The infographic details the strategic objectives and initiatives necessary to achieve the desired outcomes.</td>
<td>Infographic</td>
</tr>
<tr>
<td>59.</td>
<td>2016</td>
<td>Victorian Chief Psychiatrist direction 2016/01: Staffing requirements for safe practice where patients are in locked areas within mental health inpatient units</td>
<td>Under the Mental Health Act, the Chief Psychiatrist has statutory roles and functions, which includes the power to issue directions to mental health service providers regarding the provision of mental health services. This notice is in response to consumers being left in locked areas of inpatient units, with no staff in attendance. Staffing levels should be consistent within a framework of recovery-oriented, trauma-informed and gender-sensitive practice, and staffing numbers increased in relation to the assessed vulnerability and risk of consumers within the environment.</td>
<td>Practice advisory notice</td>
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<td>60.</td>
<td>2016</td>
<td>Reducing occupational violence in Victorian hospitals: What are we doing?</td>
<td>In Victorian hospitals, staff and patients are frequently exposed to violence and risk of injury. The overall aim is reduced levels of occupational violence in hospitals, driven by a strong, positive culture in health services that does not tolerate violence in the workplace. This is achieved by: (a) raising awareness and engaging management, frontline staff and consumers; (b) building knowledge and skills through guidance and training; and (c) responding and taking action by creating safe environments together with making hospital boards accountable.</td>
<td>Infographic</td>
</tr>
<tr>
<td>61.</td>
<td>2016</td>
<td>Violence in Healthcare Taskforce report: webpage</td>
<td>The role of the taskforce was to identify issues and make recommendations to the Minister for Health on measures to reduce violence in Victorian hospitals and support the implementation of the government’s commitments to address violence in healthcare. As a result, the taskforce produced a report, which contains findings and associated recommendations to inform the focus on reducing violence in the Victorian health services sector.</td>
<td>Report (webpage)</td>
</tr>
<tr>
<td>62.</td>
<td>2016</td>
<td>Violence in Healthcare Taskforce report: media release</td>
<td>The Victorian Government launched a new public awareness campaign to reduce violence in Victorian hospitals as part of a plan to stop attacks against frontline health workers. The taskforce found a critical need for improved awareness and reporting of violence in our health system, and recommended immediate action.</td>
<td>Media release</td>
</tr>
<tr>
<td>63.</td>
<td>2016</td>
<td>Violence in Healthcare Taskforce report: taking action to reduce violence in Victorian hospitals</td>
<td>The Violence in Healthcare Taskforce was established by the Minister for Health in August 2015. Its role is to identify issues and make recommendations on opportunities to reduce violence in Victorian hospitals and in addition support the implementation of the government’s election commitments to address violence in healthcare.</td>
<td>Report</td>
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<td>64.</td>
<td>2016</td>
<td>Safewards Victorian trial: final evaluation report</td>
<td>This report focuses on the outcome evaluation, with detailed analysis of: seclusion events pre- and post-Safewards implementation; sustained fidelity with the Safewards interventions per-unit over a one-year period; and quantitative and qualitative staff and consumer feedback about the experience, acceptability and sustainability of Safewards. The evaluation recommends further implementation of Safewards should be supported in Victoria.</td>
<td>Report (evaluation)</td>
</tr>
<tr>
<td>65.</td>
<td>2016</td>
<td>Safewards handbook: Training and implementation resource for Safewards Victoria</td>
<td>This handbook was designed to assist with the implementation of Safewards. It contains: (a) an overview of the Safewards model; (b) a description of the 10 interventions commonly used; (c) recommended readings; (d) tips for education and implementation; and (e) templates to support training and implementation of Safewards.</td>
<td>Resource (training)</td>
</tr>
<tr>
<td>66.</td>
<td>2016</td>
<td>Safewards: a model for</td>
<td>This memorandum outlines that Safewards was being trialled in several services across Victoria.</td>
<td>Memorandum</td>
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<td>67.</td>
<td>2016</td>
<td>A literature review and policy analysis on the use of physical restraint in Victoria</td>
<td>In Victoria the use of physical restraint has only recently been regulated by the Mental Health Act. The purpose of this review was to examine the national and international literature to identify best practice approaches and to determine the extent to which existing policies and training programs incorporate these approaches. Recommendations were made for practice before a physical restraint episode (to prevent its use), during the episode in order to keep all those involved safe, and after the physical restraint episode.</td>
<td>Report (literature review)</td>
</tr>
<tr>
<td>68.</td>
<td>2016</td>
<td>A literature review and policy analysis on the management of clinical aggression in Victoria</td>
<td>The purpose of this document was to: (a) review the national and international literature to identify best practice approaches to the prevention and management of clinical aggression; and (b) determine the extent to which existing policies and training programs incorporate the approaches and strategies determined by the literature to be potentially efficacious.</td>
<td>Report (literature review)</td>
</tr>
<tr>
<td>69.</td>
<td>2016</td>
<td>Minimum training standards: preventing and managing clinical aggression including using physical restraint</td>
<td>This document projected a best practice model of training in preventing and managing clinical aggression based on the above two literature reviews and policy analyses.</td>
<td>Report</td>
</tr>
<tr>
<td>70.</td>
<td>n.d.</td>
<td>Least restrictive practice</td>
<td>This document outlines the least restrictive practice recommendation in the case of older persons in mental health services. The key measures are that: (a) it is essential to establish what matters to each consumer; (b) each team should promote the older person's independence and prevent functional decline; (c) carers should work with the older person and their family to promote dignity of risk and trial least restrictive alternatives; and (d) making an application for a guardian should be a last resort.</td>
<td>Policy document</td>
</tr>
<tr>
<td>71.</td>
<td>n.d.</td>
<td>Authority to release medical information (following an occupational violence incident in the workplace)</td>
<td>The ‘Authority to release medical information’ form gives Victoria Police consent to obtain relevant medical records, reports and/or statements following the treatment by a medical practitioner or hospital. Not included in further analysis.</td>
<td>Form</td>
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<td>72.</td>
<td>n.d.</td>
<td>A collaborative approach</td>
<td>This document sets developing a behavioural assessment room in the emergency department</td>
<td>Report</td>
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<td>73.</td>
<td>n.d.</td>
<td>Assessment of inpatient services</td>
<td>There are 15 key recommendations to improve the standard of care provided by inpatient units in Victoria. These recommendations are based on a self-assessment tool developed by the Office of the Chief Psychiatrist to assist mental health staff to safeguard and monitor the quality of care in inpatient units, where people face acute and wide-ranging needs. Reducing restrictive practices are part of these recommendations.</td>
<td>Report</td>
</tr>
<tr>
<td>74.</td>
<td>n.d.</td>
<td>Preventing occupational violence and aggression in Victorian health services</td>
<td>This website outlines the strategies to reduce occupational violence, the resources required, the public awareness campaign in progress, Code Grey and Code Black procedures, training and the sharing of best practice opportunity.</td>
<td>Webpage</td>
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References


Curie CG 2005, Commentary: SAMHSA’s commitment to eliminating the use of seclusion and restraint. *Psychiatric Services*, 56(9), 1139–1140.


Massachusetts Department of Mental Health (2010). *Massachusetts Interagency Restraint and Seclusion Prevention Initiative Charter*, Department of Mental Health, Massachusetts.


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DHHS report main title

DHHS report subtitle