

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

December 2017



Ms Elizabeth Koff
Secretary
NSW Ministry of Health
73 Miller St
NORTH SYDNEY NSW 2060

Dear Ms Koff

Please find enclosed the final report of the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*.

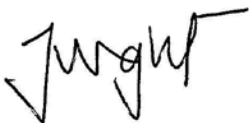
This report is informed by an evidence base from local and international experience, a self-audit of practice, 10 community consultations, consultations with more than 300 frontline mental health and emergency department staff and more than 300 mental health and emergency department leaders, site visits to 25 facilities and more than 100 written submissions. I would particularly like to express my gratitude to the many consumers, carers and their families who have shared their experiences so that we may improve our systems of care.

Reducing and, where possible, eliminating the use of seclusion and restraint will not happen overnight. As a review team, we are confident that if NSW Health implements our recommendations, they will be well on their way to achieving this.


I would like to take this opportunity to express my sincere thanks to my fellow review team members, the late Commissioner Jackie Crowe, Dr Kevin Huckshorn, Ms Karen Lenihan, Ms Julie Mooney and Dr Robyn Shields. Their commitment to this review has been unwavering.


I would also like to thank Mr Andrew McAlister, Ms Joanne Sharpe and Dr Titia Sprague for their support throughout the review.

Yours sincerely



Dr Murray Wright
NSW Chief Psychiatrist
8 December 2017





This report is dedicated to the memory of two very important women who never met, but without whom this review and report would not have occurred:

Miriam Merten, whose mistreatment and death shocked us all, and was the catalyst for establishing this review, and **Jackie Crowe**, a vital member of the review team who brought energy, compassion, integrity and courage to the review process.

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Introduction

The Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities has been an important opportunity to analyse the use of restrictive practices, compare New South Wales with national and international standards, and to hear from consumers, carers and other stakeholders.

The review was announced following the release of distressing closed circuit television (CCTV) footage of Ms Miriam Merten in seclusion showing events which contributed to her death.

Public and professional outrage spurred this review of current practice to make recommendations to reduce, and where possible eliminate, the use of seclusion and restraint in NSW. In aiming to prevent harm and promote safer services for consumers and staff, the review team has also considered the broader strategies for clinical governance, safety and quality within the services reviewed.

The use of seclusion and restraint in modern health settings is a key focus, given the well documented traumatic and damaging impact of these practices. In NSW, there were nearly 3700 episodes of seclusion in 2016–17. In this same period, 2200 people were secluded and on average they spent five and a half hours in seclusion. These figures do not include seclusions that occurred in NSW public hospital emergency departments.

A primary question is whether our system has the right vision and goals, properly supported by effective strategies, policies and resources, to enable the prevention of seclusion and restraint.

This review is based on extensive and detailed consultation. It has, at times, been a difficult and demanding process, given the stories shared by consumers and carers about their distressing

experiences. Having asked so many people to visit and revisit their own private pain, it is imperative that we not only treat all stories with respect, but ensure this information underpins sustainable changes to improve our system of care.

We thank everyone who made the effort to contribute to this review and for their courage in speaking up.

This report describes the strengths and weaknesses of services and outlines some pervasive themes clearly affecting efforts to prevent or reduce seclusion and restraint. It also provides recommendations to help in planning and developing safe, contemporary and compassionate services with the capacity to evolve and improve. This is an opportunity for services to review their models of care, and to realign them to strengthen the efforts to prevent seclusion and restraint.

A primary question is whether our system has the right vision and goals, properly supported by effective strategies, policies and resources, to enable the prevention of seclusion and restraint.

Some of the review team's findings from written submissions, audits, site visits and consultations are critical. We understand that providing safe, contemporary mental health care in acute inpatient units and emergency departments requires skilled teamwork and leadership, as well as first-class facilities, education and reporting. The review team recognises that acute mental health care is challenging and complex. Having identified gaps and deficits, the review team also wants to acknowledge the efforts of the vast majority of health professionals who do their best in this environment.

Recommendations

During the review, consumers and carers described services that traumatise and show a lack of compassion and humanity. The review has explored and identified underlying factors contributing to this culture. These have implications beyond seclusion and restraint and beyond mental health services. If this culture is not addressed, any efforts to prevent or reduce seclusion and restraint will have limited success. The review team identified seven themes and makes 19 recommendations.

The recommendations are listed below under the seven themes. The rationale for each recommendation can be found in the discussion and findings section.

Culture and leadership (pages 23-26)

Recommendation 1

There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture. Collaborative leadership was not evident to the review team. **NSW Health must establish and adopt an integrated leadership development framework applicable to all staff at all stages of their career.**

Patient safety (pages 27)

Recommendation 2

Current approaches to patient safety and quality are inconsistent. **NSW Health must adopt a mental health patient safety program, informed by contemporary improvement science.**

Accountability and governance (pages 28-31)

Recommendation 3

The integrity of mental health operations and governance is dependent on strong, visible and engaged leadership at the highest level. There is variation in mental health management and accountability structures across the state. **The Director of Mental Health should be a member of the district or network senior executive and report to the Chief Executive.**

Recommendation 4

There is currently no reliable monitoring of seclusion and restraint in emergency departments. **District and network clinical governance processes should include emergency department and mental health seclusion and restraint performance together.**

Recommendation 5

There is no routine on-site supervision after hours in several mental health units. **All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.**

Recommendation 6

The current seclusion and restraint policy environment is confusing. **NSW Health should have a single, simplified, principles-based policy that works towards the elimination of seclusion and restraint.**

Recommendation 7

There is evidence of poor management of nicotine dependence, which can contribute to irritability and aggression. **There should be an immediate reinvigoration of the implementation of the NSW Health Smoke-free Health Care Policy (PD2015_003), which includes increasing the knowledge and use of nicotine replacement therapy.**

Workforce (pages 32-34)

Recommendation 8

There are staff who have insufficient skills and basic mental health knowledge working with mental health consumers. **NSW Health should develop and implement minimum standards and skill requirements for all staff working in mental health.**

Recommendation 9

Discriminatory and stigmatising behaviour and attitudes were observed at all levels of the workforce. **NSW Health should ensure that recruitment and performance-review processes include appraisal of values and attitudes of all staff working with people with a mental illness.**

Recommendations

Recommendation 10

The valuable role of the peer workforce is undermined by inconsistent job descriptions, skill levels and supports, and low staff numbers. **The peer workforce should be developed and professionalised, with the same supports and accountabilities as other disciplines. The number of positions should be increased, but only after the supports and accountabilities are in place.**

Consumer and carer engagement (pages 35-36)

Recommendation 11

Individualised care planning is essential to prevention of seclusion and restraint, but is inconsistent across services. **Meaningful engagement with consumers and their families should occur in assessment and care planning, particularly in developing personal plans to prevent the use of restrictive practices.**

Recommendation 12

There is evidence supporting the importance of co-design. No convincing examples of it were seen during the review. **Consumer and carer co-design and systematic engagement should occur at all levels of the health service.**

Data (pages 36)

Recommendation 13

There is inconsistent use of and access to seclusion and restraint data for staff to support efforts to prevent these practices. **NSW Health should improve the transparency, detail and frequency of publication of seclusion and restraint data at the state and local level.**

Recommendation 14



There is no statewide reporting of seclusion and restraint in declared emergency departments. **The NSW seclusion and restraint data collection and reporting should include declared emergency departments.**

The built and therapeutic environment (pages 38-41)

Recommendation 15

The current use of and over-reliance on emergency department safe assessment rooms is traumatising. **All emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There needs to be a pathway that does not include the use of safe assessment rooms.**

Recommendation 16

There should be an immediate review of the design and use of safe assessment rooms, using a co-design methodology.

Recommendation 17

Many mental health units had a custodial feel. **All future capital planning of mental health facilities should include consumer co-design and be informed by evidence on preventing seclusion and restraint.**

Recommendation 18

All acute mental health units and declared emergency departments should conduct a review of their facilities and implement minor capital works and equipment purchases to improve the therapeutic potential. This will support people to self-manage and assist in the prevention of seclusion and restraint.

Recommendation 19

A purposeful and predictable therapeutic program can support the prevention of seclusion and restraint. The review team did not observe any convincing examples of this type of program. **All mental health units should have a multidisciplinary team with the skills to deliver a therapeutic program and environment on an extended-hours basis.**

Background

Human rights concerns about the seclusion and restraint of people with mental illness in Australia are not new.

In 1991, the United Nations passed a resolution adopting the Principles for the protection of people with a mental illness and the improvement of mental health care (United Nations General Assembly, 1991). In 1993, the former Australian Human Rights and Equal Opportunity Commission released the Report of the National Inquiry into the Human Rights of People with Mental Illness, also known as 'the Burdekin report', making recommendations on protocols and use of seclusion as a last resort (Burdekin, 1993).

Other reports and actions have followed:

- 2005 — *Not for service: experiences of injustice and despair in mental health care in Australia report* (Mental Health Council of Australia, 2005)
- 2005 — *National safety priorities in mental health: a national plan for reducing harm* (National Mental Health Working Group, 2005)
- 2009 — *Ending seclusion and restraint in Australian mental health services* (National Mental Health Consumer and Carer Forum, 2009)
- 2010 — *National standards for mental health services 2010* (Department of Health and Ageing, 2010)
- 2012 — *A contributing life: the 2012 report card on mental health and suicide prevention* (National Mental Health Commission, 2012)
- 2014 — *Living well: a strategic plan for mental health in NSW 2014–2024* (Mental Health Commission of NSW, 2014)
- 2015 — *A case for change: position paper on seclusion, restraint and restrictive practices in mental health services* (National Mental Health Commission, 2015)

- 2016 — *Minimising the use of seclusion and restraint in people with mental illness: position statement 61* (Royal Australian and New Zealand College of Psychiatrists, 2016)
- 2016 — *Seclusion and restraint position statement* (Australian College of Mental Health Nurses, 2016)
- 2017 — *National principles to support the goals of eliminating mechanical and physical restraint in mental health services* (Restrictive Practice Working Group, 2017)
- 2017 — *National principles for communicating about restrictive practices with consumers and carers* (Restrictive Practice Working Group, 2017).

From 2007 to 2009, the then Commonwealth Department of Health and Ageing 'National Mental Health Seclusion and Restraint Project' funded 11 'beacon sites' around Australia, as demonstration centres of excellence in reducing restrictive practices. Two beacon sites were in NSW. The project was strongly influenced by the six core strategies for reducing seclusion and restraint (Huckshorn, 2004) but, despite some local success, any broader impact does not appear to have been sustained.

To complement the beacon sites and build sustainable local initiatives to reduce restrictive practices, NSW Health funded a project officer at each former Area Health Service and a state coordinator for seclusion reduction at the Mental Health and Drug & Alcohol Office from 2009 to 2013.

Legislative context

There is inconsistency in the regulation of restrictive practices in mental health laws across Australia.

Recent reviews of Mental Health Acts in South Australia (2014), Western Australia (2015) and Queensland (2016) have seen specific provisions governing the definition and use of seclusion and restraint. NSW regulates this practice through mandatory policy directives rather than via mental health legislation. A comparison of Australian state and territory mental health laws and provisions relating to seclusion and restraint is provided in Appendix A.

Policy context

NSW Health has had policies about restrictive practices in mental health since at least 1994 that emphasise restriction as a last resort. These early policies focused more on physical restraint techniques and how to seclude consumers rather than the prevention of seclusion and restraint.

By 2007, the NSW Health policy suite on seclusion, restraint and intravenous sedation included information about prevention strategies and alternative interventions. The approach to managing behaviour disturbance was still heavily focused on the individual, with limited recognition of the contribution of the ward milieu or programs, staff attitudes and behaviours.

The current policy *Aggression, seclusion and restraint in mental health facilities in NSW (PD 2012_035)* was released in 2012 (NSW Health, 2012). With a major focus on prevention of aggression, the policy explicitly covered restrictive practices used on people with a mental illness in mental health units and declared emergency departments. It acknowledges the trauma associated with restrictive practices and provides guidance for services about meaningful engagement with consumers, families and carers in all aspects of care including debriefs and incident reviews.

In 2015, NSW Health released the policy directive *Principles for safe management of disturbed and/or aggressive behaviour and the use of restraint (PD2015_004)* (NSW Health, 2015). This directive does not apply to consumers with a mental illness in declared emergency departments or mental health units and, similarly to the Aggression, seclusion and restraint in mental health facilities in NSW policy, promotes the reduction and, where possible, elimination of restraint.

There are also policy directives outlining the minimum standards for training in violence prevention — *Violence prevention and management training framework for the NSW public health system (PD2012_008)* (NSW Health, 2012) and *Preventing and managing violence in the NSW Health workplace — a zero tolerance approach (PD2015_001)* (NSW Health, 2015) outlining the control measures and responses when violence occurs in a NSW Health facility.

Other NSW Health guidelines to support good practice include:

- *GL2012_005 — Aggression, seclusion & restraint in mental Health facilities - guideline focused upon older people* (NSW Health, 2012)
- *GL2015_001 — Safe use of sensory equipment and sensory rooms in NSW mental health services* (NSW Health, 2015)
- *GL2015_007 — Management of patients with acute severe behavioural disturbance in emergency departments* (NSW Health, 2015)
- *Mental health for emergency departments: a reference guide* commonly referred to as 'the Red Book' (NSW Health, 2015).

Dangers of seclusion and restraint

In a Cochrane review in 2000, the reviewers could find no studies of sufficient quality evaluating the value of seclusion or restraint (Sailas and Fenton, 2000). Seclusion and restraint are not therapeutic and there are many reports of serious adverse effects (World Health Organization, 2017).

Seclusion and restraint are associated with physical and psychological harm to both consumers and staff, with instances of serious physical consequences including sudden death in both Australia and internationally (Coroner's Court of NSW, 2011: Substance Abuse and Mental Health Services Administration, 2010 & 2011; Duxbury, 2015).

One international literature search reported that many consumers had a negative experience, despite the majority of staff believing that seclusion was largely beneficial (Van der Merwe et al., 2013). Consumers reported feeling angry, upset, lonely, abandoned, scared, vulnerable, humiliated, worthless, depressed, punished, trapped and bored.

There are significant physical safety risks associated with restraining people in the prone position. In July 2016, NSW Health issued *Safety notice 003/16 use of prone restraint and parenteral medication in healthcare settings* (NSW Health, 2016). Some jurisdictions are more cautious in guidance about the use of prone restraint, for example England (Department of Health, 2014) and New Zealand (Te Pou, 2015) state that prone restraint must not be used intentionally.

Historically, clinicians have justified the use of seclusion and restraint on the grounds that they were therapeutic. This stance is not supported by evidence.

It is not unusual for staff to raise concerns that staff and consumer safety will be compromised if seclusion and/or restraint are reduced (e.g. Duxbury, 2015), but this concern is not supported by the weight of evidence (Putkonen et al., 2013; Te Pou, 2014).

Evidence-based approaches

There are several literature reviews exploring the elimination or reduction of seclusion and restraint, and more rigorous published studies have also shown no increase in consumer or staff injuries (see Appendix B).

Examples of large-scale systematic approaches follow.

United States

Following the *Hartford Courant's* investigative reports into the deaths of 142 people shortly after episodes of restrictive practices (Weiss et al., 1998), the US Congress confirmed that people were being harmed as a result of seclusion and restraint. This led to requirements that federally funded programs make prevention, reduction and elimination of seclusion and restraint a priority throughout the US.

As a result, the six core strategies to prevent the use of seclusion and restraint were developed as a training curriculum through the former Office of Technical Assistance of the National Association of State Mental Health Program Directors (Huckshorn, 2004). The national training curriculum has been delivered in 48 US states.

In 2012, the six core strategies program was recognised by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices, based on the results of a five-year, eight-state research project.

SAMHSA also developed a *Roadmap to seclusion and restraint free mental health services* (Substance Abuse and Mental Health Services Administration, 2005) to support the training of direct-care staff.

England

Following the 2012 concordat pledge on action after abuses at Winterbourne View Hospital (Department of Health, 2012) and a critical nongovernment organisation report on restraint (Mind, 2013), the English Department of Health published *Positive and proactive care: reducing the need for restrictive interventions* (Department of Health, 2014), which promoted therapeutic environments, with restrictive practices as a last resort across all adult health and social care services.

Six core strategies for preventing the use of seclusion and restraint

1. Leadership for organisational change
2. Use of data to inform practice
3. Workforce development
4. Use of seclusion and restraint prevention tools
5. Consumer and family/carer involvement and roles in inpatient care
6. Rigorous debriefing

(Huckshorn, 2004; Huckshorn, 2006)

The Royal College of Nursing led a multiprofessional consortium to develop *A positive and proactive workforce* to guide the development of staff who can work in a positive and proactive way to minimise the use of restrictive practices in health and social care (Skills for Care & Skills for Health, 2014).

The National Institute for Health and Care Excellence (NICE) published updated guidance in 2015 on *Violence and aggression: short-term management in mental health, health and community settings* (National Institute for Health and Care Excellence, 2015). The update took into account new information on service users' views on the use of restrictive practices.

Scotland

'Violence, restraint and seclusion reduction' is one of the change packages in the Scottish Patient Safety Programme — Mental Health. The whole Scottish Patient Safety Programme is grounded in quality-improvement methodology. The Mental Health Programme began in 2012, and its mantra has been *Patients are and feel safe, staff feel and are safe* (Hall, 2016), which is now evolving to *People are and feel safe*. Over the four-year initiative, units achieved up to 57 per cent reduction in the rate of restraint per 1000 bed days (Scottish Patient Safety Programme, 2016).

New Zealand

Te Pou, the national workforce development centre for the mental health, addiction and disability sectors, has been supporting New Zealand inpatient mental health units in reducing seclusion and restraint since late 2008. Te Pou's approach has been informed by the six core strategies for the reduction of seclusion and restraint (Huckshorn, 2004), adapted for New Zealand culture (O'Hagan et al., 2008; Te Pou, 2008).

A challenge facing all states and territories is the consistent application of systemic, evidence-informed practices across the entire jurisdiction.

In the national mental health information reporting system, the total number of people who experienced seclusion while receiving mental health treatment in an inpatient service had decreased by 32 per cent between 2009 and 2016. The total number of hours spent in seclusion had decreased by 55 per cent between 2009 and 2016 (Shearer, 2016).

Australia

Across Australia, there are local examples of positive results in the reduction of seclusion and/or restraint in mental health inpatient units (e.g. Hamilton and Castle, 2008; Sivakumaran et al. 2011; Foxlewin, 2012). However, a challenge facing all states and territories is the consistent application of systemic, evidence-informed practices across the entire jurisdiction. Victoria has trialled the 'Safewards' model, developed in the UK to address 'flashpoints' that may lead to conflict and containment (e.g. Bowers, 2014). Although initial post-trial findings were mixed (Hamilton et al., 2016), recently published follow-up results are more promising (Fletcher et al., 2017). The Victorian Department of Health and Human Services is now consolidating and expanding the implementation of Safewards in mental health services.

Victoria also provides an online 'Creating Safety' training program for staff working in adult mental health units to reduce and, where possible, eliminate the use of seclusion and restraint. This training is based on the National Association for State Mental Health Program Directors' six core strategies curriculum (Huckshorn, 2004; National Executive Training Institute, 2005).

Data collection, reporting and performance framework

Data collection and reporting

NSW Health began routine collection and reporting of seclusion data in mental health units in 2008, using the definition for seclusion developed by the Australian Safety and Quality Partnership Standing Committee. Districts and networks began collecting and reporting restraint data in mental health units, using the nationally agreed definition in 2013. NSW has no centralised database for collection of this information. The data are captured via a summary of local paper registers for seclusion and restraint. There is no statewide reporting of seclusion and restraint in declared emergency departments.

There has been a reduction in the use of seclusion over the last 10 years, but the rate of reduction appears to have slowed. Does this mean there has been a reduction in effort to improve, or are we approaching the limits of what is achievable with the current strategies?

At present, six-monthly and quarterly reports for seclusion and restraint are provided to districts and networks to support comparison of performance between services and facilitate benchmarking. Seclusion performance is also reported in the NSW Health Service Performance Report. NSW provides seclusion and restraint data to the Commonwealth government annually. The indicator definitions can be found in Appendix C.

Public reporting

NSW seclusion performance in mental health units is publicly reported in the NSW Health annual report (NSW Health, 2017) (see Appendix D), the Bureau of Health Information's Healthcare in focus report (Bureau of Health Information, 2017), the Mental health services in Australia website of the Australian Institute of Health and Welfare (AIHW) (Australian Institute of Health and Welfare, 2017) and the Productivity Commission's Report

on government services (Steering Committee for the Review of Government Service Provision, 2017). Public reporting for seclusion commenced in 2013. In 2017, restraint was added to reporting by the AIHW on the Mental health services in Australia website.

Performance framework

The NSW Health Performance Framework is used by the NSW Ministry of Health to monitor the performance of public sector health services, including mental health services. The 2017-18 Service Agreements with districts and networks include mental health-specific Key Performance Indicators (KPIs) which are monitored by the Ministry and within the districts. Two KPIs relate to the use of restrictive practices — the rate and duration of seclusion.

The Ministry provides monthly KPI feedback to districts and networks through the health system performance reports. Significant variations from targets trigger performance discussions. If performance concerns are identified, these are addressed with the district or network through a structured process, as stipulated in the NSW Health Performance Framework.

Seclusion rates, frequency and duration are current priorities for the performance meetings with districts and networks. Mental Health Branch has preperformance meetings with District and Network Mental Health Directors to discuss performance data and service issues in detail.

Clinical benchmarking

Performance monitoring of mental health services is supported by clinical benchmarking and local quality-improvement activities. In NSW, there is a statewide mental health clinical benchmarking program facilitated by the Ministry of Health. This program is designed to support services to use data to improve the clinical care provided.

Restrictive practices have been a significant focus for the statewide mental health clinical benchmarking program, and there have been several forums to highlight and share areas of good practice across NSW. Site visits are used to explore the performance of individual units, including clarifying the definitions and recording practices.

Incident data

A clinical incident is an unplanned event that causes harm or has the potential to cause harm and must be recorded in the statewide Incident Information Management System (IIMS), including when a consumer is aggressive and is restrained or secluded.

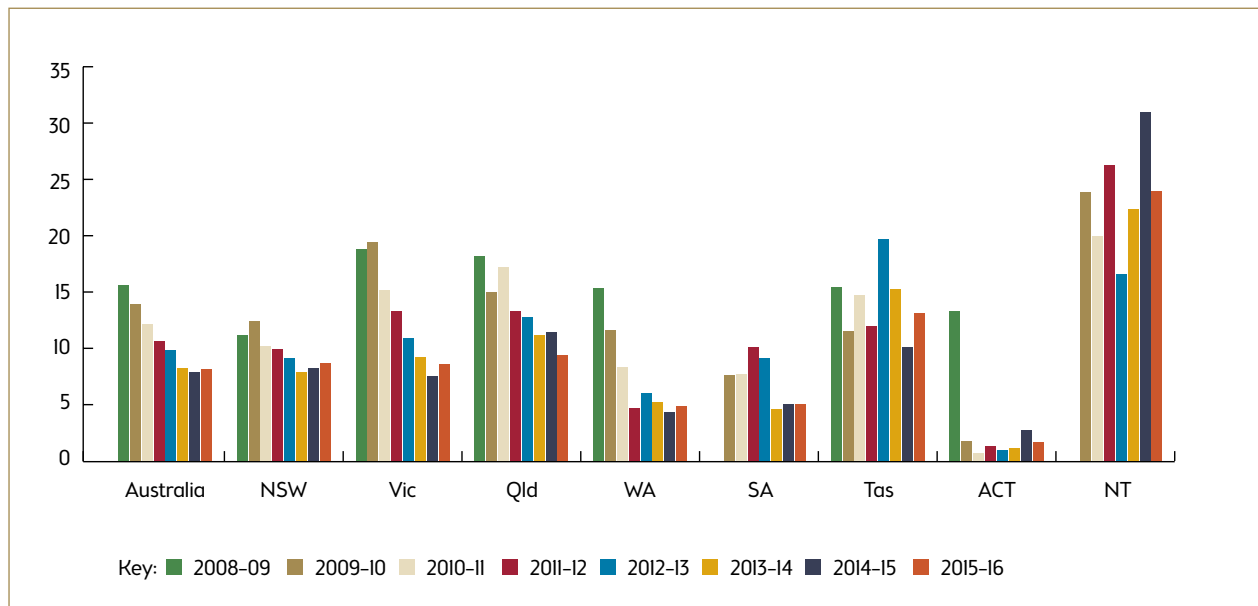
While there is some capacity for aggregate reporting, this is not the primary purpose of the IIMS. Any aggregate reporting has limited utility for comparisons at the state level, due to different reporting practices and the potential for multiple reports about an individual incident, for example, if there is more than one person injured.

Rates of seclusion and restraint

Figure 1 shows the acute seclusion rate (episodes per 1000 occupied bed days [OBDs]) for Australia and the states and territories from 2008–09 to 2015–16. In 2015–16, the rate of seclusion in acute mental health units in NSW was 8.7 episodes per 1000 OBDs, higher than the Australian rate of 8.1 episodes per 1000 OBDs.

NSW has seen an average annual reduction of approximately 3 per cent in the rate of seclusion in its acute mental health units since 2011–12. NSW has not seen as substantial average annual reductions as Queensland (8.3%) or Victoria (10.3%) but it had a lower rate of seclusion when reporting commenced.

Figure 1. Acute seclusion rate (episodes per 1000 occupied bed days) Australia and states and territories from 2008–09 to 2015–16



Source: Australian Institute of Health and Welfare (2017).

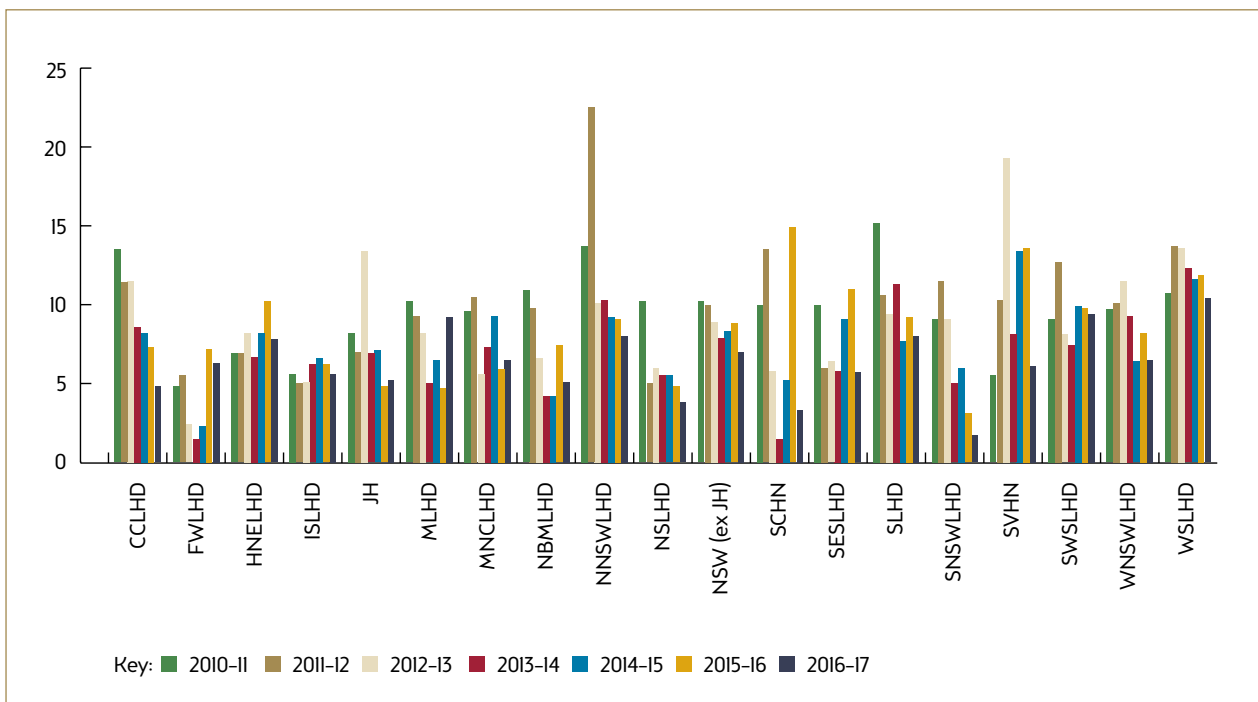
Data collection, reporting and performance framework

Efforts to reduce the use of seclusion and restraint in NSW have produced varied results. **Figure 2** shows that some districts and networks have substantially reduced their use of restrictive practices, while others have been unable to reduce restrictive practices.

There has been an obvious reduction in the use of seclusion in NSW and Australia over the last 10 years, but the rate of reduction appears to have slowed. Does this mean there has been a reduction in effort to improve, or are we approaching the limits of what is achievable with the current strategies?

Seclusion and restraint reduction is clearly about reducing patient harm and improving quality of services, but many, if not most, mental health-led efforts sit outside the mainstream health initiatives to improve safety and quality. This is a consequence of the continuing isolation ('siloing') of mental health services from mainstream health care, with all the negative implications that isolation brings to resourcing and supporting quality and safety initiatives in mental health.

Figure 2. Rate of seclusion events in specialised mental health acute inpatient units, NSW public hospitals, by local health district, 2010–11 to 2015–16



Source: Health System Information and Performance Reporting Branch, NSW Health.
 Note: NSW aggregate excludes Justice Health and Forensic Mental Health Network

Patient safety

Ensuring safe and high-quality care for patients and the health care workforce should be a priority for all health care organisations.

Australian studies estimate that 16.6 per cent of all hospital inpatient episodes resulted in adverse events, with at least half of these being preventable (Wilson et al., 1995).

The figure of approximately 16 per cent was confirmed in a subsequent review (Wilson and Van der Weyden, 2005).

Accumulating research shows that workplace cultures lacking a quality and safety focus experience higher rates of staff injury (Gomaa et al., 2015), staff absenteeism and poorer staff retention levels (World Health Organization, 2006). This may be because organisations that value quality and safety identify risk factors not just for consumers but also for staff, and subsequently take appropriate action.

In his landmark 1966 article, Donabedian proposed using the triad of structure, process and outcome (Donabedian, 1966). A huge range of efforts has since focused on improving quality and safety, but it can be argued that these initiatives have not achieved their objectives because of:

- a reliance on a narrow, single-level programmatic change strategy
- a lack of explicit consideration of the multilevel approach to change that includes the individual, group or team, organisation, and larger environment or system level
- a focus of harm minimisation, quality assessment and enhancement activities on processes that are at crisis stage only
- a lack of systemic and sustained attention to issues of leadership, culture, team development, supervision and information technology at all levels
- inadequate resourcing to educate, support and sustain improvement initiatives at the team and local level
- excessive reliance on, and disproportionate investment in, compliance and regulation through policy, standards, accreditation and audit.

Ham (2014) noted that the introduction of inspection and regulation of the National Health Service (NHS) England had not necessarily produced the intended

effect. For example, regulatory visits did not identify serious patient care problems in the Mid Staffordshire NHS Foundation Trust, which received a 'good' rating from the Healthcare Commission in 2007–08, despite the service's high mortality rate. There were similar criticisms of the sensitivity of accreditation processes in the recent Oakden review in South Australia (Groves et al., 2017).

Ferlie and Shortell (2001) have argued that a multilevel approach to change is required. The approach should recognise the importance of four organisational levels: the individual, the group or team, the overall organisation, and the larger system or environment in which individual organisations are embedded. A better balance between centralisation and decentralisation of governance to sustain the impetus for quality improvement over time is also needed.

For further improvements in patient and staff outcomes there must be a move away from excessive reliance on regulation, accreditation and compliance to the promotion and encouragement of innovative thinking at a local level (Ham, 2014).

Structured quality improvement — the use of systems-thinking, data analysis and teams to bring about improved processes, reduced variation, better outcomes and higher satisfaction — is becoming more widely practised in health care. This modern approach borrows heavily from management science used for decades in general industry, also known as 'continuous quality improvement' or 'total quality management' (Laffel and Blumenthal, 1989).

The relevance of the international paradigm shift in patient safety for efforts to prevent seclusion and restraint lies in rebalancing resources and strategic effort, which enables local and grass roots initiatives. This rebalancing is consistent with the principles of devolved governance of health services in general, and with the goal of the Fifth national mental health and suicide prevention plan for devolved and integrated management (Department of Health, 2017).

The review

Method

The review team was asked to examine seclusion, restraint and observation practices in acute mental health units and declared emergency departments. The terms of reference in Appendix E outline a 'mixed method' approach for the review.

The method involved gathering information about current practice through unit self-audits, public consultations, written submissions, staff consultations, site visits to health facilities, industry consultations with professional groups, reviews of current administrative and performance data and a targeted international literature review.

I am extremely grateful for the opportunity to be given a voice in this review of the use of seclusion and restraint.

(Written submission, consumer)

The literature review and results of the self-audit surveys were used to inform the site visits and staff consultation sessions. The review team then considered the results from all feedback channels concurrently, and met regularly to identify and agree on emerging themes.

Governance

The review and its membership were announced by the Minister for Mental Health and Minister for Health in May 2017. The team included members with expertise in medical and nursing practice, leadership, acute mental health care in Australia and internationally, as well as lived experience. Details of the review team membership can be found in Appendix F.

This independent review was led by the NSW Chief Psychiatrist. Providing independent advice to the government is a key role of this position. To assist the review, a small support team was located in the Ministry of Health. This group was separate from and independent of the routine functions of the Mental Health Branch. Information gathered by the review team was used only for the purposes of the review.

Scope and limitations

This is not a comprehensive review of mental health services in NSW. It was limited to acute mental health units and declared emergency departments in NSW. The review focused on the restrictive interventions of seclusion and physical and mechanical restraint.

The review team did not review other restrictive interventions such as acute injectable medications, Community Treatment Orders or involuntary detention. However, recommendations are likely to be relevant to restrictive practices more broadly in NSW mental health services.

It was not the task of the review team to investigate individual complaints, services or incidents. Advice on the website, at consultations and in response to submissions or enquiries was that complaints can be pursued through the existing processes of local health districts and specialty networks or the Health Care Complaints Commission (HCCC).

The method included self-audit surveys and consultation sessions which relied on self-reported data and experiences that could not be easily verified. The purpose of the review, reflected in its method, was to learn from the participant's unique perspective, including the individual experience of seclusion and restraint.

Timeframe

- May 2017 — review announced by the Minister for Mental Health and the Minister for Health
- May 2017 — review team established
- June 2017 — first review team meeting
- June–July 2017 — self-audits completed
- June to September 2017 — consultation phase
- December 2017 — final report submitted to the Minister for Mental Health and Minister for Health.

Public consultations

Ten community consultations for consumers of mental health services, their families and carers and the public were held across regional and metropolitan NSW in August and September 2017.

The consultations were held at venues in the community on weekday evenings. The sessions were advertised and promoted via the NSW Health website, Twitter and Facebook. Media releases were issued from the Minister for Mental Health and NSW Health. Mental health consumer and carer peak bodies, BEING (Mental Health & Wellbeing Consumer Advisory Group) and Mental Health Carers NSW also promoted the public consultations via their networks. Members of the community could register their interest in attending a consultation via the NSW Health website, but there was no requirement to preregister.

Public consultations opened with a short statement explaining the scope of the review, how the review was gathering information, confidentiality details, the purpose of the session and how the session would be facilitated. Audiences were then asked to share their experiences. Further support included:

- Senior representatives of the districts and networks were present at each consultation to hear what members of their communities were saying about their experiences in mental health services.
- Staff from the local mental health services were available to provide support to people if they became distressed during the consultations.
- Participants were provided with a handout which had information on support services and who to approach if they had a specific complaint (Appendix G).
- At the end of each session, people were encouraged to contribute further via written submissions.
- Following each consultation, everyone who provided their contact details was sent a letter which included information about how to have a specific complaint investigated and contact details for support services (Appendix H).

A note-taker was present at each public consultation session and, after the sessions, consistent themes were discussed by the review team members present. The notes taken at each session did not identify any individuals or services. The entire review team reviewed themes emerging from each consultation.

Consultations with professional groups

There were three consultations with professional groups. As for the public consultations, a note-taker was present and themes were discussed directly after the sessions.

The medical workforce session was co-hosted with the Royal Australian and New Zealand College of Psychiatrists, the Australian Salaried Medical Officers' Federation and the Australian Medical Association.

A consultation with the peer workforce was promoted via the NSW Mental Health Consumer Workers Committee and BEING. Members of the peer workforce in the public and community-managed sectors attended the session.

A consultation with the nursing workforce was co-hosted with the NSW Health Nursing and Midwifery Office. There were representatives from mental health and emergency department nursing groups as well as the NSW Branch of the Australian College of Mental Health Nurses.

Health sector engagement

Members of the review team met with the National Mental Health Commission, Mental Health Commission of NSW, NSW Health Senior Executive Forum and the NSW Health System Support Group during the review to discuss processes and preliminary themes.

The review

Self-audit survey

All acute mental health units and declared emergency departments completed a self-audit. The self-audit questions were derived from the requirements of NSW state policy and examples of good practice. Several other documents informed the development of the self-audit survey, which can be found in Appendix I.

There were 150 mixed-method questions in the audit, including questions on governance, data, unit practices, seclusion practices, seclusion environments, restraint practices, observation, training, staffing and emergency department practices.

Questions contained both quantitative (yes/no/multiple choice) and qualitative (open-ended) components, so units could provide context to their responses. Units were asked to supply evidence to support their response for each question. Examples of such evidence were provided as an appendix to the self-audit survey.

The self-audit was not anonymous and was required to be completed by at least one member of the leadership team, that is, a Nursing Unit Manager and/or Clinical Director of the acute mental health unit or emergency department. The Mental Health Director of each district and network reviewed and endorsed responses before their submission.

A total of 162 self-audits were completed, with all units providing responses. A range of evidence was provided to support the audits. The self-audit results were then collated and summaries were provided to the review team and back to the districts and networks.

The self-audit summaries provided a basic comparative analysis of audit results, a summary of key commentary and evidence provided at the district and network level. A statewide summary is available in Appendix J.

Site visits

The review team visited 25 NSW Health facilities and met with more than 300 leaders and 300 frontline staff from acute mental health units and declared emergency departments. The facilities visited were located across rural and metropolitan NSW with varied unit designs and models of care, servicing diverse groups of consumers. See Appendix K.

During site visits, the review team met separately with leadership and frontline staff to encourage staff to freely express their opinions. There were representatives from mental health services and emergency departments at the sessions, and some sessions also included representatives from security, NSW Police and NSW Ambulance.

The review team encouraged staff to further contribute to the review by providing written submissions. The review team visited 20 emergency departments and more than 25 acute mental health units.

Written submissions

The review team received written submissions from 22 June until 24 September 2017. Written submissions were sought through the media, the NSW Health website, and during community and staff consultations.

A total of 107 submissions were received via email, the NSW Health website, by post and during community consultations. To ensure the privacy of contributions, all submissions were sought on a confidential basis and were not made publicly available.

To ensure the privacy of contributions, all submissions were sought on a confidential basis and were not made publicly available.

The submissions were read independently by members of the review team to identify themes. Written submissions were also read 'horizontally' by the review team, which involved grouping segments of text and identifying quotations and pertinent examples of reoccurring themes.

Using a general inductive approach, the review team identified themes. This involved summarising submissions and categorising the themes that emerged in each submission. This approach allowed recurrent or important themes inherent in the submissions to emerge, without the restrictions imposed by any predetermined ideas.

The review

Submissions mostly addressed the topic of seclusion, restraint and observation practices directly. Some submissions addressed the general experience of involuntary treatment, or addressed single issues related to treatment and care.

Literature review

The team used several methods to incorporate targeted literature to inform the review. The methods included:

- accessing recent major literature reviews on the reduction of seclusion and restraint commissioned by other agencies
- a literature search conducted on reducing/preventing/eliminating, the use of seclusion and restraint in mental health units and emergency departments, conducted by the Brian Tutt Library and Resource Centre, NSW Ministry of Health, at the request of the review team
- closer exploration of primary source articles, especially those with:
 - o more robust research designs
 - o statistical analyses
 - o consumer and/or staff injuries included as outcomes.

The review team also had access to a literature review on patient safety, which was being conducted concurrently in the Mental Health Branch, NSW Ministry of Health.

Recommendations from coronial inquests

The recommendations from 54 mental health related coronial inquests from 2011 to mid-2017 were reviewed. These included recommendations about observation, avoidance of prone restraint, alignment of local and state policies, training and meaningful engagement of consumers and carers in assessment, treatment and care planning (Appendix L).

Discussion and findings

Our daughter will never be the same following her experiences as a child and adolescent being restrained and placed in seclusion. The nightmares and trauma from these experiences continue to affect her every day, both mentally and physically.

(Written submission, carer)

The discussion and findings reflect the review team's access to multiple sources of information: self-audits, literature, site visits, consultations and written submissions. In keeping with the reassurances given to everyone who contributed to this review, individuals or services are not identified in this report.

The experiences that consumers and carers described in different services were strikingly consistent across all 10 community consultations and the written submissions. The review team is of the opinion that the common themes from these stories support the validity of the findings.

We have endeavoured to honour and represent the subjective experiences of everyone who contributed to this review in reporting our findings. Where available, data and literature were used to support findings. The findings were strengthened when personal accounts, site visits, data and literature aligned.

The review team identified seven key themes for improvement:

- Culture and leadership
- Patient safety
- Accountability and governance
- Workforce
- Consumer and carer participation
- Data
- The built and therapeutic environment.

The recommendations in this report are based on consistent findings that were evident across the mental health system. The review team's view is that the key themes for improvement are relevant for all mental health units and declared emergency departments in NSW.

During the review, consumers, carers and families described their encounters with health services as lacking compassion, humanity or any real interest in the individual beyond risk management, behaviour disturbance and diagnostic labels. These findings are consistent with other published reports (Van der Merwe et al., 2013; Brophy et al., 2016).

For a period I lay there trying to get warm. This was difficult in such a cold room. The lights on the ceiling were on and it was difficult to close my eyes or get any rest. I certainly did not sleep at all. Time seemed to take forever. I had a nurse on the other side of the door observing me. Nothing happened for the most part. I was left alone with my thoughts. I couldn't get comfortable on the mattress and my back would hurt after a while so I would have to walk around. I was always cold and the blanket was thick, heavy and itchy.

(Written submission, consumer)

Many reported feeling dehumanised and stripped of their sense of autonomy, agency, dignity and human rights. Decisions to admit, discharge or transition to other levels or models of care were often perceived as more risk-related than therapeutic. Consumers reported that their autonomy was constrained unnecessarily in some aspects, such as in visiting hours, access to tea and coffee, personal devices and other everyday activities. These limitations were viewed as treating everyone as high-risk until proven otherwise. They are contrary to the principle of 'least restrictive care' outlined in the NSW Mental Health Act 2007.

Some consumers and carers reported that seclusion and restraint were used as a threat or a punishment; as a means of enforcing compliance and obedience. This form of coercive compliance has more in common with custodial correction systems than it does with a therapeutic setting. It is a major departure from the intent of seclusion and restraint policies and ignores the role of recovery and trauma-informed care in contemporary mental health care.

Culture and leadership

Culture

Service models prioritise safety above consumers rights to self-efficacy or opportunity to fail. This sort of culture promotes strip-searching, wearing of hospital gowns, removing all personal property, and other punitive interventions.

(Written submission, staff member)

A large research program to examine culture and behaviour in the NHS England noted that culture is 'a term that is widely used but notoriously escapes consensual definition' (Dixon-Woods et al., 2014, p. 107). Their analysis of definitions was that many 'have in common an emphasis on the shared basic assumptions, norms and values and repeated behaviours of particular groups into which new members are socialised'.

The casual and throwaway comments of disparagement and criticism of consumers which the review team heard during staff consultations and site visits can reinforce and encourage a discriminatory and traumatising culture. The review team held concerns that this behaviour had become normalised in many services and that staff and leaders were unaware of the lack of humanity and respect they were overtly displaying. What we say and how we behave towards each other (colleagues and consumers alike) reflect and reinforce our organisational culture, for better or worse. Words and behaviour matter.

Culture across all settings

The culture has developed in which common humanity is not recognised. The creation of this culture is multileveled and in the first instance is reflected in the manner in which clinicians and managers communicate with each other. Often punitive responses are taken, which do not communicate respect.

(Written submission, staff member)

The pre-eminence of a custodial and risk-management culture was evident in all aspects of the review. The avoidance of harm through risk management is a community expectation of services. But the pursuit of safety through risk management can often undercut the therapeutic environment. It is a trade-off that many consumers and clinicians find unacceptable, and in many instances is contrary to the principles of recovery.

One of the great fears of the health system is an adverse event resulting from a risk-management failure. The review team noted that risk as a concept is not well understood and that attempting to eliminate all risk severely limits the ability to provide services with a recovery orientation (Department of Health and Ageing, 2013). It is not the intention of the review team to criticise those who prioritise risk. At times, it is necessary to apply restrictions that ensure the safety of consumers, staff and the wider community. There is a distinct difference between blanket risk management that locks down and restricts everyone and has a detrimental impact on the therapeutic environment, and risk assessment on an individual basis. The 'dignity of risk' is a concept that needs to be discussed and integrated into mental health services (Department of Health and Ageing, 2013).

Culture in the emergency department

The culture in some emergency departments was overtly stigmatising and discriminatory towards mental health consumers and, in some instances, towards mental health staff as well. At times, this was displayed by nursing and medical emergency department leaders who were apparently unaware or unconcerned that their behaviour and language enabled a culture of discrimination, poor practice and consequent harm for consumers. Frequently repeated assertions that mental health consumers are dangerous until proven otherwise result in a lowering of the threshold for the use of most-restrictive rather than least-restrictive options.

The skills, attitudes and values of emergency department staff are important in reducing the trauma and harm associated with admissions for many consumers. The review team witnessed examples of positive leadership and constructive collaboration with mental health staff in caring for mental health consumers. There were also examples of stigmatising,

discriminatory and hostile behaviour towards consumers and mental health staff. At multiple site visits, emergency department staff displayed unprofessional attitudes and openly discussed people presenting with a mental illness differently from those presenting with a physical illness.

In some emergency departments, all mental health consumers were only seen in a safe assessment room and there was a low threshold for using security guards. The use of inappropriate language (such as referring to mental health consumers as 'taking up emergency beds' and 'distracting our services from looking after patients who are more in need of emergency services'; referring to 'your mental health patient' as a way of disowning any responsibility for the delivery of care; or mentioning that 'mental health patients are dangerous, and disturb the other patients with legitimate medical problems') was a common issue.

Often the Mental Health patients are completely ignored by the nursing staff who consider it is Security's job to observe and care for the mental health patients in the ED. The mental health patients are treated like second class citizens compared to the medical patients in the department.

(Written submission, staff member)

There were noteworthy examples of emergency department leaders who displayed concern and compassion for mental health consumers, and who made constructive efforts to improve the environment and the processes. These positive examples are contrary to the statement sometimes made that emergency departments are unsuitable for mental health consumers, or that stigmatising and traumatising environments cannot be improved. In the opinion of the review team, the difference between the services was not resources, but a difference in leadership, values and compassion. All emergency departments must be held to account and address these concerns.

People with mental illnesses commonly have physical disorders, and these can be complex (Australian Institute of Health and Welfare, 2012). Life-threatening comorbidities are common in people with mental illness

presenting to an emergency department. The reduced life expectancy documented for mental health consumers is as much due to physical conditions, for example, cardiorespiratory disease or metabolic comorbidities, as it is to suicide and misadventure (Royal Australian and New Zealand College of Psychiatrists, 2015; NSW Health, 2017).

Suggestions to the review team that there should be a separate facility for the emergency assessment of mental health consumers are flawed at best and dangerous at their worst. It is the responsibility of emergency services to meet the needs of all community members equitably and compassionately.

Leadership

The review team relied on descriptions in the literature of leadership in health, patient safety in health, and leadership in high-performing health services (e.g. Botwinick et al., 2006; Ham, 2014; West et al., 2014; West et al., 2015; National Improvement and Leadership Board, 2016; Ross and Naylor, 2017).

Traditional concepts of leadership concentrated on individual capacity in key roles, but recently there has been growing appreciation that this is an ineffective and unsustainable construct, with the conclusion that only 'collective leadership creates the culture in which high-quality, compassionate care can be delivered' (West et al., 2014). In collective or distributed leadership, staff at all levels take responsibility not just for their own job but for the success of the organisation (The King's Fund, 2011; West et al., 2014).

The review team witnessed some notable, although infrequent examples of positive and active leadership. These provided hope and showed what can be achieved by determined and strategic leadership, within existing resources.

However, the review team found no convincing examples of collective or distributed leadership in the course of this review, despite there being compelling literature suggesting that success in introducing and sustaining a patient safety culture depends on collective or distributed leadership for success (e.g. The King's Fund, 2011; Dickinson et al., 2013; West et al., 2014).

The review team noticed a disconnect between what some leaders said, either in the form of their statements,

in policy documents or in the self-audit results, and how much was understood through all levels of the system of care. Often, the reviewers were left with the impression that those present perceived leadership in these matters as arising from and entirely the responsibility of other individuals or agencies. This 'external locus of agency' will seriously limit the effectiveness of any strategy to improve patient safety, including initiatives to prevent seclusion and restraint. An improved, contemporary and more sophisticated understanding of the value of collective leadership and its implementation throughout our health system will be a fundamental enabler of moving towards a more systemic and sustainable approach to patient safety, including any initiative to address the inappropriate use of seclusion and restraint.

Viewing the leadership perspectives on seclusion and restraint reduction, from the team level through to the system level, should identify consistent views, values, themes and strategies in models of improvement, goals and governance, but this clarity of thinking and consistency of approach was not found in any site.

In no submission or visit was there evidence of a strategic vision communicated by the leaders which was understood and supported throughout the system. Where leadership vision and capability towards the reduction of seclusion and restraint were seen, they were dependent on individual passion, values and prioritisation. They were not generally shared and understood throughout the organisation, were restricted to relatively isolated parts of the system, and were not holistic, integrated or showing evidence of sustainability.

Leadership and values

Disappointingly, there were several witnessed examples of leaders lacking the courage to address stigma and discrimination shown towards consumers, sometimes by mental health staff, and at other times by emergency department staff, NSW Police and NSW Ambulance representatives. The importance of advocacy, and the necessary courage to 'call out' inappropriate behaviour whenever it occurs, is an essential part of leadership, without which all other constructive efforts to lead change will be undermined.

The tolerance of leaders for outdated, discriminatory and damaging attitudes and behaviours among staff was a matter of considerable concern, and was at odds with some of the submissions by professional groups emphasising the importance of leadership. There was a significant gap between what was asserted and what the team saw.

The tolerance of leaders for outdated, discriminatory and damaging attitudes and behaviours among staff was a matter of considerable concern...

Regardless of the model for leadership, there is an implicit expectation on all health professionals to act with courage when they witness inappropriate behaviour. To see leadership figures failing to show such a quality in response to stigmatising and discriminatory comments, behaviour or practices seriously undermines the integrity of our services, including our ability to self-regulate and to continuously improve.

There were some examples of positive leadership from mental health, emergency and district executives, but these stood out in sharp contrast to an overall culture preoccupied with process, risk and cost. Our encounters with 'lone leaders' reinforced our finding that there has been an over-reliance on individuals who have typically come from the ranks of clinicians to take up 'leader' roles without clear or well considered career development paths. Similarly, we met staff at various professional levels who misunderstood leadership as a role for others to fill instead of an activity in which everyone providing services can and should engage. High performance requires distributed leadership and cultures that enable teamwork, continuous improvement and consumer engagement (The King's Fund, 2011).

Culture and leadership

System-wide leadership development

As part of a commitment to fostering high-quality services, NHS England has recognised the importance of developing both leadership skills and quality improvement skills across NHS-funded services. The framework *Developing people — improving care: a national framework for action on improvement and leadership development in NHS-funded services* includes 'compassionate, inclusive leadership skills for leaders at all levels' as one of the critical capabilities for development (National Improvement and Leadership Development Board, 2016). The intention to develop leadership skills throughout the organisation and 'talent-management systems' also support sustained capability.

In light of the evidence, the review team is of the opinion that a system-wide approach to leadership development is an essential requirement to strengthen a culture of safety and quality, and to support the prevention of seclusion and restraint.

Recommendation 1: There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture. Collaborative leadership was not evident to the review team. NSW Health must establish and adopt an integrated leadership development framework applicable to all staff at all stages of their career.

Patient safety

Quality and safety should be the common language of clinical leadership, understood by all health professionals, including how it affects their roles and responsibilities. Ensuring safe and high-quality care for consumers should be a priority for all health care organisations and every member of their workforce.

Ensuring safe and high-quality care for consumers should be a priority for all health care organisations...

The recent review of the Oakden Older Persons Mental Health Service in South Australia was commissioned to investigate failure in the care and treatment of patients in that service. The report identified that, over 10 years, the service had cultivated a practice in which compliance with scheduled accreditation visits was valued over quality. The Oakden review:

heard and saw evidence that Oakden became better at knowing how to produce documents and records that Accrediting Bodies and Surveyors wanted to and expected to see; and better at ensuring staff knew what to say. However, it became no better at providing safe or better quality care. (Groves et al., 2017, p. 77)

NSW Health services invest considerable time and money in compliance and quality assurance activities, including accreditation. A more contemporary and higher-impact approach would be to rebalance the relative investment in these compliance-based strategies to create opportunity for unit-based quality improvement.

Mental health services which have successfully embedded structured quality improvement as their routine way of working include the Tees, Esk and Wear Valley NHS Foundation Trust, the East London NHS Foundation Trust and the Institute of Mental Health in Singapore. Learnings from these organisations have been distilled, with essential core properties identified

as: leadership at all levels; a pervasive culture that supports a bottom-up approach, reflection and learning throughout the care process; consistent method; data; and sustained effort (Ross and Naylor, 2017).

A quality and improvement science approach promotes a just culture, that is, a culture that discusses and learns from errors (Reason, 1997, cited in Institute for Healthcare Improvement, 2006). A just culture supports patient safety with balanced accountability. Recognising that health staff operate within organisational systems, it encourages self-disclosure and transparency of adverse events, supports discussion of errors in order to learn from them, and holds managers and staff accountable for establishing and adhering to reliable processes (Botwinick, 2006; Boysen, 2013).

There is a clear shift in thinking about patient safety internationally and a transformation in patient safety methodologies, including values-based leadership, safety culture, prevention of adverse events and active engagement of clinicians, consumers, carers and families (e.g. Frankel et al., 2017; American College of Healthcare Executives, 2017).

In considering seclusion and restraint prevention, it is important to align the review of current practices and recommendations for change with contemporary information about improvement science principles and methods. There has been a history of efforts at seclusion and restraint reduction in Australia, and there are well publicised examples of clear failures and a loss of momentum for further improvement in this area. These factors mean that it makes sense to embed any future efforts to improve seclusion and restraint performance within an evidence-informed model for patient safety, founded on local ownership, quality improvement and continuous learning.

Recommendation 2: Current approaches to patient safety and quality are inconsistent. NSW Health must adopt a mental health patient safety program, informed by contemporary improvement science.

Accountability and governance

Safety must be at the forefront of every decision made in health care organisations. Internationally, there is a growing trend to bring safety and corporate leaders closer together to ensure that high-value care is provided (Frankel et al., 2017).

Reliable clinical governance processes are an essential part of sustainable patient safety efforts, including those relating to a reduction in seclusion and restraint (e.g., Wale et al., 2011; Bell and Gallacher, 2016).

The use of seclusion and restraint in psychiatric treatment should be one of the most highly regulated and scrutinised practises, feedback of mental health consumers suggests that the mental health system may not, in practice, be achieving legislated and policy benchmarks.

(Written submission, organisation)

The review team saw considerable variation in the operational management and accountability structures for mental health services across the state. This variation is evident in the performance meetings between the Ministry of Health and districts and networks, with only some Directors of Mental Health attending. Previously there was a requirement in NSW Health that the Director of Mental Health is a member of the senior executive and reports to the Chief Executive. This is no longer the case in a number of services.

When Mental Health Directors are members of the senior executive they are able to develop closer working relationships with Chief Executives and other Directors within the health service. They and the services they lead are also more likely to be better integrated and aware of the challenges facing districts and networks more broadly. In light of the concerns raised in this review and the clear need for transformational change in many aspects of mental health care, the review team is recommending that the requirement, for Directors of Mental Health to be members of the senior executive and report to the Chief Executive, is reinstated.

Recommendation 3: The integrity of mental health operations and governance is dependent on strong, visible and engaged leadership at the highest level. There is variation in mental health management and accountability structures across the state. The Director of Mental Health should be a member of the district or network senior executive and report to the Chief Executive.

Monitoring

At the state and district or network level, there is a clearly described clinical governance and performance-monitoring process, but there was a wide variation in how well the monitoring of seclusion and restraint was considered at all levels in the clinical environment. For example, frontline staff were not consistently involved or informed about seclusion and restraint monitoring, which undermined any attempt to develop clear accountabilities for seclusion and restraint at all levels.

The clinical governance structures and processes in local health districts and specialty networks varied widely. The apparent siloing of mental health clinical governance in some districts was indicative of a persistent view that mental health services were operationally distinct from 'mainstream' services, and that clinical governance processes were similarly isolated.

Emergency department performance

Where there was monitoring of seclusion and restraint performance, it appeared that this was restricted to the mental health units, in spite of the need to engage emergency departments in the process. During consultations and site visits, consumers, carers and staff expressed significant concerns about seclusion and restraint practices in emergency departments. However, it appeared that the clinical governance processes of neither the mental health units nor the emergency departments reliably monitored seclusion and restraint performance in the emergency department.

Locally, there were comments made about the inadvertent consequences of 'declaring' small rural emergency departments. These included concerns that the skillsets of staff and available resources were not adequate, resulting in poor management of people with disturbed behaviour and concerns that consumers were unnecessarily secluded because of delays in transport.

Some delays were described as the result of the low priority placed on transport of mental health patients by NSW Ambulance, regardless of acuity. These concerns were raised in three rural areas, and there was an element of consistency; however, no data were available to substantiate the claims. This issue may need further attention once there are sufficient data to shed light on the issue.

Seclusion and restraint of mental health consumers in the emergency department are not included in performance monitoring at a unit, district or network level. This reflects a major shortcoming of the separate governance processes. The stories of poor performance in many emergency departments are not surprising, given the disconnect from seclusion and restraint-prevention strategies being implemented by mental health services and the inadequate monitoring of emergency department performance.

It is not much help to consumers if the emergency department experience, which was regularly described as the most traumatic part of the consumer's episode of care, is not reliably captured in the performance monitoring and clinical governance process.

Recommendation 4: There is currently no reliable monitoring of seclusion and restraint in emergency departments. District and network clinical governance processes should include emergency department and mental health seclusion and restraint performance together.

Oversight

During site visits, the review team heard that decisions about the use of seclusion and restraint were often left in the hands of the nurses on the mental health inpatient unit, with limited external scrutiny or available supervision. This was an indication of the unreliability of on-site clinical supervision and support to safeguard good practice, assist in complex decision-making, and ensure all staff are both supported and accountable. Services lacked explicit guidelines for delegation and escalation in preventing seclusion and restraint.

On-site, real-time accountability and governance have changed in recent years. The role of on-site senior management to monitor clinical performance

24 hours a day appeared to have been diluted. The review team were disturbed to discover that some mental health inpatient units very rarely received visits from the on-site, after-hours senior nurse managers. Senior managers were said to be too busy 'running the business'. This was despite the likely role that a lack of external after-hours scrutiny played in the deviation from acceptable practice on the unit where Ms Merten was secluded (in the opinion of the review team).

Management no longer provides leadership but struggles with the volume of both policy, practice, education, accountability and policy change they need to implement. There is no time to debrief – people burn out and leave.

(Written submission, staff member)

The review team are concerned that the apparent loss of capacity within some services to provide regular and meaningful clinical oversight on a 24-hour basis is a relative downgrading of patient safety in comparison with the operational and resource management demands. This imbalance brings to mind some of the findings in inquiries arising from the Mid Staffordshire service in the UK (Francis, 2013).

Management rounding with frontline staff has become a neglected component of comprehensive care. It is not simply 'keeping an eye on staff' or responding to pending crises. It also assists staff to problem-solve, develop their own skills, and raise concerns with managers. Clinical governance frameworks become rather hollow and ineffective when the on-site proactive component of monitoring and supervision is absent.

It is clear that the increasing demands associated with 'running the business' have left a significant clinical governance gap in many services, particularly after hours. This gap was pertinent in the case of Ms Merten and must be addressed.

Recommendation 5: There is no routine on-site supervision after hours in several mental health units. All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.

Accountability

Robust clinical governance structures and processes are an essential part of a 'just culture', in which staff are not blamed for poor outcomes if they have been ill-equipped to provide safe services, but are held to account if they have failed to do what is expected when adequately prepared and equipped (Botwinick 2006; Boysen, 2013).

The nurses responsible for Ms Merten's care on the night she was secluded were appropriately held accountable, and this is true also of other staff who had blatantly failed to conduct clinical observations. But these may represent exceptional cases and the reviewers were left unconvinced that individual staff and their managers are consistently held to account for failing to do what they were trained, employed, adequately equipped and reasonably expected to do.

Complaint processes

Many consumers, carers and family members provided stories of poor experiences in emergency departments and mental health inpatient units, reporting that they found the complaints process dismissive, arduous, unhelpful and sometimes traumatic. This was the case for those who dealt with health services directly and also for those who pursued their complaint through the HCCC.

I was told to meet with the complaints officer at the LHD, who offered meeting times, but with little notice, and only within working hours. I asked for the hospital's seclusion policy, but she insisted I could only receive information via a meeting, and could not specify who would attend, or what would be discussed.

(Written submission, consumer)

In written submissions and at public consultations, consumers and carers described how their complaints were not taken seriously and they felt dismissed because they had a mental illness. It appears the burden of proof about complaints unfairly rests with consumers and carers due to stigmatising attitudes towards mental illness. The team found that there was clear potential for complaints management processes to better align with contemporary trauma-informed and recovery-oriented care, and for service responses to be more compassionate and less bureaucratic.

Policies

The self-audits and site visits showed clear evidence of a failure to implement policies. Many local policies governing seclusion, restraint and observation were found to be duplicative or contradictory. There were documents that contradicted themselves, for example, one policy mandated that fluid should be offered to consumers at a minimum half hourly, hourly and every two hours. There were also policies that contradicted the Aggression, seclusion and restraint in mental health facilities in NSW policy. An example was where a metropolitan district did not require a medical officer to authorise an episode of seclusion and this could be done by a senior nurse. According to the policy, this should only occur in rural, regional or subacute and nonacute services where they are unable to contact a medical officer for authorisation.

In staff consultations, the review team encountered confusion about current NSW Health policies and guidelines related to restrictive practices. This confusion was increased by having different statewide policies to cover interventions for mental health consumers in mental health and nonmental health settings.

The current NSW state policy PD2012_035 (NSW Health, 2012) is a lengthy document that contains a mix of high-level principles and detailed clinical procedures which are distracting and over-detailed. The review team found that there was confusion about the mandatory requirements. There was also confusion expressed about the terminology, particularly relating to collaborative reviews or debriefing sessions with consumers after an incident. This policy environment should be simplified.

Recommendation 6: The current seclusion and restraint policy environment is confusing. NSW Health should have a single, simplified, principles-based policy that works towards the elimination of seclusion and restraint.

The concept of safety for all consumers, carers, staff members and the public is well-intentioned, but the Preventing and managing violence in the NSW Health workplace — a zero tolerance approach policy (PD2015_001) and related training do not align with a preventive approach to aggression. They are also incongruent with a compassionate understanding of and engagement with mental health consumers. The 'zero tolerance' policy encourages an adversarial stance, as attention is focused on reaction to escalating agitation, aggression and violence. Muir-Cochrane and Duxbury (2017) have recently noted that international contemporary care is now moving away from this concept.

Smoke-free health care policy

The review team heard assertions that the NSW Health smoke-free health care policy (PD2015_003) (NSW Health, 2015) has contributed to consumers confronting staff and their behaviour escalating, which has led to restraint and seclusion. The review team notes the contrasting evidence that the introduction of a well supported smoke-free policy has been followed by a reduction in physical assaults in four English psychiatric hospitals. A study from the South London and Maudsley NHS Foundation Trust, of multiple adult units in the Trust's four hospitals and spanning the start of a comprehensive smoke-free policy, has recently been published (Robson et al., 2017). The study found a 39 per cent reduction in all physical assaults, 47 per cent reduction in patient-to-staff assaults, and 15 per cent reduction in patient-to-patient assaults.

During consultations and site visits, the review team heard arguments that patient smoking 'back in the day' was innocuous, which is clearly an inaccurate portrayal of history. When consumers were able to

smoke in mental health units there was often aggression between consumers and between consumers and staff about access to cigarettes. Smoking 'privileges' were previously administered in a manner that was not recovery-oriented. Transactions, at times, approached a token economy, and conflict over 'privileges' was not uncommon.

Patients made to go cold turkey for 2 days with limited Nicotine Replacement Therapy available. Whilst others were allowed to smoke in courtyard.

(Written submission, consumer)

The review team rejects the assertions that the NSW Health smoke-free health care policy contributes to aggression and is associated with increased seclusion and restraint. During the consultations and site visits, the review team identified problems with proper implementation of the NSW Health smoke-free health care policy, especially problems with ineffective offering and use of sufficient nicotine replacement therapy. Nicotine dependence and withdrawal should be viewed in the same category as any other addictive substance and treated with the same respect to management and reduction of withdrawal symptoms. This could be addressed easily and should be remedied.

Recommendation 7: There is evidence of poor management of nicotine dependence, which can contribute to irritability and aggression. There should be an immediate reinvigoration of the implementation of the NSW Health Smoke-free Health Care Policy (PD2015_003), which includes increasing the knowledge and use of nicotine replacement therapy.

Workforce

This is a difficult field to work in and front-line clinicians, like those working on community teams, in EDs or inpatient units; are at the coal-face and subject to intense pressure... I believe the key to assisting with improving this issue, lies in having experienced, well-qualified staff delivering the care.

(Written submission, staff member)

The review team acknowledges that most staff in the mental health system are motivated to provide quality care in a challenging environment. We have identified current approaches, strategies and leadership issues that constrain staff and limit the system's capacity to prevent harm and trauma. The findings and recommendations in this section focus on improved support for the workforce to deliver effective trauma-informed and recovery-oriented care.

Skills and attitudes

A skilled workforce is vital to the creation of a therapeutic environment and the implementation of any strategy to improve patient safety. The review team heard repeatedly that many staff were recruited to work in mental health inpatient settings with little or no previous mental health experience or skills. Some staff working with mental health consumers knew little about trauma-informed care or its relevance in restrictive practices, and in some cases expressed views and opinions that reflected stigmatising attitudes towards consumers.

There were examples where emergency department staff lacked confidence and expected to hand assessment of all people presenting with mental health problems to mental health clinicians. Ensuring all emergency department staff working with mental health consumers acquire a minimum set of mental health care skills (including trauma-informed care as a universal precaution) will improve the experience of consumers at a common first point of interaction with the health service.

In specific training relating to seclusion and restraint, many staff commented that very little attention was given to prevention of restrictive practices. It was also apparent that the content of training varied significantly from service to service, with limited evaluation. During the staff consultations, concerns were consistently raised about the current violence-prevention management training. The concerns were about the amount of time the training focused on the physical skills for restraint (3 days) compared to the time on prevention strategies (less than 1 day).

Training in systemic, multifaceted and evidence-based strategies to prevent seclusion and restraint was uncommon but, where it was implemented and supported, it was clearly beneficial. Some services have provided training in trauma-informed care as a universal precaution, and dissemination of this approach may further assist in providing more compassionate service responses.

The review team were encouraged to hear that NSW Health is training security officers in a course designed for the health environment and which includes trauma-informed care and prevention of seclusion and restraint components.

We need definitely to be looking at ongoing education at learning how to de-escalate earlier rather than later. We need to be looking at education further for using least restrictive interventions, for example, 1:1 nursing, sitting with the patient in a quiet area that is non-threatening and so on.

(Written submission, organisation)

All services have an obligation to ensure that supervision is appropriate, defined and supported by a transparent process. The review found that most units were providing access to clinical supervision for nursing, allied health and medical staff, although the format varied and was more commonly for junior or less experienced clinicians.

For example, for nursing staff, units reported that models of clinical supervision were generally a 1-hour session per month or, often, group supervision sessions during nursing transition programs, with optional supervision thereafter or if requested. Point-of-care supervision, provided by a senior clinician or an educator to a junior clinician during the course of their routine work, was less apparent. Services should be providing clinical supervision for all clinicians and in different forms, and should not be restricted to junior or less experienced clinicians.

Recommendation 8: There are staff who have insufficient skills and basic mental health knowledge working with mental health consumers. NSW Health should develop and implement minimum standards and skill requirements for all staff working in mental health.

There appeared to be little consistency in the attitudes and values observed among staff, an important issue given the impact of shared values and attitudes in influencing change (e.g. West et al., 2014; West et al., 2015). From site visits and accounts of consumers, carers and families, the review team also found misalignment between stated values and values displayed through action across all levels of services.

Disengagement and lack of a compelling shared vision compromise a culture of safety and care (Botwinick et al., 2006). Individuals 'with optimal values for the delivery of high-quality compassionate care, may be at risk of changing practice if placed within teams with suboptimal values' (Health Education England, 2014).

The review team identified a need for districts and networks to strengthen a common values base in mental health services and emergency departments.

One approach to aligning values has been values-based recruiting. In 2014, NHS England needed to focus their culture on patient care and experience after adverse findings from inquiries such as the Mid Staffordshire NHS Foundation Trust Public Inquiry. They added values-based recruiting as one component to support high-quality, safe and compassionate

health care, acknowledging that it does not solve all problems (Health Education England, 2014). Staff also need relevant skills, abilities and continuing support throughout their employment. Services need to follow through from values-based recruiting to values-based employment, including talent management and appraisal (Health Education England, 2016).

Recommendation 9: Discriminatory and stigmatising behaviour and attitudes were observed at all levels of the workforce. NSW Health should ensure that recruitment and performance-review processes include appraisal of values and attitudes of all staff working with people with a mental illness.

The peer workforce

The importance of consumer and carer peer-worker participation in the mental health workforce generally, and in efforts to prevent seclusion and restraint specifically, was evident in the literature (Huckshorn, 2006; National Association of State Mental Health Program Directors, 2006; Department of Health, 2013) and was raised at every public consultation.

Peer workers witness firsthand and hear second hand from consumers the profound and traumatic impact seclusion and restraint has on their lives.

(Written submission, organisation)

There is variation in the definition, accountabilities and roles of the peer workforce. There was no evidence, in site visits, self-audits or consultations, of enough suitably skilled and supported peer workers to contribute to a multidisciplinary effort to prevent the use of restrictive practices. Self-audits also showed that even where peer workers were available, full-time access to a peer worker was rare. Some peer workers have district-wide responsibilities and most appeared to work quite limited hours. These factors combined to reduce the likely benefits of a properly trained and resourced peer workforce.

Supporting the growth and recognition of the peer workforce as an emerging profession is crucial in helping people live contributing lives, and in building a stronger and more resilient mental health system. To achieve this, it is vital to create clarity and consistency in relation to roles, qualifications, supervision and accountabilities before increasing numbers. To do otherwise will reduce the effectiveness of these positions, adversely affect recruitment, retention and professional advancement and tarnish the reputation of this profession, which is an essential component of contemporary mental health services.

All disciplines and professional groups, including consumer and carer peer workers, should be recruited on the basis of their skills, experience, values and attitudes, and their capacity to contribute to the goals of the organisation. They should also have all the same benefits as other staff including professional development, supervision and be held to account for their performance.

Recommendation 10: The valuable role of the peer workforce is undermined by inconsistent job descriptions, skill levels and supports, and low staff numbers. The peer workforce should be developed and professionalised, with the same supports and accountabilities as other disciplines. The number of positions should be increased, but only after the supports and accountabilities are in place.

Consumer and carer participation

The NSW state policy Aggression, seclusion and restraint in mental health facilities in NSW (PD 2012_035) requires that, after an aggressive incident, a collaborative review or debrief must take place. The collaborative review involves a member of the clinical team offering to discuss the incident with the consumer. The consumer's primary carer should also be offered the opportunity to participate, and the review can include an opportunity to engage in a post-incident discussion with consumer workers.

The collaborative review process or debrief is designed to prevent further occurrences of seclusion and restraint and is consistent with trauma-informed care and quality-improvement principles. Foxlewin (2012) has described the value of consumer and clinician collaboration in seclusion and restraint review meetings.

Many instances of seclusion and restraint begin with communication breakdowns and poor engagement by front line staff. Not enough time is spent being with a client to assist in calming, providing a space, to being heard & taking away the fear.

(Written submission, consumer)

It became clear from self-audit responses and during site visits that, for many services, there is a limited understanding of what collaborative reviews, as defined in the policy PD 2012_035, require. Overwhelmingly, the review team was told by consumers that they were not offered an opportunity to discuss or debrief after a seclusion or restraint event. Without these discussions, it is not possible for staff and consumers to reflect on the situation and work together to avoid future instances of restrictive practices.

Consumers and carers reported difficulties accessing and meeting with treating teams. Families also reported feeling shut out, with services not listening to, acknowledging or acting on their concerns. Findings from coronial inquests in NSW have emphasised the role of families and carers, and recommended that the input of families, carers and consumers into the assessment

and development of care plans is actively facilitated, and includes provision of written material (Appendix K).

One of the prevention activities in a multicomponent approach to prevent seclusion and restraint is the development of a safety plan (Huckshorn, 2006). This is when staff work with consumers to help identify triggers for aggressive behaviours and strategies to manage or de-escalate the behaviour without resorting to restrictive practices. During public consultations, consumers described that restrictive practices were used before they had an opportunity to engage in safety planning.

The review team acknowledges that developing a safety plan can be challenging when someone is acutely distressed. However, there are multiple opportunities to do this activity (ideally early in the admission), as part of assessment and care planning. It can complement other restraint and seclusion prevention tools too, including activities and plans for promoting self-regulation, self-soothing and calming (Huckshorn and LeBel, 2009).

When the review team asked about safety planning, it appeared that districts and networks had limited understanding of the process, and that the practice was sporadic across the state and even differed between units at the same hospital.

One of the challenges staff reported was that care plans and safety plans were not always visible or easily found or, if provided, were often not current or given a review date. The review team concluded that individual care-planning must occur in a more systematic, consistent and comprehensive manner with greater involvement of consumers, carers and community and inpatient teams. The plans need to be reviewed regularly and need to be easy to locate, including in the electronic medical record.

Considering the specific requirements for consumer and carer involvement in seclusion and restraint reduction, both in individual cases and in policy and strategic implementation, the review team found little evidence that meaningful, sustained and systematic engagement with consumers and carers was taking place across the system.

Consumer and carer participation

Recommendation 11: Individualised care planning is essential to prevention of seclusion and restraint, but is inconsistent across services. Meaningful engagement with consumers and their families should occur in assessment and care planning, particularly in developing personal plans to prevent the use of restrictive practices.

It was encouraging to see that the Your Experience of Service (YES) questionnaire and its results were visible in many services, and the review team was pleased to hear that NSW Health will soon implement the nationally developed Mental Health Carer Experience Survey. However, there was limited evidence that services are routinely using this information to inform their quality-improvement activities.

Some services reported that they had adopted the principles of co-design but, when this was explored during the site visits, it was more reflective of a traditional consultation process. Co-design means that consumers and carers must be at the centre of, and embedded in, mental health service planning, and contribute from the start rather than simply being asked to provide comment. They must be active participants in the process, not merely passive sources of information.

The impression of the review team was that more must be done to abide by the principles articulated in the Fifth national mental health and suicide prevention plan, which recognises that consumers and carers have vital contributions to make and should be partners in planning and decision-making.

Recommendation 12: There is evidence supporting the importance of co-design. No convincing examples of it were seen during the review. Consumer and carer co-design and systematic engagement should occur at all levels of the health service.

Data

The transparency, detail and frequency of data provided across the system is inadequate for the purposes of reducing and eliminating seclusion and restraint.

State-level data and KPIs have limited capacity to drive change at a local level and, although they are helpful in understanding what is happening across the sector and for broad comparisons, they shed insufficient light on practices in individual units. During the site visits, the review team observed vastly different practice between services with similar rates of seclusion. Caution needs to be exercised in drawing conclusions about the quality of services based solely on their performance on KPIs.

These failures are reinforced by a system that does not adequately, independently and transparently report on seclusion and restraint rates and incidences.

(Written submission, organisation)

To drive change in the use of restrictive practices, services need to be able to produce more frequent and timely local reports, at the unit level, that have a greater level of information than the state reporting system. For example, some services had local reporting about the time of day of the event, day of the week, time from admission to the event, and consumer characteristics, but there were large variations in data collection and reporting practices for seclusion and restraint across the system.

We heard from frontline staff who told us they participated in the routine gathering and recording of seclusion and restraint data, for the purposes of reporting and auditing. It was disappointing that, although frontline staff were often aware of seclusion and restraint data, this knowledge did not necessarily lead to critical reflection on practices and adjustments to improvement activities.

At site visits, some services had seclusion and restraint data displayed for staff to see. However, in many other sites staff appeared to be unaware that these data were available or how they would use them to improve practice. There is a clear opportunity for services to take a more proactive approach to disseminating and using information so that staff are aware of unit performance.

The review team acknowledges the good efforts to provide greater transparency; however, services must ensure they engage with consumers so that data displayed are easily understood. Caution needs to be exercised when publicly displaying seclusion and restraint data, as it may have the unintended consequence of increasing the anxieties of people accessing the unit.

The review team heard that access to seclusion and restraint data reports was limited. Currently NSW Health provides statewide quarterly reporting to a small number of district and network staff. Some services are producing and distributing local electronic reporting, but there appears to be a reliance on paper reporting in NSW. A more contemporary approach would be to use an online platform to allow direct access.

The review team acknowledges that NSW does publicly report seclusion rates, durations and frequencies at the hospital level. This occurs in the NSW Health Annual Report, but these statistics (in Appendix IV of the NSW Health Annual Report) are not easily accessible.

Recommendation 13: There is inconsistent use of and access to seclusion and restraint data for staff to support efforts to prevent these practices. NSW Health should improve the transparency, detail and frequency of publication of seclusion and restraint data at the state and local level.

Emergency department reporting

In visits to declared emergency departments, the review team found that data collection processes were variable, poorly reported and insufficient. For seclusion and restraint data to be meaningful, it must be comprehensive, reliable and include an emergency department component. Currently, there is no state reporting or ability for emergency departments to compare their performance.

Recommendation 14: There is no statewide reporting of seclusion and restraint in declared emergency departments. The NSW seclusion and restraint data collection and reporting should include declared emergency departments.

The built and therapeutic environment

Safe assessment rooms

After visiting 20 emergency departments, the review team had significant concerns about the design and use of safe assessment rooms. Typically the review team were confronted by small, noisy, cold rooms, often with no natural light, no activities to distract, no chair to sit on, no one to talk to, and only a foam mattress and blanket on the floor. Most commonly, the rooms were located in the middle of the emergency department or in a thoroughfare which is not a low-stimulus environment. There was little or no clear signage about consumer or carer rights, or avenues for complaints and suggestions.

At site visits, the review team saw CCTV displays from safe assessment rooms that were on view to people who were not involved in the care of the person being monitored, with some located in areas open to the public. It is not appropriate for a tool ostensibly being used to support safety to actually compromise consumers' privacy and dignity. Some services had recognised this problem and found more discreet and suitable locations for monitors.

It is acknowledged that the design and location of safe assessment rooms is limited by the physical possibilities of existing emergency departments and the recommended standards, such as the Australasian health facility guidelines, which impose constraints. However, Section 68(f) of the NSW Mental Health Act requires the restriction on the liberty of consumers and interference with their rights, dignity and self-respect to be kept to the minimum necessary in the circumstances. The arrangements for assessment in many emergency departments are not consistent with this requirement.

The review team are concerned by the use and design of safe assessment rooms, and are of the view that these rooms cannot possibly provide assessment and treatment in the least restrictive way, with the fewest possible restrictions on the rights and dignity of mental health consumers. During site visits, the review team did not find any safe assessment room to be an appropriate treatment space for low acuity mental health presentations, despite several emergency departments reporting they place all mental health consumers in a safe assessment room as a first option. Consumers and carers gave the review team examples where

seclusion in safe assessment rooms had been used as a default option for all mental health presentations in some emergency departments. This is clearly not least-restrictive practice, and safe assessment rooms are not an appropriate first environment for all mental health consumers to receive hospital care.

The unit is cramped, noisy and unnecessarily grim. In my view it is not an environment which is conducive to recovery from mental illness but is certainly one which promotes boredom and dissatisfaction amongst inpatients — and, more often than is comfortable, violence.

(Written submission, staff member)

During site visits, the review team were told by staff that safe assessment rooms may be routinely locked while occupied, or that mental health consumers may be monitored by security staff and prevented from leaving. In these circumstances, it was not clear that staff understood that these practices were seclusion, nor if these responses were necessary and proportional to the person's risk of harm. These circumstances represent a breach of the Aggression, seclusion and restraint in mental health facilities in NSW policy (PD2012_035) (NSW Health, 2012).

At community consultations, the review team heard examples of mental health consumers being left for extended periods in safe assessment rooms without access to family or other supports and with little information. This included the story of a young person, with the courage and foresight to seek treatment, having their first encounter with mental health services result in a 10-hour wait in a safe assessment room with sporadic review of their wellbeing and little communication.

Safe assessment rooms are increasingly used as a 'one size fits all' solution for all mental health presentations. Safe assessment rooms should not be the default clinical pathway for all mental health presentations to emergency departments.

Recommendation 15: The current use of and over-reliance on emergency department safe assessment rooms is traumatising. All emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There needs to be a pathway that does not include the use of safe assessment rooms.

Recommendation 16: There should be an immediate review of the design and use of safe assessment rooms, using a co-design methodology.

Built environment

Feedback from consumers and their families during public consultations was that the mental health units often had a custodial feel. This was confirmed by the review team on their site visits. Many units had obvious signs on display about rules, were dark, and had marked walls, metal toilets, sheets of metal instead of mirrors, bare courtyards without plants, and staff who remained behind perspex, observing consumers. During site visits, the review team saw that it was possible for a unit to take down the 'fishbowl' barrier between staff and consumers.

A number of current high dependency units are built like prisons with drab colours, bare walls and courtyards with high walls and no vegetation- this is not a very pleasant environment to be held in and if it was me I would feel trapped, claustrophobic and agitated.

(Written submission, staff member)

The custodial feel of many services is at odds with the intention to provide person-centred models of care, the need to consider holistic treatment needs, and a focus on recovery on clients' own terms. Shared bedrooms also provide limited privacy and are not calm, quiet, safe environments supporting trauma-informed care and personal recovery. To create therapeutic environments that rely less on restrictive interventions, we must design and build facilities that are consistent with that stated philosophy.

Recommendation 17: Many mental health units had a custodial feel. All future capital planning of mental health facilities should include consumer co-design and be informed by evidence on preventing seclusion and restraint.

Lack of maintenance and cleanliness in some facilities is a serious issue. The standards of maintenance and cleanliness were not related to the age or design of the facility. Some facilities were very well maintained, which indicated that good maintenance is possible within current resources.

The standards of maintenance and cleanliness were not related to the age or design of the facility.

During site visits, the review team observed several facilities with basic maintenance problems, such as broken fixtures or unhygienic seclusion rooms and bathrooms. The physical condition of seclusion rooms in some facilities was poor. They were not clean or properly maintained, and were without access to bathrooms or fresh air. The acceptance of substandard amenities by staff is a concern that needs addressing.

Borckardt et al. (2011) found that change to the physical characteristics of the therapeutic environment was associated with a statistically significant reduction in the use of seclusion and restraint.

The review team noted that many facilities could benefit from immediate minor capital works improvement such as repainting, repair of fixtures and new furniture. The review team also found that sensory rooms remain under-utilised across NSW facilities and could be implemented for a relatively small cost in some services (less than \$10 000).

The built and therapeutic environment

Recommendation 18: All acute mental health units and declared emergency departments should conduct a review of their facilities and implement minor capital works and equipment purchases to improve the therapeutic potential. This will support people to self-manage and assist in the prevention of seclusion and restraint.

Legal processes

Through consultations and submissions, consumers reported to the review team that Mental Health Review Tribunal hearings can feel intimidating, adversarial, and sometimes like a trial. This finding is consistent with research interviews of Australian consumers, including those from NSW about Mental Health Review Tribunals (Carney, 2009). The review team also heard from consumers, carers, families and staff that Tribunal hearings can sometimes precipitate disagreements between consumers, their carers and families and the treating team. Consumers, carers, families and staff gave examples of where this conflict had directly contributed to escalation of aggression followed by restraint and/or seclusion.

Therapeutic environment

Consumers and carers at public consultations and through written submissions told the review team about the importance of personal support and comfort. They described the many ways in which this is overlooked or unnecessarily restricted in some inpatient units. Examples included limited visiting hours for carers and families, restricted access to hot drinks and snacks, and not being allowed to use personal mobile phones or access social media or personal choice in music. The review team were somewhat reassured to see that some services were beginning to address this matter, although the efforts were very much in their infancy.

Some restrictions within the therapeutic environment are a function of culture, one that views people as high-risk until proven otherwise. A more compassionate culture and leadership will help staff explore new ideas and create a more 'normalised' therapeutic environment, to work closely with consumers and carers in a recovery framework to consider calculated risk-taking.

A recent international approach to improving health care environments is the 'Breaking the Rules for Better Care' initiative, supported by the Institute for Healthcare Improvement. When services have been encouraged to ask staff and consumers 'If you could break or change any rule in service of a better care experience for patients or staff, what would it be?' they have been surprised that the majority of identified rules were within the administrative control of health care executives and managers to change (Berwick et al., 2017; Feeley, 2017).

Mental health units can be further 'normalised', as consumers are not 'bed-bound'. Consumers reported through consultations and submissions that they wanted more spaces and areas in the units to spend time other than just their bedrooms. They also wanted staff to tailor their engagement especially when feeling distressed.

Evidence is that coping strategies based on the use of sensory modalities can assist consumers with emotional regulation and result in a decrease in the need for seclusion and physical restraints (Champagne and Stromberg, 2004).

**Ensure there is meaningful activity.
Colouring isn't usually going to excite
people to engage.**

(Written submission, organisation)

Observation and engagement

Boredom. One staff member did organize walks, gym plus cooking. This person only worked 3-4 days per week.

(Written submission, consumer)

During the course of this review, NSW Health released the Engagement and observation in mental health inpatient units policy (PD2017_025) which focuses on meaningful and therapeutic engagement instead of visual monitoring (NSW Health, 2017). It is consistent with the requirement to verbally interact with consumers during episodes of seclusion. Through the self-audits and site visits, the review team noted that many seclusion rooms did not have intercoms. This meant that staff either did not verbally interact with consumers in seclusion, or staff and consumers resorted to shouting through thick doors to communicate. The self-audit showed that there were units using CCTV to observe people in seclusion.

The review team heard a strong message that boredom is common. Boredom can be a contributing factor for aggression, which can escalate to the use of seclusion and restraint (e.g. Larue et al., 2009; Muir-Cochrane et al., 2015).

Consultations with staff, consumers and carers confirmed the importance of meaningful activity to encourage recovery, improve health literacy and help combat boredom.

Concerns about the limited availability of therapeutic programs to contribute to consumers' recovery on mental health units were common. They were expressed by consumers, carers and staff alike during consultations and in written submissions. The superficial nature or even absence of therapeutic programs in some cases was partly a result of insufficient multidisciplinary input and, at times, reflective of an outdated model of care.

Multidisciplinary teams

The importance of a multidisciplinary workforce is not controversial or new to mental health, but its achievement is inconsistent across mental health units in NSW. The self-audits showed that where there was a multidisciplinary team, they were often only available Monday to Friday during business hours.

Multidisciplinary teams can support the delivery of trauma-informed and recovery-focused care, which is tailored to the needs of the individual consumer. When staff work in this way, they are more than a collection of people from different disciplines working in the same setting. The value of the multidisciplinary team is in the use of their complementary skills. Access to the range of specific professional skillsets can ensure that 'all "bio-psycho-socio-cultural" components of intervention and care are delivered' (Mental Health Commission, 2006, p.13).

Recommendation 19: A purposeful and predictable therapeutic program can support the prevention of seclusion and restraint. The review team did not observe any convincing examples of this type of program. All mental health units should have a multidisciplinary team with the skills to deliver a therapeutic program and environment on an extended-hours basis.

Recommendations

The review makes 19 recommendations to help prevent the use of seclusion and restraint in NSW acute mental health units and declared emergency departments.

Depending on the urgency, complexity and/or lead-in time, the recommendations have been listed as needing:

- immediate implementation (within 6 months);
- short-term implementation (over 6 to 12 months); or
- medium-term implementation (over 1 to 5 years).

Immediate implementation

Recommendation 5

There is no routine on-site supervision after hours in several mental health units. **All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.**

Recommendation 7

There is evidence of poor management of nicotine dependence, which can contribute to irritability and aggression. **There should be an immediate reinvigoration of the implementation of the NSW Health Smoke-free Health Care Policy (PD2015_003), which includes increasing the knowledge and use of nicotine replacement therapy.**

Recommendation 12

There is evidence supporting the importance of co-design. No convincing examples of it were seen during the review. **Consumer and carer co-design and systematic engagement should occur at all levels of the health service.**

Recommendation 14

There is no statewide reporting of seclusion and restraint in declared emergency departments. **The NSW seclusion and restraint data collection and reporting should include declared emergency departments.**

Recommendation 15

The current use of and over-reliance on emergency department safe assessment rooms is traumatising. **All emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There needs to be a pathway that does not include the use of safe assessment rooms.**

Recommendation 16

There should be an immediate review of the design and use of safe assessment rooms, using a co-design methodology.

Recommendation 18

All acute mental health units and declared emergency departments should conduct a review of their facilities and implement minor capital works and equipment purchases to improve the therapeutic potential. This will support people to self-manage and assist in the prevention of seclusion and restraint.

Short-term implementation

Recommendation 2

Current approaches to patient safety and quality are inconsistent. **NSW Health must adopt a mental health patient safety program, informed by contemporary improvement science.**

Recommendation 3

The integrity of mental health operations and governance is dependent on strong, visible and engaged leadership at the highest level. There is variation in mental health management and accountability structures across the state. **The Director of Mental Health should be a member of the district or network senior executive and report to the Chief Executive.**

Recommendation 6

The current seclusion and restraint policy environment is confusing. **NSW Health should have a single, simplified, principles-based policy that works towards the elimination of seclusion and restraint.**

Recommendation 9

Discriminatory and stigmatising behaviour and attitudes were observed at all levels of the workforce.

NSW Health should ensure that recruitment and performance-review processes include appraisal of values and attitudes of all staff working with people with a mental illness.

Recommendation 11

Individualised care planning is essential to prevention of seclusion and restraint, but is inconsistent across services. **Meaningful engagement with consumers and their families should occur in assessment and care planning, particularly in developing personal plans to prevent the use of restrictive practices.**

Medium-term implementation

Recommendation 1

There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture. Collaborative leadership was not evident to the review team. **NSW Health must establish and adopt an integrated leadership development framework applicable to all staff at all stages of their career.**

Recommendation 4

There is currently no reliable monitoring of seclusion and restraint in emergency departments. **District and network clinical governance processes should include emergency department and mental health seclusion and restraint performance together.**

Recommendation 8

There are staff who have insufficient skills and basic mental health knowledge working with mental health consumers. **NSW Health should develop and implement minimum standards and skill requirements for all staff working in mental health.**

Recommendation 10

The valuable role of the peer workforce is undermined by inconsistent job descriptions, skill levels and supports, and low staff numbers. **The peer workforce should be developed and professionalised, with the same supports and accountabilities as other disciplines. The number of positions should be increased, but only after the supports and accountabilities are in place.**

Recommendation 13

There is inconsistent use of and access to seclusion and restraint data for staff to support efforts to prevent these practices. **NSW Health should improve the transparency, detail and frequency of publication of seclusion and restraint data at the state and local level.**

Recommendation 17

Many mental health units had a custodial feel. **All future capital planning of mental health facilities should include consumer co-design and be informed by evidence on preventing seclusion and restraint.**

Recommendation 19

A purposeful and predictable therapeutic program can support the prevention of seclusion and restraint. The review team did not observe any convincing examples of this type of program. **All mental health units should have a multidisciplinary team with the skills to deliver a therapeutic program and environment on an extended-hours basis.**

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Glossary and abbreviations

Term	Definition
AMA	Australian Medical Association
ASMOF	Australian Salaried Medical Officers' Federation
CCTV	Closed circuit television
Collaborative review	Following an aggressive incident or the use of seclusion or restraint, a member of the clinical team will offer to discuss the incident with the consumer. The consumer's primary carer will be offered the opportunity to participate (NSW Health, 2012).
Collective leadership	Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or area. This contrasts with traditional approaches focused on developing individual capability (West et al., 2014).
Consumer co-design	Working in reciprocal and equal partnership with consumers at all stages of change, which includes exploring, planning, developing, implementing and evaluating (National Mental Health Consumer and Carer Forum, 2017).
Declared emergency department	Under s109 of the Mental Health Act 2007, an emergency department may be 'declared', which empowers the emergency department to provide treatment of involuntary patients. This also invokes a range of accountability and transparency measures. (Mental Health Act 2007 NSW).
HCCC	Health Care Complaints Commission
IIMS	Incident information management system
Just culture	Just culture is a culture in which frontline operators and others are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated (Reason, 1997).
Management rounding	Management rounding is a purposeful and clearly defined process of engaging with frontline staff to help them problem-solve and develop their own skills, and to provide staff an opportunity to raise concerns with managers.
Mechanical restraint	<p>The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture, except where the devices are used solely for the purpose of restraining a person's freedom of movement.</p> <p>The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint (NSW Health, 2012).</p>
NHS England	National Health Service of England
NICE	The National Institute for Health and Care Excellence

Term	Definition
Occupied bed day	An occupied bed is an available bed where there is a patient physically in the bed or the bed is being retained for a patient. This excludes same-day admissions (Australian Institute of Health and Welfare, 2009).
Patient safety	'Making care continually safer by reducing harm and preventable mortality' (Institute for Healthcare Improvement, 2017).
Physical restraint	The application by health care staff of 'hands-on' immobilisation, or the physical restriction of a person to prevent the person from harming himself/herself or endangering others, or to ensure the provision of essential medical treatment (NSW Health, 2012).
Quality improvement	'Quality improvement in health care is based on a principle of organisations and staff continuously striving to improve how they work. There is no single definition, but it is generally understood to be a systematic approach based on specific methodologies for improving care – enhancing patients' safety, outcomes and experiences ... It puts significant emphasis on the role of frontline teams in consistently applying an agreed set of tools and techniques to test, measure and learn.' (Ross and Naylor, 2017).
RANZCP	Royal Australian and New Zealand College of Psychiatrists
Recovery-oriented care	The application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. Practices include evidence-informed treatment, therapy, rehabilitation and psychosocial support that aim to achieve the best outcomes for people's mental health, physical health and wellbeing (Department of Health and Ageing, 2013)
Restraint	Restriction of an individual's freedom of movement by physical or mechanical means. This applies to consumers receiving specialist mental health care, regardless of the setting. Key elements are: <ul style="list-style-type: none"> o The safety of the consumer and others is paramount. o The restraint is used for urgent intervention only where all other interventions have been tried or considered and excluded. o Restraint is used for the shortest period necessary. o A minimal amount of force necessary is used (NSW Health, 2012).
Safe assessment room	A multipurpose room that provides a private space to manage sensitive needs, such as for grieving relatives, to manage behaviourally disturbed patients, for patients requiring high-level observation, and to undertake assessments of mental health patients (NSW Health, 2015).
Seclusion	Confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. Key elements are: <ul style="list-style-type: none"> o The consumer is alone. o The seclusion applies at any time of the day or night. o Duration is not relevant in determining what is or is not seclusion. o The consumer cannot leave of their own accord (NSW Health, 2012).

Glossary and abbreviations

Term	Definition
Trauma-informed care	Trauma-informed care and practice is a strengths-based approach that understands and responds to the impact of trauma. This approach emphasises physical, psychological and emotional safety, and creates opportunities for survivors of trauma to rebuild a sense of control and empowerment (Mental Health Coordinating Council, 2017).

