Queensland Health
Office of the Chief Psychiatrist

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Mental Health Act 2016 Report

Review into the use of Seclusion, Mechanical Restraint and Physical Restraint under the Queensland *Mental Health Act 2016*

Queensland Government

The review team acknowledges Aboriginal and Torres Strait Islander peoples as the First peoples and Traditional Custodians of the lands and waters we meet, live and work.

We acknowledge the rich thriving diversity of Aboriginal and Torres Strait Islander cultures, the oldest continuing living cultures in the world, and pay respect to Elder's past, present and future.

We would also like to recognise the ongoing impacts of colonisation which have profoundly impacted Aboriginal and Torres Strait Islander peoples. We acknowledge the social, emotional, and physical consequences for Aboriginal and Torres Strait Islander people and that despite this Aboriginal and Torres Strait Islander people's communities continue to demonstrate resilience and strength.

The original artwork was produced for Queensland Health by Gilimbaa. Gilimbaa is an Indigenous creative agency.

Mental Health Act 2016 Report: Review into the use of Seclusion, Mechanical Restraint and Physical Restraint under the Queensland _Mental Health Act 2016_

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The external reviewers thank Ms Bobbie Clugston, Director, Legislation Unit, OCP for her assistance with the drafting of this report.

Executive Summary

For more than a decade, there have been collective efforts at the national, state and local level to reduce and eliminate seclusion and restraint. These efforts include nationally focused reporting and data collections, the introduction of new models of care and extensive research, position statements and media attention. These efforts are vitally important. However, it is equally important to recognise and acknowledge at a person-centred level the trauma that the use of seclusion and restraint has on individuals, their families, and staff working within mental health service settings. At times this focus can be lost amongst consideration of rates and data. The impact though, is never lost. These practices impinge fundamental human rights. This needs to be remembered each and every time that seclusion and restraint is being considered. It is the intention of the authors of this report that the person-centred impact remains in readers' minds throughout consideration of the literature, insights and recommendations contained within this report.

This report details insights, lessons and recommendations from a collaborative external review of the use of seclusion, mechanical restraint, and physical restraint in inpatient components of services which are representative of differing elements of the Queensland mental health system.
The purpose of the review was to identify how seclusion and restraint are used across the various components of the service system to identify themes, lessons and actions which can be embedded at system and service levels to support improvement in clinical practice and the reduction, and where possible the elimination of seclusion and restraint over time.

The delivery of mental health services that promote and support human rights, consumer choice and staff safety and wellbeing is fundamental to achieving optimal outcomes. The use of seclusion and restraint in mental health services can be an acute indication of broader systemic issues which, if addressed, may assist with eliminating these practices.

As highlighted above, the use of seclusion and restraint in the delivery of mental health services can be extremely traumatising for the individual, their family, and staff involved. There is also a risk of injury arising from these practices. This report does not contain details of specific events which have occurred and does not seek to address individual matters, instead it outlines the review findings from a whole of system approach to understanding the issues which surround the use of, or contribute to barriers to eliminating, seclusion and restraint. This approach has been taken in recognition that system level approaches and insights will impact person-centred outcomes and experiences.

... system level approaches and insights will impact person-centred outcomes and experiences

The following Authorised Mental Health Services (AMHSs) participated in the review:

1. Children's Health Queensland (CHQ) AMHS (adolescents and children).
2. Redcliffe-Caboolture AMHS (secure mental health rehabilitation)
3. Wide-Bay AMHS (adult acute)

The Office of the Chief Psychiatrist was also a participant in the review due to its system oversight role.

The High Security Inpatient Service (HSIS) also initially elected to participate in the review, however due to service demands at the time of the site visits, the HSIS was unable to proceed in the review. The reviewers would like to acknowledge the commitment that the leadership of this service has to engage with a review process at a more appropriate time.

The review was auspiced under the *Mental Health Act 2016* (MHA), with 12 reviewers appointed by the Chief Psychiatrist to provide independent input into the review. Reviewers were appointed for each site participating in the review. The Review Lead, Dr Nathan Gibson was appointed for all sites.

The reviewers are appreciative of the openness and willingness of all who engaged in the review, with particular gratitude going to those persons with lived experience of mental illness and seclusion and/or restraint.

Recommendations

The recommendations outlined below are predicated on the Queensland Health leadership, both within specialist mental health alcohol and other drugs services, and across other health settings, acknowledging and committing to working towards reducing and eliminating seclusion and restraint in all settings.

This commitment must meaningfully support and engage with initiatives, whether arising from this review or otherwise, that aim to reduce and eliminate seclusion and restraint. These initiatives must be applied across all health settings where individuals with mental illness may receive treatment and care.

Lived Experience

The active participation of persons with lived experience, their families and carers is fundamental to reducing and eliminating seclusion and restraint

1. The mental health alcohol and other drugs service system leadership, within services and the department, must lead a process of true co-design with persons with lived experience, their families and support persons in the implementation of activities arising from the review.

First Nations

First Nations expertise and input is essential to supporting culturally safe and capable services that use least restrictive practices

2. The mental health alcohol and other drugs service system leadership, within services and the department, must lead a process of true engagement and collaboration in the implementation of activities arising from the review, with First Nations people, including First Nations people with lived experience, their families and support persons, and the First Nations workforce.

Office of the Chief Psychiatrist (OCP)

The OCP has a pivotal role in bridging regulatory requirements with clinical practice to support services using alternatives to seclusion and restraint

3. The OCP will take a greater leadership role to support and assist services with their efforts to reduce and where possible eliminate seclusion and restraint. This should include:

    a. Developing a communication strategy to shine a spotlight on alternatives to seclusion and restraint and increase sharing of knowledge across the service system, and other areas of health and other health stakeholders e.g. consumers, peak bodies, advocates.

    b. Facilitating, including through funded support, dedicated Forums/Round tables to build on and share learnings regarding strategies to reduce and minimise seclusion and restraint across service settings e.g. learning health networks[1]. Where there are limited equivalent services within Queensland (for example children's or forensic services) there is value in this engagement being facilitated at the national or international level.

        Note: the advice of services regarding whether the existing clinical network, clusters or other collaborative forums can be used to achieve this recommendation should be sought prior to establishing any new processes to reduce duplication. The mechanism for shared learnings must be linked into appropriate governance structures within the department and Hospital and Health Services to ensure they are sustainable.

4. The OCP will enhance the interface among policy, the MHA and clinical practice by:

    a. Reviewing the regulatory framework to consider whether amendments are required to the framework to capture different population needs more appropriately, such as the needs of young people, high risk consumers and consumers on forensic order (disability).

    b. Undertaking a project to evaluate the use of seclusion and restraint forms within operational and clinical practice, to identify opportunities to reduce administrative reporting requirements that do not support the protection of patients' rights, reflect contemporary clinical practice or support efforts to reduce the use of seclusion and restraint. This project should be undertaken in collaboration with services and be supported by evidence

[1] The USA National Academy of Medicine describes a learning healthcare system (LHS) as one in which science, informatics, incentives, and culture are aligned for continuous improvement, innovation, and equity, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience. A rapidly progressing virtuous, iterative cycle where evidence (both internal data and external evidence) drives care through knowledge translation, and then learning from the care rapidly drives further knowledge and evidence, which can further influence healthcare delivery. This can result in services that provide improved quality, more efficient and safe care and are better places to work.

In a Learning Health Network, consumers, families, clinicians, researchers and health system leaders work together across multiple sites to solve particular health problems, using data to drive clinical care, improvement, and research.

"Learning networks align participants around a common goal; use standards, processes, policies and infrastructure to enable multi-actor collaboration; and … create and share resources to achieve goals. The networks also act as "learning labs" for ongoing improvement and research, both on individual conditions and the learning network model itself." (Building a Learning Healthcare System Network, 2020).

and data (see 18b). Possible alternatives to using administrative forms to collect regulatory information should be identified and implemented.

c. Developing and delivering enhanced training and resources for Administrator Delegates to help with data transparency, consistency and comparisons across and within services.

d. Undertaking a review of the Chief Psychiatrist policies for seclusion, mechanical restraint and physical restraint with a particular focus on the post-event, and ensure that where possible, the policies provide for a restorative just and learning culture approach[2] when responding to, reviewing and learning from seclusion and restraint events.

Leadership and culture

Leadership and a culture that supports learning and improvement is fundamental to reducing the use of seclusion and restraint

5. Service leaders (executive and clinical directors, and Administrators) should undertake projects to evaluate and implement local service improvement related to reduction of seclusion and restraint which is guided by shared learning from forums established in response to recommendation 3(b).
6. Queensland Health must ensure through policy that clinical leadership teams within mental health alcohol and other drug services are trained in and understand leadership in the context of trauma-informed care. The delivery of this could be achieved through embedding practical and sustainable, centrally developed leadership training packages across all services to ensure there is visible and compassionate leadership enabling complex and reflective decision-making in the area of seclusion and restraint within teams with safety.
7. At a service level, the principles of a restorative just and learning culture should be adopted and embedded into practice in relation to responding to, reviewing and learning from seclusion and restraint events to support local contexts and processes. Additionally, the OCP should use a co-design approach with Hospital and Health Services to consider how these principles are embedded within the regulatory frameworks and procedures that apply to incident reviews generally and identify opportunities to support local processes and facilitate statewide uptake.

[2] Restorative just and learning culture (RJLC merges a range of restorative approaches with an increasing understanding of learning and improvement in our complex systems. RJLC recognises that we work in complex adaptive systems and that we need new systems approaches to learning and improving following harm. It is both a proactive relational approach of setting the safety culture (building a sense of belonging, respect and trust, psychological safety, learning, systems improvement, resilient healthcare), and a response to harm in our complex systems (a deeply accountable process of engaging all stakeholders in a forward-looking process of identifying hurts and needs of all involved, healing relationships and people, effective systems approaches to learning, and improvement.)

The OCP should also consult with the Clinical Excellence Queensland Patient Safety and Quality Unit about opportunities to expand this work more broadly across the health service system.

Models of Care

There must be a focus within all models of care adopted by inpatient services to delivering alternatives to seclusion and restraint

8. There is a need to enhance implementation of Safewards or equivalent frameworks at a local and statewide level. This responsibility sits with mental health alcohol and other drug service leadership within the department and services and should include:
    a. Embedding Safewards or equivalent framework updates and learnings into standard agenda items for collaborative forums such as the clinical network, clinical clusters and other collaborative networks.
    b. At the service level, executive and clinical directors prioritising building clinician and service capacity through training, professional development and adequate resourcing in Safewards or equivalent principles and frameworks of engagement, early intervention, genuine interest, time, and de-escalation skills.
    c. At the service level, training for Safewards or equivalent approaches being embedded within orientation programs and onboarding processes for all new staff and student clinicians.
    d. At the service level, implementing refresher or career-long training and education for all clinicians working in inpatient settings in Safewards or equivalent frameworks. For statewide consistency, this may be achieved by the OCP commissioning the development of a training module which is available to services as part of mandatory annual (or biennial) training programs.
9. The OCP should develop an evaluation tool/ quality improvement cycle specific for Safewards or equivalent framework to improve ongoing implementation of the principles, focus on service improvement and avoid fatigue. The development of this tool should be done in collaboration with services and persons with lived experience.
10. The OCP should consider alternative and additional monitoring and support approaches for some higher complexity groups, such as classified patients and forensic order disability consumers to support a whole of system response when required. This may include:
    a. Strengthening clinical escalation pathways to the Chief Psychiatrist for consumers who are secluded directly on admission to a unit and who remain in seclusion for an extended period (e.g. beyond an initial Seclusion

and Restraint Reduction Elimination Plan (SRREP), or another nominated time period).

b. Reviewing the regulatory framework to enhance the priority of the SRREP process, or equivalent, for monitoring and reviewing the complex cohort of consumers who are subject to extended periods of seclusion. This review should support a move away from administrative processes which may result in a tick-box culture to providing and implementing genuine support and strategies for clinical staff to implement strategies that minimise and reduce the use of seclusion and restraint.

Workforce

A skilled and engaged workforce, working to their top of scope, is required to support whole of system approaches to reducing and eliminating seclusion and restraint

11. Workforce strategies, at the state and local level, must specifically consider the beneficial role that the lived experience workforce and First Nations workforce can have in relation to de-escalation approaches and incident reviews relating to seclusion and restraint use.
12. Workforce strategies, at the state and local level, must incorporate the importance of leadership and skills development and training. Mechanisms to do this may include quarantined time to access training, succession planning strategies and support for peer networks or learning opportunities. Within this, there may also be opportunities to share skills and experiences across different settings and services (refer 3(b)).
13. Training needs identified by the review, which would be beneficial to be consistently implemented across all services, are:
    (i) Trauma informed care.
    (ii) Risk assessment and management.
    (iii) Safewards approaches, or equivalent, particularly early intervention and de-escalation (see 8).
14. Workforce strategies, at the state and local level, must include strategies for multidisciplinary team members to work to their top of scope and for allied health staff in particular to be supported to deliver therapeutic interventions that aim to reduce seclusion and restraint.
15. Recognising seclusion and restraint occurs outside of mental health alcohol and other drugs services, increased partnerships between authorised mental health services (AMHSs) and other areas of the Hospital and Health Service are encouraged. The mechanisms to do this could include shared training and the establishment of collaborative review and/or debriefing processes to assist with

continuous service-wide learning and improvement. Additionally, Hospital and Health Services may consider establishing 'champions' within mental health services and other hospital settings such as Emergency Departments, to ensure these partnerships are facilitated.

Environment

Environmental enhancements ranging from minor practical changes to purpose-built designs can be made to support alternatives to seclusion and restraint

16. The OCP must coordinate a statewide review of all seclusion and dedicated sensory modulation areas in AMHSs to obtain a baseline of the environmental state of the inpatient units. The baseline should be used as an opportunity to identify, within existing environmental structures, opportunities to enhance or improve structural elements including furniture and design elements, that may be contributing to increased rates of seclusion and restraint.
17. For new builds, and where modifications are occurring to existing environments, the mental health alcohol and other drugs services leadership, within the department and in services, must use co-design processes from the beginning of the capital and procurement process to ensure the consumer voice and seclusion and restraint minimisation is at the forefront of the design. To support this process, the Mental Health Alcohol and Other Drugs System Planning Branch and the OCP must prioritise a statewide policy or guideline which supports co-design and focuses on alternatives to seclusion and restraint at the conception phase of a new environmental build.

Information

Information, including data, must be used as an enabler to deliver transparency and promote responsibility and accountability

18. To support transparency and promote responsibility and accountability, services must:
    a. Publish data at the AMHS level, so that it is readily and publicly accessible and available, to increase visibility to all stakeholders (staff, consumers and their families) on a regular basis (e.g. every 3-6 monthly) in a standard format e.g. rates per 1000 bed days displayed in each inpatient setting to promote transparency. To support this process, the OCP and the Mental Health Alcohol and Other Drugs Branch should lead a consultation process with services, consumers, and other relevant stakeholders to establish

appropriate data parameters for reporting which should also include an ability to report on alternative strategies which are being used to reduce the use of seclusion and restraint.

b. Transparently demonstrate and interrogate data relating to complexities with consumers who are being secluded or restrained enabling those to be rapidly identified, analysed and addressed. This should occur with a co-design approach and may include mapping data trends and changes over time and developing outcomes which can be measured throughout the patient journey. The work of the SMHRU in examining patient pathways may be beneficial in this regard.

> "There are no excuses.
> We all need to do the work"
>
> Lived Experience Workforce Leader

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Glossary

AAMHIU	Adult Acute Mental Health Inpatient Unit
ACT	Acute Care Team
AMHS	Authorised Mental Health Service
CP	Chief Psychiatrist
CHQ	Children's Health Queensland Hospital and Health Service
CYMHS	Child and Youth Mental Health Service
CFOS	Community Forensic Outreach Service
CIMHA	Consumer Integrated Mental Health and Addiction Application
FDS	Forensic Disability Service
FO	Forensic Order
FO(D)	Forensic Order (Disability)
HHS	Hospital and Health Service
HSIS	High Security Inpatient Service
IPRA	Independent Patient Rights Adviser
MHA	*Mental Health Act 2016* (Qld)
MHAOD	Mental Health Alcohol and Other Drugs
MHICU	Mental Health Intensive Care Unit
MHC	Mental Health Court
OCP	Office of the Chief Psychiatrist
QH	Queensland Health
QPS	Queensland Police Service
PICU	Psychiatric Intensive Care Unit
SMHRU	Secure Mental Health Rehabilitation
SRREP	Seclusion and Restraint Reduction and Elimination Plan
VRAM	Violence Risk Assessment and Management

Mental Health Act 2016

Section 244 Mechanical Restraint:
1. Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.
2.However, mechanical restraint does not include—
(a) the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury; or
(b) restraint of a person that is authorised or permitted under a law other than this part.

Section 254 Seclusion:
1. Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.
2. However, seclusion does not include—
(a) confinement of a person in a high security unit, or in another AMHS approved by the chief psychiatrist for the purposes of this part, if the confinement is—
(i) for a period, approved by the administrator of the service, of not more than 10 hours between 8p.m. and 8a.m.; and
(ii) for security purposes;
(b) confinement that is authorised under a law other than this part.

Section 268 Physical Restraint:
1. Physical restraint, of a patient, is the use by a person of his or her body to restrict the patient's movement.
2. However, physical restraint of a patient does not include—
(a) the giving of physical support or assistance reasonably necessary—
(i) to enable the patient to carry out daily living activities; or
(ii) to redirect the patient because the patient is disoriented; or
(b) physical restraint of the patient that is authorised under a law other than this part; or
(c) physical restraint of the patient that is required in urgent circumstances.

Introduction

Background

The *Mental Health Act 2016* (MHA) requires treatment and care to be provided in a way that is least restrictive of an individual's rights and liberties. Least restrictive practices also continue to be a national focus as a critical strategy in trauma-informed care.

Since the commencement of the MHA in March 2017, there has been an increase in the use of seclusion and restraint across the service system, and in particular in relation to patients with complex and/or higher risk presentations.

Within Queensland, the rates of seclusion and restraint are subject to ongoing monitoring and review. In the 2021-22 financial year, 70% of all seclusion events related to a small cohort of patients with complex or higher risk presentations. This cohort represented just 3% of the total number of unique patients secluded during the period. Mechanical restraint use is also similarly higher for a very small cohort of patients with complex presentations.

Working towards eliminating restrictive interventions remains a priority of Queensland mental health services. Identifying common themes, strategies and lessons from the authorised mental health services (AMHSs) participating in this provides an opportunity to maximise the value and effectiveness of these strategies across the broader service system.

Scope

There are a range of restrictive interventions which consumers of mental health alcohol and other drugs services may experience while receiving treatment and care in inpatient and community settings. The terms of reference for this review however were limited to a focus on seclusion, mechanical restraint and physical restraint as defined under the MHA.

One of the mechanisms for authorising and monitoring seclusion and mechanical restraint under the MHA is via a Seclusion and Restraint Reduction and Elimination Plan (SRREP). These plans provide for the use of seclusion or mechanical restraint on a relevant patient and must include information about strategies proposed to reduce and eliminate future seclusion and restraint use.

The Chief Psychiatrist has established policies which outline additional guidance and requirements for the use of seclusion, mechanical restraint and physical restraint in AMHSs. These policies are applicable to all AMHS staff, or other persons, who are using the provisions of the MHA when providing treatment and care.

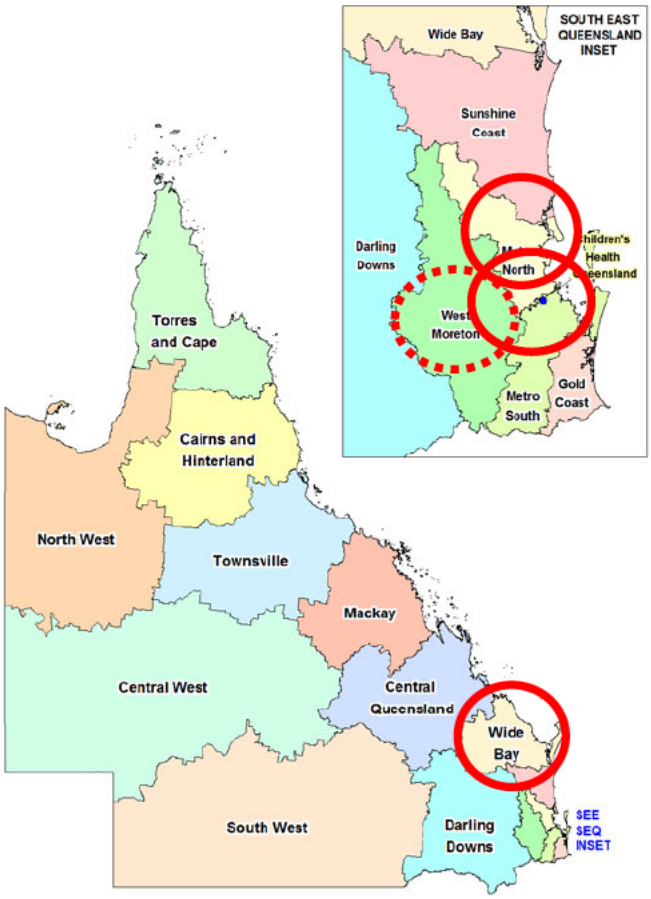
Principles

In addition to the least restrictive framework set by the MHA, overarching principles and guiding ethical and human rights frameworks at the state, national and international level are relevant to the issue of seclusion and restraint use in Queensland AMHSs:

- ***Human Rights Act 2019 (Qld)*** which aims to protect and promote human rights, and is applicable to all Queensland public sector services, including AMHSs. Of particular relevance are the human rights established to provide that every person has a right to access health services without discrimination and to protect individuals from treatment in a cruel, inhuman or degrading way.
- ***RANZCP Position Statement - Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness (2021)*** which makes recommendations for implementation by governments and mental health services aimed at minimising, and where possible, eliminating seclusion and restraint practices. Of note is the Statement's view that alternatives to seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.
- ***United Nations principles for the protection of people with mental illness and for improvement of mental health care (1991)*** which sets out, amongst other things, that:
  - people have a right to be treated in the least restrictive environment and with the least restrictive treatment appropriate to the patient's health needs and the need to protect the physical safety of others
  - seclusion or restraint must be used only in accordance with approved procedures and only when it is the only means available to prevent immediate or imminent harm to the patient or others, for the minimum time necessary
  - clinical record-keeping and notifications requirements which support transparency, and
  - observation requirements and environmental conditions for seclusion and restraint use.
- ***United Nations convention on the rights of persons with disabilities (2007)*** which aims to promote, protect and ensure fundamental human rights for persons with disabilities. Relevant articles outlined in the convention include:
  - the right to liberty and security of person
  - freedom from torture, or cruel, inhuman or degrading treatment or punishment
  - a requirement for effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.
- ***World Psychiatric Association Position Statement Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care (2020)*** which sets a direction and practical starting point for action to implement alternatives to coercive practices, including seclusion and restraint, as a core component of delivering treatment and care that upholds the human rights of people with psychosocial disabilities.

Participating services

Adult acute



The Bundaberg Adult Acute Mental Health Inpatient Unit (AAMHIU) provides short to medium term and intermittent inpatient mental health care to low, moderate and high risk/complex voluntary and involuntary adult mental health consumers. It is part of the Wide Bay AMHS and it is a regional unit.

Adolescent consumers older than 14 years of age and consumers aged over 65 years, may access this service where clinically and developmentally appropriate. Admission occurs based on issues of clinical risk and safety and the level of distress which is being experienced by the consumer, or degree of complexity of the clinical presentation.

The AAMHIU has two high dependency beds and 10 low dependency beds with capacity for two "swing" beds to be used as either lower or higher dependency care beds. The unit also contains a multi-sensory room. There is a seclusion room within the unit, located in the high dependency area.

The high dependency environment within the AAMHIU is a designated, lockable area[3] designed to facilitate the care of consumers who cannot be safely managed in a less contained environment and require more intensive mental health care.

[3] Queensland Health uses the term Mental Health Intensive Care Units (MHICUs) for high dependency areas. MHICUs are designated, lockable areas designed to facilitate the care of consumers who cannot be safely managed in a less contained environment and require more intensive mental health care. The MHICU guideline is available here: https://www.health.qld.gov.au/system-governance/policies-standards/guidelines/mental-health-icu .

Adolescents and children

The Children's Health Queensland (CHQ) Child and Youth Mental Health Service (CYMHS) specialises in helping infants, children and young people up to the age of 18 years who have complex mental health needs.

The Child Mental Health Inpatient Unit provides specialist mental health assessment and treatment to young people aged from birth to 13 years old who are experiencing severe and/or complex mental health difficulties. There are facilities available for parents to stay with younger children during their admission. The unit also has one family accommodation suite for planned family-based admissions. Referrals and admissions are accepted from across Queensland.

The Adolescent Mental Health Inpatient Unit provides specialist mental health assessment and treatment to young people aged between 14 and 18 years who are experiencing severe and/or complex mental health difficulties. The Brisbane South Metropolitan area is the primary catchment area, however young people from other areas may be accepted on a case-by-case basis.

Jacaranda Place is an extended treatment centre for young people who have severe and complex mental health issues. It includes the Jacaranda Place Adolescent Unit, a 12-bed statewide sub-acute inpatient service, and the 10-place Jacaranda Place Day Program delivered in partnership with the Department of Education to provide an integrated educational and mental health treatment service

Each unit is part of a designated AMHS which enables seclusion and restraint to be authorised. However Jacaranda Place decommissioned its seclusion room and therefore seclusion does not take place in this unit.

Secure mental health rehabilitation

Secure Mental Health Rehabilitation Units (SMHRUs) provide a safe and structured environment and 24-hour clinical support for people requiring medium to long term recovery oriented inpatient treatment and rehabilitation due to unremitting and severe symptoms of mental illness.

The Redcliffe-Caboolture SMHRU is part of the Redcliffe-Caboolture AMHS and provides extended-care mental health inpatient services 24 hours a day, seven days a week, a specialised secure environment, and contemporary, high quality and multidisciplinary rehabilitation services to assist consumers to recover from mental illness and to gain skills needed to live in a less restrictive setting. The seclusion room for the SMHRU is located in the AAMHIU.

Consumers admitted to the SMHRU are adults (18+) with schizophrenia or related psychosis and mood disorders. Additionally, consumers admitted to the SMHRU often also have complex presentations related to personality disorders, substance use disorders, complex trauma and clinically significant deficits in psychosocial functioning. Bed allocation spans Sunshine Coast to Brisbane.

Office of the Chief Psychiatrist

The OCP incorporates the statutory position of the Chief Psychiatrist and three units – Legislation Unit, Clinical Governance Unit and the Legislative Projects Unit. The Chief Psychiatrist also holds the position of Chief Mental Health Alcohol and Other Drugs (MHAOD) Officer. The OCP supports the statutory responsibilities of the Chief Psychiatrist for the purpose of the administration of the MHA and strives to improve outcomes and promote recovery for, and rights of, consumers with substance use disorders and/or other mental disorders. It provides specialist consultation and support, advice and direction to services providing clinical care, with a particular focus on services within Queensland Health's (QH's) MHAOD services.

The Chief Psychiatrist has specific functions under the MHA in relation to seclusion and restraint, including approval of all instances of mechanical restraint use and devices, and approval of seclusion and restraint reduction and elimination plans. The Chief Psychiatrist also establishes statutory policies in relation to, amongst other things, seclusion and restraint.

The statutory functions of the Chief Psychiatrist are supported by compliance monitoring and related policy and system development managed by the OCP, including in relation to seclusion and restraint. Clinical governance activities are led by the OCP at a statewide level to promote high quality and safe MHAOD services, consistent with clinical standards.

High Security

The High Security Inpatient Service (HSIS) is located within the West Moreton Hospital and Health Service (HHS) and is a declared high security mental health unit under the MHA. The HSIS is a statewide forensic inpatient service that provides for the assessment, treatment and rehabilitation of consumers requiring involuntary treatment under the MHA. The HSIS has 70 beds and five units.

The majority of consumers admitted to HSIS are classified patients[4] or patients subject to a forensic order[5]. Minors (aged less than 18 years) can only be admitted to the HSIS with the approval of the Chief Psychiatrist. Consumers admitted to the HSIS have generally either been diagnosed with or are suspected to have a serious mental illness.

The circumstances of consumers referred to the service are complicated by diagnostic, legal and risk factors. Furthermore, co-occurring substance use, psychosocial stressors,

[4] A classified patient is a person who has been transferred from a place of custody (e.g. prison or watch house) to an inpatient AMHS for assessment or treatment of mental illness

[5] Forensic orders are (primarily) made by the Mental Health Court following a finding of unsoundness of mind or unfitness for trial, where the Court considers that, due to a person's mental condition or intellectual disability, the order is necessary having regard to risk to the community,

geographical and social isolation are overrepresented among the consumer group. Accordingly, the HSIS is highly specialised in assessing, treating and monitoring these factors.

The HSIS was ultimately unable to participate in the review, however the leadership met with the Lead Reviewer and expressed a firm desire to contribute to the culture of reducing and eliminating seclusion and restraint, including through sharing their expertise and insights at a future time regarding the management of the complex consumer group which are admitted to the HSIS.

Review Structure

A copy of the overarching terms of reference is provided at appendix 1. Each stream reviewer had their terms of reference modified to limit relevant aspects to the specific service component that they were engaged for.

The review was undertaken through a collaborative and voluntary process, with AMHSs, staff and persons with lived experience participation occurring through an Expression of Interest (EOI) and invitation process.

The basis for expressing an interest to participate in the review was reasonably consistent across each site, with the primary reason being to eliminate seclusion and restraint and to share knowledge across the service system. Each of the AMHSs that participated had also recently (within 2-3 years) implemented changes at the local level to respond to seclusion and restraint use and/or implemented new models of care which were relevant to the review focus.

For the OCP, there was an impetus to review seclusion and restraint use and strategies to minimise these, due to challenges being identified statewide relating to restrictive practices (particularly for acute presentations with higher risk of aggressive behaviour in patients with co-morbidities, including at HSIS), inpatient acute behavioural management issues, and occupational violence prevention. In the context of the implementation of *Better Care Together,* the new five-year plan for state-funded mental health alcohol and other drug services, the OCP advised it was timely to refocus efforts in a collaborative way on strategies to reduce seclusion and restraint.

Approach to the review

The methodology for the review was intended to promote opportunities to focus on learning and improvement and allow for consideration of complex system issues which contribute to the use of seclusion and restraint. For this reason, rather than using a formal investigative approach, the approach taken was a more flexible, collaborative and voluntary approach to better enable forward-looking, multi-level factors which may contribute to the use of seclusion and restraint being considered. The complex system factors contributing to these practices, and the consequent impact that they may have on individuals, is at the forefront of the review focus. Additionally, this approach allowed

positive factors that are contributing to the minimisation of these practices to be identified and recommendations made.

The approach to the review aimed to share and involve participants in the review design as much as possible, and while a true co-design approach did not occur, all aspects of the terms of reference were consulted on and jointly endorsed by the lead AMHS contact and the OCP, as well as the Chief Executives of each participating HHS. The engagement process in establishing and setting up the logistical requirements of the review resulted in significant sharing of approaches and resources, and each AMHS and the OCP had responsibility to share relevant information, establish interview schedules and support staff and participation by people with a lived experience in a manner in which the service felt best contributed to the review.

Although the review was established under the MHA, it adopted restorative just and learning culture principles as much as possible to encourage participants in the review to share their perspectives and concerns in an open, voluntary and transparent way, to lessen the fear of reprisal which can arise from investigative approaches. It is noted the development of terminology and principles around Restorative Just Culture (Dekker, Oates, & Rafferty, 2022) are an increasing focus in healthcare. The term learning culture is also increasingly used in reference to organisations where learning and improvement are actively prioritised. Language has been iterative in this space, and there is some variability in local use of terminology in Queensland. Internationally, there has been a combining of these terms in some locations (e.g. Merseycare, NHS, UK). This review will use "Restorative Just and Learning Culture" to capture the principles of restorative just culture and the associated need for an active organisational learning culture, unless specified separately.

The focus of the review was on learning and improving, and identification of opportunities for how the service system could improve to reduce contributors to the use of seclusion and restraint. While the appointed reviewers were vested with powers under the MHA to, for example, require documentation or interviews to occur, the process for engagement relied solely on voluntary participation and collaboration by those involved.

Implications of the adopted methodology

The methodology for the review was deliberately adopted to be collaborative, in contrast to approaches for external enquiries which have historically been adopted which can be predicated on discovering flaws and faults in the current system, those allegedly responsible for the failings, with recommendations to follow, the yields of which remain debatable. Such investigation processes run the risk of contributing to distrust and resistance to recommended change.

What is a Restorative Just and Learning Culture?

Restorative Just and Learning Culture (RJLC) is a concept that has emerged from the application of restorative practices in fields such as criminology, sociology, education, child maltreatment and most recently healthcare.

A Restorative Justice approach emphasises the central role of interconnectedness through a web of relationships and respect which supports balancing concern for all parties (Zehr, 2015) when responding to conflict and harm.

A restorative organisation *"develops policies and practices that recognize the needs of its staff or clients as whole persons, exhibits a distributed style of leadership and inclusive decision-making, and develops a culture of belonging and respect throughout the organization"* (Marshall, 2018).

RJLC merges restorative approaches with an increasing understanding of learning and improvement in our complex systems. RJLC recognises that we work in complex adaptive systems and that we need new systems approaches to learning and improving following harm. It is both a proactive relational approach of setting the safety culture (building a sense of belonging, respect and trust, psychological safety, learning, systems improvement, resilient healthcare), and a response to harm in our complex systems (a deeply accountable process of engaging all stakeholders in a forward-looking process of identifying hurts and needs of all involved, healing relationships and people, effective systems approaches to learning, and improvement.)

This means:

- Identifying who has been hurt, including the consumer, family, carers as well as clinicians, the organisation and the community.
- Identifying the needs of those who have been hurt and how harms and relationships can be repaired. This can include support, healing and learning.
- Identifying whose obligation it is to meet the needs of those who have been hurt.
- Identifying how we can prevent it from happening again.

Building a RJLC is a relational process and requires conversations, reflection and co-design with all stakeholders.

The chosen approach was one of collaborative enquiry, seeking to learn together, that which had resulted in improvement, and how best to ensure improvements in the future in reducing the use of seclusion and restraint of individuals within the mental health care system. The approach thus mirrors the openness and inclusiveness suggested by contemporary management literature, aiming despite the obvious challenges, to create an atmosphere of psychological safety in which the above goals can be achieved, without the fear of being humiliated for flaws and faults or from fear of being blamed, yet seeking ways to improve and rectify such issues in the broader system and the very specific

context in which they arise (Khatri, Halbesleben, Petroski, & Meyer, 2007; Nembhard & Edmondson, 2006; Khatri, Brown, & Hicks, 2009). The approach thus embraces a system level focus, with an awareness of the role of individuals within the system, shifting the nexus of power and accountability from boardrooms to the wards and clinics, the real world context in which health care is provided, capitalising on the knowledge and intellect of those receiving and delivering care (Khatri, Halbesleben, Petroski, & Meyer, 2007).

Overarching structure

EOI circulated to AMHSs

↓

Independent Lead and Stream teams appointed

↓

AMHSs participation confirmed

Correspondence to Chief Executives HHS

↓

Collaborative desk-top review material collated (OCP and AMHSs)

(Background material, literature review, environmental scans, audits)

↓

'Face to Face' engagement

Site visits, stakeholder meetings, interviews

↓

Service specific insights documented

↓

OCP and AMHS feedback provided on service specific insights

↓

Report drafted

Review Lead

Dr Nathan Gibson, Chief Psychiatrist, Western Australia was engaged to oversight the review.

Dedicated stream leads

To support the review process, professional leads external to each site were appointed. These leads participated in site visits and engaged with staff to gather service specific insights for the review. Dr Ed Heffernan was initially appointed as a reviewer for the HSIS; however this was revoked when that service withdrew from the process and his appointment was amended to that of advisor to support forensic mental health expertise and advice into the initial stages of the review.

Stream reviewers

In addition to the stream leads, HHS staff working in the MHAOD service system were appointed to provide relevant expertise into each site review.

AMHS/OCP lead contact

Each site also nominated one or more contact persons for the review who were responsible for supporting the Service or OCP engagement with the review.

Table 1 - Reviewers and contacts

Appointed across all AMHSs and for the OCP			
Dr Nathan Gibson, Chief Psychiatrist of Western Australia (Review Lead)			
Appointed as an advisor			
Dr Ed Heffernan, Director, Queensland Forensic Mental Health Service			
Adult Acute External	**Child and Youth External**	**SMHRU External**	**OCP External**
Dr Isabel Wesdorp Susan Hills-Johnes (nursing) Katrina Hanson (Indigenous Health Worker)	Dr Prue McEvoy Paul Roberts (nursing)	Dr Furhan Iqbal Ashleigh Bayly (nursing)	Dr Elizabeth Rushbrook Dr Terry Stedman Warren Storey (MHA administrator)
Adult Acute AMHS	**Child and Youth AMHS**	**SMHRU AMHS**	**OCP**
Clarissa Schmierer, Program Manager Katie Rogers, Nurse Unit Manager	Dr Stephen Stathis, Administrator	Dr Kathryn Turner, Executive Director, MNMH Liam Wishart, Operations Director Redcliffe Caboolture AMHS	Rebekah Stewart, Manager CIT

Review Support

The OCP provided administrative and logistical support to the review and in doing so worked closely with the AMHS lead contacts.

Staff from the OCP attended each site visit with appointed reviewers to assist with recording and documenting insights gained during the visits. However, importantly, the appointed reviewers formed independent views and findings / recommendations as part of the review and OCP staff did not determine any view, finding or recommendation for or on behalf of the Inspectors.

The Director, Legislation Unit, OCP reported directly to the Review Lead to support the operation of the review. Where draft documentation was prepared by OCP staff for the review, these were all overseen and reviewed by the Review and Stream Leads, who had responsibility for the final drafting and content of the review report.

Avenues of inquiry

The review included the following activities:

- site visits to the units and the OCP (refer Table 2)
- stakeholder consultations (see appendix 2)
- review of written submissions to the review
- review of legislative, policy and program documents
- data analysis and review
- jurisdictional scan
- literature scan
- meetings with First Nations Workforce Leadership and Lived Experience Workforce Leadership to discuss themes and recommendation areas of focus prior to finalising the report.

Table 2 - Site visit schedule

Adult Acute	Child and Youth	SMHRU	OCP
Stream leads Site visit			
26 October	31 October	4 November	1 November
External lead visit			
9 November	8 November	10 November	7 and 11 November

Process challenges

Despite the collaborative approach to the review, it was evident through the site visits that the process of participating in a review involving external reviewers remained a source of concern for staff who engaged in the review.

Notably, the HSIS, which was initially included in the review determined just prior to the site visits that due to service demands they were unable to participate in the review. Although these demands arose from activities unrelated to the review, the establishment of the review and associated processes could have benefited from clearer and earlier communication about roles and expectations, particularly regarding discrete responsibilities across the OCP and the AMHS, and the role of the lead and stream reviewers. Given the commitment that the HSIS leadership had demonstrated by electing to participate in the review, improved communication may have enabled the HSIS to

manage the competing demands at the time in a way which could have supported participation in the review.

There were also operational and logistical challenges with coordinating a review of this nature which limited the time that could be spent at each site. This may have inhibited the ability for stakeholders to provide fulsome advice to the reviewers. There may also have been some duplication with having two separate site visits occur as part of the review. It was however also noted that staff who had the opportunity to engage with the two site visits had time to reflect on the earlier visit and were able to provide further insights or additional clarity to the earlier information which was of benefit.

Finally, as noted above in terms of the review structure, the OCP provided administrative and logistical support to the review. The Reviewers acknowledge the inherent conflict in this approach, however, also note that the OCP maintains a significant role in supporting service development, and quality and safety improvement initiatives. The role of OCP staff in supporting the review directly aligns with these functions and supports their understanding of service-level approaches. The Reviewers maintained their independence in formulating recommendations and identifying lessons from the review, and it is considered that overall, the collaborative review approach meant that potential conflicts arising from the logistical support role of the OCP were able to be appropriately managed.

The lessons identified from the above process challenges will continue to assist the service system to collectively consider how best to approach this type of review going forward.

Literature

The literature scan below represents a synthesis of key research and evidence regarding the themes of leadership, learning culture and alternatives to seclusion and restraint. It is not intended to be an exhaustive review of the available literature, rather it is a representative summary of the current available evidence relevant to the review.

Leadership

Within the literature, leaders have consistently been found to contribute to the promotion of quality care and positive safety cultures, yet the role of leadership has also been linked to negative impacts on patient safety where elements of poor leadership or frequent turnover rates are evident (Brittian & Carrington, 2021). Specifically for seclusion and restraint, leadership, and articulation of a clear mission and roles and responsibilities, has been highlighted as critical to reducing the use of these practices (Huckshorn, 2004).

Literature on the effects of different leadership styles suggests that ineffective leadership is not simply the absence of certain behaviours (Einarsen, Aasland, & Skogstad, 2007). Destructive leadership, defined as behaviours that undermine or sabotage an organisation's goals, has been linked to counterproductive work behaviour, resistance towards change, negative attitudes towards the leader along with poor staff well-being and individual performance (Schyns & Schilling, 2012). As such, it is important to understand the components of effective leadership that can enable and support sustained change.

Recently, Restivo et al (2022) reviewed the evidence supporting effective leadership in healthcare settings. They found that transformational leadership styles could improve team performance but note that much of the available evidence to date has only considered the impact of different leadership styles on specific outcomes, such as checklist adherence.

These findings align to recent theory on microsystem culture change, which suggests that transformational leadership can influence successful implementation of evidence into practice within frontline teams, by enabling and supporting effective workplace culture change (Manley, Jackson, & McKenzie, 2019). The evidence suggests that transformational leadership is comprised of inspirational motivation, idealized influence, individual consideration, intellectual stimulation and centres on the engagement between the leaders and their employees (Kark & Shamir, 2003; Ring & Moody Fairchild, 2013).

With respect to the broader implementation of evidence-based practices, Li, Jess, Barwick & Stevens (2018) further demonstrated that transformational leadership may help cultivate a culture of learning and could support sustained change by ensuring clear roles and effective teamwork structures. During these implementation efforts, specific elements of effective leadership included expressing enthusiasm for change; being present, supportive and attentive to implementation processes; and demonstrating

willingness to ask for feedback from staff regarding the change (Li, Jeffs, Barwick, & Stevens, 2018).

More broadly and within the context of patient safety, it has been proposed that to improve system functionality, key functions of successful leadership should include visibility, flexibility, and effective communication built on trust (Ring & Moody Fairchild, 2013). Senior leaders have been found to play a crucial role in embedding new processes into "business as usual" practices and achieving staff buy in and engagement (Li, Jeffs, Barwick, & Stevens, 2018). Similarly, nurse managers have been found to play a fundamental role in supporting the implementation of evidence-based practice and creating environments that are conductive to change (Bianchi, et al., 2018).

The presence of psychological safety has also been found to be vital for the provision of safe care by health care teams, due to the highly complex and interdependent nature of their work (O'Donovan & McAuliffe, 2020). Psychological safety is defined as a climate in which people are not constrained by the possibility of others' disapproval and feel free to speak up and be themselves (Edmondson, 2019). Despite the importance of psychological safety in these settings, O'Donovan and McAuliffe (2020) suggest it is often a crucial missing element. Their recent review examining factors that cultivate psychological safety in healthcare teams found that staff need to see leadership that acts with behavioural integrity for safety, is change-orientated, supports staff to prioritise patient safety, and are visible and present on a regular basis (O'Donovan & McAuliffe, 2020). While factors such as professional status can influence a person's psychological safety in the workplace, the literature also identifies critical leadership behaviours, for example inclusiveness, that can overcome these effects (Nembhard & Edmondson, 2006) and help to promote and support psychological safety.

However, while leadership is often found to have a powerful influence on shaping healthcare cultures, the available literature has historically focused on individuals as leaders. This is inherently limited as it does not consider the role of individuals within the system (De Brun, et al., 2020). Given that health care is predominantly delivered by multidisciplinary teams, it may be difficult for an individual to effect the change necessary within a large and complex health system. Consequently, recent systemic reviews have investigated the importance and effectiveness of team-based collective leadership (Wu, Cormican, & Chen, 2022; Silva, et al., 2022).

The literature suggests that collective leadership can foster positive team outcomes such as attitudinal outcomes, team cognition, staff wellbeing and team performance (Silva, et al., 2022). Collective leadership is one that recognises that leadership is not necessarily the sole responsibility of one individual (De Brun, et al., 2020). Rather, collective leadership involves multiple professionals sharing viewpoints and knowledge (Silva, et al., 2022). De Brun and colleagues suggest that this form of leadership may be particularly vital in settings with high-risk and complex presentations where multidisciplinary teams are required to optimise quality and safety and improve patient outcomes.

Nembhard and Edmondson (2006) have also considered elements of effective leadership that can support and enable multidisciplinary teams to collaborate. They found that leaders that practice inclusiveness, through expressing words or actions that invite and

appreciate others' contributions, enable teams to collaborate in process improvement activities. Further, they found that leader inclusiveness increased psychological safety, which in turn led to better team engagement in quality improvement work.

Learning culture

A review of the literature examining safe and effective workplaces suggests that those that prioritise learning to support continuous quality improvement experience better outcomes for patients and staff (McKellar, et al., 2020; Manley, Jackson, & McKenzie, 2019; Ring & Moody Fairchild, 2013; Linnander, et al., 2021). In particular, the adoption of a learning culture has been found to be highly associated with the successful implementation of evidence-based practices within healthcare settings, while the absence of a learning culture has been found to be a major barrier (Li, Jeffs, Barwick, & Stevens, 2018).

Gawne, Fish and Machin (2020) identified that a learning culture should be integral to health care delivery, not separate from it, suggesting that education for clinical staff should be continuous and integrated into their working day. To support this, they found that clinical staff need a shared vision of education within their organisation and for their leadership to consider education as a priority.

Despite the need for collaborative learning within the context of multidisciplinary teams, the literature has identified barriers to team-based quality improvement efforts, including the attitudes and values of management and staff. For example, Nembhard and Edmondson (2006) highlighted key barriers to collaborative learning including risk aversion, which can inhibit willingness to engage in the uncertainty of experimentation; practical limitations with respect to sharing comprehensive information; and the status and hierarchy embedded within health care teams, which can make it difficult for staff to speak across professional boundaries.

While a number of barriers to the development of a learning culture have been identified, the existing literature also identifies potential enablers. This includes the creation of a supportive environment, in which staff feel free to share without fear of retribution (Gawne, Fish, & Machin, 2020), is supportive of collaboration, relationship building, and positive role-modelling (Walker, Cooke, Henderson, & Creedy, 2011) and has an emphasis on developing psychological safety within the workplace (McKellar, et al., 2020).

Psychological safety was a predominant theme in the literature and has been found to be associated with improved team learning (O'Donovan & McAuliffe, 2020). Psychological safety encourages staff to ask questions, experiment and share ideas and is thought to be particularly important in the context of health care settings as staff must work interdependently and within a complex environment (O'Donovan & McAuliffe, 2020). A recent review examining factors that cultivate psychological safety in healthcare teams found that an organisation's learning orientation can have a positive impact on this feature (O'Donovan & McAuliffe, 2020). Specifically, staff within environments that valued continued quality improvement and innovative thinking reported greater psychological safety.

Psychological safety is also a cornerstone of a just safety culture (Dekker, Oates, & Rafferty, 2022; Khatri, Brown, & Hicks, 2009). In a just culture, all staff feel they can question existing practices, express concerns of dissent and report mistakes without fear of reprisal. Building a culture of trust and organisational learning has been found to be vital to improving patient safety (Ring & Moody Fairchild, 2013; Brittian & Carrington, 2021). Further, McKellar and colleagues (2020) found that embedding practices of continual learning, encouraging personal growth for all and promoting psychological safety and self-awareness can support sustained culture change which has positive implications for patient experience, staff well-being and service outcomes.

The literature has also identified that specific learning initiatives that adopt collaborative approaches to learning are most acceptable to staff and most effective in practice (Campbell, Wozniak, Philip, & Damarell, 2019). Within health care organisations, while Nevalainen, Lunkka & Suhonen (2018) found that the culture of a workplace also shapes the attitudes of nurses towards work-based learning, the ability to transform staff from passive recipients of information into active knowledge seekers requires a culture change throughout the entire organisation.

As health care organisations have such complex cultures this form of cultural change takes time, effort and patience, however, leadership across all levels of the organisation acts as an enabler and supporter of positive learning cultures (Campbell, Wozniak, Philip, & Damarell, 2019). Safety II and resilient health care approaches also recognise that due to the complexity of health systems (Anderson & Watt, 2020) learning and improvement require an understanding of the many interactions of the system, why work is done the way that it is done and why things go well most of the time.

Unfortunately, reviewing adverse events remains predominantly a feedback and learning mechanism within the context of health systems and this has the potential to compound harm (Wailing, Kooijman, & O'Hara, 2022). This focus on failure may be problematic as it attempts to simplify the reality of health care delivery and can perpetuate a blame culture (Braithwaite, Wears, & Hollnagel, 2015). In effective learning cultures, blame must be eliminated and care taken to better understand the complexity of the systems in which we work, including considering how shared accountability may be identified as appropriate (Anderson & Watt, 2020; Braithwaite, Wears, & Hollnagel, 2015).

Wailing et al (2022) have proposed that restorative approaches should also be embedded in an effective learning culture. They suggest that including these practices in health professionals' education can build capability and encourage healing alongside system learning. Recent literature has also highlighted the benefits of shifting from a culture of blame to a restorative and learning culture, through a shift towards forward looking accountability (Turner, et al., 2022; Kaur, de Boer, Oates, Rafferty, & Dekker, 2019). Forward looking accountability considers how harms can be addressed and safety improved going forward and considers the collective and proactive responsibility of all stakeholders (Dekker, 2014).

Regardless of the approach, culture plays a crucial role in expectations and commitment to learning and the willingness of staff to take responsibility (Nevalainen, Lunkka, & Suhonen, 2018). Organisations that support collaborative, inclusive and participative

approaches to develop person-centred, safe and effective learning cultures are able to sustain change and result in learning that brings about the necessary transformation of individuals and teams (Manley & Jackson, 2019).

Alternatives to seclusion and restraint

There is extensive literature which outlines the trauma, injury and risks of harm to consumers, staff and support persons following the use of seclusion and restraint, as well as economic impacts associated with injuries or incidents related to seclusion and restraint (Huckshorn, 2006). The focus of research addressing these effects has highlighted a range of strategies which can be used as alternatives to these practices. Implementation of these strategies as part of a continuous quality improvement approach, rather than stand-alone interventions, is important to their overall success (Huckshorn, 2004).

'Safewards' is an intervention framework for use in acute mental health settings that aims to reduce conflict and containment events (Bower, et al., 2015; Fletcher, Buchanan-Hagen, Brophy, Kinner, & Hamilton, 2019). The framework consists of 10 interventions which are inter-related and which focus on the role of both staff and patient as contributors, and moderators, to conflict and containment. The interventions are outlined in Table 3 (Higgins, Meehan, Dart, Kilshaw, & Fawcett, 2018; Fletcher, et al., 2017). Evaluation of the model has found decreased rates of seclusion use, across adolescent, adult, secure and older person settings (Hamilton, Fletcher, Sands, Roper, & Elson, 2016; Fletcher, et al., 2017). Consumer responses to Safewards as a model for reducing conflict and containment has been found to improve inpatient experiences overall and support consumers to feel safer, more respected and more hopeful while admitted to an inpatient setting (Fletcher, Buchanan-Hagen, Brophy, Kinner, & Hamilton, 2019).

An important consideration of implementation of the Safewards model is maintaining fidelity to the 10 interventions which are inter-related and which each play a role in contributing to reducing the rates of seclusion. Adequate training and support, as well as regular review, have been identified as being necessary to successfully maintain the Safewards model (Higgins, Meehan, Dart, Kilshaw, & Fawcett, 2018).

Table 3 - Safewards interventions

Intervention	Description
Bad news mitigation	Staff to use specific techniques and share knowledge about consumer experience of bad news or potential events (e.g. leave cancellation) to support engagement with consumers
Calm down	Set of resources or activities for sensory self-soothing freely available for consumers
Clear mutual expectations	A negotiation process between staff and consumers around behaviour expectations; resulting expectations are displayed in a poster
Discharge messages	Collecting and displaying encouraging messages from consumers for other consumers to read with the aim of reducing conflict associated with hopelessness
Know each other	Non-controversial information about staff and consumers is displayed in a folder, poster, or similar to support interactions on the ward
Mutual help meeting	A daily or frequent ward meeting which is structured to encourage the sharing of support and requests between consumers
Positive words	Clinical handovers to include positive comments about each consumer
Reassurance	Deliberate and direct support is provided to every consumer who might have been impacted after a conflict event
Soft words	Encourages consumer-centred language and consistent statements particularly in relation to 'flashpoints' (e.g. saying no)
Talk down	A structured, de-escalation approach, supported by champion role modelling and individually mentoring staff

The Six Core Strategies framework to reduce seclusion and restraint has also been highlighted within the literature as an effective organizational approach to reducing these practices (Huckshorn, 2006; Riahi, 2016). The Six Core Strategies are founded on trauma-informed care principles and are pitched at an organisational level with local adaptations able to occur to suit local contexts. For example, within adolescent settings, the use of the Strategies with appropriate adaptations for youth settings has been found to contribute significantly to reducing both seclusion and restraint (Riahi, 2016).

The Six Core Strategies are:

- ***leadership towards organisational change*** to clearly articulate the goal of reducing and eliminating seclusion and restraint, and the roles and responsibilities of all staff to achieve this
- ***using data to inform practice***
- ***workforce development***, including ensuring support is available for staff to develop practical skills in alternatives to seclusion and restraint
- ***use of preventative/proactive tools*** such as risk assessments and de-escalation strategies
- ***co-design,*** and
- ***debriefing techniques*** to support continuous learning (Huckshorn, 2004).

Environmental design is also a factor which has been highlighted as contributing to seclusion and restraint use (NSW Ministry of Health, 2017; Van der Schaaf, 2013). This focus builds on literature that identifies key design features as impactful for broader mental health outcomes and consumer experiences, including the need for security and privacy, green spaces, low stimulus areas and adaptations for local or cohort contexts (e.g. First Nations consumers, adolescents, persons with disabilities etc) (Oostermeijer, et al., 2021). In relation to seclusion and restraint alternatives specifically, environmental design features which have been identified range from minor practical changes, such as painting walls or bringing in artwork, to purpose-built designs which include open ward spaces, areas for therapeutic activity and access to privacy when required (Oostermeijer, et al., 2021).

Sensory areas and spaces are an important environmental element which can reduce seclusion and restraint use, assist with emotional regulation and promote recovery-oriented mental health treatment. (Champagne & Stromberg, 2004; Andersen, Kolmos, Andersen, Sippel, & Stenager, 2017). However, equally as important is staff training and skills development that supports sensory modulation approaches in order to optimise environmental enhancements which may be made available (Oostermeijer, et al., 2021).

Data

Data on seclusion, mechanical restraint and physical restraint use in public acute mental health services are reported at a national level by the Australian Institute of Health and Welfare. These metrics have been used to support the national priority to minimise seclusion and restraint use and support transparency of practice at a national level. Although legislative frameworks are different, there is agreement at a national level regarding the collection of these variables which enables learnings and insights to across jurisdictions.

Seclusion

The national data demonstrates that there has been an overall downward trend in seclusion since the data was first reported in 2009/10, with the national seclusion rate nearly halving over the past decade, from 13.9 events per 1000 bed days to 7.3 events per 1000 beds day (Figure 1). Over this period, Queensland has also had an overall downward trend in seclusion events, however the rate increased to 9.3 in 2020/21 from a low of 6.1 in 2017/18. As noted in Table 4, the 2021/22 rate for Queensland has reduced to 7.3 events per 1000 bed days.

Figure 1 – National Rate of Seclusion per 1,000 bed days

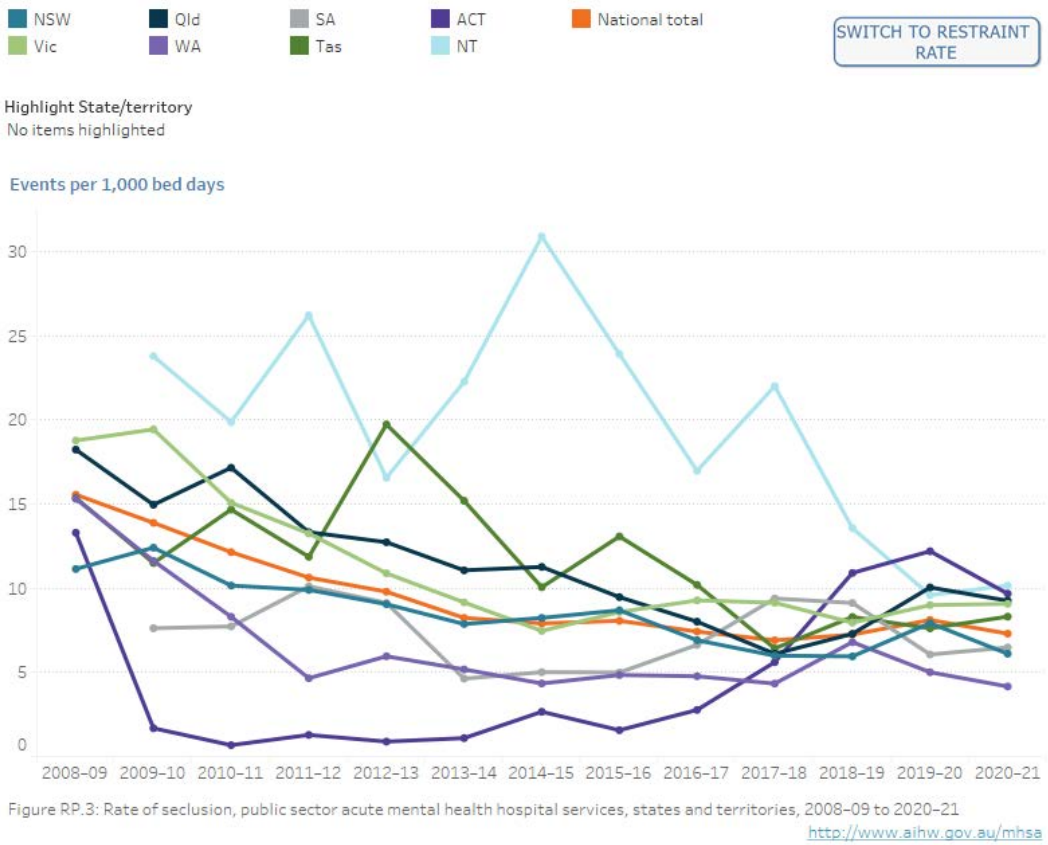


Figure RP.3: Rate of seclusion, public sector acute mental health hospital services, states and territories, 2008–09 to 2020–21
http://www.aihw.gov.au/mhsa

(AIHW, 2023)

Data on seclusion aligning to the nationally agreed specifications for reporting is also reported annually by the Chief Psychiatrist. The scope of this dataset is limited to acute settings. As shown in Table 4, the statewide average duration of time spent in seclusion during an acute admission has increased over the past five years, while the proportion of admissions with at least one seclusion event has fluctuated (Queensland Health, 2022).

Table 4 - Seclusion indicators (five-year trend)

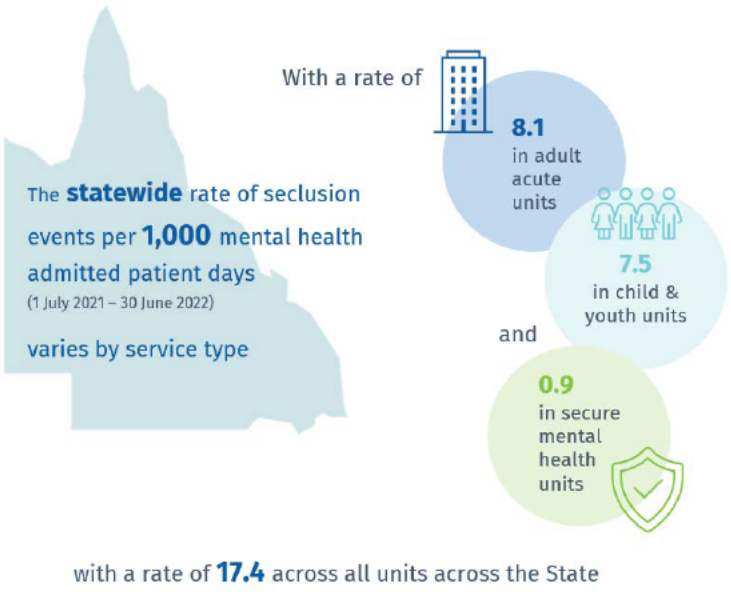
Indicator	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Seclusion events per 1,000 acute bed days	6.1	7.3	10.0	9.3	7.3
Proportion of acute episodes with one or more seclusion events	2.1	2.4	3.1	2.7	2.5
Average duration of seclusion events (hours) in acute episodes	2.8	3.2	3.7	3.5	5.3

The Chief Psychiatrist also publicly reports seclusion authorisations by AMHS in an annual report as required under the MHA. The Chief Psychiatrist's annual report shows that for 2021-2022, the majority of seclusion authorisations occurred within the HSIS (Queensland Health, 2022) (Table 5). This is consistent with prior years.

Table 5 - Seclusion authorisations (1 July 2021 – 30 June 2022)

AMHS	Seclusion Authorisations			
	Doctor	Emergency	Total	Total number of consumers
Statewide	18,649	1,525	20,174	891
HSIS	15,217	81	15,298	45

The rate of seclusion in Queensland at a statewide level is significantly higher at 17.4 events per 1000 bed days when forensic services are included. This is also consistent with national forensic service data with the national rate for 2020/21 being 27.3 events per 1000 bed days. Seclusion events may occur more frequently within these settings due to the complexity of presentations in the consumer group who are admitted to forensic services.



The below tables outline the rate of seclusion per 1,000 mental health admitted patient days for each service participating in the review, for the 2022/23 financial year (as at November 2022). There is a comparison made with the statewide rate (inclusive of HSIS) and the statewide rate for the relevant service type.

Table 6 - Rate of seclusion events per 1,000 mental health admitted patient days – Adult acute

Service	2022/23 financial year to date
Statewide – all	17.4
Statewide – adult acute	8.1
Bundaberg	**2.52**

Table 7 - Rate of seclusion events per 1,000 mental health admitted patient days – Child and Youth

Service	2022/23 financial year to date
Statewide – all	17.4
Statewide – Child and Youth	7.5
CHQ	**3.7**

Table 8 - Rate of seclusion events per 1,000 mental health admitted patient days – SMHRU

Service	2022/23 financial year to date
Statewide – all	17.4
Statewide - SMHRU	0.9
Redcliffe-Caboolture	**0.9**

Across both adult settings included in the review, consumers on a forensic order (disability) (FO(D)) were raised as a cohort that presented significant challenges and

impacted seclusion use. Consumers on FO(D) have been found by the Mental Health Court to be unsound of mind or not fit for trial due to an intellectual or cognitive disability. These consumers may be detained under their order in either the Forensic Disability Service or an AMHS. Table 9 outlines the statewide data to date for this cohort. However, caution must be taken in interpreting this data as the rates of FO(D) consumers detained in AMHSs are comparatively lower than the rates of consumers detained with a mental illness.

Table 9 - Rate of seclusion events per 1,000 mental health admitted patient days – FO(D)

Service	2022/23 financial year to date
Statewide - all	17.4
Statewide – SMHRU FO(D)	0.1
Statewide – AAMHIU FO(D)	3.6
Statewide – HSIS FO(D)	36.0

Mechanical restraint

The national data for mechanical restraint use was first reported in 2015/16 and there has been an overall downward trend over this time from 1.7 events per 1000 bed days to 0.7 events per 1000 beds day in 2020/21 (Figure 2). Over this period, the Queensland rate has remained consistently low at 0.2 events in 2015/16 to 0.1 in 2020/21, with the data for 2021/22 indicated a small increase to 0.2 events (see Table 10) (Queensland Health, 2022).

Figure 2 – National Rate of Mechanical Restraint per 1,000 bed days

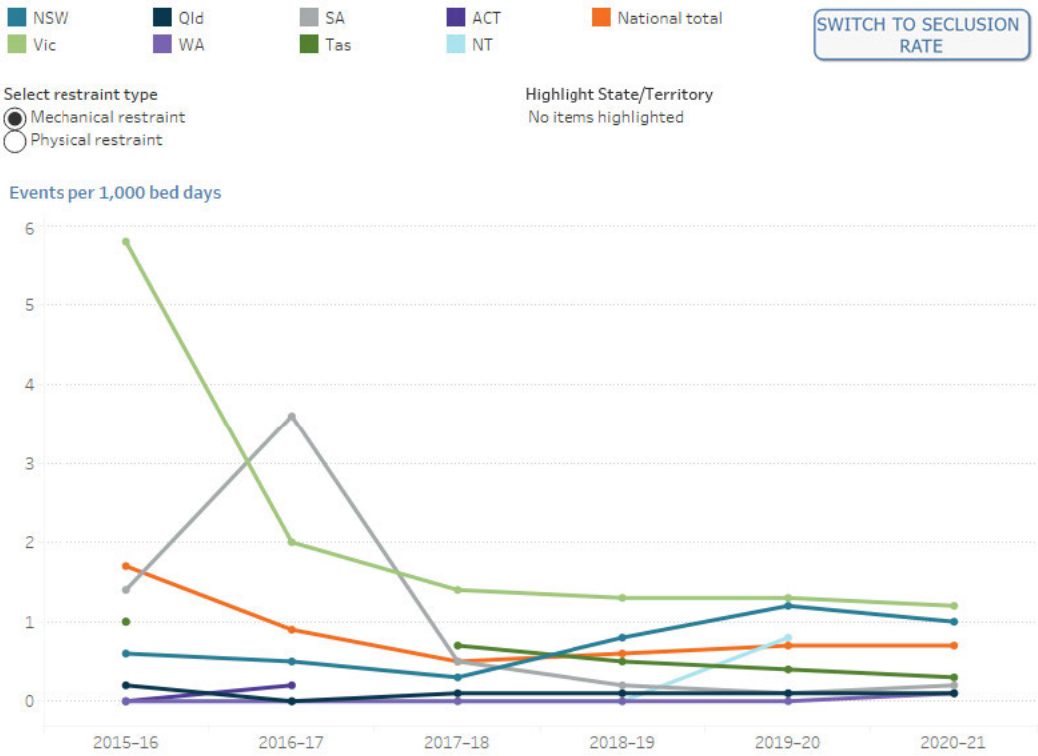


Figure RP.3.1: Rates of mechanical and physical restraint, public sector acute mental health hospital services, states and territories, 2015–16 to 2020–21

http://www.aihw.gov.au/mhsa

(AIHW, 2023)

Table 10 – Total mechanical restraint events per 1,000 acute bed days (five-year trend)

Indicator	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Mechanical restraint events in acute episode	20	20	19	26	55
Total mechanical restraint events per 1,000 bed days	0.1	0.1	0.1	0.1	0.2

As with seclusion, the rate of mechanical restraint use increases when forensic services are included within the data. The national rate for 2020/21 is 5.3 events per 1000 bed days (compared with 0.7 events in general acute settings). For Queensland the rate increases to 1.7 events per 1000 bed days when forensic services (e.g. HSIS) are included.

The Chief Psychiatrist also publicly reports mechanical restraint use by AMHS with the 2021/22 annual report also showing the majority of mechanical restraint use occurs within the HSIS.

Table 11 – Mechanical restraint approvals and events (1 July 2021 – 30 June 2022)

AMHS	Number of approvals	Number of consumers	Number of events
Statewide	194	18	486
HSIS	153	7	407

The below tables outline the rate of mechanical restraint per 1,000 mental health admitted patient days for each service participating in the review, for the 2022/23 financial year (as at November 2022). There is a comparison made with the statewide rate (inclusive of HSIS) and the statewide rate for the relevant service type.

Table 12 - Rate of mechanical restraint events per 1,000 mental health admitted patient days – Adult acute

Service	2022/23 financial year to date
Statewide - all	1.6
Statewide – adult acute	0.7
Bundaberg	**0.0**

Table 13 - Rate of mechanical restraint events per 1,000 mental health admitted patient days – Child and Youth

Service	2022/23 financial year to date
Statewide - all	1.6
Statewide – Child and Youth	0.0
CHQ	**0.0**

Table 14 - Rate of mechanical restraint events per 1,000 mental health admitted patient days – SMHRU

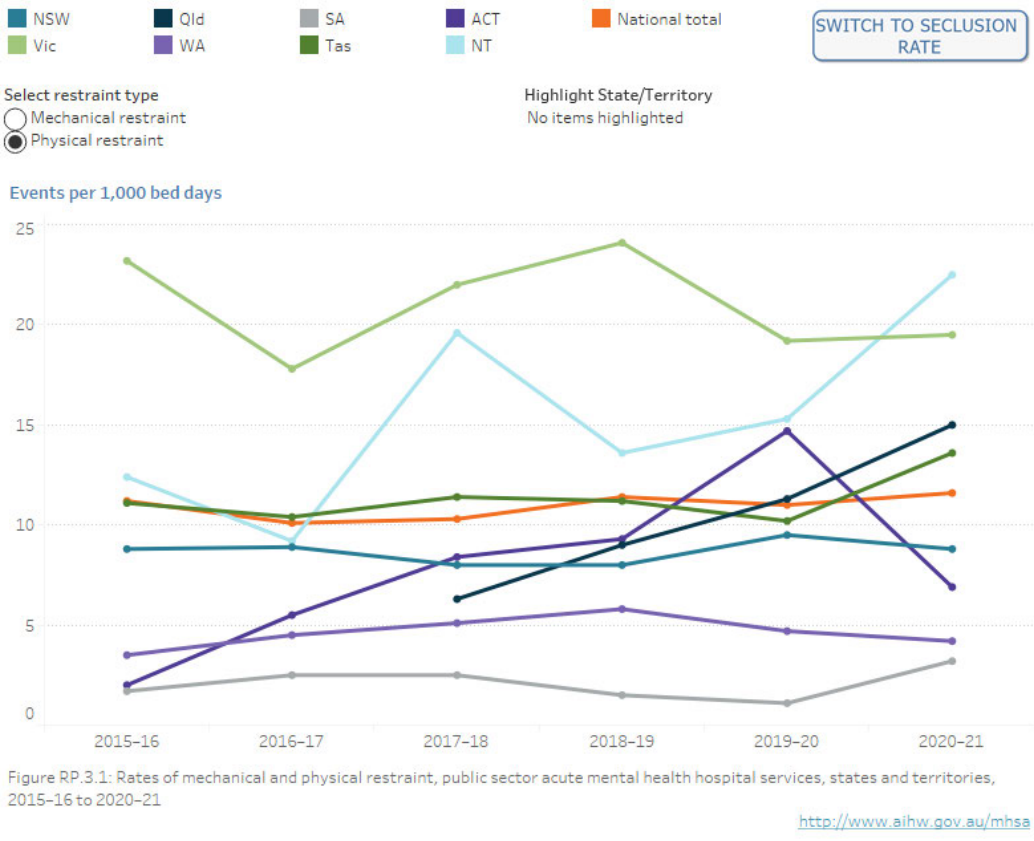
Service	2022/23 financial year to date
Statewide - all	1.6
Statewide - SMHRU	0.0
Redcliffe-Caboolture	**0.0**

Physical restraint

Prior to 2017, physical restraint events were not required under the MHA to be recorded in CIMHA. There is now a requirement for any use of physical restraint on a relevant patient, including that used in urgent circumstances, to be recorded on CIMHA. At a national level, physical restraint events have increased from 10.3 in 2017/18 (when Queensland first contributed to the collection) to 11.6 per 1,000 bed days. During this period the Queensland data increased significantly from 6.3 in 2017/18 to 15.2 in 2020/21 (Figure 3). While not yet reported in the national collection, the data provided for this review indicates the rate decreased in 2021/22 to 11.3 events per 1000 bed days (Table 15).

As noted in the Chief Psychiatrist annual report however, as this is a new collection in Queensland, caution is required when interpreting comparisons over time as these may be reflective of differences in business processes for recording data rather than a true variation in the use of physical restraint (Queensland Health, 2022).

Figure 3 - National Rate of Physical Restraint per 1,000 bed days



(AIHW, 2023)

Table 15 outlines the total count of physical restraint events in acute settings, and the count per 1,000 bed days. This data has fluctuated over the five-year period and as noted in the Chief Psychiatrist's annual report, this may be contributed to by differences in reporting processes. Within one participating service for example, there were different views at the leadership level as to what constitutes physical restraint and to what degree actions such as

escorting a person to their room by placing a hand on their back or holding their arm to escort/assist them while they walked would be required to be captured. The lack of clarity in relation to physical restraint appears to be most pertinent to child and youth services.

Table 15 - Total physical restraint events per 1,000 acute bed days (five-year trend).

Indicator	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Physical restraint events in acute episode	1,835	2,703	3,503	4,601	3,305
Total physical restraint events per 1,000 bed days	6.4	9.2	11.7	15.2	11.3

The below tables outline the rate of physical restraint per 1,000 mental health admitted patient days for each service participating in the review, for the 2022/23 financial year (as at November 2022). There is a comparison made with the statewide rate (inclusive of HSIS) and the statewide rate for the relevant service type.

Table 16 – Rate of physical restraint events per 1,000 mental health admitted patient days – Adult acute

Service	2022/23 financial year to date
Statewide - all	8.9
Statewide – adult acute	11.4
Bundaberg	**9.4**

Table 17 - Rate of physical restraint events per 1,000 mental health admitted patient days – Child and Youth

Service	2022/23 financial year to date
Statewide - all	8.9
Statewide – Child and Youth	26.7
CHQ	**31.2**

Table 18 - Rate of physical restraint events per 1,000 mental health admitted patient days – SMHRU

Service	2022/23 financial year to date
Statewide - all	8.9
Statewide - SMHU	0.7
Redcliffe-Caboolture	**0.4**

Insights

Although the sites included in the review have different purposes, goals and cohorts (particularly with respect to age), there were broadly consistent themes identified which are relevant across all settings. These themes are summarised below. Additionally, where site-specific lessons or takeaways were identified, which may be beneficial across the MHAOD service system, these have been highlighted.

OCP

The OCP role includes a legislative and regulatory component as well as clinical/professional leadership and expertise. The interrelationship between these functions is an important factor in how the OCP interacts with mental health services, consumers and support networks (and vice versa). Primarily the OCP implements its functions and roles through working with services and building relationships. There is however a tension in this role as there can be a real, or perceived, imbalance across the OCP and services, particularly given the regulatory function of the OCP, which means that at times there are natural points of difference. It is important that the OCP and mental health services continue to work collaboratively together in their efforts to reduce and eliminate seclusion and restraint, as each has an important role to play in this shared goal.

- Services engaged in the review reflected that the OCP is a source of support and advice, particularly in relation to clarifying regulatory matters or complex patient care issues. There were no barriers identified to engaging with the OCP.
- There were some misconceptions about CP policy requirements noted, including in relation to the types of interventions and therapies which may be able to be accessed in the MHICU environments.
- The OCP noted that due to COVID there had been a decrease in direct engagement (visits) with services and emphasised that this was to be recommenced and was viewed as an important collaboration and feedback mechanism for services.
- At the individual clinician level, the role of the OCP is less well understood.

Leadership and culture

Observations at the services visited, highlighted the role of senior management, leadership offered and the broader impact in bringing about a change in the organisational culture and the ensuing effects on the day to day clinical practice of clinicians within the organisations. Contemporary literature suggests a move away from top-down to open and inclusive approaches, improving psychological safety, moving away from blame-based cultures to restorative just and learning cultures within organisations.

Changes in leadership and management approaches with observable behaviours, informed by contemporary evidence with regards to management, are necessary in developing a milieu conducive to positive change in culture and practice.

In adopting such changes, leadership and management behaviours and approaches necessary for such culture will need to be encouraged, and those deemed destructive relinquished.

At the SMHRU, observations indicated leadership behaviours offered from the executive, directors (operational, allied health, nursing and medical), as well as Team Leaders and Consultant Psychiatrist, aligned with effective behaviours suggested by research literature on leadership and management. The behaviours observed were suggestive of a move towards a more open and inclusive approach, predicated on psychological safety, aiming to move from a blame-based culture towards a restorative just culture. The aforementioned change in behaviour and culture, from senior management with effects on practices, clinical and others, have positive effects in improving patient safety, potentially reducing the use of seclusion and restraint.

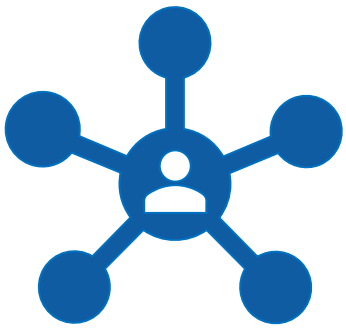
Considerable efforts had been made by the services involved in the review to change cultural aspects which may have contributed to prior higher rates of seclusion and restraint use. This included a major review of the SMHRU model of service and focused work/approaches in both CHQ and the AAMHIU in relation to seclusion and/or restraint reduction.

Specific takeaways include:

- Focussed efforts to move services away from seclusion and restraint, including through environmental changes, increased lived experience workforce and escalation strategies were identified as having an overall impact on the culture of the unit, with one stakeholder noting their unit had *"become a much friendlier and pleasant place"*, while another noted that '*they were empowering patients, reducing stigma,* [being more] *patient focused, energetic,* [and] *humanistic in approach*".
- A restorative just and learning culture approach that supported honest and open communication with staff at all levels and from all disciplines, and which focused on lessons which could be learned in a no-blame culture was evident in the services involved in the review.
- Team leadership and shared visions are important as these values pervade all aspects of care (both positively and negatively).
- Individual leaders at varying levels (including for example the consultant psychiatrist for the SMHRU and the nurse unit manager of the AAMHIU) are also important and appear to have had an impact, suggesting that personal learning and development and accountability are essential tools that contribute to effective leadership and culture.

In each service, the leadership and senior staff strongly emphasised that seclusion in particular is a last resort practice, however of particular note is that this view was also expressed by all stakeholders interviewed, regardless of their level or discipline or point of reference.

Models of Care



Integration, communication and collaboration as part of the model of service were emphasised by each site that participated in the review. Consultative care planning processes were identified as contributing to reducing duplication of efforts and ensuring shared knowledge and understanding. The SMHRU was noted to be moving away from multidisciplinary teams and towards interdisciplinary teams. This shift supports the consumer to identify their goals and then each member of the treating team works out how they can contribute to meeting the goals.

Pre-admission planning was highlighted consistently by each service as assisting with reducing seclusion and restraint use. This included identification of strategies for de-escalation and commencing formulation and treatment interventions pre-admission where possible to support the person's therapeutic goals and achieve positive outcomes. Transition planning, use of tele-health and co-developed community management plans were also identified as beneficial for continuity of care and consideration of least restrictive options to admissions to inpatient settings.

- The use of the longitudinal summary, together with a case management model with PSPs (Principal Service Provider) who have day in, day out management of patients, was outlined as a useful care review and management model.
- A strength identified by the AAMHIU in being a regional service is that a consistent model of care operated across all elements of the service to provide holistic care to consumers. This includes an ability for clinicians and medical management to be able to work across the continuum of care settings, within the mental health service and across other health and hospital settings within the HHS.
- The SMHRU had the benefit of being the first purpose-built SMHRU which did not have to pivot from being a medium secure service, which was viewed as having more restrictive, corrections-like model of service. The development of the local SMHRU model of service was comprehensive and supported involvement from all staff, as well as consumers, families and their support networks.

Risk assessment and risk management practices

- All service sites participating in the review had implemented Maybo's Occupational Violence Prevention training.
- The AAMHIU utilises local 'Safety Plans' which are developed for and where possible with consumers within the high dependency unit who have challenging behaviours and who are at risk of being secluded or restrained to share knowledge and support alternative de-escalation strategies. The Plans are contributed to by the whole team, signed by the consumer and kept in front of the consumer's chart and on drive as live document use, though the Plan is not currently uploaded into CIMHA. The SMHRU use a personal safety and sensory plan which appears to have a similar intent.

- Ambassador programs were implemented or had commenced at adult sites with feedback on this program differing across these locations; the adult acute site noted that there had been a significant relational change between health security staff and consumers, with health security staff also all now trained in first aid and involved in the development of the local Safety Plan, while the SMHRU advised that whether or not the ambassador was well received really depended on the individual employed and that this could vary.
- Time, resourcing and training constraints for staff were identified as impacting capacity to comply with the Violence Risk Assessment (VRAM) framework[6].

Evidence-based care and improvement activities

- A dedicated research project is underway at the AAMHIU looking at seclusion practices and medication. The project is in the process of receiving ethical clearance but aims to consider, amongst other things, if medication has been used effectively and how does this impact seclusion events.
- Sensory rooms were available in all services and were identified as beneficial. Sensory or de-escalation options also included outdoor spaces and gardens, colouring materials, gym space, tv and multipurpose rooms, access to weighted blankets and fidget toys. A family suite was available in the child unit and safety pods were used in the sensory room.
- The Chief Psychiatrist policies outlines de-briefing requirements following a seclusion or mechanical restraint event and all sites were engaging in these processes. Escalation of events and further review as appropriate was also occurring. Where relevant health security staff were also involved, or were offered opportunities to be involved, in the de-briefing processes.

The statewide SMHRU model is out of date and there would be benefit in this being reviewed and finalised. Lessons can be taken from the process of developing the local SMHRU model of care which occurred over a period of two years.

Safewards activities had been implemented at the sites in varying degrees, with one site noting that further development and upskilling in Safewards strategies would be beneficial.

[6] The VRAM framework provides Queensland Health MHAOD services with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence towards others.

Workforce

A stable and skilled workforce, with shared goals was identified as a key factor in assisting with reducing seclusion and restraint rates. Of particular note was that each site involved in the review had senior staff who either led or supported other staff to lead a concerted effort on embedding alternatives to seclusion and restraint use.

Workforce mix was also highlighted with all services noting medical, nursing, allied health, First Nations, lived experience and health security staff all have a role in reducing and eliminating seclusion and restraint. The role of the Independent Patient Rights Advisers (IPRAs) in assisting with understanding of rights under the MHA was also noted in this context.

Multidisciplinary teams

There is varied balance of skills and disciplines across teams that work in or support areas where seclusion and restraint occur, with identified gaps, particularly in allied health disciplines being able to work to their top of scope. There is an opportunity to better embed allied health into multidisciplinary teams to contribute to the full care continuum. The enhancement of these roles may assist with reducing patient frustration by, for example:

- providing earlier access to an Occupational Therapy assessment to support discharge which may reduce frustration with not being able to transition out of the inpatient environment
- enabling the delivery of targeted therapies such as cognitive behavioural therapy, and
- supporting structured activities and exercise physiologist services, to support access to exercise may be beneficial for recovery, physical health and reducing pent-up energy.

Lived experience workforce

> "Creating an environment where all members can contribute throughout the patient journey maximises opportunities for reducing seclusion and/or restraint and provides more opportunities for diversion as an alternative".
>
> Clinician, SMHRU

The role that having people with lived experience working or engaged on the unit was consistently highlighted as beneficial in reducing and responding to events which may otherwise have led to seclusion or restraint This includes roles in relation to de-escalation and debriefing after an incident has occurred, either with the consumer involved or other consumers on the unit who may also be impacted.

- The lived experience workforce role across the services engaged in the review was broad[7], with functions ranging from engaging in individual consumer matters to quality improvement initiatives, policy changes, and unit strategic planning. An on-the-ward presence was highlighted as being important, as well as embedding the role within the leadership group.
- Access to peer support for consumers was generally offered or available to all if/when required (within resourcing limitations).
- The adolescent and children's service outlined that the lived experience workforce within their service were not usually 'peers' as such, but rather were people who had prior experience within CYMHS but were adults and had progressed in their recovery journey. Considerable thought had gone into the process of engaging appropriate lived experience workforce which was focused on holistic needs of the cohort in the service rather than just age.

Genuine integration of lived experience workforce was emphasised with the value of this workforce consistently raised.

Multidisciplinary team members each bring both unique and complementary skills and experiences.

The role of the IPRA in incident review or opportunities for learning was identified as an area that could be strengthened and may assist in helping with a rights-based focus to incident reviews.

Consumer and carer engagement in care

Consumer engagement throughout the consumer's treatment journey was identified as critical. For young people, engagement with the young person's family or support person is equally as important.

Engagement with consumers needs to be embedded across the whole service, and all elements of the consumer journey: treatment planning, information sharing, discharge and return to the community, choices regarding medication etc. There were different ways to engage and the importance of supporting consumers to have a voice in a way that best enables them to contribute to their treatment planning was noted.

[7] A range of different positions and roles are covered by the Lived Experience Workforce, including consumer engagement facilitator, peer workforce, consumer consultant and consumer and carer coordinators. Throughout this report the term Lived Experience Workforce has been used but this is not intended to minimise that there are different roles and functions which are undertaken by this Workforce.

- Work had occurred within the AAMHIU to develop templates for consumers to support their preparation for medical reviews which includes prompts to help focus what may be raised in these discussions.
- Meaningful, remunerated consumer and carer engagement in strategic and unit planning was also emphasised. For example, lived experience advisory groups were established to consider quality improvement processes and the leads of these groups meet with the MHAOD executive regularly.
- Practical steps for engagement were consistently highlighted e.g. coffee mornings or weekly BBQs provided an opportunity for staff, including medical staff, to sit and talk with consumers. It was noted these provoked real conversations and discussions and were important to building therapeutic engagement and alliance. More formal opportunities for consumers to discuss concerns or raise suggestions were also provided regularly.

First Nations people

In each service setting the importance of First Nations input and cultural connections was recognised. The OCP also highlighted that a key priority under *Better Care Together* is to focus efforts across MHAOD services to strengthen cultural safety and the delivery of culturally capable and appropriate MHAOD services.

The AAMHIU has a high percentage of the patient population that are First Nations people, while the SMHRU population can vary. For the adolescent and children's service, referral numbers are very low, which may reflect both the catchment area for the adolescent service and the reluctance of Indigenous young people and their families to travel to Brisbane for an admission to the children's service.

- In the adult services, engagement occurs with First Nations mental health workers[8] as early as possible as part of treatment and care planning. Within resourcing limitations, First Nations mental health workforce engagement occurs in both formal and informal ways, including cultural input into care plans and transition and discharge planning, including linkages with First Nations community services.
- First Nations mental health workers engaged consumers in relation to connections with country, particularly supporting connections to the local area and community, and participation in Sorry Business. Engagement also included "having a yarn" with consumers about rights and treatment by the AMHS. These conversations and connections also extended to non-First Nations staff and consumers and were identified as an important strategy in understanding differences, reducing challenging behaviours and reducing the use of restrictive interventions.

[8] It is noted that there a range of positions and titles for the designated First Nations mental health workforce, with First Nations mental health workers and workforce being adopted only for consistency within this report, however it is acknowledged that there are different roles and functions which are undertaken by this workforce.

- The need for more First Nations representation was highlighted, for example the AAMHIU has no access to this capability outside of standard work hours. Additionally it was highlighted that there can be challenges with the processes for engagement that impact on First Nations involvement, including limited flexibility in the approaches for formal engagement, and that for families, systemic trauma is also a barrier to engagement. It was identified by the CYMHS that MHAOD services have a responsibility to find ways to repair these traumas.

Cultural considerations must occur in all parts of assessment, treatment and care planning, with an understand of Social and Emotional Wellbeing fundamental to supporting First Nations consumers

Increasing the involvement of the First Nations workforce when an incident is occurring which may lead to seclusion, or when seclusion has occurred, was identified as an opportunity for growth

Adolescents and Children

In general, the MHA does not distinguish between adult and youth populations in terms of involuntary processes. The provisions which apply to adults in relation to seclusion and restraint also apply to young people (under 18), with the Chief Psychiatrist policies detailing that particular consideration must be given to the vulnerabilities of minors who are at higher risk for trauma, harm and suicide, if seclusion and restraint are to be used.

There was a tension identified in the review with the general approach taken in the MHA to these practices for children and young people. Within this population, it was raised with the reviewers that there are contextual issues for the child and youth cohort and that what may be developmentally appropriate for someone under the age of 13 in terms of physical contact may not necessarily be a last resort option such as in the adult populations. At this time staff are supported to record any physical contact/holding enabling further clinical review of these children. Additionally, where parents or carers want to distance themselves from treatment decisions so that they are not 'blamed' for what is occurring again the use of the MHA may be a least restrictive option to seeking alternative consent.

Higher risks and complex needs cohorts

There was consistent feedback from services participating in the review in terms of concerns related to admitting classified patients, forensic disability patients, and for the youth population, patients from youth justice or child safety. These concerns stem from limitations arising from environmental issues, limited security responses or options and clinical capability. An additional issue can arise regarding transition from an inpatient unit back to a community setting (including youth justice or child safety settings) when community

supports have fallen away following a period of inpatient treatment, and barriers to accessing NDIS supports.

Service provided feedback in relation to a service system gap for consumers with high-risk acuity, particularly where there are environmental limitations within the setting and/or limited staff with expertise to manage these consumers (this was particularly the care for classified, forensic and FO(D) consumers). The reviewers were advised that at times, the Queensland Police Service (QPS) have been requested to have an extended presence within inpatient units to assist with managing consumers with very challenging behaviours.

> "[the] biggest thing that keeps me awake is that one of my staff with be killed".
>
> Senior Leader, AAMHIU

- Access to services from Brisbane for regional based acute adult services can be difficult, with recommendations for treatment not always being able to be put into practice (e.g. recommendations for specific offending intervention programs or Robust Supported Independent Living accommodation options). This incongruence can impact on consumer and family expectations of treatment options and recovery.

Environmental factors

The impact that environmental design has on reducing and eliminating seclusion and restraint cannot be understated. There is an ongoing need to not only consider the design aspects of new environments, but also the maintenance of existing environments. Access to therapeutic spaces and access to outdoor spaces and natural light are critical.

In Queensland, it is of note that adult acute wards have been locked in accordance with Chief Psychiatrist policy since 2013. The CYMHS inpatient unit is also a locked unit. It is understood by the reviewers that a trial of discretionary locking was occurring in some units across the state and that this is something all units will need to consider going forward to support least restrictive options of mental health treatment and care.

- Jacaranda Place decommissioned its seclusion room and intentional decisions were made to retain potential ligature points. There were multi-factorial reasons for decommissioning of seclusion room at Jacaranda Place with environmental factors identified as including the co-design approach and that the building was made fit for purpose, multiple courtyards, gym, art, music and sensory room areas. The environmental design contributed to consumers feeling valued. The CYMHS were also aspiring to decommission the seclusion room in the adolescent unit and were taking lessons from the Jacaranda Place experience in relation to this goal. Other stakeholders noted the environment of the crisis stabilisation unit on the Gold Coast and the work which had resulted in the seclusion room in that unit not being used.
- There was some reflection of involvement of consumers in the ward environment design at each site i.e. paintings or choice of colours of the furniture and walls.

- Co-location of staff on the ward was highlighted as important to the unit environment. The AAMHIU had implemented a "Safety Nurse" who must be on the floor at all times throughout their shift to enable consumers to have immediate access to staff.
- Some specific environmental challenges were identified while on the site visits:
  - The **AAMHIU MHICU** area was very bare, without colour or greenery and was not ideally placed structurally.
  - The **CYMHS unit** had limited private spaces or break out areas and was situated around a centralised space. Shading had only recently been installed in some outside areas to encourage these to be a more useful space, as previously it got too hot to allow for use. The high care space was not purposefully designed to be a low stimulation and calming environment where higher levels of care could be provided.
- In relation to the seclusion rooms within each site visited, these were similar across the sites. None had a toilet within the room with paper/disposable toilets available as well as facilities immediately outside of the room. At one site a person with lived experience raised the importance of being able to quickly orient themselves to time and place while in seclusion where the consumer may already be feeling disoriented, with the suggestion being made to situate digital calendars and clocks within, or in viewing distance, of the rooms. The seclusion room in the Adolescent CYMHS Unit used a safety pod with success.
- The AAMHIU noted that the initial change from discretionary or open units to locked led to a development program for the unit to consider how the space could be more therapeutic even when locked i.e. by developing gardens and a BBQ area.
- Access to leave and personal items were consistently identified as a potential stressor, particularly when the access is limited due to resourcing or other factors (e.g. COVID-19 restrictions); other triggers for stress which were highlighted included association issues on the unit in the context of mental illness. Being able to take consumers to alternative spaces, even when leave cannot be accessed, was noted to be beneficial.

Smoke-free environments

Both adult services participating in the review identified the complexities for consumers who have smoking (or vaping) habits in the community which are required to cease, or be managed very differently, when they are admitted to an inpatient setting. Particularly for consumers who are unable to access any leave, staff within the adult acute unit and the SMHRU noted that the first 1-2 days were a potentially increased risk period for behaviours which, if unable to be alternatively managed, may lead to seclusion and restraint. It was raised by some staff that there was a disparity for people admitted to mental health units compared with other units where, provided they were physically able to manage it, admitted patients are able to leave to smoke outside of the hospital area.

However, although the issue was raised consistently, it was also clear that staff were not advocating for smoking to be allowed on the units.

Services currently manage this issue with nicotine replacement options, particularly in the early stages of admission. It was also noted that issues relating to smoking are a key escalation point requiring clear risk assessment and management processes, throughout a person's admission particularly on weekends or when activities may not be as readily available, as well as on the person's return to the community either for periods of leave or on discharge from the ward.

"[We need] to keep in mind the mortality gap and life expectancy outcomes and the effect that smoking and medicines have on health outcomes and quality of life. Not necessarily a matter of just providing a mechanism for them to do this, it is about addressing the actual issues. Are we really doing holistic healthcare? It is our obligation to look at the culture and the resources and holistic care".

Lived Experience Workforce Leader

The physical separation of the SMHRU seclusion room being in the AAMHIU was identified as a helpful environmental structure. The separation assists with reinforcing seclusion as a last resort option as the person needs to be moved from the SMHRU environment to access it.

Lived experience consumer engagement and co-design occurred for Jacaranda Place from the beginning, including the design of the building, contributed to the successful decommissioning of the seclusion room.

Clinical information, records management and use of data

All services participating in the review had processes in place to consider seclusion and restraint data. This included consideration of the KPI data as well as interrogating the data to understand areas of concern or lessons e.g. multiple events or patterns in practices. The KPI data is also included in HHS executive data sets, though the extent to which this data is routinely considered and well understood outside of mental health services is variable.

At a statewide and AMHS level, data is reported publicly in the Chief Psychiatrist's annual report. Instances of seclusion and restraint of young people (below 18) must also be reported to the Public Guardian[9].

The clinical information and record keeping requirements for inpatient settings and MHA compliance requirements were consistently highlighted as a source of frustration by services. Issues were raised in relation to the useability of CIMHA for staff while on the ward, for example signatory requirements and timeframes for emergency authorisations of seclusion or the ordering of assessment and treatment documents does not align with the practical processes.

- Local resources had been developed which translated OCP or MHA requirements to operational and practical instruments which could be completed rapidly and were identified as beneficial to reducing frustration associated with documentation requirements.
- It was consistently noted that consumers struggle to understand MHA requirements, and this could be an area of focus for the OCP.
- There are Wi-Fi/network and computer access issues within AMHSs environments which impact on CIMHA being used in real time.
- The work of the Queensland Mental Health Benchmarking Unit was noted during the review; however there was also feedback that context of the data was not always explored in benchmarking. A community of practice or learning health network approach was proposed as an alternative to a data collection and comparison process.
- Building on the consideration of data at the consumer level, the SMHRU outlined a project which has been started within Metro North HHS to look at developing tools to more objectively look at outcome measures against a person's needs, and then consider how this could be used to manage referral needs and the SMHRU model of care.

Outside of the mental health service system, it was identified that there may not be comprehensive visibility over seclusion and restraint use. Improving data collection and sharing across the HHS may assist with awareness of (and in turn responsiveness to) these practices across all areas of the HHS.

[9] 274, MHA2016 – Obligation to notify public guardian of treatment of minors

Interface with other hospital units and emergency departments

The interface with emergency departments and other hospital settings regarding seclusion or restraint use was consistently identified as a challenging area, and it was noted across all sites that the mental health service experience of consumers can be shaped at the outset when first admitted via an emergency department setting.

- Issues raised focused on difference of practice across the mental health service system and the emergency departments, workforce development and/or use of dedicated mental health staff in the emergency department, environmental/structural issues, challenging clinical presentations (particularly people affected by methamphetamine) confusion regarding which legislative framework applies in the emergency department, pressures to admit arising from NEAT (National Emergency Access Target), and the role of the mental health service system in influencing emergency department practices.
- Similar challenges were also noted for consumers requiring mental health treatment when in another ward in the hospital, though it appeared clearer in those settings that mental health clinicians provide support to other staff regarding issues such as seclusion and restraint.
- A particular point of concern for the child and youth service however was the legislative authorities and clinical governance issues for young people experiencing eating disorders who required some form of restraint as part of nasogastric feeding. The OCP also noted this issue was becoming more regularly raised by adult services.

Expanding the role of the IPRAs to emergency departments was raised by some stakeholders as an opportunity to support awareness of rights and obligations under the MHA at the outset of an admission.

Recommendations

The recommendations outlined below are predicated on the Queensland Health leadership, both within specialist mental health alcohol and other drugs services, and across other health settings, acknowledging and committing to working towards reducing and eliminating seclusion and restraint in all settings.

This commitment must meaningfully support and engage with initiatives, whether arising from this review or otherwise, that aim to reduce and eliminate seclusion and restraint. These initiatives must be applied across all health settings where individuals with mental illness may receive treatment and care.

Lived Experience

The active participation of persons with lived experience, their families and carers is fundamental to reducing and eliminating seclusion and restraint

1. The mental health alcohol and other drugs service system leadership, within services and the department, must lead a process of true co-design with persons with lived experience, their families and support persons in the implementation of activities arising from the review.

First Nations

First Nations expertise and input is essential to supporting culturally safe and capable services that use least restrictive practices

2. The mental health alcohol and other drugs service system leadership, within services and the department, must lead a process of true engagement and collaboration in the implementation of activities arising from the review, with First Nations people, including First Nations people with lived experience, their families and support persons, and the First Nations workforce.

Office of the Chief Psychiatrist (OCP)

The OCP has a pivotal role in bridging regulatory requirements with clinical practice to support services using alternatives to seclusion and restraint

3. The OCP will take a greater leadership role to support and assist services with their efforts to reduce and where possible eliminate seclusion and restraint. This should include:

    a. Developing a communication strategy to shine a spotlight on alternatives to seclusion and restraint and increase sharing of knowledge across the service system, and other areas of health and other health stakeholders e.g. consumers, peak bodies, advocates.

    b. Facilitating, including through funded support, dedicated Forums/Round tables to build on and share learnings regarding strategies to reduce and minimise seclusion and restraint across service settings e.g. learning health networks[10]. Where there are limited equivalent services within Queensland (for example children's or forensic services) there is value in this engagement being facilitated at the national or international level.

        Note: the advice of services regarding whether the existing clinical network, clusters or other collaborative forums can be used to achieve this recommendation should be sought prior to establishing any new processes to reduce duplication. The mechanism for shared learnings must be linked into appropriate governance structures within the department and Hospital and Health Services to ensure they are sustainable.

4. The OCP will enhance the interface among policy, the MHA and clinical practice by:

    a. Reviewing the regulatory framework to consider whether amendments are required to the framework to capture different population needs more appropriately, such as the needs of young people, high risk consumers and consumers on forensic order (disability).

    b. Undertaking a project to evaluate the use of seclusion and restraint forms within operational and clinical practice, to identify opportunities to reduce administrative reporting requirements that do not support the protection of patients' rights, reflect contemporary clinical practice or support efforts to reduce the use of seclusion and restraint. This project should be undertaken in collaboration with services and be supported by evidence

[10] The USA National Academy of Medicine describes a learning healthcare system (LHS) as one in which science, informatics, incentives, and culture are aligned for continuous improvement, innovation, and equity, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience. A rapidly progressing virtuous, iterative cycle where evidence (both internal data and external evidence) drives care through knowledge translation, and then learning from the care rapidly drives further knowledge and evidence, which can further influence healthcare delivery. This can result in services that provide improved quality, more efficient and safe care and are better places to work.

In a Learning Health Network, consumers, families, clinicians, researchers and health system leaders work together across multiple sites to solve particular health problems, using data to drive clinical care, improvement, and research.

"Learning networks align participants around a common goal; use standards, processes, policies and infrastructure to enable multi-actor collaboration; and … create and share resources to achieve goals. The networks also act as "learning labs" for ongoing improvement and research, both on individual conditions and the learning network model itself." (Building a Learning Healthcare System Network, 2020).

and data (see 18b). Possible alternatives to using administrative forms to collect regulatory information should be identified and implemented.

c. Developing and delivering enhanced training and resources for Administrator Delegates to help with data transparency, consistency and comparisons across and within services.

d. Undertaking a review of the Chief Psychiatrist policies for seclusion, mechanical restraint and physical restraint with a particular focus on the post-event, and ensure that where possible, the policies provide for a restorative just and learning culture approach[11] when responding to, reviewing and learning from seclusion and restraint events.

Leadership and culture

Leadership and a culture that supports learning and improvement is fundamental to reducing the use of seclusion and restraint

5. Service leaders (executive and clinical directors, and Administrators) should undertake projects to evaluate and implement local service improvement related to reduction of seclusion and restraint which is guided by shared learning from forums established in response to recommendation 3(b).
6. Queensland Health must ensure through policy that clinical leadership teams within mental health alcohol and other drug services are trained in and understand leadership in the context of trauma-informed care. The delivery of this could be achieved through embedding practical and sustainable, centrally developed leadership training packages across all services to ensure there is visible and compassionate leadership enabling complex and reflective decision-making in the area of seclusion and restraint within teams with safety.
7. At a service level, the principles of a restorative just and learning culture should be adopted and embedded into practice in relation to responding to, reviewing and learning from seclusion and restraint events to support local contexts and processes. Additionally, the OCP should use a co-design approach with Hospital and Health Services to consider how these principles are embedded within the regulatory frameworks and procedures that apply to incident reviews generally and identify opportunities to support local processes and facilitate statewide

[11] Restorative just and learning culture (RJLC) merges a range of restorative approaches with an increasing understanding of learning and improvement in our complex systems. RJLC recognises that we work in complex adaptive systems and that we need new systems approaches to learning and improving following harm. It is both a proactive relational approach of setting the safety culture (building a sense of belonging, respect and trust, psychological safety, learning, systems improvement, resilient healthcare), and a response to harm in our complex systems (a deeply accountable process of engaging all stakeholders in a forward-looking process of identifying hurts and needs of all involved, healing relationships and people, effective systems approaches to learning, and improvement.)

uptake. The OCP should also consult with the Clinical Excellence Queensland Patient Safety and Quality Unit about opportunities to expand this work more broadly across the health service system.

Models of Care

There must be a focus within all models of care adopted by inpatient services to delivering alternatives to seclusion and restraint

8. There is a need to enhance implementation of Safewards or equivalent frameworks at a local and statewide level. This responsibility sits with mental health alcohol and other drug service leadership within the department and services and should include:
    a. Embedding Safewards or equivalent framework updates and learnings into standard agenda items for collaborative forums such as the clinical network, clinical clusters and other collaborative networks.
    b. At the service level, executive and clinical directors prioritising building clinician and service capacity through training, professional development and adequate resourcing in Safewards or equivalent principles and frameworks of engagement, early intervention, genuine interest, time, and de-escalation skills.
    c. At the service level, training for Safewards or equivalent approaches being embedded within orientation programs and onboarding processes for all new staff and student clinicians.
    d. At the service level, implementing refresher or career-long training and education for all clinicians working in inpatient settings in Safewards or equivalent frameworks. For statewide consistency, this may be achieved by the OCP commissioning the development of a training module which is available to services as part of mandatory annual (or biennial) training programs.
9. The OCP should develop an evaluation tool/ quality improvement cycle specific for Safewards or equivalent framework to improve ongoing implementation of the principles, focus on service improvement and avoid fatigue. The development of this tool should be done in collaboration with services and persons with lived experience.
10. The OCP should consider alternative and additional monitoring and support approaches for some higher complexity groups, such as classified patients and forensic order disability consumers to support a whole of system response when required. This may include:
    a. Strengthening clinical escalation pathways to the Chief Psychiatrist for consumers who are secluded directly on admission to a unit and who

remain in seclusion for an extended period (e.g. beyond an initial Seclusion and Restraint Reduction Elimination Plan (SRREP), or another nominated time period).

b. Reviewing the regulatory framework to enhance the priority of the SRREP process, or equivalent, for monitoring and reviewing the complex cohort of consumers who are subject to extended periods of seclusion. This review should support a move away from administrative processes which may result in a tick-box culture to providing and implementing genuine support and strategies for clinical staff to implement strategies that minimise and reduce the use of seclusion and restraint.

Workforce

A skilled and engaged workforce, working to their top of scope, is required to support whole of system approaches to reducing and eliminating seclusion and restraint

11. Workforce strategies, at the state and local level, must specifically consider the beneficial role that the lived experience workforce and First Nations workforce can have in relation to de-escalation approaches and incident reviews relating to seclusion and restraint use.
12. Workforce strategies, at the state and local level, must incorporate the importance of leadership and skills development and training. Mechanisms to do this may include quarantined time to access training, succession planning strategies and support for peer networks or learning opportunities. Within this, there may also be opportunities to share skills and experiences across different settings and services (refer 3(b)).
13. Training needs identified by the review, which would be beneficial to be consistently implemented across all services, are:
    (iv) Trauma informed care.
    (v) Risk assessment and management.
    (vi) Safewards approaches, or equivalent, particularly early intervention and de-escalation (see 8).
14. Workforce strategies, at the state and local level, must include strategies for multidisciplinary team members to work to their top of scope and for allied health staff in particular to be supported to deliver therapeutic interventions that aim to reduce seclusion and restraint.
15. Recognising seclusion and restraint occurs outside of mental health alcohol and other drugs services, increased partnerships between authorised mental health services (AMHSs) and other areas of the Hospital and Health Service are encouraged. The mechanisms to do this could include shared training and the

establishment of collaborative review and/or debriefing processes to assist with continuous service-wide learning and improvement. Additionally, Hospital and Health Services may consider establishing 'champions' within mental health services and other hospital settings such as Emergency Departments, to ensure these partnerships are facilitated.

Environment

Environmental enhancements ranging from minor practical changes to purpose-built designs can be made to support alternatives to seclusion and restraint

16. The OCP must coordinate a statewide review of all seclusion and dedicated sensory modulation areas in AMHSs to obtain a baseline of the environmental state of the inpatient units. The baseline should be used as an opportunity to identify, within existing environmental structures, opportunities to enhance or improve structural elements including furniture and design elements, that may be contributing to increased rates of seclusion and restraint.
17. For new builds, and where modifications are occurring to existing environments, the mental health alcohol and other drugs services leadership, within the department and in services, must use co-design processes from the beginning of the capital and procurement process to ensure the consumer voice and seclusion and restraint minimisation is at the forefront of the design. To support this process, the Mental Health Alcohol and Other Drugs System Planning Branch and the OCP must prioritise a statewide policy or guideline which supports co-design and focuses on alternatives to seclusion and restraint at the conception phase of a new environmental build.

Information

Information, including data, must be used as an enabler to deliver transparency and promote responsibility and accountability

18. To support transparency and promote responsibility and accountability, services must:
    a. Publish data at the AMHS level, so that it is readily and publicly accessible and available, to increase visibility to all stakeholders (staff, consumers and their families) on a regular basis (e.g. every 3-6 monthly) in a standard format e.g. rates per 1000 bed days displayed in each inpatient setting to promote transparency. To support this process, the OCP and the Mental Health Alcohol and Other Drugs Branch should lead a consultation process with services, consumers, and other relevant stakeholders to establish

appropriate data parameters for reporting which should also include an ability to report on alternative strategies which are being used to reduce the use of seclusion and restraint.

b. Transparently demonstrate and interrogate data relating to complexities with consumers who are being secluded or restrained enabling those to be rapidly identified, analysed and addressed. This should occur with a co-design approach and may include mapping data trends and changes over time and developing outcomes which can be measured throughout the patient journey. The work of the SMHRU in examining patient pathways may be beneficial in this regard.

Areas for future focus

The following areas were identified as opportunities for further in-depth focus as part of continued efforts to eliminate seclusion and restraint:

- HSIS – noting that it was not an opportune time for this service to participate in the review, it is important that the commitment and momentum which was identified as part of the initial stages of this review be built upon. There is an opportunity for the HSIS to be leaders in change in relation to the management of the complex cohort of consumers who are admitted to that service.

- The specific needs of different populations, including culturally and linguistically diverse consumers and LGBTIQ+ consumers must be considered as part of a wholistic human rights, trauma-informed approach to individualised treatment and care planning.

- Emergency Departments/non mental health settings – consumers of mental health services interact with a range of touch points within the health system where restraints or restrictive interventions may be used. The role that mental health services and clinical staff can have in influencing and impacting these broader health settings should be considered to support efforts to eliminate seclusion and restraint across all settings.

Governance and use of findings

To support transparency and engagement with the recommendations from this review, the reviewers recommend that it be made available to be used openly and transparently as far is as possible.

It is recommended the report be shared with executive directors and senior clinical leaders within the mental health alcohol and other drugs service system, as well as the Director-General, Chief Executives of Hospital and Health Services and Chairs of the HHS Boards, and the Queensland Mental Health Commission.

Acknowledging the collaborative nature of the review, the reviewers recommend the views of the participating sites be sought prior to public distribution of the report.

Signed

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Chief Psychiatrist, Western Australia
Lead Reviewer
Date: 10/05/2023

Signed

Dr Elizabeth Rushbrook
Chief Medical Officer, Metro North Health
Stream Lead Reviewer – OCP
Date: 10/05/2023

Signed

Dr Furhan Iqbal
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Appendix 1 Terms of reference

Terms of Reference

Review into the use of Seclusion, Mechanical Restraint and Physical Restraint under the Queensland *Mental Health Act 2016*.

Introduction

The Office of the Chief Psychiatrist (OCP) in collaboration with the following Authorised Mental Health Services (AMHSs) is undertaking a review of the use of seclusion, mechanical restraint and physical restraint in inpatient units which are representative of the differing types of services available across the Queensland mental health system:

- Children's Health Queensland AMHS (adolescents and children).
- Redcliffe-Caboolture AMHS (secure mental health rehabilitation)
- The Park High Security Inpatient Service AMHS (high secure)
- Wide-Bay AMHS (adult acute)

The OCP is also a participant in the review due to its system oversight role.

The purpose of the review is to support AMHSs' efforts to reduce, and where possible eliminate, the use of seclusion and restraint, and to improve adherence to regulatory requirements under the *Mental Health Act 2016* (the Act) in relation to the management of involuntary patients with complex or higher risk presentations, who have these interventions applied.

Authorising legislation

Under sections 308 and 555 of the Act, the Chief Psychiatrist has appointed 12 Inspectors to provide independent input into the review. Inspectors have been appointed for each of the different service-types available across the Queensland mental health system as outlined below. Instruments of appointment are limited in scope for each Inspector to the relevant AMHS and/or OCP. The Review Lead, Dr Nathan Gibson will be appointed for all AMHSs and the OCP.

Appointed across all AMHSs and for the OCP				
Dr Nathan Gibson, Chief Psychiatrist of Western Australia (Review Lead)				
Adult Acute	Child and Youth	HSIS	SMHRU	OCP
Dr Isabel Wesdorp Susan Hills-Johnes (nursing) Katrina Hansom (IHW)	Dr Prue McEvoy Paul Roberts (nursing)	Dr Ed Heffernan Dr Fiona Davidson (nursing) Matthew Quinn (nursing)	Dr Furhan Iqbal Ashleigh Bayly (nursing)	Dr Elizabeth Rushbrook Dr Terry Stedman

As part of their appointment, the above-listed appointees have the authorities and powers outlined for Inspectors in Chapter 14 of the Act. These authorities, among other things, allow Inspectors to make inquiries about the treatment of a patient in an AMHS and inspect any document (including a health record) about a patient who has been examined or assessed, or has received or is receiving treatment in the AMHS.

However, despite this appointment process, it is not intended that the appointees will use the

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enforcement powers provided under Chapter 14, Parts 3 to 6 of the Act in relation to information access and entry to places. These processes will be required to be undertaken by the Inspectors with the consent, approval and engagement of the AMHSs.

It is a requirement for a report to be produced at the conclusion of the review, in accordance with section 309 of the Act.

The appointment of the Inspectors will cease upon completion and submission of the report to the Chief Psychiatrist.

Scope

The review is centred on seclusion, mechanical restraint and physical restraint practices authorised in specific circumstances under Chapter 8 of the Act. The purpose is to identify how these practices are used in AMHSs and identify themes, lessons and actions which can be embedded at system and service levels to support optimal clinical practice and if appropriate, the reduction and possible elimination of seclusion and restraint over time. The review may also seek ways to optimise individual experiences for patients, support persons and staff, and support healing by encouraging open communication and trust, and by identifying areas of good practice.

The focus of the review is seclusion, mechanical restraint and physical restraint as defined under the Act to enable the review to be targeted and consistent in terms of the identified practices being considered across all AMHS settings. The definitions in the Act are outlined below:

Section 244 Mechanical Restraint:

1. *Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.*
2. *However, mechanical restraint does not include—*
   (a) the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury; or
   (b) restraint of a person that is authorised or permitted under a law other than this part. Example for paragraph (b)— The restraint of a person by a police officer may be authorised under the Police Powers and Responsibilities Act 2000, section 615.

Section 254 Seclusion:

1. *Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.*
2. *However, seclusion does not include—*
   (a) confinement of a person in a high security unit, or in another authorised mental health service approved by the chief psychiatrist for the purposes of this part, if the confinement is—
      (i) for a period, approved by the administrator of the service, of not more than 10 hours between 8p.m. and 8a.m.; and
      (ii) for security purposes;
   (b) confinement that is authorised under a law other than this part.

Section 268 Physical Restraint:

1. *Physical restraint, of a patient, is the use by a person of his or her body to restrict the patient's movement.*
2. *However, physical restraint of a patient does not include—*
   (a) the giving of physical support or assistance reasonably necessary—
      (i) to enable the patient to carry out daily living activities; or
      (ii) to redirect the patient because the patient is disoriented; or
   (b) physical restraint of the patient that is authorised under a law other than this part; or
   (c) physical restraint of the patient that is required in urgent circumstances.

To facilitate achieving the purpose of the review, the following areas of practice, insofar as they relate to the use of seclusion and restraint under the Act, may be considered as part of the review, although this list is not an exhaustive one:

- Models of Service and models of care and application within settings
- care planning and review

- risk assessment and risk management practices
- workforce
- leadership and culture
- consumer and carer engagement in care
- environmental factors
- specific strategies or approaches when caring for First Nations people and culturally and linguistically diverse populations
- specific structured evidence-based care and improvement activities, including current therapeutic approaches and any lessons learnt from them
- interface with the OCP and policy requirements, including clinical information and documentation requirements.

Review roles and support

Administrative and logistical support

The OCP will provide administrative and logistical support to the review and will work closely with the AMHSs contacts. The Director, Legislation Unit, OCP will report directly to the Review Lead (Dr Nathan Gibson) in relation to administrative issues and operational matters as required.

Staff from the OCP will attend each site visit with appointed Inspectors to assist with recording and documenting insights gained during the visits. However, importantly, the appointed Inspectors will form independent views and draft findings / recommendations as part of the review and OCP staff will not determine any view, finding or recommendation for or on behalf of the Inspectors.

Staff within the Legislation Unit, OCP will also prepare draft documentation for the review as requested by the Inspectors. The Review Lead will oversee and have responsibility for the final drafting of the review report.

AMHS support

Each AMHS has nominated one or more contact persons for the review. Inspectors will liaise with these nominees as required as the contact point for the relevant AMHSs engagement in the review. The role of the AMHS contact is to:

1. engage in meetings with the Inspectors and Review Lead, and the Legislation Unit, OCP, as required
2. provide AMHS documentation relevant to the review
3. facilitate site visits and staff engagement
4. review and input into outputs.

Outputs and use of findings

Discussion papers will be prepared for each component of the review (AMHSs and OCP), summarising the key areas of good practices, lessons and themes identified through the review process. This will enable stream specific lessons to be captured separately as needed.

The discussion papers will be used to form the overarching review report and all documents will be circulated for feedback to the AMHS contacts prior to the review report being finalised.

The discussion papers and review report may identify areas of good practice, lessons and proposed alternative approaches which can be used to inform policy and practice requirements. The review may also inform policy and practice approaches, including those relating to longer term seclusion management, models of care and associated information gathering and sharing, training needs, and infrastructure considerations.

Timeframe

The methodology for the review and having dedicated teams across AMHSs and the OCP allows flexibility in approaches to site visits and may result in components of the review being finalised at different stages.

However, regardless of the approaches taken, all components of the review must be completed by March 2023.

Sections 309 and 310 of the Act detail what actions may be taken once the review report is provided.

The findings of the review will be provided by the Chief Psychiatrist to the participating AMHSs for their use in the first instance.

The further intention is that where appropriate, findings or themes will be shared more broadly across the Queensland mental health service system without identification of participating AMHSs. However, if any findings or themes could be linked to individual participating AMHSs, any wider sharing of these findings or themes will only occur with the agreement of the relevant participating AMHSs and in compliance with any relevant confidentiality and privacy laws.

Appendix 2 Consultation List

Site	Position	Name
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
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AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
AAMHIU – Wide Bay	Redacted	Redacted
CHQ	Redacted	Redacted
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CHQ	Redacted	Redacted
CHQ	Redacted	Redacted
CHQ	Redacted	Redacted
CHQ	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
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SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted
SMHRU – Metro North	Redacted	Redacted

SMHRU – Metro North	Redacted	Redacted
OCP	Redacted	Redacted
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OCP	Redacted	Redacted
OCP	Redacted	Redacted
MHAOD Branch	Redacted	Redacted
MHAOD Branch	Redacted	Redacted
MHAOD Branch	Redacted	Redacted

MHAOD Branch	Redacted	Redacted
Queensland Occupational Violence Strategy Unit	Redacted	Redcated
Office of the Chief Nursing and Midwifery Officer	Redacted	Redacted
Patient Safety and Quality	Redacted	Redacted
Aboriginal and Torres Strait Islander Workforce Leadership Group	Redcated	Redacted
Allied Health MHAOD Advisory Group	Redacted	Redacted
Lived Experience Workforce Leadership Group	Redacted	Redacted