Guidelines: The management of disturbed/violent behaviour in inpatient psychiatric settings

Government of Western Australia
Department of Health

Acknowledgement

Disclaimer

This guideline has been adapted from Clinical Guideline 25: Violence: The short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments; published by the National Institute for Clinical Excellence (NICE), February 2005 and available from www.nice.org.uk[1] Extracts from the NICE Clinical Guideline have been reproduced with the permission of NICE. The original NICE recommendations were prepared in relation to the National Health Service in England and Wales. NICE has not been involved in the development or adaptation of the NICE recommendations for use in Western Australia or in checking that its recommendations have been reproduced accurately.

Foreword

These Guidelines are the first statewide guidelines for the management of aggression and violence in inpatient settings in Western Australia. The information is based on the latest available research and on significant consumer and clinician input.

The appropriate management of behavioural disturbance and violence is crucial in providing a safe environment for staff and patients, which enables the provision of high quality care. The Mental Health Division is committed to building safe, high quality mental health services and has funded the development of a number of initiatives to improve the safety of consumers and clinicians, including:
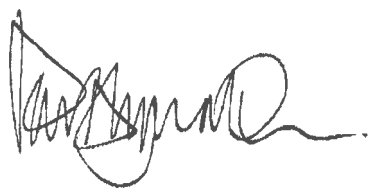
- *The Safety Guidelines*: *Guidance on Safety Issue*s from the WA Mental Health Safety Working Group.
- The Clinical Risk Assessment and Management Project;
- Enhancement of Health Services' duress systems; and
- *The Guidelines For the Management of Disturbed/Violent Behaviour in Inpatient Psychiatric Settings.*

The Guidelines For the Management of Disturbed/Violent Behaviour in Inpatient Psychiatric Settings describe areas of best practice when managing potentially violent behaviour. Recommendations are made including working in partnership with consumers and carers, and using de-escalation techniques that are considered to be the most effective.

In WA we are fortunate to have many mental health clinicians who already practice the recommendations of the guidelines for the management of aggression and violence in the workplace. The formalising and standardising of these practices across all services in Western Australian will allow for ongoing monitoring and evaluation to ensure the continued development of best practice.

I would like to thank the Dr Adam Brett and the WA Guideline Group for their input and hard work in creating these Guidelines.

I encourage all clinicians to read this document, and work together to create safer and better mental health services in WA.

Dr Peter Wynn Owen
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Preamble

Violence is a primary concern of all health services in Australia. There is a growing concern about the safety of patients and clinicians in health care settings, including those in the mental health service. Australian research shows that violence in mental health units occurs more frequently than in any other health care setting, and over half of all violent incidents in any health care setting involve mental health problems as a patient-related contributing factor.[2]

Improving the safety of patients and staff in Western Australian mental health services is a priority for the Department of Health. The Mental Health Division has initiated a number of projects to improve safety in mental health services and has supported the formation of these guidelines for the management of violence, together with the *'Safety Guidelines: Guidance on safety issues in the workplace'*.[3]

The recommendations of the *WA Mental Health Safety Working Group in 'Safety Guidelines: Guidance on safety issues in the workplace'*[3] are more extensive and consider additional staff safety issues than in the current guidelines for the management of disturbance/violence. The two documents should be considered together.

An important part of improving safety in the workplace is to consider consumer satisfaction with services. This document seeks to incorporate and acknowledge the feedback received from consumers.

Scope of Guidelines

The scope of the guideline is the management of disturbed and/or violent behaviour in adult psychiatric inpatient settings. The guidelines cover all public adult psychiatric inpatient settings. For the purposes of this guideline, adult is defined as a patient who is in an adult public mental health unit.

These guidelines provide a framework and identify training strategies for prediction and risk assessment, de-escalation techniques, observation, physical intervention, seclusion and sedation.

In addition, the guideline examines factors in the inpatient environment that relate to the management of disturbed/violent behaviour and consumer perspectives on interventions to manage violence, as well as exploring how ethnicity, gender and other special concerns need to be taken into consideration when applying interventions.

Who developed the Guidelines?

These guidelines were based on those produced by the National Institute of Clinical Excellence (NICE) in February 2005: Guideline 25: Violence: The short-term management of disturbed/violent behaviour in inpatient settings and emergency departments. The NICE guidelines were based on a rigorous review of available research and on the opinions of an expert panel.[1]

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[1] For the full explanation of the development of the NICE guidelines, please refer to the website: www.nice.org.uk

In WA the Guideline Development Group for the Management of Disturbed/Violent Behaviour in Inpatient Psychiatric Settings (Guideline Group) was convened by the Mental Health Division to prepare clinical guidelines for Western Australian public mental health services. The Guideline Group consisted of a panel of consumers, psychiatrists, mental health nurses, and representatives from the Mental Health Division and the Office of the Chief Psychiatrist. The group was convened in May 2005 and met seven times, concluding in November 2005.

During this time, the Project Officer of the Guideline Group conducted focus groups with clinicians from inpatient sites across the metropolitan area to present an overview of the guidelines, and to receive feedback regarding their content and implementation. The consumer representatives of the Guideline Group also conducted focus groups with consumers to gather opinions on many of the issues surrounding inpatient disturbance/violence. This feedback was used to inform the development of the guidelines.

The draft guidelines were sent out to the wider community for comment and consultation, including the Area Health Service managers and clinicians, The Multicultural Forum, The Council of Official Visitors, The Mental Health Review Board and Western Australian Therapeutics Advisory Group (WATAG).

Review

The process of reviewing the evidence is expected to begin two years after the issue date of this guideline. This review may begin earlier if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within two years of the review commencing.

Amendments to this document will be made, if necessary, following the completion of:

- The Review of the *Mental Health Act 1996*; and

- The recommendations from the Seclusion and Time Out Committee (a sub-committee of the Mental Health Network Coordinating Group).

Executive Summary

Environment

1. The inpatient environment can have a significant influence on the management of disturbed/violent behaviour. Design ideas that encourage managing the consumer in the least restrictive environment are recommended, such as:

    - Providing a designated area or room specifically for the purpose of reducing arousal;
    - Providing activity rooms and spaces, which encourage consumers to engage in physical exercise, group interaction, therapy and recreation; and
    - Consumers to have easy access to fresh air and natural daylight.

2. The environment is also an important factor in catering for consumer needs by taking into account the needs of the diverse consumer group and allowing space for cultural and gender specific activities.

3. In Authorised Hospitals the seclusion room should be designated for seclusion only. The room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand damage.

4. The policies of local services must address:

    - The need for alarms according to a risk assessment of the clinical environment, consumers and staff;
    - Regular training in responding to alarm; and
    - Regular training in the risk assessment of the clinical and physical environment.

Assessment

1. Measures to reduce disturbed/violent behaviour must be based on risk assessment and risk management strategies. Mental health service providers need a full risk management strategy for all services, and policies to ensure that these are clearly explained and followed.

2. Standardised risk assessment procedures using actuarial tools and structured clinical judgement should be in place in every service. The risk assessments must be ongoing and regularly updated according to clinical need.

3. A structured sensitive interview with the consumer, and where appropriate their carers, is an important assessment tool with the potential to de-escalate situations which may become violent. The aim of the interview should be to elicit the consumer's view regarding their triggers, early warning signs and possible management strategies that have worked previously.

4. All those who conduct risk assessments should be trained to do so, as well as how to recognise antecedents and signs of potential aggression and to understand cultural differences that may be misinterpreted as such.

Training

1. Statewide standards for training in the management of disturbed/violent behaviour should be developed.

2. All service providers should have a policy for training employees regarding the management of disturbed/violent behaviour. The policy should standardise and ensure consistency regarding who receives the training, who provides the training and how often training and updates occur.

3. Training in de-escalation, including competency training to recognise anger, potential aggression, antecedents and risk factors should be provided to all clinical staff. Specific de-escalation techniques and their application in potentially violent situations must also be included.

4. Other areas of importance include training in areas such as:

    -   Observation;

    -   Cardiopulmonary resuscitation for all those involved in physical restraint, seclusion and medication;

    -   Training in medications, including those used for sedation; and

    -   Training that considers racial, cultural, social and spiritual, social and special needs to ensure that staff are aware of and know how to work with diverse populations.

Working with Consumers

1. Recognising and respecting individual and cultural diversity within the patient group is a priority.

2. The guidelines emphasise collaboration with consumers to have their needs and wishes recorded in the form of an Advance Statement. This will outline the consumer's wishes for treatment, especially in the event of a disturbed/violent incident.

3. Working closely and respectfully with consumers by providing information regarding treatment and by concentrating on effective communication between staff and consumers is seen as an important way of strengthening this relationship. Working together with consumers in this way also helps to de-escalate future disturbed/violent incidents and recognises the importance of involving consumers in their treatment.

4. Services must also be responsible for ensuring the adequacy of service provision in relation to the management of disturbed/violent behaviour including training on all matters relating to equality and diversity, monitoring service usage by ethnicity and in consultation with Culturally and Linguistically Diverse (CALD) and Indigenous groups.

Searching

1. All services must have a policy concerning the searching of patients, their belongings and the environment in which they are accommodated. The searching policy is to ensure the creation and maintenance of a safe and therapeutic environment for patients, staff and visitors.

2. The searching policy should address all aspects of personal through to environmental searching from the decision to initiate the search through to the storage, return or other disposal of items found.

3. Legal issues around searching must be explored and addressed by the policy.

4. Patient consent should always be obtained, and the policy must address what is to happen if the patient does not consent to the search.

5. Staff must be informed of all policies and procedures regarding searching.

6. Searches should be undertaken with sensitivity and respect for the patient's dignity, and should have a level of intrusiveness proportionate to the need and reason for the search.

7. Post-search support must be available for those who need it, and a review should be conducted after consent has been withheld.

De-escalation

1. De-escalation is a significant factor in reducing the use of physical intervention and seclusion; therefore, de-escalation techniques are emphasised. Working closely and respectfully with consumers, while taking into consideration their Advance Statement as much as possible, is seen as a significant part of de-escalation.

2. Staff training and awareness of diversity in the consumer group and how to work within these differences is another important factor.

3. Standardised training in de-escalation techniques must be provided for all staff involved with consumers.

4. Staff must recognise that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

Observation and Engagement

1. All services should use standardised terminology for different observation levels. This document recommends four levels of observation and recommends the adoption of these terms across WA services.

2. Each service must have comprehensive policies regarding the use of observation, covering who instigates observation, when reviews should take place and how consumer's perspectives will be taken into account.

3. The least intrusive level of observation appropriate to the situation should always be adopted, with consideration for the consumer's dignity and privacy whilst maintaining the safety of those around them.

4. Staff should receive training in observation techniques, and the potential that these techniques have to de-escalate certain behaviour and also to engage with the consumer. However, staff must also be aware of different sensitivities to observation amongst certain consumers, such as Indigenous and CALD populations, and victims of abuse.

5. Consumers should be continually informed regarding why they are under observation, the aims of observation and how long it is likely to be maintained.

Physical Intervention/Restraint

1. Physical intervention/restraint should only be considered once all de-escalation techniques have failed.

2. Services must identify and promote best practice in the prevention, reduction and where possible elimination of the use of physical intervention/restraint.

3. If physical intervention is unavoidable, then it must not be used for prolonged periods, and must be concluded at the earliest opportunity.

4. The dignity of the patients must be respected during physical intervention, and the reasons for using the intervention explained as much as possible.

5. A crash bag must be available within three mins, and a doctor available to attend an alert by staff.

6. All staff involved in physical intervention/restraint should be trained in a standardised technique and receive ongoing refresher courses.

7. After the intervention patients should have the opportunity to document their account, and their Advance Statement should be updated.

Seclusion

1. Services must identify and promote best practice in the prevention, reduction and where possible elimination of the use of seclusion.

2. Seclusion should be for the shortest time possible and must be reviewed at least every two hours.

3. Consumers in seclusion must be provided with their basic needs including bedding, clothing, food, drink and toilet facilities. Any deviation must be reported to the Mental Health Review Board.

4. The dignity of the patients must be respected during seclusion, and the reasons for using seclusion explained as much as possible.

5. A crash bag must be available within three mins, and a doctor available to attend an alert by staff.

6. Following the intervention patients should have the opportunity to document their account, and their Advance Statement should be updated.

Use of Pharmacology

1. There are specific risks associated with the different classes of medications. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded.

2. Staff need to be aware and trained about the risks associated with the various medications and what to do if a patient has an adverse or unpredicted reaction to the medication.

3. Oral medication should be offered before parenteral medication as far as possible.

4. All those who prescribe medications must be aware of the current WATAG recommendations.

5. The dignity of the patients must be respected during sedation, and the reasons for using medications explained as much as possible.

6. A crash bag must be available within three mins, and a doctor available to attend an alert by staff.

7. Following sedation patients should have the opportunity to document their account, and have their Advance Statement updated if necessary.

Incident Reporting and Post-Incident Review

1. Health services must provide an integrated, blame-free system for identifying, reporting and managing all hazards, accidents and incidents (e.g. physical intervention or seclusion).

2. A post incident review should take place within 72 hours of the incident, and the aim of the review is to support staff and patients, seek to learn lessons and encourage the therapeutic relationship between patients, their carers and staff.

3. Mental health service providers should have systems and skilled staff in place to ensure a range of post incident-support options and review mechanisms is available.

Outline of Legal Framework

These guidelines make recommendations about the short-term management of disturbed/violent behaviour in adult psychiatric inpatient settings. Any actions take place within a multi-faceted legal framework, compliance with which is a core measure of quality and good practice. For instance, the management of disturbed/violent behaviour frequently involves interventions to which an individual is unable or refuses to consent. It is essential that all interventions are in accordance with best practice and that specific requirements are complied with e.g. seclusion, emergency psychiatric treatment.

Failure to act in accordance with these guidelines may be a failure to promote best practice, and in some circumstances may have legal implications. For example, any intervention required to manage disturbed behaviour must be a reasonable and a proportionate response to the risk it seeks to address.

Services should consult on an individual basis with Legal and Legislative Services, Department of Health, for advice when required in relation to the management of disturbed/violent behaviour.

There is legal provision to respond to disturbed/violent behaviour in some circumstances, and clinicians should familiarise themselves with what action they may legally take.

All those involved in the management of disturbed/violent behaviour in psychiatric inpatient settings need to be familiar with:

- The relevant sections of the *Mental Health Act 1996* and the Mental Health Regulations 1997, including:

  - Division 2, Part 5 - Informed consent;

  - Section 109 - Consent not required for psychiatric treatment;

  - Division 7, part 5 - Emergency Psychiatric Treatment;

  - Division 8, Part 5 – Seclusion of patients;

  - Division 9, Part 5 – Mechanical bodily restraint;

  - Section 162 - Offence of ill-treatment; and

  - Regulation 11, 12, 13, 14, 15, 16, 17.

- The principles underlying the common law doctrine of 'necessity'.
- The Criminal Code with special regard to the provisions for the use of force.
- The *Civil Liability Act 2002*.
- The *Occupational Safety and Health Act 1984,* which place duties on both employers and employees.

- The *Occupational Safety and Health Regulations 1996* (WA), which place specific duties on the employer to ensure suitable arrangements for the effective planning, organisation, control, maintenance and review of health and safety issues.

- The Department of Health's Prevention of Workplace Aggression and Violence: Policy and Guidelines 2004.

- The Operational Circular from the Office of the Chief Psychiatrist regarding Matters to be Reported to the Chief Psychiatrist.

All staff should -

- Receive regular training on the legal aspects of the management of disturbed/violent behaviour.

- Ensure that a comprehensive record is made of any intervention necessary to manage an individual's disturbed/violent behaviour, including full documentation of the reason for any clinical decision.

- Ensure or contribute to ensuring that all aspects of the management of disturbed/violent behaviour are monitored on a regular basis, and that any consequential remedial action is drawn to the attention of those responsible for implementing it.

- Be aware of the obligations owed to a patient while his/her disturbed/violent behaviour is being managed, and of parallel obligations to other patients affected by the disturbed/violent behaviour, to members of staff, and to any visitors.

- Ensure or contribute to ensuring that any patient who has exhibited disturbed/violent behaviour should continue to be treated with dignity and respect, irrespective of the patient's behaviour, and that where the disturbed/violent behaviour is thought to warrant criminal sanction, it is drawn to the attention of the proper authority.

The information contained in these Guidelines is not intended to be, nor should it be relied upon as a substitute for, legal or other professional advice.

If you have a legal problem you should seek legal advice tailored to your circumstances from the Legal and Legislative Services Directorate of Health System Support within the Department of Health (or from the State Solicitor's Office in the case of teaching hospitals).

Guidelines

1. Environment (adult inpatient psychiatric settings)

The right physical and therapeutic environment can help to de-escalate and potentially eliminate disturbed/violent behaviour. The following recommendations are minimum requirements expected within inpatient psychiatric settings.

The literature indicates that there is a move towards small (8-10 bed) specialist close-observation units, internationally known as Psychiatric Intensive Care Units (PICU) for patients with acute mental health problems. The design of these units emphasise personal space, easily observable patient areas and homely and safe fittings. A high staff to patient ratio, which allows a more psychotherapeutic approach to treatment, is an important feature of a PICU.[4] These environmental considerations are supported by the recommendations below and should be consulted when planning and building future mental health services.

These guidelines should be considered in conjunction with *The WA Mental Health Safety Working Group* recommendations in '*Safety Guidelines: Guidance on safety issues in the workplace*'.[3]

The *WA Mental Health Safety Working Group* recommends that services work towards achieving these recommendations within the next five years. A comprehensive audit of the current facilities against the recommendations is suggested as the initial step in reviewing the environment in each service.

1.1   *The WA Mental Health Safety Working Grou*p recommends that prior to the development or refurbishment of any State funded inpatient mental health facility, suitable consultation with user groups is conducted.

Clinical Environment

1.2   Local protocols should be developed to ensure that police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between agencies. Such policies should set out what constitutes an emergency requiring police intervention. Statewide protocols between the Western Australian Police Service and the Mental Health Division have been developed and can guide the development of local policies.

1.3   Management should ensure a stable and consistent inpatient staff team and commit to regular updates of the professional skills of staff. High staff turnover and overuse of casual, locum and agency healthcare staff may contribute to destabilising the environment.

1.4   Regularly conducted risk assessments will help to ensure the safety of the clinical environment.

1.5   Full bed occupancy should not, if at all possible, be exceeded, as overcrowding can lead to tension for patients and staff.

1.6   The movement of patients between wards (and back again) to manage bed pressures should also be recognised as a potential catalyst of disturbed/violent behaviour.

1.7   When staff are engaged in the management of disturbed/violent behaviour, every effort should be made to manage the patient in the least restrictive physical environment.

General Environment

1.8   All services should aim to provide a designated area or room that staff may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation. In services where seclusion is practised, this area should be in addition to a seclusion room.

1.9   In Authorised Hospitals there should be a designated seclusion room. This room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand attack/damage.

1.10   The environment should take into account patient needs for:

- Safety;
- Privacy;
- Dignity;
- Gender and cultural-sensitivity;
- Sufficient physical space; and
- Social and spiritual expression.

1.11   The environment should also address the patient's needs for engaging in activities and individual choice:

- There should be an activity room and a dayroom with a television, as boredom can lead to disturbed/violent behaviour;
- Patients should have gender-specific toilets, washing facilities and sleeping accommodation; and
- There should be a quiet room that can be used for prayer or quiet reflection.

1.12   There should be daily opportunities for patients to engage in physical exercise, group interaction, therapy and recreation. The particular needs of Culturally and Linguistically Diverse (CALD) patients should be considered and accommodated within the capabilities of the service.

1.13   There should be access to the day room at night for patients who cannot sleep if this does not conflict with the patient's clinical management plan.

1.14 Patients should have easy access to fresh air and natural daylight. The outdoor areas should be well designed to ensure adequate space and facilities. The outdoor design should be visually pleasing and not institutional or prison-like. Staffing numbers need to be consistently adequate to allow for easy access to these areas if access is only in the company of staff.

1.15 A patient should have the capacity to lock their own room, bathroom and toilet area, with a staff override facility.

1.16 Where possible, patients should have privacy when making phone calls, receiving guests, and talking to a staff member. The *Mental Health Act 1996* stipulates the right of patients to reasonable privacy in these circumstances unless ordered by the treating psychiatrist for reasons in the patient's interest (*Mental Health Act 1996 sections 167 – 171*).

1.17 The internal design of the ward should be arranged to facilitate observation, and sight lines should be unimpeded (for example, not obstructed by the opening of doors). Measures should be taken to address blind spots within the facility, including consideration of the use of closed circuit television (CCTV) and parabolic mirrors.

1.18 Facilities should ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.

1.19 There should be a separate area to receive patients with police escorts.

1.20 Where practicable, access to an external area should be via the unit and where necessary, appropriate standards of fencing should be provided.

1.21 Facilities should have adequate means of controlling light, temperature, ventilation and noise.

1.22 Internal smoking areas/rooms should have powerful ventilation and be fitted with a smoke-stop door(s).

1.23 All areas should look and smell clean.

1.24 Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment or other special needs.

Alarms

The '*Safety Guidelines: Guidance on safety issues in the workplace*' provides guidelines on duress alarms.

1.25 Each service should have a local policy on alarms and determine the need for alarms according to a risk assessment of the clinical environment, patients and staff. The policy should be disseminated and staff made familiar with its contents.

1.26 Risk assessment of the clinical and physical environment should be used to determine whether supplementary personal alarms should be issued to vulnerable patients and individual staff members.

1.27 Coordinated responses to alarm calls should be agreed before incidents occur and be consistently applied and rehearsed.

1.28 Furniture should be arranged so that alarms can be reached and doors are not obstructed.

1.29 Alarms should be accessible in interview rooms, reception areas and other areas where one patient and one staff member work together.

1.30 All alarms (for example, duress buttons and personal alarms) should be well maintained and checked at least monthly.

1.31 Regular training regarding the operation of, and response to, the alarms in place is recommended by the *WA Mental Health Safety Working Group, 'Safety Guidelines: Guidance on safety issues in the workplace'*.

Main Recommendations

1. The environment can have a significant influence on the management of disturbed/violent behaviour. Design ideas that encourage managing the consumer in the least restrictive environment are recommended, such as:

   - Providing a designated area or room specifically for the purpose of reducing arousal;
   - Providing activity rooms and spaces, which encourage consumers to engage in physical exercise, group interaction, therapy and recreation; and
   - Consumers to have easy access to fresh air and natural daylight.

2. The environment is also an important factor in catering for consumer needs by taking into account the needs of the diverse consumer group and allowing space for cultural and gender specific activities.

3. In Authorised Hospitals the seclusion room should be designated for that purpose only. The room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand damage.

4. The policies of local services must address:

   - The need for alarms according to a risk assessment of the clinical environment, consumers and staff.
   - Regular training in responding to alarms.
   - Regular training in the risk assessment of the clinical and physical environment.

2. Assessment

Disturbed/violent behaviour can never be predicted with complete accuracy and accurate prediction is not the aim of risk assessment. Rather, undertaking a structured, evidenced based and comprehensive risk assessment that takes into account the patient's history and circumstances will assist in formulating clinical management strategies.

Risk Management policy and guidelines should be in place for all health service organisations as part of their responsibilities under the *Occupational Safety and Health Act 1984*. Risk management at an organisational level will clarify how to identify, analyse, treat and communicate risk. These guidelines will focus on the clinical risk assessment and clinical risk management of a patient, not on the broader organisational risk assessment. They will include considerations of clinical environmental factors as they affect the patients' mental health and potential for risk.

2.1 Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all services.

2.2 The Clinical Risk Assessment and Management Project will develop a policy and framework which will be available during 2006. In the interim, refer to *The Framework for Clinical Risk Assessment and Management of Harm* when developing policies for mental health services.

2.3 Risk assessment should be used to establish whether the clinical treatment plan should include specific interventions for the management of disturbed/violent behaviour.

2.4 Risk assessment should include a structured and sensitive interview with the patient and, where appropriate, carers. Efforts should be made to ascertain the patient's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process.

2.5 When assessing for risk of disturbed/violent behaviour, care needs to be taken not to make negative assumptions based on ethnicity. Staff members should be aware that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective, with consideration being given to the degree to which the perceived risk may be culturally appropriate.

2.6 Since the components of risk are dynamic and may change according to circumstance, risk assessment (of the environment and the patient) should be ongoing and care plans based on an accurate and thorough risk assessment that is regularly updated as per clinical need.

2.7 The approach to risk assessment should be multidisciplinary and reflective of the care setting in which it is undertaken. The findings of the risk assessment should be communicated across relevant agencies and care settings, in accordance with the law relating to patient confidentiality.[6]

2.8 All staff should be aware of the following factors that may provoke disturbed/violent behaviour:

- 🟧 Attitudinal;
- 🟧 Situational;
- 🟧 Organisational; and
- 🟧 Environmental.

2.9 Actuarial tools and structured clinical judgment should be used in a consistent way to assist in risk assessment. Actuarial tools are those that have been standardised and psychometrically tested.

The Clinical Assessment of Risk Decision Support (CARDS) is an example of a structured clinical judgement system and contains checklists that can aid assessment.[7] The CARDS assessment tool has been well evaluated for clinical application.

Clinical variables

2.10 Certain features can serve as warning signs to indicate that a patient may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive and these warning signs should be considered on an individual basis.

- 🟧 Facial expressions tense and angry;
- 🟧 Increased or prolonged restlessness, body tension, pacing;
- 🟧 General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils);
- 🟧 Increased volume of speech, erratic movements;
- 🟧 Prolonged eye contact;
- 🟧 Discontentment, refusal to communicate, withdrawal, fear, irritation;
- 🟧 Thought processes unclear, poor concentration;
- 🟧 Delusions or hallucinations with violent content;
- 🟧 Verbal threats or gestures;
- 🟧 Replicating, or behaviour similar to that, which preceded earlier disturbed/violent episodes;
- 🟧 Reporting anger or violent feelings; and
- 🟧 Blocking escape routes.

Certain factors can indicate an increased risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

2.11   Demographic or personal history should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features:

- History of disturbed/violent behaviour;
- History of misuse of substances or alcohol, including previous withdrawal symptoms;
- Carers reporting patient's previous anger or violent feelings;
- Previous expression of intent to harm others;
- Evidence of rootlessness or 'social restlessness';
- Previous use of weapons;
- Previous dangerous impulsive acts;
- Denial of previous established dangerous acts;
- Severity of previous acts;
- Known personal trigger factors;
- Verbal threat of violence;
- Evidence of recent severe stress, particularly loss event or the threat of loss;
- Reckless driving; and
- The loss of a parent before the age of eight years.

2.12   Clinical variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features:

- Misuse of substances and/or alcohol;
- Drug effects (disinhibition, akathisia);
- Active symptoms of schizophrenia or mania, in particular:
    - Delusions or hallucinations focused on a particular person;
    - Command hallucinations;
    - Preoccupation with violent fantasy;
    - Delusions of control (especially with a violent theme); and
    - Agitation, excitement, overt hostility or suspiciousness.
- Poor collaboration with suggested treatments;
- Antisocial, explosive or impulsive personality traits or disorder; and
- Organic dysfunction.

2.13   Situational variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features:

- Extent of social support.
- Immediate availability of a potential weapon.
- Relationship to potential victim (for example, difficulties in relationship are known).
- Access to potential victim.
- Limit setting (for example, staff members setting parameters for activities, choices etc.).
- Perceived staff attitudes.
- Issues relating to CALD consumers e.g.
  - Those awaiting the outcomes of visa applications; and
  - Grief/loss issues e.g. over kin whose fate remain unknown.

2.14   For further information on the development of risk management strategies please consult:

- Australian/New Zealand Standard on Risk Management AS/NZS 4360:2004[8];
- The Treasurer's Instruction 825[9]; and
- Mental Health Division website for an agreed risk management framework[5].

Main Recommendations

1. Measures to reduce disturbed/violent behaviour must be based on risk assessment and risk management strategies. Mental health service providers need a full risk management strategy for all services, and policies to ensure that these are clearly explained and followed.

2. Standardised risk assessment procedures using actuarial tools and structured clinical judgement should be in place in every service. The risk assessments must be ongoing and regularly updated according to clinical need.

3. A structured sensitive interview with the consumer, and where appropriate their carers, is an important assessment tool and can also help to de-escalate situations that have the potential to become violent. The aim of the interview would be to help elicit the consumer's view regarding their triggers, early warning signs and possible management strategies that have worked in past situations.

4. All those who conduct risk assessments should be trained to do so, as well as how to recognise antecedents and signs of potential aggression and to understand cultural differences that may be misinterpreted as such.

3. Training

Staff need to have the appropriate skills to manage disturbed/violent behaviour in psychiatric inpatient settings. Training in the interventions used for the management of disturbed/violent behaviour safeguards both patients and staff. Training that highlights awareness of racial, cultural, social and religious/spiritual needs, age and gender differences, along with other special concerns, also mitigates against disturbed/violent behaviour. Such training should be properly audited to ensure its effectiveness.

3.1   All service providers should have a policy for training all employees in relation to the management of disturbed/violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and the techniques in which they will be trained.

3.2   Statewide standards for the training of staff in the management of disturbed/violent behaviour need to be developed to ensure the consistency of training provided across services in WA.

3.3   Services should review their training strategy annually to identify those staff groups that require ongoing professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical intervention to manage disturbed/violent behaviour.

3.4   All training should be monitored and evaluated.

3.5   Consumers and/or consumer groups will have the opportunity to be involved in setting the training agenda. The process of collaboration will include consumer membership on any future training reference groups and wide consultation with consumers regarding preferred training and training agendas.

3.6   Independent bodies/consumer groups should, if possible, be involved in evaluating the effectiveness of training.

3.7   Participants should demonstrate skills and knowledge in the management of aggression, as well as attitudes reflective of contemporary guidelines and current practice.

3.8   The training programme should include a component that considers racial, cultural, spiritual and social issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes. Such courses should also cover any special populations, such as migrant populations and asylum seekers, which are relevant to the specific locality or to WA in particular.

3.9   All staff should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, deescalating or coping with disturbed/violent behaviour (Consult section 6 De-escalation).

3.10 All staff who are required to manage the risk of disturbed/violent behaviour should be trained to complete a clinical risk assessment.

3.11 Staff members responsible for carrying out observation and engagement should receive ongoing competency training in observation, so that they are equipped with the skills and confidence to engage with patients.

3.12 All staff involved in administering or prescribing intravenous medication, or monitoring patients to whom parenteral medication has been administered, should receive ongoing annual competency based training to a minimum of Advanced Resuscitation (St John) or equivalent (covers airway, cardiopulmonary resuscitation [CPR] and use of defibrillators).

3.13 Staff who employ physical intervention or seclusion should as a minimum be trained in Basic Life Support (St John) or equivalent.

3.14 All staff should receive training to ensure current competency in the use of physical intervention, which should adhere to approved State standards.

3.15 Service providers should be aware that the staff's physical health may impact on their capability to undertake physical intervention and physical intervention training courses.

3.16 All staff should receive ongoing competency training in the use of seclusion. Training should include appropriate monitoring arrangements for patients placed in seclusion.

3.17 All staff involved in the administration of intravenous medication should be trained in the use of pulse oximeters.

3.18 Medical and nurse practitioners who prescribe and administer medicines should be familiar with and have received training in medications for sedation, including:

- The properties of Benzodiazepines; their antagonist, Flumazenil; antipsychotics; antimuscarinics; and antihistamines.
- The potential for drug side effects (such as Extrapyramidal side effects and Neuroleptic Malignant Syndrome) and drug interactions.
- The risks associated with sedation, including cardiorespiratory effects of the acute administration of these drugs, particularly when the patient is highly aroused and may have been misusing drugs; is dehydrated or possibly physically ill.
- The need to titrate doses to effect.

3.19 All staff should receive appropriate instruction on undertaking of searches which is repeated and regularly updated.

3.20 Staff need to be aware of and trained to respond to the different physical requirements of certain groups/individuals e.g. older adults and those with co-morbid organic issues.

3.21 Training should be given to all appropriate staff to ensure that they are aware of how to correctly record any incident using the appropriate local and statewide templates.

Main Recommendations

1. Statewide standards for training in the management of disturbed/violent behaviour should be developed.

2. All service providers should have a policy for training employees regarding the management of disturbed/violent behaviour. The policy should standardise and ensure consistency regarding who receives the training, who provides the training and how often training and updates occur.

3. Training in de-escalation, including competency training to recognise anger, potential aggression, antecedents and risk factors should be provided to all clinical staff. A significant part of the training needs to concentrate on de-escalation techniques and their application in potentially violent situations.

4. Other areas of importance include training in areas such as:

    -   Observation.

    -   Cardiopulmonary resuscitation for all those involved in physical restraint, seclusion and giving medication.

    -   Training in medications, including those used for sedation.

    -   Training that considers racial, cultural, social and spiritual, social and special needs to ensure that staff are aware of and know how to work with diverse populations.

4. Working with Consumers

There is a growing acceptance that patients in adult psychiatric inpatient settings ought to be involved in their care, as far as possible. This extends to the management of disturbed/violent behaviour where patient input can be made through measures such as Advance Statements. Listening to patients' views and taking them seriously is now also regarded as an important factor in the management of disturbed/violent behaviour. Patients may also have physical needs that should be taken into account when using the interventions discussed in this guideline.

It is important that patients are treated in a fair and non-judgmental manner irrespective of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs.

4.1   Services are responsible for all matters relating to equity and diversity. Responsibilities include the nature and adequacy of service provision in relation to the management of disturbed/violent behaviour, training on all matters relating to equality and diversity, monitoring service usage by ethnicity and consultation with CALD groups.

4.2   Patients should have access to relevant information to enable them to feel safe and understand what may happen to them in the event that they become disturbed/violent. This is intended to prevent unnecessary aggravation.

4.3   Patients should have access to information about the following in a suitable format:

- Which staff member has been assigned to them and how and when they can be contacted.

- Why they have been admitted (and if detained, the reason for detention, the legislative powers used and their extent, and rights of appeal).

- An explanation of their rights with regard to consent to treatments, complaints procedures, and access to independent help and advocacy. This should be given in both an oral and written form (*Section 156, Mental Health Act, 1996*).

- What may happen if they become disturbed/violent. This information needs to be provided at each admission, repeated as necessary and recorded.

- Where necessary the use of translators may be required to translate information into the patient's preferred language. Written is information to be provided in the patient's language, where possible.

4.4   Prescribers should be available and responsive to requests from the patient for a medication review.

4.5   Patients must be supplied with information regarding their medication both verbally and in a written form (ensuring the patient has an adequate level of literacy and understanding). This information must include the names of the medications, what they do, how often they need to be taken and potential side effects. Information regarding medications should be supplied on admission, at review, and at discharge.

4.6   During the administration or supply of medicines to patients, confidentiality should be maintained.

4.7   Clinicians need to be mindful that the language they use when communicating with patients about medications and general care is plain and easy to understand. Medical terminology may be difficult for patients to understand. It should also be recognised that even when CALD and Indigenous patients understand English, there may still be a need for an interpreter in a clinical consultation.

4.8   Patients identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an Advance Statement. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review (See Appendix A).

4.9   During the staff/patient risk assessment interview, efforts should be made to ascertain the patient's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these.

4.10   The patient should be given a copy of the care plan and, subject to their agreement; a copy and explanation should be given to their carer. In the case of CALD and Indigenous patients, a translator may be needed to make sure the process is understood.

4.11   Crisis care plans – all patients likely to relapse and require hospitalisation should have a crisis care plan that outlines what will happen if the patient becomes unwell. The crisis plan is completed by the patient and clinician and signed by the patient wherever possible. The patient should also be encouraged to agree to make the crisis care plan available to all services that become involved in their care.

4.12   The physical needs of the patient should be assessed on admission or as soon as possible thereafter and then regularly reassessed. The care plan should reflect the patient's physical needs and any concerns regarding the use of physical interventions.

4.13   Special provision should be made for pregnant women in the event that interventions for the management of disturbed/violent behaviour are needed. These should be recorded in the patient's care plan.

4.14   Staff should be able to take the time to develop a therapeutic alliance with patients, including those from diverse backgrounds (taking into account that this may take longer when using interpreters).

4.15   Where possible, patients should have a choice of staff who will be their key worker.

4.16   Every effort should be made to continue to treat the patient with dignity and respect, irrespective of the patient's behaviour during a disturbed/violent episode.

4.17   Following any intervention for the management of disturbed/violent behaviour, every opportunity should be taken to ensure the patient understands why this has happened. Where possible, and at the discretion of the patient, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the patient's medical notes.

4.18 An effective, fair and responsive complaints/feedback procedure will be made available to all patients.

4.19 All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas.

4.20 In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable, in accordance with relevant policies of the service.

Indigenous consumers

4.21 All staff require training about potential communication barriers which can occur when dealing with Indigenous consumers. These barriers can prevent the formation of an important therapeutic alliance and therefore limit the optimal provision of mental health care to Indigenous consumers.

4.22 Mental health staff are to be trained to recognise and treat those mental health conditions which are particular or common to the Indigenous population.

4.23 Skilled interpreters must be available for Indigenous consumers and staff when needed. Staff must be aware that for some Indigenous consumers an interpreter will be required, and this option must be made accessible.

Consumers with Disabilities

4.24 Each service should have a policy that outlines the procedures for dealing with consumers who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

4.25 Individual care plans should detail staff responsibilities for de-escalation, sedation, physical intervention and seclusion of patients who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

Managing the Risk of Infectious Diseases

4.26 Services should have policies in place, developed in conjunction with the infection control officer or relevant officer in the service, that outline the reasonable steps that can be taken to safeguard other patients and staff if a patient who has HIV, hepatitis or other infectious or contagious diseases is acting in a manner that may endanger others.

4.27 If staff are aware that a patient has HIV, hepatitis or other infectious or contagious diseases, the advice of the infection control officer or relevant officer in the service should be sought.

4.28 Please consult the Mental Health, HIV and AIDS – Policy Statement for a state-wide policy framework[10].

4.29   If any patient or staff member has sustained any injury during the management of disturbed/violent behaviour where blood has been spilt or the skin has been broken, or there has been direct contact with bodily fluids (all bodily fluids should be treated as potentially infectious), the local infection control policy should be followed.

4.30   Patients' confidentiality is paramount but may be breached in certain circumstances to safeguard others (*Operational Circular OP2050/06; Section 206 Mental Health Act 1996*). This may be relevant where a patient has HIV, hepatitis or other infectious or contagious diseases, and is acting in a manner that puts others at risk. Legal and ethical advice should always be sought in these circumstances.

Main recommendations

1.   Recognising and respecting individual and cultural diversity within the patient group is a priority.

2.   The guidelines emphasise collaboration with consumers to have their needs and wishes recorded in the form of an Advance Statement. This will outline the consumer's wishes for treatment, especially in the event of a disturbed/violent incident.

3.   Working closely and respectfully with consumers by providing information regarding treatment and by concentrating on effective communication between staff and consumers is seen as an important way of strengthening this relationship. Working together with consumers in this way also helps to de-escalate future disturbed/violent incidents and recognises the importance of involving consumers in their treatment.

4.   Services must also be responsible for ensuring the adequacy of service provision in relation to the management of disturbed/violent behaviour including training on all matters relating to equality and diversity, monitoring service usage by ethnicity and consultation with CALD and Indigenous groups.

5. Searching

The undertaking of necessary and lawful searches of patients can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric inpatient settings.

Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour.

Policy

5.1 All facilities should have a policy on the searching of patients, their belongings and the environment in which they are accommodated. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison. The searching policy should be in place to ensure the creation and maintenance of a safe and therapeutic environment for patients, staff and visitors.

5.2 The searching policy should address the legal ramifications and justifications for conducting a search. The service should consult with Legal and Legislative Services Division of the Department of Health (or the State Solicitor's Office in the case of teaching hospitals) for advice regarding the law in relation to search and seizure.

5.3 The searching policy should address all aspects of personal through to environmental searching from the decision to initiate a search through to the storage, return or other disposal (including the lawful disposal of any items such as firearms, weapons, alcohol and illicit drugs) of items found.

5.4 The consent of the patient (or his or her guardian) to the search must be obtained. The searching policy should set out, in terms that can easily be understood by all those with responsibilities under the policy, what course of action will be taken if consent is withheld.

5.5 Pat down or personal searching should be addressed in the policy, including what staff should do if consent is withheld.

5.6 The searching policy should provide for the circumstances in which a patient physically resists being searched. This policy should include:

- The circumstances in which the police are called to conduct a search.
- Options available to deal with the situation, if a decision is made not to proceed with the search.

5.7 The searching policy should specifically address the searching of patients detained under the *Mental Health Act 1996*; voluntary patients without capacity to consent at the time of the search; voluntary patients with capacity to do so; and staff.

5.8 The searching policy should also extend to the searching of patients and their environment, where undertaking such searches is a proportionate response to a need and/or allegation; and where it is proposed to do so for reasons such as a substance abuse problem on the ward, suspicion of weapons being concealed and/or for reasons of self harm.

5.9   The policy should clearly describe the different phases of searching and the reasons for progression from one phase to the next. It should define who has the authority to determine that progression to a higher level of search is necessary.

Carrying out Searches

5.10   Staff should be informed of all policies and procedures regarding searches through information sessions and supervision.

5.11   The policy should stipulate that:

- Involuntary/voluntary patients and staff are informed that there is a policy on searching.
- On admission, patient and carers are provided with a brochure outlining the searching procedure.
- Consent to a search must always be sought from the patient (or his or her guardian).
- The person being searched is to be kept informed of what is happening and why.
- A comprehensive record of every search is made, including its justification, e.g. a report from other patients.
- Any consequent risk assessment and risk management strategies are placed in the appropriate records/care plan.

5.12   The level of intrusiveness of any personal search undertaken must be a reasonable and proportionate response to the reason for the search.

5.13   All searches should be undertaken with due regard to the patient's dignity and privacy and by a member(s) of staff of the same sex. Staff should also be aware of any issues that may be sensitive for CALD patients e.g. touching of various areas of the body.

5.14   Post-search support for all those involved should be provided as required.

5.15   Following every incident where consent has been withheld there should be a post-incident review.

5.16   The search procedures should be audited regularly at a health service level.

5.17   If a visitor is suspected of carrying weapons, drugs or of any activity that could be harmful to patients or staff, the visitor should be asked to leave. The visitor should not be searched.

Mental Health Act 1996

Currently changes are being considered regarding the searching of patients in relation to the *Mental Health Act 1996. The Mental Health Act 1996*, along with these Guidelines, should inform local service policy.

Main Recommendations

1. All services must have a policy on the searching of patients, their belongings and the environment in which they are accommodated. The searching policy is to ensure the creation and maintenance of a safe and therapeutic environment for patients, staff and visitors.

2. The searching policy should address all aspects of personal through to environmental searching from the decision to initiate the search through to the storage, return or other disposal of items found.

3. The legal issues surrounding searching must be explored and addressed by the policy.

4. The consent of the patient should always be obtained, and the policy must address what is to happen if the patient does not consent to the search.

5. Staff must be informed of all policies and procedures regarding searching.

6. Searches should be undertaken with sensitivity and respect for the patient's dignity, and should have a level of intrusiveness proportionate to the need and reason for the search.

7. Post-search support must be available for those who need it, and a review should be conducted after consent has been withheld.

6. De-escalation

De-escalation involves the use of techniques that have the potential to ease an escalating situation.

Action plans should encompass the use of de-escalation techniques at the earliest time in any escalating situation and detail how to call for help in an emergency.

6.1   A patient's anger needs to be treated with an appropriate, measured and reasonable response. De-escalation techniques should be employed prior to other interventions being used.

6.2   In a crisis situation the staff are responsible for avoiding provocation.

6.3   Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour, such as body posture and eye contact, tone of voice etc.

6.4   Staff should work with the patient to recognise the cues and triggers that upset and calm them. This will involve listening to individual patient's and carer's reports of what upsets the patient and then reflecting this in the patient's care plan and a copy given to the patient.

6.5   Where possible and appropriate, patients will be encouraged to recognise their own trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities. Patients should also be encouraged to discuss and negotiate their wishes in case they become agitated. This should be recorded as an Advance Statement (see Appendix A).

6.6   Where de-escalation techniques fail to sufficiently calm a situation or patient, verbal de-escalation is an ongoing element of the management of disturbed/violent behaviour. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

De-escalation Techniques

6.7   One staff member should assume control of a potentially disturbed/violent situation.

6.8   The staff member who has taken control should:

- Consider which de-escalation techniques are appropriate for the situation;
- Manage others in the environment, such as removing other patients from the area, enlisting the help of colleagues and creating space;
- Explain to the patient and others in the immediate vicinity what you intend to do;
- Give clear, brief, assertive instructions; and
- Move towards a safe place and avoid being trapped in a corner.

6.9   The staff member who has taken control should ask for facts about the problem and encourage reasoning. This will involve:

- Attempting to establish a rapport and emphasising cooperation;

- Offering and negotiating realistic options and avoiding threats;

- Asking open questions and inquiring about the reason for the patient's anger, for example 'What is causing you to feel upset/angry?';

- Showing concern and attentiveness through non-verbal and verbal responses; and

- Listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations, and not being patronising or minimising patient concerns.

6.10 The staff member who has taken control should ensure that their own non-verbal communication is non-threatening and not provocative. This will involve:

- Paying attention to non-verbal cues, such as eye contact and allowing greater body space than normal;

- Adopting a non-threatening but safe posture;

- Maintaining a non threatening tone of voice; and

- Appearing calm, self-controlled and confident without being dismissive or over-bearing.

6.11 Where there are potential weapons the disturbed/violent person should be relocated to a safer environment, if at all possible.

6.12 Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.

6.13 Encouraging the patient to make use of the designated area or room specifically for the purpose of reducing arousal and/or agitation can help them to calm down. In services where seclusion is practised, the seclusion room should not routinely be used for this purpose.

Main recommendations

1. De-escalation is a significant factor in reducing the use of physical intervention and seclusion, therefore de-escalation techniques are emphasised. Working closely and respectfully with consumers, while taking into consideration their Advance Statement as much as possible, is seen as a significant part of de-escalation.

2. Staff training and awareness of the diversity in the consumer group and how to work within these differences is another important factor.

3. Standardised training in de-escalation techniques must be provided for all staff involved with consumers.

4. Staff must recognise that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

7. Observation and Engagement

The primary aim of observation should be to identify and record signs of improvement or deterioration and to engage with the patient. This involves a two-way relationship, established between a patient and a staff member, which is meaningful, grounded in trust, and therapeutic for the patient. Observation is an intervention that is used both for the management of disturbed/violent behaviour and to prevent self-harm.

The following recommendations are specifically directed towards the use of observation as an intervention for the management of disturbed/violent behaviour. However, many are also applicable where observation is used to prevent self-harm. The terminology covers both uses of observation.

Definitions of Levels of Observation

7.1   The observation terminology used in this guideline should be adopted across WA to ensure consistency of use.

General observation is the minimum acceptable level of observation for all inpatients. Staff should know the location of all patients, but not all patients need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the mental state of the patient and engage positively with the patient. The aim of this should be to develop a positive, caring and therapeutic relationship with the patient. This assessment should always include an evaluation of the patient's moods and behaviours associated with risks of disturbed/violent behaviour, and these should be recorded in the notes.

Intermittent observation means that the patient's location should be checked every 15 to 30 minutes (exact times to be specified in the notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the patient. This level is appropriate when patients are potentially, but not immediately, at risk of disturbed/violent behaviour. Patients who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation.

Within eyesight means the patient should be kept within eyesight and accessible at all times, by day and night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the patient could, at any time, make an attempt to harm themselves or others. It may be necessary to search the patient and their belongings, while having due regard for the patient's legal rights and conducting the search in a sensitive way. Positive engagement with the patient is an essential aspect of this level of observation.

Within arms length is needed for patients at the highest levels of risk of harming themselves or others, who should be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the patient is an essential aspect of this level of observation.

7.2   All decisions about the specific level of observation should take into account:

- The patient's current mental state;
- Any prescribed medications and their effects;
- The current assessment of risk; and
- The views of the patient as far as possible.

7.3   Each service should have a policy on observation and engagement outlining observation levels that ensure safe working. This policy should also include:

- Purpose of observation;
- Who can instigate observation above a general level;
- Who can increase or decrease the level of observation;
- Who should review the level of observation;
- When reviews should take place (at least every shift);
- How patients' perspectives will be taken into account; and
- A process through which a review by a full clinical team will take place if observation above a general level continues for more than one week.

7.4   Designated levels of observation should only be implemented after positive engagement with the patient has failed to dissipate the potential for disturbed/violent behaviour.

7.5   The least intrusive level of observation that is appropriate to the situation should always be adopted, with consideration for the patient's dignity and privacy whilst maintaining the safety of those around them.

7.6   Decisions about observation levels should be recorded by both medical and nursing entries in the patient's notes. The reasons for using observation should be clearly specified and follow the currently accepted standard of best practice.

7.7   Observation skills should be used to recognise, prevent and therapeutically manage disturbed/violent behaviour. This is the responsibility of all members of the inpatient clinical multidisciplinary team, with duties delegated by the Team Leader.

7.8   In addition to the antecedents that indicate disturbed/violent behaviour, observation above a general level should be considered if any of the following are present:

- History of previous suicide attempts, self-harm or attacks on others;
- Command hallucinations, particularly voices suggesting harm to self or others;
- Paranoid ideas where the patient believes that other people pose a threat;
- Thoughts or ideas that the patient has about harming themselves or others;
- Threat control override symptoms;
- Past or current problems with drugs or alcohol;

- Recent loss;

- Poor adherence to medication programmes or non-compliance with medication programmes;

- Marked changes in behaviour or medication; and

- Known risk indicators.

7.9 When making decisions about observation levels, clear directions should be recorded that specify:

- The name/title of the persons who will be responsible for reviewing the observation levels; and

- The timing of the review.

7.10 Nurses and other staff undertaking observation should:

- Take an active role in engaging positively with the patient.

- Be appropriately briefed about the patient's history, background, specific risk factors and particular needs.

- Be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment.

- Be able to increase or decrease the level of engagement with the patient as the level of observation changes.

- Be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued.

7.11 An individual staff member should not undertake a one-to-one special for prolonged periods. However, on occasion it may be appropriate for a staff member to continue longer than normal in the one-to-one duty if they are positively engaged with the patient, are agreeable and are not stressed/tired by the duty.

7.12 The patient's psychiatrist/on-call doctor should be informed of any decisions concerning observation above the general level as soon as practical.

7.13 A nominated hospital manager should be informed when observation above the general level is implemented so that adequate numbers and grades of staff can be made available for future shifts.

7.14 Decisions regarding observation levels must be based on clinical need rather than staffing need.

7.15 Staff members should be aware that patients sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation.[1]

7.16   Staff members should also be aware that for some patients the upper levels of observation may be counter productive. Sensitivity should be adopted when dealing with all patients, including those from Indigenous or CALD backgrounds and those who have been victims of abuse.[12]

7.17   The patient should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained.

7.18   The aims and level of observation should, where appropriate, be communicated with the patient's approval to the nearest relative, friend or carer.

7.19   Although difficult, where possible, a handover from one nurse or staff member to another should involve the patient so that they are aware of what is being said about them. This handover should have a positive focus. However, staff may need to exchange additional information separately.

Main recommendations

1. All services should use standardised terminology for different observation levels. This document recommends four levels of observation and recommends the adoption of these terms across WA services.

2. Each service must have comprehensive policies regarding the use of observation, including who instigates and undertakes observation, when reviews should take place and how consumers' perspectives will be taken into account.

3. The least intrusive level of observation that is appropriate to the situation should always be adopted, with consideration for the consumer's dignity and privacy whilst maintaining the safety of those around them.

4. Staff should receive training in observation techniques, and the potential that these techniques have to de-escalate certain behaviour and to engage with the consumer. Staff must also be aware of different sensitivities to observation amongst certain consumers, such as Indigenous and CALD populations and victims of abuse.

5. Consumers should be continually informed regarding why they are under observation, the aims of observation and how long it is likely to be maintained.

8. Other Interventions

Where de-escalation techniques have failed to calm a patient, it may be necessary to make use of additional interventions, such as physical intervention, sedation and seclusion to manage the incident. All such interventions should only be considered once de-escalation techniques have been tried and have not succeeded in calming the patient. These interventions are management strategies and are not regarded as primary treatment techniques. The choice of intervention(s) will depend on a number of factors, but should be guided primarily by:

- The protection of patients, staff, and visitors;
- The clinical needs of, and risks to, the patient;
- Patient preference (if known);
- Obligations to other patients affected by the disturbed/violent behaviour; and
- The facilities available within the particular setting.

The intervention selected must amount to a proportionate and reasonable response to the risk posed.

8.1 Services should identify good practices in the prevention, reduction and, where possible, elimination of physical intervention (restraint) and seclusion that are applicable across all service settings. Services should have standards for monitoring and reporting of physical intervention (restraint) and seclusion, and identifying alternatives to the use of restraint that are applicable across services and settings.

8.2 Mental health services should have policies and procedures in place for the use of restraint and seclusion. Clinical audits of restraint and seclusion should be considered part of the quality improvement process.

8.3 A crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medications) should be available within three minutes in healthcare settings where sedation, physical intervention and seclusion might be used. This equipment should be maintained and checked weekly.

8.4 At all times, a doctor should be readily[2] available to attend an alert by staff members when sedation, physical intervention and/or seclusion are implemented.

8.5 All staff need to be aware of the legal framework that authorises the use of medication, physical intervention and seclusion.

8.6 If a person is a detained involuntary patient, then treatment can be provided without consent. Consent should always be sought in the first instance.

8.7 If the person is detained on a 'Referral for Examination by a Psychiatrist' Form (*Mental Health Act 1996*, Section 29, Form 1) or is a voluntary patient, consent must be sought. If the person refuses to consent or is unable to, due to the nature of their mental illness, then treatment can only be provided in line with Division 2 of Part 5 of the *Mental Health Act 1996*, Emergency Psychiatric Treatment.

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[2] The Bennett report recommended that a doctor should be available within 20 minutes. The NICE Guideline Development Group defines quick attendance as within 30 minutes of an alert.

8.8   In the circumstances where psychiatric treatment is necessary in order to save the person's life or to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person, then emergency psychiatric treatment can be given without consent.

8.9   If emergency psychiatric treatment is given, a report outlining the particulars of the treatment, the time, place and circumstances in which the treatment was given, and the names of the persons involved in the giving of the treatment, must be provided to the Mental Health Review Board (*Mental Health Act 1996*, section 115(b)).

8.10   When using interventions such as pharmacology, physical intervention or seclusion, steps should be taken to try to ensure that the patient does not feel humiliated (such as respecting a patient's need for dignity and privacy commensurate with the needs of administering the intervention).

8.11   The reasons for using pharmacology, physical intervention or seclusion should be explained to the patient at the earliest opportunity and repeated subsequently, as necessary.

8.12   After the use of pharmacology, physical intervention or seclusion, the patient's care plan should be reassessed and the patient should be helped to reintegrate into the ward milieu at the earliest safe opportunity.

8.13   Patients should be given the opportunity to document their account of the intervention in their notes.

Physical Intervention/Restraint

8.14   During physical intervention, staff should continue to employ de-escalation techniques.

8.15   There are real dangers with continuous physical intervention in any position. Physical intervention should be avoided if at all possible, should not be used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention an alternative strategy, such as sedation or seclusion (where available), should be considered.

8.16   During physical intervention, one team member should be responsible for ensuring the protection and support of the head and neck, where required. The team member who is responsible for monitoring the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

8.17   During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the patient should be continuously monitored throughout the process.

8.18   A number of physical skills may be used in the management of a violent incident.

- The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
- Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
- The deliberate application of pain has no therapeutic value and should not be used. However, in the immediate rescue of patients, staff, and/or others the use of reasonable force is lawful (sections 237, 234, 248, 249 & 250 of the Criminal Code).

8.19   Mechanical restraints are not a first-line response or standard means of managing disturbed/violent behaviour in acute mental health care settings. In the event that they are used, it must be a justifiable, reasonable and proportionate response to the risk posed by the patient, and only after a multidisciplinary review has taken place. Any Mechanical Bodily Restraint applied must comply with Division 9 of Part 5 of the *Mental Health Act 1996* and Regulations 14, 15 and 16 of the Mental Health Regulations 1997.

Main recommendations

1.   Physical intervention/restraint should only be considered once all de-escalation techniques have failed.

2.   Services must identify and promote best practice in the prevention, reduction and where possible elimination of the use of physical intervention/restraint.

3.   If physical intervention is unavoidable, then it must not be used for prolonged periods, and must be concluded at the earliest opportunity.

4. The dignity of the patients must be respected during physical intervention, and the reasons for using the intervention explained as much as possible.

5. A crash bag must be available within three minutes, and a doctor available to attend an alert by staff.

6. All staff involved in physical intervention/restraint should be trained in a standardised technique and receive ongoing refresher courses.

7. After the intervention patients should have the opportunity to document their account, and their care plans should be updated.

Seclusion

8.20   Seclusion, the sole confinement in a room that it is not within the control of the person confined to leave (s.116, *Mental Health Act 1996*), is only legal in an authorised hospital.

8.21   The use of seclusion must comply with Division 8 of Part 5 of the *Mental Health Act 1996* and Regulations 11, 12, 13 and 17 of the Mental Health Regulations 1997.

8.22   Seclusion should be for the shortest time possible and should be reviewed at least every two hours by the treating psychiatrist or medical practitioner. The patient should be made aware that reviews will take place at least every two hours.

8.23   A person in seclusion must be observed every 15 minutes by a mental health practitioner (Regulation 13, Mental Health Regulations 1997). This observation cannot be via CCTV and therefore must be a direct visual contact.

8.24   A report of the patient being kept in seclusion must be made as soon as practicable to the Mental Health Review Board (s120(d) *Mental Health Act, 1996*), and to any Commission for Occupational Safety and Health reporting systems (e.g. Section 19(3) of the *Occupational Safety and Health (OSH) Act*).

8.25   The patient in seclusion must be provided with his or her basic needs, including bedding, clothing, food, drink and toilet facilities. Only in the most exceptional of cases would it be justifiable to deviate from this requirement. Any deviation must be recorded and included in the report to the Mental Health Review Board.

8.26   Patients in seclusion should be allowed to keep personal items including those of religious or cultural significance (such as items of jewellery) as long as they do not compromise their safety or the safety of others.

Sedation and Seclusion

8.27   When the use of seclusion with sedation is indicated, the following points are recommended:

- If the patient is secluded, the potential complications of sedation may be exacerbated.
- The patient should be monitored through appropriate observation by a nurse trained in observation skills. If there are any concerns regarding the patient's well being, then a 'within eyesight' observation schedule should be employed.
- Once sedation has taken effect, whether or not seclusion has been terminated, the risks associated with sedation should continue to be monitored.

Main recommendations

1. Services must identify and promote best practice in the prevention, reduction and where possible, elimination of the use of seclusion.

2. Seclusion should be for the shortest time possible and must be reviewed at least every two hours.

3. Consumers in seclusion must have their basic needs met, including bedding, clothing, food, drink and toilet facilities. Any deviation must be reported to the Mental Health Review Board.

4. The dignity of the patients must be respected during seclusion, and the reasons for using seclusion explained as much as possible.

5. A crash bag must be available within three minutes, and a doctor available to attend an alert by staff.

6. Following the intervention, patients should have the opportunity to document their account, and their care plans should be updated.

Use of Pharmacology

Sedation is the allaying of irritability or excitement by the administration of psychopharmacology. Conscious sedation is a nursing intervention classification defined as administration of sedatives, monitoring of the patient's response, and provision of necessary physiological support during a diagnostic or therapeutic procedure.[13]

Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[13]

General Anaesthesia is a drug-induced loss of consciousness during which patients are not arousable. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of a depressed spontaneous ventilation or drug induced depression of neuromuscular function. Cardiovascular function may be improved.[13]

Levels of sedation can vary greatly, and individual responses are largely unpredictable. Therefore practitioners intending to produce a given level of sedation should be able to manage patients whose level of sedation becomes deeper than initially intended.[14]

8.28 Local protocols should be produced that cover all aspects of the use of medications for sedation. Such protocols should be in accordance with this document, all legal requirements (especially in respect of Division 2 – Informed consent, Division 6 - Other Treatments and Division 7 – Emergency psychiatric treatment, of Part 5 of the *Mental Health Act 1996*), relevant Western Australian Therapeutic Advisory Group (WATAG) guidance, and should be subject to regular review.

8.29 Medication for sedation, particularly in the context of physical intervention, should be used with caution. Risks include:

- Loss of consciousness instead of tranquillisation;
- Sedation with loss of alertness;
- Loss of airway;
- Cardiovascular and respiratory collapse;
- Interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition);
- Possible impact to patient–staff relationship; and
- Underlying coincidental physical disorders.

8.30 There are specific risks associated with the different classes of medications. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. Staff need to be aware of the following.

For Benzodiazepines

- Loss of consciousness;
- Respiratory depression or arrest;
- Potential for seizure; and
- Cardiovascular collapse (in patients receiving both clozapine and benzodiazepines).[1]

For Antipsychotics

- Loss of consciousness;
- Cardiovascular and respiratory complications and collapse;
- Seizures;
- Subjective experience of restlessness (akathisia);
- Acute muscular rigidity (dystonia);
- Involuntary movements (dyskinesia);
- Neuroleptic malignant syndrome; and
- Excessive sedation.[1]

For Antihistamines

- Excessive sedation;
- Painful injection; and
- Additional antimuscarinic effects.[1]

8.31 Extra care should to be taken when administering medications for the purpose of sedation in the following circumstances:

- Any history of cardiovascular/pulmonary problems, including corrected QT-interval (QTc) syndromes. These should be clearly indicated in a designated section of the notes.
- The concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly.
- The presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, diabetes, stress and extreme emotions, and extreme physical exertion.
- The presence of any mental disorders with accompanying physiological consequences, such as anorexia.
- The elderly and the frail.
- Differences in specific CALD groups with regard to their different responses and tolerance levels.[15,16]
- The use of any alternative forms of medicine e.g. traditional herbal remedies, which may interact with drugs to be prescribed.

- First episode clients who may be unfamiliar with the processes and medications used in any interventions.

Carrying Out Sedation

8.32 A standardised medication chart with a simple rating scale for agitation should be developed to help match level of arousal with corresponding drug algorithms.

8.33 The patient should be able to respond to communication throughout the period of sedation. The aim of sedation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others.

8.34 When a patient is transferred between units, a full medication history, including the patient's response to medications, any adverse effects, and an advance statement should accompany them. Where possible, the patient's account of their experience of sedation should also be included. On discharge, all such information should be filed in their healthcare record and be subject to regular review.

8.35 Oral medication should be offered before parenteral medication as far as possible.

8.36 Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m (oral = o; intramuscular = i/m) should not be used.

8.37 Sufficient time should be allowed for a clinical response between oral doses of medication.

8.38 If parenteral treatment proves necessary, the intramuscular route is preferred over intravenous from a safety point of view. The patient should be prescribed oral routes of administration at the earliest opportunity.

8.39 Sufficient time should be allowed for a clinical response between intramuscular doses of medications for sedation.

8.40 The use of two drugs of the same class for the purpose of sedation should not occur.

8.41 Medications should never be mixed in the same syringe.

8.42 When using intramuscular Haloperidol as a means of managing disturbed/violent behaviour, an antimuscarinic agent such as procyclidine or benzatropine should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given intramuscularly or intravenously as per manufacturer's recommendations.

8.43 Where intravenous administration of Benzodiazepine or Haloperidol is necessary (e.g. prior to and during transportation), treatment should be fully documented and not initiated by junior medical staff without the supervision of a senior medical officer.

8.44 Where intravenous administration of sedation is necessary, attending staff should be trained to recognise symptoms and respond appropriately to respiratory depression, dystonia or cardiovascular compromise (such as palpitations, significant changes in blood pressure or collapse).

8.45 If intravenous medication is used, the patient should never be left unattended. Intravenous administration should never occur without full access to the resuscitation equipment and staff who are trained to use it.

8.46 Zuclopenthixol Acetate injection (Acuphase) is not recommended for sedation due to long onset and duration of action. For this reason, it should never be administered to those without any previous exposure to antipsychotic medication. The manufacturer's Summary of Product Characteristics (SPC) should be consulted regarding its use.

Zuclopenthixol Acetate injection may be considered as an option for sedation when:

- It is clearly expected that the patient will be disturbed/violent over an extended period of time.
- A patient has a history of good and timely response to Zuclopenthixol Acetate injection.
- A patient has a history of repeated parenteral administration.
- An advance statement has been made indicating that this is a treatment of choice.

8.47 The following medications are not recommended for sedation:

- Intramuscular Chlorpromazine is unsuitable for use in sedation as it can have a local irritant effect and is absorbed erratically. Use of this medication also has the potential to cause hypotension due to α-adrenergic receptor blocking effects.
- Intramuscular diazepam.
- Intramuscular depot antipsychotics.
- Olanzapine or risperidone should not be used for the management of disturbed/violent behaviour in patients with dementia.

8.48 It is recognised that clinicians may decide that the use of medication outside of the SPC is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

8.49 When using medication for the purpose of sedation there may be certain circumstances in which the current WATAG uses and limits and manufacturer's SPC may be knowingly exceeded (for example, for Lorazepam). This decision should not be taken lightly and the risks should not be underestimated. A risk–benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan. Where the risk–benefit is unclear, advice may be sought from clinicians not directly involved in the patient's care.

8.50 If current WATAG or manufacturer's recommended doses are exceeded, it is particularly important that frequent and intensive monitoring of a calmed patient is undertaken, with particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration.

8.51 In all circumstances of sedation, the prescriber and medication administrator should pay attention to:

- The total dose of medication prescribed.

- Arrangements for review.

- Issues of consent, WATAG and the manufacturer's requirements and physical and mental status of the patient.

8.52 The dose of antipsychotic medication should be individualised for each patient. This will be dependent on several factors including the patient's age (older patients generally require lower doses); concomitant physical disorders (such as renal, hepatic, cardiovascular, or neurological); concomitant medication; and patient's ethnicity.

8.53 Where possible, a specialist mental health pharmacist should be a member of the multidisciplinary team where sedation is used. Pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication.

Care After Sedation

8.54 After sedation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the patient becomes active again.

8.55 In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should be paid to the patient's respiratory effort, airway, and level of consciousness, where:

- The patient appears to be or is asleep/sedated.

- Intravenous administration has taken place.

- The WATAG limit or manufacturer's recommended dose is exceeded.

- The patient has been using illicit substances or alcohol.

- The patient has a relevant medical disorder or concurrently prescribed medication.

- Other high-risk situations.

8.56 If verbal responsiveness is lost as a consequence of administration of medication, a level of care identical to that needed for general anaesthesia should be given.

8.57 Post sedation:

- A standardised post incident debriefing form should be developed to assist with the post incident review (See Appendix B).

- The staff and the patient should review what has occurred and update the advance statement to include any preferred interventions for future reference.

Main recommendations

1. There are specific risks associated with the different classes of medications. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded.

2. Staff need to be aware and trained about the risks associated with the various medications and what to do if a patient has an adverse or unpredicted reaction to the medication.

3. Oral medication should be offered before parenteral medication as far as possible.

4. All those who prescribe medications must be aware of the current WATAG recommendations.

5. The dignity of the patients must be respected during sedation, and the reasons for using medications explained as much as possible.

6. A crash bag must be available within three minutes, and a doctor available to attend an alert by staff.

7. Following sedation patients should have the opportunity to document their account, and their care plans updated if necessary.

Incident reporting and post-incident reviews
(following sedation, physical intervention and seclusion)

Incident Reporting

All hazards, accidents and incidents (e.g. physical intervention or seclusion) occurring in the workplace are to be reported and investigated. Incident reporting and investigation aims to prevent injury to staff and others, to identify high-risk areas and tasks and implement preventive strategies.

9.1   Any incident requiring physical intervention or seclusion should be recorded contemporaneously, using a local template. Health services shall be committed to providing and maintaining an integrated, blame-free system for identifying, reporting and managing hazards, near misses, incidents, adverse and sentinel events within the legislative framework of the *Occupational Safety and Health (OSH) Act*.

Individual hazards and incidents shall be managed locally via the OSH Management Systems.

9.2   Each health service shall manage the review, investigation and initiation of corrective actions for high to extreme risks, incident trends, patterns and injury performance indicators supplied by RiskCover.[17]

9.3   Any incident resulting in serious injury to an employee (over ten days lost time) shall be reported to Commission for OSH, in accordance with Section 19(3) of the *OSH Act*.

9.4   Mental health services are to report to the Chief Psychiatrist all occurrences of any unexpected death of patients in any mental health services and any serious incidents and associated issues that will or are likely to reflect on the standards of mental health care in Western Australia. For further information, see OCP Operational Circular 1646/03.

9.5   The *Mental Health Act 1996* also specifies additional reporting to the Mental Health Review Board regarding the use of seclusion, restraint etc.

Post-Incident Reviews

9.6   A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending.

9.7   A post incident review is seen as a separate process from diffusing, which occurs soon after an incident and is a way of calming the situation and of providing support.

9.8   Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post incident support and review mechanisms are available and take place within a supportive culture. The following people should be included:

■ Staff involved in the incident;

■ Patients involved in the incident;

- Carers and family where appropriate;
- Other patients who witnessed the incident;
- Visitors who witnessed the incident;
- Independent advocates (in relation to CALD consumers, consider the Ethnic Advocacy Centre); and
- OSH staff and possibly a local Security Management Specialist.

9.9   The aim of a post-incident review should be to seek to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers.

9.10   The post-incident review should address what happened during the incident, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel at the time of the review, how they may feel in the near future, and what can be done to address their concerns. A person not directly involved in the incident should lead the review.

9.11   It is important that the post-incident review explores how and why the de-escalation techniques worked or failed to work. This exploration should inform future practice.

9.12   A system of reviews will be in place, including separate and dual processes for patients and staff if needed. Appropriate support, including ongoing individual post-incident review sessions, should be available as required.

9.13   Line managers and OSH staff should positively monitor and carefully manage consequential sick leave and the return to work, to ensure that staff are supported.

9.14   Consequential sick leave should be audited to identify trends within the organisation and to inform future management of disturbed/violent behaviour.

See Appendix B for an example of an outline of a post incident review currently in use in Australia.

Main recommendations

1. Health services must provide an integrated, blame-free system for identifying, reporting and managing all hazards, accidents and incidents (e.g. physical intervention or seclusion).

2. A post incident review should take place within 72 hours of the incident, and the aim of the review is to support staff and patients, seek to learn lessons and encourage the therapeutic relationship between patients, their carers and staff.

3. Mental health service providers should have systems and skilled staff in place to ensure a range of options of post incident support and review mechanisms is available.

APPENDIX A: Advance Statement

The advance statement is a document that contains the instructions of a person with mental health problems setting out their requests in the event of an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent, suicidal or at risk of self-harming. It also contains the contact details of people who they wish to be contacted and any other personal arrangements that they may wish to be made.[1]

The team who usually works with the person, and the consumer, should develop the advance statement together when the consumer is well. The consumer may also wish to involve a support person such as a primary carer in the process.

This process may take place in the community, for all those who may require hospital admission, or as soon as is appropriate in the inpatient setting. At times in the inpatient setting the patient may only be well enough nearing discharge, and the advance statement could be completed at this stage for future admissions. The case manager has responsibility for ensuring an advance statement is completed.

The advance statement sets out the patient's preferred treatment, however it is not legally binding. The clinical staff will continue to make treatment decisions with clinical need and safety being the priority. The advance statement is seen as a tool that should be followed as much as possible in the treatment of the individual. It encourages consumers to have a voice in their treatment, to take responsibility for their behaviour and in gaining an understanding of their illness and the treatment required.

The advance statement should be continually updated, especially after an intervention for the management of disturbance/violence or self-harming behaviour.

For an example see *The Safety Tool*, The Massachusetts Department of Mental Health: Restrain/Seclusion Reduction Initiative.[18]

APPENDIX B: Bleuler Acute Arousal Programme

24-48 Hour Post-Intervention Patient Debriefing Form

About a day ago we needed to take some actions to make things safe for you and other people here.

Do you remember that?   Yes ☐   No ☐

2. Do you remember what happened?   Yes ☐   No ☐

    Details: _____

    _____

3. Do you know the reasons why?   Yes ☐   No ☐

    Why?: _____

    _____

4. Do you believe it was necessary?   Yes ☐   No ☐

    Why?: _____

    _____

5. Do you know what medication was used?   Yes ☐   No ☐

    Please specify: _____

    _____

How did it make you feel (place a circle around the most appropriate number):

	Not angry at all								Very angry		
Angry	0	1	2	3	4	5	6	7	8	9	10

	Not unhappy at all								Very unhappy		
Unhappy	0	1	2	3	4	5	6	7	8	9	10

	Not anxious at all								Very anxious		
Anxious	0	1	2	3	4	5	6	7	8	9	10

	Not grateful at all								Very grateful		
Grateful	0	1	2	3	4	5	6	7	8	9	10

	Not fearful at all								Very fearful		
Fearful	0	1	2	3	4	5	6	7	8	9	10

For CALD consumers please ensure access an interpreter, as many concepts around inner experiences may be difficult to quantify in different cultures.
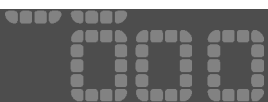
APPENDIX C: Glossary

Advance Statement: A document that contains the instructions of a person with mental health problems setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people who they wish to be contacted and any other personal arrangement that they wish to be made.

Aggression: A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Antecedents: Warning signs that indicate that a consumer is escalating towards a violent act.

Authorised Hospital: a) A public hospital, or part of a public hospital, that is for the time being authorised under section 21 *Mental Health Act 1996*; and

b) A private hospital whose licence is endorsed under section 26DA of the Hospitals and *Health Services Act 1927*.

Basic Life Support: The maintenance of an airway and the support of breathing and the circulation without using equipment other than a simple airway device or protective shield.

CALD: People from cultural and linguistically diverse backgrounds who have one or more of the following descriptions:

- Those whose country of birth has a national language other than English.
- Those who were born in Australia and have at least one parent born in a mainly non-English speaking country.
- Those whose predominant social orientation or identification is with a non-English speaking culture.

Calming: The reduction of anxiety/agitation.

Clinical Assessment of Risk Decision Support (CARDS): A system to support the clinical decision making by aiding clinicians in their assessment and management of the risk of violence and suicide in adults of working age using mental health services. It is intended to support and not replace clinical judgement.

De-escalation: A complex range of skills designed to abort the assault cycle during the escalation phase; these include both verbal and non-verbal communication skills *(The Prevention and Management of Aggression: A Good Practice Statement, The Scottish Office, 1996)*.

Disturbed Behaviour: To be experiencing emotions and exhibiting behaviours that deviate from the accepted norm as a result of mental ill-health.

Emergency Psychiatric Treatment: Psychiatric treatment that it is necessary to give a person –

> a) To save the person's life; or

> b) To prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or another person (*Mental Health Act 1996*).

Environment: The physical and therapeutic external conditions or surroundings.

Exceptional Circumstances: Circumstances that cannot reasonably be foreseen and as a consequence cannot be planned for.

Gender: Those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined (*Mainstreaming Gender and Women's Mental Health Implementation Guide*, 2003).

Immediate Life Support: Basic life support and safe defibrillation (manual and/or automatic external defibrillator).

Mechanical Bodily Restraint: Means preventing the free movement of a person's body or a limb by mechanical means other than by the use of a medical or surgical appliance for the proper treatment of physical disease or injury (s. 121 Mental Health Act 1996). This may include a method of physical intervention involving the use of authorised equipment applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the individual concerned.

Observation: The primary aim of observation is to identify and record signs of improvement or deterioration and to engage with the patient. This should establish a two-way relationship, established between a patient and a nurse, which is meaningful, grounded in trust, and therapeutic for the patient (UKCC, 2002).[11]

Physical Intervention: A skilled, hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

Positive/therapeutic Engagement: May be defined as a skilled nursing intervention that aims to empower the patient to actively participate in their care. Rather than 'having things done to' him or her, the patient negotiates the level of engagement that will be most therapeutic.

Post-incident Review: A review carried out within 72 hours of an incident, by someone independent of the incident, to determine antecedents, consequences and future positive action without apportioning blame.

PRN (pro re nata): Medication that may be used as the occasion arises.

Psychiatric inpatient Settings: Any care setting in which psychiatric treatment is given to inpatients.

QT Interval: The period in the cardiac cycle between depolarisation (causing contraction) and repolarisation of the heart muscle. Some drugs prolong this interval. This can lead to the development of arrhythmias (abnormal electrical activity in the heart) that may cause cardiovascular collapse and death.

Respiratory Effect: The changes in thoracic or abdominal circumference that occur as the subject breathes.

Seclusion: Means sole confinement in a room that it is not within the control of the person confined to leave (s. 116 of the *Mental Health Act 1996*). This may include the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others. Seclusion should be used as a last resort, for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; or where there is any risk of suicide or self-harm. Seclusion of a voluntary patient should be taken as an indicator of the need to consider referral under the *Mental Health Act 1996* for an examination by a psychiatrist.

Sedation: The use of medication to calm/lightly sedate the patient, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the patient, sedation may lead to deep sedation/anaesthesia.

Threat Control Override Symptoms: A combination of feeling threatened and losing the sense of internal control of our own thoughts and actions. This cluster of symptoms tends to be most related to an increased risk of violent behaviour toward others.

Violence: The use of physical force which is intended to hurt or injure another person (Wright S, Gray R, Parkes J, Gournay K. (2002) *The Recognition, Prevention and Therapeutic Management of Violence in Acute Inpatient Psychiatry: A Literature Review and Evidence-Based Recommendations for Good Practice,* prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. London).

Vulnerability: Specific factors that relate to the likelihood of an individual being victimised, taken advantage of or exploited by others. Vulnerable individuals may be subject to verbal abuse or harassment, physical or sexual abuse or intimidation, coercion into unwanted acts and bullying. Assessment of vulnerability may include consideration of mental state, physical/physiological conditions, psychological or social problems, and cultural or gender issues.

APPENDIX D: The WA Guideline Group

The WA Guideline Development Group for Short-Term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Settings

1   Dr Adam Brett, State Forensic Mental Health Service (Chair)

2   Karen Dickinson, Mental Health Division

3   Beverley Seth, Consumer representative

4   Arthur Davies, Consumer representative

5   Dr Joseph Lee, North Metropolitan Area Health Service

6   Trevor Gee, South Metropolitan Area Health Service

7   Jo Owen, Goldfields South East Health Region

8   Dr John Dingle, Women's & Children's Area Health Service

9   Tim Rolfe, Office of Chief Psychiatrist

10 Michelle Lusty, South West Health Region

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