Final report

Inquiry into the Legislative, Workplace Governance and Clinical Frameworks of Dhulwa Secure Mental Health Unit

11 November 2022

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Letter to the Chief Minister presenting the report

The Hon Andrew Barr MLA

Chief Minister of the Australian Capital Territory

GPO Box 1020

Canberra ACT 2601

Dear Chief Minister

Final report of the Inquiry into the Legislative, Workplace Governance and Clinical Frameworks of Dhulwa

In accordance with the terms of reference I present the Final report of the Inquiry into the Legislative, Workplace Governance and Clinical Frameworks of Dhulwa.

This Final report contains the Inquiry's recommendations to ensure a safe workplace and a best practice environment and is inclusive of a draft implementation program from finding-based recommendations for consideration.

Yours sincerely

Barbara Deegan

Chairperson

Dhulwa Inquiry

11 November 2022

Executive summary

The terms of reference of the Board of Inquiry into the Legislative, Workplace Governance and Clinical Frameworks of Dhulwa Secure Mental Health Unit (the Inquiry) acknowledge that the complex and unsettled governance arrangements at the Dhulwa Secure Mental Health Unit (Dhulwa or the unit) have likely precipitated significant and concerning workplace safety and clinical practice matters. In reaching its findings and recommendations, the Inquiry is mindful of the complex nature of the service and environment and the unique challenges these present for work health and safety (WHS), particularly the prevention of occupational violence.

The information gathered from submissions, interviews and review of procedural documents indicates that there is a persistent and pervasive poor safety culture at Dhulwa. The key findings identified and detailed below reach into all aspects of the functioning of the unit and identify issues that are hampering the efforts and commitment made by parts of the workforce to drive continuous improvements and create a safe environment.

Key findings of the Inquiry are:

- the Model of Care that should provide the overarching framework for the governance and operational functioning of Dhulwa is unclear.
- a lack of consistent leadership, effective consultation and clear communication has contributed to a poor work culture at Dhulwa.
- uncertainty about the security arrangements at Dhulwa has contributed to safety concerns.
- WHS practices at Dhulwa are driven by a reactive safety culture.
- the WHS and clinical governance frameworks at Dhulwa do not appear to take a best practice approach to risk management.
- the review of incidents within the unit could be improved to drive better practice.
- approaches to understanding aggression in the inpatient setting do not appear to be consistently understood and applied to mitigate the risk of violence.
- the Dhulwa workforce does not appear to have had the support, training and development required to manage the complexity of the consumers admitted to the unit.
- safety at Dhulwa could be improved by the introduction of Safewards and the use of a Trauma Informed Care approach.

Written and oral submissions from individuals and organisations have highlighted the dysfunction between different levels of the workforce. Consistently raised themes include:

- unsupportive leadership;
- poorly managed change;
- fractured workforce relationships;
- poor communication and lack of transparency; and

- workforce cliques.

Over the period of the Inquiry, Canberra Health Services (CHS) and the Dhulwa leadership team have been working to improve current practices and procedures and have commenced initiatives that focus on some of the issues raised in this report. These have included, but are not limited to:

- the introduction and evaluation of Safety Huddles;
- recruitment to fill vacancies in nursing leadership roles;
- ongoing training of nursing staff; and
- training for all staff on the prevention and management of aggression to reduce occupational violence risks.

The Inquiry supports the work that has commenced at Dhulwa. However, there has been a level of dysfunction occurring at Dhulwa for some time and the implementation of the Inquiry recommendations will require a commitment to change and an investment of both time and resourcing if improvements are to be made.

From its inception, Dhulwa has had the opportunity to function as a highly successful facility. The unit was purpose-built and provided with the best training, policies and procedures that existed (domestically and internationally) when it was established. In addition, Dhulwa has been very well resourced in terms of nursing staff. Despite these factors, it appears that CHS and the Dhulwa workforce have failed to take full advantage of the opportunities provided. The submissions, interviews, meetings, site visits and closed-circuit television footage reviewed by the Inquiry show that the standard of care at times provided to consumers at Dhulwa is well below that expected of the unit and contemporary practice.

The Inquiry has noted that previous reviews concerning Dhulwa, together with reviews of various incidents, have included findings and recommendations similar to some made in this Final report. Despite these earlier reviews and recommendations, no significant or lasting improvements have occurred at Dhulwa.

The Inquiry makes 25 recommendations for the ACT Government to consider. In accordance with the terms of reference the Inquiry has provided a draft implementation program that includes detailed actions and a timeline to implement the recommendations (see Appendix C).

The Inquiry recommendations are broad, focussing on clinical care and service delivery, WHS, workplace relations, governance, leadership, culture and engagement. The implementation of the recommendations will help drive systems change and workforce engagement to manage clinical and WHS risks and improve safety and the quality of clinical care.

The ACT Government, CHS, the Dhulwa workforce and stakeholder organisations must ensure that Dhulwa is operating as a safe workplace and quality service for its consumers. The Inquiry also recommends independent oversight of the implementation of the recommendations to effect change as soon as reasonably practicable.

Recommendations

Recommendation 1: Independent oversight

There should be independent oversight of the implementation of the recommendations to ensure that change occurs at Dhulwa, and that the change is effected as soon as reasonably practicable.

Recommendation 2: Model of Care

The Model of Care for Dhulwa should be clarified to confirm that its primary purpose is the provision of forensic mental health services, which in turn will inform the therapeutic and work health and safety management of the unit.

Recommendation 3: Information for consumers

The Dhulwa Consumer and Visitor Handbooks should be updated and disseminated in order to clearly communicate the Model of Care for Dhulwa and operational procedures to all stakeholders.

Recommendation 4: Policies and procedures

Following confirmation of the Model of Care, to ensure consistency, the policies and procedures relating to clinical and work health and safety management at Dhulwa should be reviewed.

Recommendation 5: Policies and procedures - Leave Management

Where legally required, matters for external leave (leave from the unit) for consumers should be considered by ACT Civil & Administrative Tribunal (ACAT), and in all other cases leave should be a matter for clinical decision at an appropriately senior level on an individual consumer basis.

Recommendation 6: Staffing profile

The staffing model for Dhulwa should be restructured to provide clear leadership and an appropriate skill-mix on every shift. Emphasis should be given to the provision of therapeutic, occupational, vocational, educational and social activities for consumers through the recruitment and retention of allied health staff.

Recommendation 7: The inclusion of the lived experience workforce

Dhulwa should ensure there is representation from the lived experience workforce in the multidisciplinary team.

Recommendation 8: Implementation of Safewards

The Safewards model should be fully implemented at Dhulwa and, once embedded, consideration given to the implementation of the Safewards Secure model.

Recommendation 9: Reducing the use of restrictive practices

A framework to reduce the occurrence of restrictive practices at Dhulwa including seclusion and restraint should be implemented.

Recommendation 10: Governance arrangements

The governance arrangements for management at Dhulwa should be re-affirmed to ensure that those who have the ultimate responsibility for quality and safety at the unit have the appropriate delegations and reporting lines to be able to manage effectively.

Recommendation 11: Clinical oversight and leadership

To improve accountability and consistency of clinical care at Dhulwa, enhanced clinical oversight arrangements should be established. These include: a designated nursing team leader position for each shift, an after-hours clinical support position, the institution of a Primary Nurse model, and the provision of specialist psychiatric support for Dhulwa at all times.

Recommendation 12: Integration of security into clinical and therapeutic practice

Practices at Dhulwa should be revised to ensure that personal safety of staff is improved through relational security becoming an integral part of clinical and therapeutic practice, and that clinical care is not delivered in a custodial manner.

Recommendation 13: Role of security staff

The role of the security staff at Dhulwa should be clarified to ensure that it is consistent with the Model of Care and that the role is limited to the provision of perimeter security.

Recommendation 14: Best practice use of security cameras

The use of security cameras at Dhulwa should be reviewed and best practice use of security cameras in a forensic mental health facility adopted.

Recommendation 15: Consultation and communication arrangements

In order to establish a strong safety culture at Dhulwa existing consultation and communication arrangements should be reviewed, having regard to Canberra Health Services work health and safety management system requirements and working with staff to identify an approach that aligns with the organisational requirements and is fit for purpose for the unit.

Recommendation 16: Resources to manage change

Appropriate resources should be allocated to support change management at Dhulwa to ensure there are proper processes in place for communication, engagement and implementation of the Inquiry's recommendations, and to embed effective change management practice for the future.

Recommendation 17: Documenting risk

Dhulwa should have a risk register that is monitored and reviewed and that captures work health and safety risks within the unit, including the psychosocial safety of workers.

Recommendation 18: Use of the DASA risk assessment instrument

Dhulwa staff should be retrained in the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument and its application should be continuously monitored to ensure appropriate use.

Recommendation 19: Risk mitigations following risk assessment

Consideration should be given to the use of a framework such as the Aggression Prevention Protocol (APP) to ensure that appropriate risk mitigation interventions are put in place after risk is identified.

Recommendation 20: Incident management process

An incident management process should be implemented at Dhulwa to ensure immediate review involving all relevant staff, and timely remedial action.

Recommendation 21: Competencies and training

Clinical competencies should be mapped for all levels of staff at Dhulwa to ensure the effective delivery of the Model of Care, and training requirements should align with the clinical competencies and address any risks raised by the workforce.

Recommendation 22: Ethics, human rights, confidentiality and privacy training

Training should be provided for existing Dhulwa staff and all new recruits on the legislative and other requirements and obligations relating to ethics, human rights and in particular, the rights of consumers to both confidentiality and privacy.

Recommendation 23: Improve nursing staff capabilities

Nursing staff should be rotated through other mental health facilities, including forensic mental health facilities, to gain greater experience and to improve clinical capability.

Recommendation 24: Leadership external support

The leadership team at Dhulwa should develop contacts with forensic mental health professionals in other jurisdictions in order to assist in the maintenance of contemporary practice.

Recommendation 25: Trauma Informed Care

Dhulwa should adopt a Trauma Informed Care approach and all staff should be trained in Trauma Informed Care.

Chapter 1: Introduction

1.1 Purpose

The Board of Inquiry into the Legislative, Workplace Governance and Clinical Frameworks of Dhulwa Secure Mental Health Unit (the Inquiry) was appointed following a perceived increase in incidents of occupational violence and assaults on staff at the Dhulwa Secure Mental Health Unit (Dhulwa or the unit). The Inquiry's terms of reference required it to review the existing Legislative, Workplace Governance and Clinical Policy Frameworks at Dhulwa in the context of ensuring a safe workplace and a best practice environment.

The terms of reference acknowledge that the existence of complex and unsettled governance arrangements at Dhulwa has, inter alia, likely precipitated the existing significant and concerning workplace safety and clinical practice matters. The Inquiry was established to consider all aspects of the functioning of Dhulwa and provide findings-based recommendations.

The Inquiry had particular regard to:

1. The nature, reciprocation and application of the rights of workers and consumers contained within the relevant enabling legislation (including the *Human Rights Act 2004* (ACT), *Work Health and Safety Act 2011* (ACT), the *Fair Work Act 2009* (Cth) and the breadth of ACT Mental Health legislation).
2. The available evidence and/or expert advice pertaining to the operation of comparable facilities outside the ACT.
3. The coherence, merits and risks of all Dhulwa workplace, clinical and education policies, procedures, structures and committees, and their current operationalisation and compliance.
4. Opportunities to improve existing workplace and clinical decision-making frameworks, and ensure their consistent application.
5. Establishing a draft comprehensive implementation program from finding-based recommendations for consideration.
6. A review of any other relevant matters, including contemporary reviews by other agencies, and recent case and case-mix history, as deemed necessary by the Inquiry.

The Inquiry was assisted by a member with expertise in forensic mental health, Dr Tessa Maguire and a member with expertise in work health and safety, Ms Rebecca Parton.

The Chief Minister, Treasury and Economic Development Directorate provided secretariat services to support the Inquiry.

1.2 Review methodology

The Inquiry has undertaken an extensive consultation process to inform its review. The Inquiry sought public submissions, held a roundtable session with relevant unions, conducted individual

meetings and visited mental health facilities within the Australian Capital Territory (ACT) and in other comparable jurisdictions. While the Inquiry had the power to hold public hearings, it determined at the outset that the interests of staff and consumers at Dhulwa would be better served by conducting the Inquiry in a manner that respects and preserves the privacy of individuals.

The Inquiry:

- conducted 52 introductory meetings with internal and external stakeholders, carers, consumers, unions, advocacy groups and other interested parties. This included meetings with current and former staff of Dhulwa, ACT Health Directorate and Canberra Health Services (CHS). Staff at all levels of these organisations were represented and included administrative, medical, nursing, allied health, security, corporate and executive staff. These meetings were either requested by individuals or instigated by the Inquiry. All meetings were conducted privately.
- held a stakeholder roundtable session with union representatives.
- received and considered 68 submissions including supplementary submissions from individuals and organisations. Where requested, the confidentiality of a submission has been noted and is respected in the reporting of the Inquiry findings. The Inquiry undertook to consult with the authors of submissions about publication of any part of a submission if it were considered its publication would assist the report findings and recommendations.
- attended site visits in the ACT to the following facilities:
  - Dhulwa Mental Health Unit (Dhulwa);
  - Gawanggal Mental Health Unit (GMHU);
  - Adult Mental Health Unit (AMHU); and
  - Crisis Support Unit at the Alexander Maconochie Centre.
- attended site visits outside the ACT to the following facilities:
  - Thomas Embling Hospital in Melbourne;
  - The Forensic Hospital in Sydney; and
  - The Wilfred Lopes Centre in Tasmania.
- reviewed hundreds of clinical, policy and reporting documents provided by CHS.
- considered forensic mental health service provision in other jurisdictions.
- considered ACT and other state and territory legislation and other relevant materials including contemporary research.
- convened and conducted additional consultation meetings with internal and external stakeholders including CHS Senior Executives, ACT Government stakeholders including the Human Rights Commission, Official Visitor, Public Advocate, WorkSafe ACT and unions.
- analysed all written submissions and identified common themes which are described in Appendix D; and
- analysed all reported incidents of occupational violence at Dhulwa.

The Inquiry has also considered the findings of other reviews conducted in recent years, a number specific to Dhulwa and one regarding mental health inpatient services in the ACT more generally. These include:

- The *Dhulwa Mental Health Unit Incident – RCA [Root Cause Analysis] Investigation Report Case identifier 05/2017;*
- The *Independent External Review of Mental Health Inpatient Services within ACT Health* conducted by an independent panel consisting of three representatives from the North Western Mental Health Team from Victoria;
- The report on the *Review of the Mental Health (Secure Facilities) Act 2016* (completed by Ms Angelene True on behalf of ACT Health in March 2022 and tabled in the ACT Legislative Assembly on 4 August 2022). A summary of the recommendations and observations noting the support or otherwise of this Inquiry is at Appendix E as this was clearly within the Inquiry's terms of reference;
- A report completed in May 2022 by the Deputy Director of Nursing and the Nurse Manager, Staff Safety and Restrictive Practices, from the NSW Health Justice Health and Forensic Mental Health Network at the Malabar Forensic Hospital in Sydney in relation to three adverse safety incidents which occurred in Dhulwa in April 2022.[1]

The Inquiry noted there was a degree of consistency in the issues identified and recommendations made in the previous reports. This Final report (the Report) will not go into detail regarding the recommendations of those reviews, however, has noted the broad findings and themes which are consistent with our recommendations. These include:

- the Model of Care requires review;
- the policies and procedures should be reviewed to support delivery of the Model of Care and a safer workplace;
- the Model of Care, policies and procedures should be communicated to consumers and their advocates;
- a structured leadership team is required;
- staff with specialist forensic mental health qualifications and expertise should be recruited;
- the current nursing structure should be reviewed to support clinical and operational leadership and care provision, particularly for after-hours operations; and
- improved communication and consultation with staff is required.

Despite these earlier recommendations, the Inquiry found that no significant or lasting improvements have occurred at Dhulwa.

1.3 Incidents that led to the Inquiry

The Inquiry was not tasked to investigate individual incidents of occupational violence at Dhulwa given that such incidents were managed in accordance with existing systems. In examining the operation of those systems, the Inquiry was exposed to information about individual incidents and

has considered the information gathered from the individual incident reports in the broader context of the systemic issues related to clinical, workplace and WHS practices.

The incidence of occupational violence at Dhulwa, occurring in the form of physical or verbal assaults, and the ACT Government's response to these, has attracted media attention since 2018. This Inquiry was established in response to claims made in early 2022 relating to occupational violence at Dhulwa, including a report that a nurse from Dhulwa suggested that working at the unit was like being "sent into the killing fields"[2] and a public statement made by the Australian Nursing and Midwifery Federation ACT Branch that nurses working at Dhulwa had "reported over 100 physical assaults by patients over a six-month period to February".[3] In response to these claims, CHS acknowledged receiving "83 reports of assault over the period".[4]

While a perception has been created that Dhulwa is a dangerous place to work, only a small minority of the incident reports that were reviewed by the Inquiry resulted in the person needing time off work and fewer resulted in serious injury. Of the incidents that resulted in injury few were the direct result of aggression by consumers but appeared to be the result of poorly managed or implemented clinical or work practices.

While the Inquiry was established as a result of the media attention that implied that the extent of occupational violence in the unit was extreme, the Inquiry noted that there were no actual or potential incidents of occupational violence reported in the three-weeks prior to the statements being made in the media.

1.4 Final report

This Report contains the Inquiry findings and recommendations and incorporates, where appropriate, feedback received on the Preliminary report from both internal and external stakeholders. The recommendations are designed to provide a clear direction for comprehensive action to improve the safety of staff and consumers, and to achieve a best practice environment for Dhulwa.

The terms of reference also required the Inquiry to establish a draft comprehensive implementation program from findings-based recommendations. The Inquiry recommends that there is independent oversight of the implementation of the recommendations to ensure that change occurs at Dhulwa, and that the change is effected as soon as reasonably practicable.

Recommendation 1: Independent oversight

There should be independent oversight of the implementation of the recommendations to ensure that change occurs at Dhulwa, and that the change is effected as soon as reasonably practicable.

Chapter 2: Dhulwa Mental Health Unit

2.1 The unit

On 24 August 2016, Dhulwa was declared a secure mental health unit and commenced receiving consumers in November 2016.

Dhulwa is a 25-bed secure mental health unit for people with complex mental illness or people with mental illness who have or are likely to come into contact with the criminal justice system and are unable to be cared for in a less restrictive environment.[5]

The unit offers a safe and structured environment for people who cannot be safely cared for in other environments or in another inpatient unit in the ACT. The 25 beds of the unit are configured into an acute wing with 10 beds, known as Lomandra, and a rehabilitative wing with 15 beds, known as Cassia and Mallee.

At the time of the Inquiry the unit was operating with 17 of the 25 beds commissioned across both the acute and rehabilitative wings.

2.2 Mental health services in the ACT

To provide appropriate recommendations for Dhulwa, the Inquiry considered it was important to understand how Dhulwa functioned in the broader context of mental health services in the ACT. The Inquiry noted that CHS has, in addition to Dhulwa, multiple mental health inpatient units including facilities that provide 24-hour treatment and care for adults with complex mental health needs.

These units are:

- AMHU - a 40-bed inpatient mental health unit at Canberra Hospital which provides both high dependency and low dependency care for people with acute mental health issues.
- GMHU - a 10-bed community rehabilitation and reintegration unit located next to Calvary Public Hospital Bruce which supports people to transition back into the community setting from inpatient mental health care.
- Mental Health Short Stay Unit - a 6-bed inpatient unit located within the Emergency Department at Canberra Hospital which provides short-term care for people who need extended mental health assessment or crisis intervention.
- Ward 12B Low Dependency Unit - a 10-bed low dependency mental health inpatient unit at Canberra Hospital which provides low dependency care for people with acute mental health issues in a purpose-built unit designed to support recovery.
- Adult Mental Health Rehabilitation Unit - a 20-bed specialist mental health rehabilitation unit located at the University of Canberra Hospital which provides care and support for people with a primary diagnosis of mental illness, who would benefit from an intensive rehabilitation program.[6]

The Inquiry visited the AMHU and the GMHU during its review to develop an understanding of the clinical operations of those units in the broader ACT mental health service function. Additionally, the Inquiry also visited the Crisis Support Unit at the Alexander Maconochie Centre to gain an understanding of the pathway from the Alexander Maconochie Centre to Dhulwa for detainees requiring acute mental health care.

2.3 Consumers

The Operational Model of Care – Secure Mental Health Unit – Mental Health, Justice Health and Alcohol & Drug Services (the 2016 Model of Care) states that:

> *"….a consumer is admitted to Dhulwa through a clinician referral. Although the source of referrals can vary, it is anticipated that the majority will be from one of the following categories:*
>
> 1. *Sentenced or remand detainees who require ongoing mental health care and treatment and who due to legal status, require this to be delivered within conditions of a secure mental health unit;*
> 2. *Criminal Courts following assessment by mental health staff and made subject to provisions of the forensic sections of the Mental Health Act 2015 (the Mental Health Act); and*
> 3. *People in Adult Mental Health Services e.g. high dependency units who require admission to secure care."*[7]

The Inquiry has determined that on occasion, the admission and referral of consumers to Dhulwa has departed from the original admission criteria, and the beds have been used as general mental health beds for CHS bed management purposes.

2.4 Mental Health Orders

The majority of consumers at Dhulwa are subject to a Mental Health Treatment Order.

Pursuant to the Mental Health Act, the ACT Civil & Administrative Tribunal (ACAT) can make a number of Mental Health Orders which include:

- Psychiatric Treatment Orders (PTO);
- Community Care Orders;
- Restriction Orders;
- Forensic Psychiatric Treatment Orders (FPTO); and
- Forensic Community Care Orders.

Consumers at Dhulwa are generally admitted under a PTO or a FPTO.

"ACAT may make a PTO if it finds that:

- *the person has a mental illness; and*
- *the person refuses to receive treatment, care or support where they do not have decision-making capacity or where they do not have decision-making capacity or where they do not consent to treatment, care or support and do have decision-making capacity; and*
- *the person is doing, or is likely to do, serious harm to themselves or someone else, or that they are suffering, or likely to suffer, serious mental or physical deterioration; and*
- *the harm or deterioration is so serious that it outweighs the person's right not to consent; and*
- *psychiatric treatment, care or support are likely to reduce the harm or deterioration (or the likelihood of it) or lead to an improvement in the mental illness that the person is experiencing; and*
- *the treatment care or support cannot be adequately provided to the person in another way which would involve less restriction on their freedom of choice and movement.*

A FPTO may be made by ACAT where a person with a mental illness or mental disorder is involved with the criminal justice system.

ACAT may make a Forensic Mental Health Order where the person with a mental illness or mental disorder is:

- *detained in a correctional centre or place of detention; or*
- *serving a community-based sentence; or*
- *referred to ACAT by a court where the person has been deemed as 'unfit to plead' or 'mentally impaired' under the Crimes Act 1900 (ACT) or the Crimes Act 1914 (Cwlth).*

Before ACAT makes a FPTO, ACAT must be satisfied that the person not only has a mental illness or mental disorder, but must also believe on reasonable grounds that the person:

- *is doing, or is likely to do, serious harm to themselves or someone else; or*
- *is suffering, or is likely to suffer, serious mental or physical deterioration; and*
- *has seriously endangered, or is likely to seriously endanger, public safety.*

ACAT must also be satisfied that the treatment, care or support is likely to improve the person's condition and reduce the risk to the person, another person or to public safety. ACAT must also be satisfied that treatment cannot be provided in a way that is less restrictive to the person's freedom of choice and movement. It is not required to consider decision-making capacity in making a Forensic Mental Health Order.

Finally, ACAT must be satisfied that, in the circumstances, a Mental Health Order should not be made." [8]

However, it should be noted that according to the Model of Care described above, there is no requirement that a consumer at Dhulwa be subject to a Mental Health Order and that some consumers could be admitted to Dhulwa on a voluntary basis.

2.5 Jurisdictional comparisons

Whilst the Inquiry considered the functioning of Dhulwa in the broader context of mental health services in the ACT and CHS, it was important to consider the forensic nature of the unit. In accordance with the terms of reference, the Inquiry considered the operations of comparable facilities providing forensic mental health services.

The Inquiry visited three facilities outside the ACT:

- The Forensic Hospital – a 135-bed high secure mental health unit for mentally ill patients who have been in contact with the NSW criminal justice system, and high-risk civil patients. The Forensic Hospital is a New South Wales Justice Health unit located in Sydney near the Long Bay Correctional Complex and hospital.[9]
- The Thomas Embling Hospital - a 136-bed secure forensic mental health hospital providing care and treatment spanning across intensive, acute, sub-acute, extended rehabilitation and transitional rehabilitation.[10] The Thomas Embling Hospital is a service provided by Forensicare, a public statutory authority established under the *Mental Health Act 2014 (Vic)*. Forensicare is governed by an independent Board, reporting to the Minister for Mental Health and provides forensic mental health services in Victoria. The hospital is in central Melbourne.[11] The hospital has access to, but is not co-located with, acute hospital services.
- The Wilfred Lopes Centre - a 35-bed unit (currently accommodating 19 consumers) providing high dependency and extended treatment and care, and semi-independent living for people with mental health issues who are involved with the criminal system. The unit is located near, but is not part of Risdon Prison.[12]

Chapter 3: Creating a sense of purpose for Dhulwa through a clear Model of Care

3.1 Model of Care

A 'Model of Care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place.[13]

Purpose and identity are fundamental elements of any Model of Care and the governance structures, policies and procedures to uphold it. The Inquiry reviewed a Model of Care for Dhulwa from 2014 published on the ACT Health website[14] which it understood to have been developed to inform the design and operations of the unit pre-construction, and to inform community and stakeholder engagement.

A revised Model of Care called The Operational Model of Care – Secure Mental Health Unit – Mental Health, Justice Health and Alcohol & Drug Services[7] (the 2016 Model of Care) was developed to support the unit opening in 2016. This Model of Care appears to be neither officially adopted nor published, thus creating confusion about the purpose of the unit.

The service purpose and scope outlined in the 2016 Model of Care states that Dhulwa (referred to as the Secure Mental Health Unit (SMHU)) was designed to:

> *"...support a person's treatment, care and recovery by responding to the needs of people with moderate to* severe *mental illness who are or are likely to become involved with the criminal justice system (forensic) and for those civilian people who cannot be treated in a less restrictive environment.*
>
> *As well as secure mental health care there is also a need to provide secure and longer-term inpatient care for people who have unremitting and severe symptoms of mental illness or disorder and associated behaviour disturbance and are unable to be safely or adequately treated in less restrictive settings."*

Further, the 2016 Model of Care states:

> *"As a secure specialist service, the beds of the SMHU will not be included as general mental health beds for bed management purposes."*

and

> *"The SMHU is not a corrections facility and will not operate as such. It will fundamentally be a therapeutic setting, underpinned by contemporary, evidence-*

based multidisciplinary mental health care to ensure the highest quality of person-focused care which enables recovery of the person's mental illness which played a functional role in the offending or difficult behaviour."

The Inquiry found that whilst issues related to the 2016 Model of Care have been identified in previous reviews[1,15,16] undertaken at Dhulwa, actions to address and clarify the purpose of the unit do not appear to have either progressed or been progressed in a transparent manner.

In submissions to, and interviews conducted with, the Inquiry, current and former staff reported a lack of clarity concerning the consumer profile for admission to Dhulwa. This in turn has created confusion about treatment practice, clinical care delivery and WHS practices to support rehabilitation and treatment. This Inquiry and at least one earlier review[1] noted that while statements of intended purpose and operation in the 2016 Model of Care demonstrate an intent to provide recovery-oriented therapeutic care, a consistent theme from stakeholders was that recovery-oriented therapeutic care does not always appear to be the case in practice.

The Inquiry also found that a CHS service realignment in July 2021, which realigned Dhulwa from the 'Justice' stream of the CHS Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS) into the Adult Acute Mental Health Program area, also contributed to the sense of confusion about appropriate consumer admissions and impacted upon clinical care and the application of clinical and operational policy and procedure.

The Inquiry recognises that clinical unit functions change over time in response to broader community service and operational needs, but the service realignment in 2021 created the opportunity for mental health consumers, who do not require accommodation in a secure forensic inpatient setting, to be admitted to Dhulwa. This change is a significant departure from Dhulwa's (albeit unpublished) 2016 Model of Care. The admission of mainstream mental health consumers into the unit does not appear to comply with that object of the Mental Health Act which is to "ensure that people with a mental disorder or mental illness receive assessment and treatment, care or support in a way that is least restrictive or intrusive to them".[17]

In the absence of a clearly understood Model of Care, the clinical and operational governance and associated policies and procedures of Dhulwa are compromised. This presents in practical terms at Dhulwa as confusion about the purpose, identity and operation of the unit, and the roles and responsibilities of staff, all of which then impact care and safety for all at Dhulwa.

The lack of clarity regarding the services Dhulwa offers and to whom, and how care is to be delivered, creates uncertainty about therapeutic and recovery-oriented practice. This is being expressed in restrictive intervention practices, extended length of stay and discharge challenges, consumer frustration, and workforce confusion and frustration. Clarity is required regarding the consumer population that can be admitted to Dhulwa. Admission of mainstream mental health consumers who do not require accommodation in a secure inpatient setting does not meet the requirement of least restrictive care and may present challenges when trying to discharge the consumer into less restrictive settings.

The confusion about the Model of Care is also evident in the physical environment of the unit. The layout, security and furnishings of the unit resemble a custodial, rather than a rehabilitative, environment. The Inquiry considered that the starkness of the physical environment of the unit could also have the potential to escalate consumer agitation, particularly for those who have interacted with custodial environments, rather than provide them with a safe, familiar and supportive environment to assist in their rehabilitation. The physical environment at Dhulwa was in stark contrast to the environments of the facilities that the Inquiry visited in other jurisdictions. Consumers told the Inquiry that the unit did not provide support for their social reintegration, such that might be expected from a rehabilitation unit. Providing a softer, more homely atmosphere with more ready access to the natural environment in and around the unit buildings would reinforce the rehabilitative role of Dhulwa rather than stressing the deprivation of liberty for consumers whilst they receive treatment and care.

A clearly understood Model of Care, and strong clinical and managerial leadership at Dhulwa will ensure staff practices remain focussed on the delivery of quality person-focused care in a therapeutic environment rather than those more akin to a correctional unit. This focus will ensure that the required standard of clinical and rehabilitation support is available for consumers admitted to Dhulwa and that their care is tailored to meet their individual rehabilitation needs and delivered by an appropriately skilled and competent workforce.

Without a clear Model of Care and basis to align a therapeutic quality and safety framework, both safety and care are compromised.

Recommendation 2: Model of Care

The Model of Care for Dhulwa should be clarified to confirm that its primary purpose is the provision of forensic mental health services, which in turn will inform the therapeutic and work health and safety management of the unit.

3.2 Information for consumers

The Inquiry noted that, whilst the 2016 Model of Care remains unpublished, consumers and consumer advocates do not have the information required to fully understand and interact with the service provided at Dhulwa, creating confusion and frustration. The Inquiry also noted there are consumer and visitor handbooks available,[18,19] however, consumers and consumer advocates advised they were not provided this information.

From interviews with individual consumers, the Inquiry noted that the lack of information about what to expect while accommodated at Dhulwa created in consumers, a sense of helplessness and frustration. Consumers interviewed stated that they primarily relied on information provided by fellow consumers to navigate their stay at Dhulwa.

These concerns were expressed in interviews and included confusion about:

- care provision, planning and process;
- general operations of the unit;
- access to leave and leave arrangements;
- visitation access and process arrangements; and
- complaints processes and access to independent support and advocacy.

Recommendation 3: Information for consumers

The Dhulwa Consumer and Visitor Handbooks should be updated and disseminated in order to clearly communicate the Model of Care for Dhulwa and operational procedures to all stakeholders.

3.3 Operational policies and procedures

Confirmation of the Model of Care is required to inform and manage both the clinical and WHS risks at Dhulwa. A lack of clarity about the Model of Care for the unit has resulted in staff attempting to work in accordance with policies and procedures that may not be appropriate for the needs of the consumers admitted to the unit, or with policies and procedures being amended and implemented to address changes in clinical requirements in an ad hoc and poorly consulted manner.

As noted, earlier reviews also identified the lack of a clear Model of Care and its resultant impact on both the clinical service provision and consumer outcomes, and workforce understanding, skills and knowledge to deliver services in a safe environment. This impact is exacerbated at Dhulwa as there is an increased disconnect for staff attempting to align WHS policies and practices with the original intent of the unit. This manifests as a lack of staff confidence and competence to know, understand and implement the directions for management of WHS in the unit.

It was clear to the Inquiry from discussions with staff that there is a lack of adherence to the policies and procedures in place at Dhulwa. Review of incident reports indicate that situations that have led to WHS risk or injury have, at times, been predicated and/or exacerbated, by a deviation from documented practices. It was evident that good intentions were behind some deviations from agreed policies and procedures, however it was apparent such deviations did not trigger a proper review of the policy or procedure to inform change and improve clinical, operational or health and safety practice.

The Inquiry noted several Dhulwa clinical policies and procedures were updated in June 2021.[20,21,22] While efforts have been made to engage the workforce in consultation about policies, it is not clear that the engagement with staff has been effective or has met the requirement to consult. Staff must be consulted on any changes to their work practices and may have relevant experience that should inform any changes to policies or procedures. Additionally, staff must be made aware of the appropriate mechanisms available to them to raise concerns relating to development, implementation and review of policies and procedures with management.

Recommendation 4: Policies and procedures

Following confirmation of the Model of Care, to ensure consistency, the policies and procedures relating to clinical and work health and safety management at Dhulwa should be reviewed.

3.4 Leave Management

The Inquiry noted that the CHS procedure Dhulwa and Gawanggal Mental Health Units – Leave Management for People Admitted[23] was issued in March 2021. While some aspects of the procedure appear appropriate, there is a concern that the document is unnecessarily prescriptive and, if strictly applied, could lead to unintended consequences and consumer frustration.

On the evidence gathered by the Inquiry the matter of the granting and cancellation of leave for consumers has been a direct cause of some consumer aggression. The cancellation of leave for punitive purposes is counter-intuitive in circumstances where cancellation is likely to increase feelings of frustration and aggression in an affected consumer (see Chapter 8 for further detail on this matter).

While it is necessary, for legal reasons, for some consumers to have their access to external leave (leave from the unit) regulated by the ACAT, this is not a requirement for leave within the grounds of Dhulwa. Information provided by consumers and other stakeholders suggests that there is a lack of clarity about the circumstances in which a consumer's leave may be cancelled. The current practice includes cancelling a consumer's access to the exercise areas within the grounds of the unit because the consumer is showing early signs of heightened anxiety or aggression. This seems incongruous when access to sport facilities or the walking track may be an ideal tool to assist in the de-escalation of the consumers anxiety or aggression.

The Inquiry recognises that, on occasion, leave must be cancelled for the safety of consumers and others but recommends that such decisions are made by appropriately qualified senior clinicians, are not made arbitrarily, and are made for valid clinical reasons.

Cancellation of leave for reasons of staff convenience should be avoided. Every effort should be made to ensure consumers are not subjected to disappointment or frustration in relation to anticipated leave where such cancellation is avoidable.

Recommendation 5: Policies and procedures – Leave Management

Where legally required, matters for external leave (leave from the unit) for consumers should be considered by ACT Civil & Administrative Tribunal (ACAT), and in all other cases leave should be a matter for clinical decision at an appropriately senior level on an individual consumer basis.

3.4 Staffing

In 2016, prior to accepting its first consumers, a draft staffing profile was developed for Dhulwa. While it is not apparent that this was put into practice, the current workforce profile at Dhulwa bears little resemblance to that originally proposed. The 2016 draft staffing profile clearly supported the 2016 Model of Care.

In order to support the delivery of the Model of Care for Dhulwa, a review and reshaping of the staffing profile is required. There should be an emphasis on clearly delineated leadership roles (see Chapter 5 - Governance and Leadership) and ensuring the appropriate staffing skill-mix on every shift. This can only be achieved if there is clarity of the Model of Care for Dhulwa.

The 2016 draft staffing profile for Dhulwa proposed shifts led by a registered nurse at a senior level assisted by a small number of less senior registered nurses (such as registered nurse level 1), enrolled nurses (EN) and assistants in nursing (AIN). The current staffing profile at Dhulwa has a greater number of senior level nurses (registered nurse level 2 (RN2)) regularly rostered each shift. It appeared to the Inquiry that there is insufficient meaningful work for the number of RN2s rostered at Dhulwa, creating confusion about who is leading the shift. With a single appropriately qualified senior nurse in a leadership role, there will be less opportunity for confusion about who is responsible for clinical and other operational decisions.

While Dhulwa has a 25-bed capacity, it has only ever operated with a maximum consumer cohort of 17. This small number of consumers has resulted in Dhulwa being unable to take advantage of proper economies of scale for its functioning as a unit. Reshaping, but not numerically increasing, the staffing profile for Dhulwa would enable the unit to operate at maximum capacity and take advantage of the economies of scale allowing appropriate use of allied health staff to provide a full range of therapeutic, occupational, vocational, educational and social activities and services for consumers.

From interviews with consumers and other stakeholders, it is apparent that few meaningful activities are offered for consumers at weekends or during holiday periods. Any review of the staffing model should enable consumers to be provided with a range of therapeutic activities during these times. This will ensure that consumers do not become frustrated or bored, are less likely to become aggressive and contribute to a safer workplace.

Over recent years many of the allied health positions at Dhulwa have been vacant for extensive periods. Increased effort should be made to ensure all these positions are filled and that Dhulwa has its full complement of occupational and art therapists and exercise physiologists. It is acknowledged that recruiting properly qualified forensic psychologists to Dhulwa has at times been problematic. Given the importance of this role in the recovery of forensic consumers, the Inquiry believe that consideration should be given to the use of forensic psychologists from other areas of CHS Forensic Mental Health services to provide services to Dhulwa on a sessional basis. It is noted that the Wilfred Lopes Centre has successfully implemented this type of model to address their staffing needs.

The Inquiry noted that GMHU currently operates as a 'step down' facility for Dhulwa creating an additional step in the discharge process for consumers. If Dhulwa were operating at full capacity and in accordance with a therapeutic rehabilitative Model of Care, there would be less of a requirement for this to occur as the unit can operate as a secure mental health facility whilst still enabling individual consumers a level of independence and freedom of movement consistent with their progress through the rehabilitation pathway.

The Inquiry considers, that were Dhulwa operating at full capacity (25-beds) and in accordance with a therapeutic rehabilitative Model of Care, there would be less requirement for GMHU to operate as a 'step-down' facility for the unit. It is possible for the level of security that is required to enable Dhulwa to operate as a secure forensic mental health facility to be retained while enabling individual consumers a level of independence and freedom of movement consistent with their progress through the rehabilitation pathway. Other than staff convenience, there is no reason for Dhulwa to operate on a 'one size fits all' basis and consumers should be treated as individuals and subject to individual risk assessments to inform all aspects of their treatment plan including leave and access to various therapies. A greater concentration on individual risk assessment should assist in the early identification and management of re-emergence of concerning behaviours, thereby contributing to the maintenance of a safe workplace for staff and consumers.

Recommendation 6: Staffing profile

The staffing model for Dhulwa should be restructured to provide clear leadership and an appropriate skill-mix on every shift. Emphasis should be given to the provision of therapeutic, occupational, vocational, educational and social activities for consumers through the recruitment and retention of allied health staff.

3.5 Lived experience workforce and carer input

The lived experience workforce refers to the roles in mental health that include consumer consultants, peer workers and carer consultants. These roles are differentiated from clinical roles, in that people who have had direct experience of mental ill health, or who have experience as carers providing support and assistance for a person who has a mental illness, use their lived expertise and experiential knowledge to assist and support others and contribute to service change.[24,25] This workforce covers a range of activities that can include direct service delivery, individual or group assistance and support, encouraging feedback from the consumers on the unit, initiating service change when needed to enhance care, as well as providing leadership.[24]

The lived experience workforce creates an important link between the consumers on the unit, the clinical team and management, and there are benefits of this workforce for the consumers as well as clinical staff.[26] Furthermore, lived experience roles in mental health settings has support from national and international guidelines (e.g Council of Australian Governments 2017, National Institute of care and excellence State of Victoria, 2021), is expected as a part of Australian service delivery standards and is suggested as best practice.[24,25,27]

The Inquiry found there to be little to no input from any members of the lived experience workforce (consumer consultants, peer workers and carer consultants) into the daily operation of Dhulwa. This is also apparent in the Consumer Information Handbook, where there is no mention of this workforce. The 2016 Model of Care does mention a peer worker as a member of the multidisciplinary team, however the Inquiry was not made aware of any involvement of peer workers through any of the consultations, the review of documentation or discussions with stakeholders.

From discussion with current and former consumers, there appears to be a lack of effective representation of the consumer and carer perspective in many elements of service delivery at Dhulwa. The lived experience roles are essential in contemporary mental health service delivery, and Dhulwa would benefit from this workforce as part of the multidisciplinary team, not only from the consumer and carer perspective, but also from the clinical team perspective.

Recommendation 7: The inclusion of the lived experience workforce

Dhulwa should ensure there is representation from the lived experience workforce in the multidisciplinary team.

Chapter 4: Understanding preventing and managing aggression at Dhulwa

4.1 Understanding, preventing and managing aggression

Mental health inpatient units are intended to deliver specialised care and treatment to people who are experiencing acute symptoms of mental illness who otherwise cannot be assessed and treated safely and effectively in the community.[28] Inpatient aggression is a common feature and nurses are often exposed to aggression.[29]

Nurses may be exposed to aggression more frequently because they spend the most time with consumers and because of other aspects related to the provision of care (e.g., the requirement to set certain boundaries and unit rules, the administration of medication, and at times undertaking intrusive procedures).[30] Nurses are also more likely to be involved in the use of restrictive interventions in efforts to prevent or manage aggression. Restrictive interventions can have a range of negative consequences for both nurses and consumers.[31,32] This is reflective of the situation at Dhulwa, although the Inquiry has found that the arrangements in place to understand, mitigate and manage aggression are poorly understood, and/or poorly implemented.

Historically, efforts to understand aggression in the inpatient setting have focussed on consumer characteristics, rather than examination of the broader contextual factors.[33,34,35] It is important to highlight that inpatient aggression occurs as a result of a complex interplay of consumer factors (such as style of interaction, illness factors, substances use etc.), along with a range of staff factors (such as interpersonal skills, knowledge and ability to apply interventions to prevent and manage aggression) and factors present on the unit (such as consumer mix, boredom, lack of privacy).

It is also important to highlight that no single factor accounts for aggression in the inpatient setting, and consideration of contextual factors are just as important as the personal consumer factors.[31] Therefore, a broad understanding of inpatient aggression is required by staff if they are to be effective and safe in a mental health inpatient setting.

Secure inpatient units like Dhulwa, have a range of inherent differences from general mental health units due to the reasons for admission, the legal status of the consumers, the extended length of stay, the security features, and certain characteristics some of the consumers may have (for example presence of offence issues, bringing with them aspects of the prisoner culture, negative attitudes and significant trauma histories).[36,37,38,42]

For these reasons, it is important that there is a broader examination of the relevant factors that contribute to aggression within the setting. This assists staff to generate suitable interventions for consumers who engage in aggressive behaviour, while working with the inherent restrictions of the setting.[39]

To prevent and manage aggression, a proactive, rather than reactive, approach is required.[38] While at the individual consumer level, containment of aggression is sometimes necessary, the responsibility is on clinical teams to facilitate non-violent resolution of challenging situations and promote skills that will allow consumers to meet their needs in non-violent ways.

There is also a national and international movement towards reducing, and where possible eliminating, the use of restrictive interventions which are often used to manage aggression, and this also applies to secure inpatient units.[38]

The Inquiry observed that there is a lack of a framework or model for understanding inpatient aggression at Dhulwa. This appears to have resulted in the sole attribution of aggression being directed towards consumer characteristics, with little regard of other contributing contextual factors such as overly restrictive unit rules, authoritarian limit-setting styles, and limited treatments for violence reduction. The evidence from discussions with numerous stakeholders and the review of incident reports and clinical notes, supports this finding that episodes of aggression were often attributed to consumer characteristics, with little to no review of other possible relevant contextual factors.

Risk assessment and intervention is an important part of forensic mental health practice. Validated risk assessment instruments should be used in units such as Dhulwa to identify who might be at risk of engaging in aggression. Risk assessment should be accompanied by the development of an intervention plan and the implementation of appropriate strategies. Risk assessment and management will be covered in more detail later in Chapter 8 - WHS integrated risk management.

Discussions with stakeholders revealed a 'them and us' culture between staff and consumers. This disconnect was also evident in the care planning and documentation of incidents where there appears to have been a lack of interventions directed towards preventing and managing conflict, and a reliance on containment methods once aggression and/or conflict events occurred.

4.2 Implementing Safewards

There are a number of ways in which Dhulwa staff could work towards reducing both inpatient aggression and the use of restrictive interventions. The Inquiry considered Safewards to be a highly suitable model for use at Dhulwa.

The Safewards model consists of six domains that can be used to understand how events occur and to generate ideas for change that have the potential to reduce both conflict and containment.[40] It should be noted that only one domain refers to consumer characteristics, with the other five referring to the staff, the environment, the legal framework, the consumer community and the physical environment, thereby prompting a review of all possible relevant contributors, rather than a narrow focus on the consumer. The Safewards model is described in more detail in Appendix F.

Some of the Safewards interventions that would be particularly helpful for the staff and consumers at Dhulwa include:

- 'know each other' which would assist in breaking down some of the barriers and the "them and us" culture;
- 'positive words' would encourage positive reflections about consumers and prompt understanding about the function of certain behaviours;
- 'talk down' provides a sound model for de-escalation;
- 'bad news mitigation' encourages thoughtful delivery of bad news and appropriate support; and
- 'soft words' provides ways to avoid confrontation and promotes more collaborative ways of working with consumers.

It is also important that the introduction of any model for understanding aggression at Dhulwa ensures the integration of that model into assessment, planning, implementation of care and review of incidents, including near miss events. It is anticipated that using a contemporary model will encourage a comprehensive approach that takes into consideration contextual factors that appear to have been overlooked at Dhulwa in the past.

CHS has implemented the Safewards model in other areas of the hospital, including the inpatient acute mental health units, and has made a previous unsuccessful attempt to introduce Safewards at Dhulwa.

It is the view of the Inquiry that Dhulwa would benefit from the full implementation of the Safewards model (including approaches to monitor and evaluate use) to ensure that there is a broader examination and understanding of how conflict event, including aggression occur. Once embedded, consideration should be given to introducing Safewards Secure. Safewards Secure is designed to be used in secure settings to address some of the factors pertinent to forensic settings and is inclusive of offence and risk issues, trauma issues, and factors associated with long term stay.[41]

Recommendation 8: Implementation of Safewards

The Safewards model should be fully implemented at Dhulwa and, once embedded, consideration given to the implementation of the Safewards Secure model.

4.3 A framework for reducing the use of restrictive practice

Dhulwa like all mental health services is required to reduce and where possible eliminate the use of restrictive interventions. While there has been work undertaken to reduce the use of restrictive interventions at Dhulwa, which is commendable, this work would be further enhanced by using an evidence-informed approach effective in reducing seclusion and restraint events, such as the Six Core Strategies.

The Six Core Strategies approach is a whole-of-system framework and was developed by the National Association of State Mental Health Program Directors Medical Directors Council in the United States.

The six strategies are:

1. leadership in organisational culture change;
2. the use of data to inform practice;
3. workforce development;
4. inclusion of families and peers;
5. specific reduction interventions (use of validated risk assessment like the Dynamic Appraisal of Situational Aggression (DASA), trauma assessment, crisis planning and sensory modulation); and
6. rigorous debriefing.[42]

Furthermore, a framework such as the Six Core Strategies may address some of the current problems noted at Dhulwa such as issues with the reporting and analysis of data related to aggression and occupational violence. Currently the data reporting is making it difficult to decipher and fully understand the problem (see Chapter 8 - WHS integrated risk management).

Recommendation 9: Reducing the use of restrictive practices

A framework to reduce the occurrence of restrictive practices at Dhulwa including seclusion and restraint should be implemented.

Chapter 5: Governance and leadership

5.1 Organisational governance and leadership

At least half of the staff submissions received by the Inquiry refer to a staff perception that the Dhulwa workplace and work culture is 'toxic'. The submissions describe issues which have, over an extended period, contributed to this perception. Concerns about the Dhulwa workplace culture were also raised in interviews conducted with staff at all levels, including former Dhulwa staff.

The Inquiry noted evidence of strong staff resistance to managerial efforts to effect change in the workplace. This resistance, together with the apparent level of distrust between staff and management, has resulted in poorly implemented change practices and over-involvement of the nursing industrial body in the day-to-day management of Dhulwa. In this context it should be noted that despite previous reviews identifying the need for change in many aspects of Dhulwa's operations, no lasting or beneficial change has occurred.

Non-management staff at Dhulwa cited 'leadership' and 'management practices' as key risks in the unit. The Inquiry noted that several key leadership roles, notably the Assistant Director of Nursing (ADoN) and Clinical Nurse Consultant (CNC), have been subjected to a large turnover of personnel since Dhulwa commenced clinical operations.

Successive leaders have brought disparate approaches to service delivery, some of which have not been fully accepted or embraced by staff. This has resulted in significant distrust and discontent, together leading to a lack of confidence amongst staff, and has inhibited the development of a cohesive approach to workplace culture and safety.

The apparent shift away from Dhulwa's initial intended purpose as a secure forensic mental health unit following the organisational realignment in July 2021, has exacerbated the tensions within the unit and reinforced the need for clarity of the Model of Care to support the operational leadership, management and governance.

A review of the systems and processes for the clinical, therapeutic and WHS management of the unit has highlighted a further lack of clarity regarding organisational governance, as compared to operational management, of the unit. The organisational structure that Dhulwa works within should be governing the clinical and corporate processes for the unit, which are then in turn implemented by the workforce. This does not seem to be functioning effectively.

It was apparent from feedback and submissions that many Dhulwa staff that they do not consider themselves part of the broader CHS organisation. It is likely that this disconnect has been exacerbated by the isolated way that many aspects of Dhulwa are functioning. This is particularly evident in the consideration of WHS issues by Dhulwa staff. Whilst expertise and input are sought from the WHS leads in CHS, advice is sometimes not accepted due to personal preference or desired outcome. Such advice should be considered as valued, evidence-based input to inform decisions regarding WHS and clinical needs and risks.

A key aspect of governance of an organisation involves ensuring that responsibilities for the operation are appropriately delegated. The National Safety and Quality Health Service (NSQHS) Standard states that the 'governing body provides leadership to develop a culture of safety and quality improvement and satisfies itself that this culture exists within the organisation'.[43] At Dhulwa this requires the leadership team to be clear about their role, who they report to, what the performance measures of the unit are, how performance is monitored and how progress is reported. These matters do not appear to be occurring consistently or transparently at Dhulwa.

Whilst the mechanisms for workers to raise, inform and lead change are important, this must be considered in the broader context of the strategic direction and policy framework for the unit. Workplace tensions within the unit over several years have resulted in inconsistent approaches from the leadership team in their attempts to clarify and deliver the strategic intent of the unit and confusion within the workforce about how they participate in informing or providing feedback on the delivery of the strategic intent.

Recommendation 10: Governance arrangements

The governance arrangements for management at Dhulwa should be re-affirmed to ensure that those who have the ultimate responsibility for quality and safety at the unit have the appropriate delegations and reporting lines to be able to manage effectively.

5.2 Clinical oversight and leadership

Uncertainty about roles and responsibilities at Dhulwa is permeating all areas of its functioning. The workforce culture at Dhulwa is fractured and there appears to be no common goal for delivering quality patient care. The staff lack an understanding of the requirement for a clear, single point of leadership, often perceiving management decisions and direction as bullying rather than as part of effective operational management and delivery of clinical care.

Many aspects of clinical care at Dhulwa would benefit from a clear and structured approach, with a primary point of leadership and direction. It is apparent on review of the WHS incident reports, and from discussions with stakeholders, that at critical times confusion has resulted from a failure by staff to recognise, or accept direction from, a single point of authority. On other occasions confusion has resulted from the failure of the person with the authority to take responsibility for managing the incident. Information reviewed by the Inquiry showed that during many of the incidents where injury occurred, more than one person, and not the person with the appropriate authority, was talking or directing action, creating confusion for the other staff involved and exacerbating a difficult situation for the consumer concerned.

Designated shift team leader

The review of comparable facilities in other jurisdictions highlighted that the staffing arrangements at Dhulwa could be significantly improved with the appointment of a designated clinical leader to

every shift. Both the Forensic Hospital and Thomas Embling Hospital roster staff so that each shift has a designated, suitably qualified and experienced team leader. The team leader oversees the shift and provides clinical leadership, including for the purposes of crisis intervention, clinical deterioration or incident response.

The Inquiry noted that currently at Dhulwa a Nurse in Charge is appointed for each shift. A review of incidents led the Inquiry to consider that more rigour is required in the appointment to the shift leadership role. Only suitably qualified, and experienced, senior nurses should be considered for appointment to the team leader role.

Dhulwa would benefit from reviewing the current nursing profile and appointing a designated team leader each shift. This would ensure that when an emergency response is required, it is clear who is in charge and what their role is. Furthermore, this would also provide greater opportunity for career progression, providing opportunities for staff to gain and develop clinical leadership experience.

Primary nurse model

Primary Nursing is a model where a mental health nurse is assigned a consumer for whom the nurse assesses the needs, plans care and treatment and then implements and evaluates the plan. In doing so the nurse takes responsibility for the outcomes of the care of a consumer, from the time of admission to discharge.

The primary nurse role includes:

- developing a therapeutic relationship with the consumer;
- making time to meaningfully engage with the consumer on every shift;
- ensuring the consumer understands the primary nursing model;
- engaging the consumer in the development of the care plan by discussing the consumer's goals, aspirations and preferences to ensure they are represented in the care plan;
- supporting the consumer to participate in care reviews; and
- engaging and working with the consumer's family/carers/supporters.

In a Primary Nurse model, the assigned nurse is not only responsible for the coordination of nursing care but also the coordination of input into the care plan of the entire multidisciplinary team, the consumer, their family/carers/supporters, other clinicians, and external agencies.

The Consumer Handbook states that Dhulwa uses a Primary Nursing model, however, this appears to have only been the case intermittently over the course of Dhulwa's operation. CHS should immediately implement the Primary Nursing model to ensure comprehensive oversight of care for each consumer at Dhulwa.

Due to the length of admission for some of the consumers at Dhulwa, commonly spanning many months, or in some circumstances years, a consumer may have several different Primary Nurses assigned to them over the course of their admission.

After hours clinical support

There is limited expert clinical support available to the nurses at Dhulwa after hours, including over the weekend. To support the proposed team leader and other staff, a position should be established to provide effective operational management and clinical support for the unit after hours. The position, to be occupied by a senior mental health nurse, would assist the unit with clinical decision making, resource allocation, attend incidents and approve (or manage requests for) emergency leave.

Specialist medical support

In the current staffing model, the Clinical Director of Dhulwa has an expansive role also covering general mental health services. This combined with the current Staff Specialist Psychiatrist being only 0.6 full time equivalent, has resulted in a lack of consistent leadership and clinical oversight to drive the Model of Care.

The specialist medical roles at Dhulwa need to be reviewed so that there is one specific role with management authority and clinical oversight for the unit. In a similar sized service, the Wilfred Lopes Centre, there is a Clinical Forensic Psychiatrist who holds the position of Clinical Director for that centre alone.

In addition, every effort should be made to ensure that staff have immediate access to responsive specialist psychiatric support when there is no psychiatrist on-site at Dhulwa.

Recommendation 11: Clinical oversight and leadership

To improve accountability and consistency of clinical care at Dhulwa, enhanced clinical oversight arrangements should be established. These include: a designated nursing team leader position for each shift, an after-hours clinical support position, the institution of a Primary Nurse model, and the provision of specialist psychiatric support for Dhulwa at all times.

Chapter 6: Safety and security arrangements

6.1 Types of therapeutic safety and security

Although the need for safety and security is necessary in all health settings, in secure forensic mental health inpatient units like Dhulwa, the need is heightened. Consumers who are admitted to these types of facilities have a mental illness, a history of offending and may also have certain attributes that may increase their risk potential. It is important for staff, and in particular nurses, to be able to integrate security and safety policy and procedures with clinical practice. While there is a need for staff to maintain vigilance and adhere to the security policies and procedures to prevent consumers from escaping from the unit or absconding from approved leave, this must be balanced with the requirement to maintain a therapeutic environment.

Broadly speaking there are three types of therapeutic security in the management of mental health facilities: environmental, relational and procedural.[44,45,46,47] The elements of each type of security are described below in Table 1.[46]

Table 1. Types of security

Environmental (or Physical) Security	Relational Security	Procedural Security
Environmental or physical security pertains to structural aspects of the environment that makes a facility physically 'secure' and includes building design, composition and maintenance, lockable doors, keys, alarms, cameras, screening x-rays at the entrance etc	Relational security pertains to the relationships between staff and consumers, including aspects relating to quality of care as well as resource aspects such as consideration of staff-to-consumer ratio and staff-consumer relationships. Relational security involves knowing and understanding the consumer group, and the circumstances in which there is a security risk. It requires staff to have a therapeutic relationship with the consumers and know their history, risk potential, current mental state, behaviour, stressors and protective factors.	Procedural security is the methods used by the staff to maintain security that are guided by policies and procedures and can include aspects such as counting of consumers, searching of the unit, consumers and their items, storage of equipment, management of visits etc. It also includes legislation and guidelines governing treatment and management of incidents, including 'policy and practices relating to consumers which control access, communications, personal finances and possessions' as well as those relating to 'quality and governance, including information management, legal obligations, audit, research and human resources'.

Application of physical security appears to be a strong component at Dhulwa, the other necessary components of security, relational and procedural security, appear to be lacking. While there is inherent tension in maintaining security and therapeutic goals, good practice requires the integration of security, safety and clinical practice. To be overly focused on physical and procedural security without a therapeutic lens, can see practices become more restrictive and custodial.[48,49]

The literature describes tensions that occur between the "unique needs of each patient and the need to provide services to groups...relational and procedural security, which are easier to individualise, are the most important elements of patient care in any mental health service."[50]

Relational and procedural security requirements must be integrated with therapeutic goals. This requires constant appraisal of organisational processes and therapeutic relationship "to ensure that opportunities for therapeutic practice are maximised".[44]

The staff at Dhulwa must be able to integrate all components of security with therapeutic goals and adhere to established procedures. If security is not maintained the unit will lose the confidence of the justice/correctional agencies that refer consumers. There are also implications for public safety if a consumer engages in unsafe or offending behaviour while on leave. There can also be a range of repercussions for consumers, as their leave may be cancelled, and/or discharge delayed if they breach security measures.

The requirement to integrate security into treatment goals is based on the premise that consumers require treatment so their illness and offending needs can be addressed, and their risk to themselves and others is reduced. The Inquiry was informed that recently some of procedural security measures at Dhulwa have been inconsistently implemented (e.g., room searches and random urinary drug screens).

Consumers understand the need for security and appreciate it when nurses are respectful when carrying out security procedures. Some of the procedures are intrusive, and it is important that staff remember that how the procedure is conducted will have an impact on the consumer and the therapeutic relationship. Insensitive practices when carrying out security procedures can damage relationships impacting clinical care.

To prevent a restrictive and custodial culture occurring, safety and security procedures must be monitored and reviewed. The Inquiry noted that Dhulwa needs to review their procedures as some practices, such as the requirement for search on entry to the unit and personal searches, are becoming custodial in their application.

Recommendation 12: Integration of security into clinical and therapeutic practice

Practices at Dhulwa should be revised to ensure that personal safety of staff is improved through relational security becoming an integral part of clinical and therapeutic practice, and that clinical care is not delivered in a custodial manner.

6.2 Role of security personnel

Currently, the role of security staff at Dhulwa is unclear.

The 2016 Model of Care states that:

> *"Security staff will be responsible for active observation of the perimeter, both internally and externally and for the response to any perimeter alarm activated, or observation of any suspicious activity."*[7]

The 2016 Model of Care also recognised that there was a need for "a close collaborative relationship between clinical and security staff, while providing a boundary for the limits of information sharing and an appreciation of professional differences."[7]

The role for security staff that was anticipated in the 2016 Model of Care does not appear to have been reflected in the *Mental Health (Secure Facilities) Use of Force Secure Mental Health Unit Direction 2016* (the 2016 Direction). The 2016 Direction provided for the use of force at Dhulwa by Authorised Health Practitioners, Security Officers, Court Security Officers and Escort Officers.

Under the provisions of the 2016 Direction, security officers at Dhulwa were authorised to use force to assist an authorised health practitioner when searching a consumer, in circumstances of "clinical risk or necessity (where force is used incidental to treatment care or support of a consumer)" and in circumstances of "imminent danger to the safety, security or good order of the person or the unit (e.g., risk of, or actual, assault)". Other provisions allowed security staff to use force, including the use of handcuffs, in circumstances of 'escape.'

The 2016 Direction was revoked on 5 July 2021 and replaced with the *Mental Health (Secure Facilities) Use of Force Mental Health Unit Direction 2021* (the 2021 Direction). The 2021 Direction states that the use of force by Canberra Health Security Officers is outside the scope of that Direction. It now appears that security staff at Dhulwa are covered by the CHS Use of Force by Security Officers Policy and Procedures but the position remains confused.

Best practice models in similar facilities suggest that the presence and intervention of security staff on forensic mental health units, does not enhance safety and may trigger or escalate aggression in some consumers.

There is a greater presence of, and intervention by, security staff at Dhulwa in the clinical environment when compared to similar facilities visited by the Inquiry. At the Wilfred Lopes Centre, a unit similar in both size and function to Dhulwa, the security staff manage the security of the perimeter of the unit and the screening of visitors into the centre. This role for security staff is consistent with the security arrangements at both the Thomas Embling Hospital and the Forensic Hospital.

Clinical staff at Dhulwa are overly reliant on the intervention of security staff in managing consumers and, consequently, do not engage with consumers in a manner which contributes to their own safety, and that of others. Some nursing staff do not have proper regard to environmental, procedural or, importantly, relational security.

An examination of the Dhulwa staff incident reports indicates that security staff were frequently involved in use of force incidents involving consumers, and that in 2019 and 2020 security staff involved in restraint and seclusion incidents experienced more serious injuries than clinical staff involved in the same incidents.

It is apparent that for some time there has been confusion as to the role of security staff at Dhulwa. In order to ensure a safe workplace for Dhulwa, the role of security staff at the unit requires clarification.

Recommendation 13: Role of security staff

The role of the security staff at Dhulwa should be clarified to ensure that it is consistent with the Model of Care and that the role is limited to the provision of perimeter security.

6.3 Use of security cameras

There is an extremely high use of security cameras at Dhulwa. All areas of Dhulwa occupied by consumers, except for bedrooms, bathrooms and seclusion rooms, are monitored by security cameras. The camera feeds are monitored by security staff on a twenty-four-hour basis.

It was suggested that by monitoring consumer activity, security staff could assist nurses to identify early signs of aggression on the part of consumers. The Inquiry does not consider that monitoring consumers for signs of aggression in a mental health facility is a role for security staff. Observing and engaging with consumers is a core part of the mental health nursing role and far more informative than a non-clinical person reviewing consumer activity. Security staff should not be involved in the clinical care of consumers.

A reliance on security staff to monitor consumer behaviour also contributes to the attitude adopted by some of the nurses that it is unnecessary for them to engage with the consumers in a therapeutic manner and assume responsibility for their own safety through the maintenance of relational security.

Information provided by consumers also suggested that the presence of security cameras in areas of Dhulwa where personal searches are conducted, or where consumers may be engaging in activities that expose them to unwanted and unnecessary surveillance, may breach an individual's right to privacy.

While accepting the need for appropriate security in a forensic mental health facility, the Inquiry noted that the security cameras at the similar sized Wilfred Lopes Centre are primarily for perimeter security.

The Inquiry considers that the use of security cameras at Dhulwa should be reviewed to determine whether the security arrangements for the unit require the current level of camera monitoring. Consideration should also be given as to whether appropriate consumer confidentiality can be maintained with the current use of the cameras and monitoring by security staff.

Recommendation 14: Best practice use of security cameras

The use of security cameras at Dhulwa should be reviewed and best practice use of security cameras in a forensic mental health facility adopted.

Chapter 7: Ensuring a safe environment for all

7.1 Determining what is reasonably practicable

The *Work Health and Safety Act 2011* (the WHS Act) provides the framework to ensure the protection of the health and safety of workers and other people who might be affected by their work.[51]

The WHS Act aims to:

- protect the health and safety of workers and others by eliminating or minimising the risks arising from the work or workplaces;
- ensure fair and effective representation, consultation and cooperation to address health and safety issues associated with the work or the workplace;
- encourage unions and employer organisations to take a constructive role in improving work health and safety practices and assist workplaces and workers to achieve a healthier and safer working environment;
- promote the provision of advice, information, education and training in relation to work health and safety;
- provide effective compliance and enforcement measures; and
- deliver continuous improvement and progressively higher standards of work health and safety.

In achieving these aims, workplaces must have regard to what is reasonably practicable to provide the highest level of protection against harm to health and safety. The term 'reasonably practicable' means what could reasonably be done at a particular time to ensure health and safety measures are in place. In determining what is reasonably practicable, there is a requirement to weigh up all relevant matters including:

- the likelihood of a hazard or risk occurring;
- the degree of harm that might result if the hazard or risk occurred;
- what the person concerned knows, or ought to reasonably know, about the hazard or risk and ways of eliminating or minimising it;
- the availability of suitable ways to eliminate or minimise the hazard or risk; and
- the cost of eliminating or minimising the hazard or risk.

The Inquiry notes the significant risk that the behaviours of the consumer cohort at Dhulwa may pose, and through a review of the information and of the submissions, has sought to determine whether actions are in place, or could reasonably be in place, to eliminate or minimise this risk.

The WHS Act cannot be applied without regard to other legislative requirements such as human rights etc. and, in the case of Dhulwa, the Mental Health Act and other legislative instruments. The interaction of the WHS Act and other legislative instruments have been critical to the considerations of the Inquiry. The function of Dhulwa to provide forensic mental health care to consumers in a safe and structured environment must have regard to what is reasonably practicable for the health and safety of workers, consumers and visitors to the unit.

7.2 Moving Dhulwa to a culture that values safety

The information gathered by the Inquiry from submissions, interviews and review of procedural documents indicates that a persistent and pervasive poor safety culture currently exists at Dhulwa. Many of the submissions, and discussions with stakeholders, suggested that despite the suite of measures that have been introduced over several years to address safety risks, these measures are likely to be ineffective due to the reactive safety culture of the unit.

The Inquiry notes there has been significant dedication of effort and commitment to the continuous improvement of WHS at the unit by CHS, however, the reactive safety culture driven by pockets of the Dhulwa workforce is impacting on the ability to improve safety performance and effect the necessary change. It was apparent from submissions and interviews, that a range of factors are driving the reactive safety culture in the unit including:

- misuse of positions of power at all levels within the unit resulting in bullying and harassment, poor professional behaviour and reactive responses rather than systemic changes;
- inconsistencies in the execution of the policies and procedures that should be guiding activities to address identified WHS risks;
- aspects of policy and procedure that were repeatedly followed, such as submitting incident reports, appeared to have been done as a means of apportioning blame rather than to drive improved performance and reduce the likelihood of further incidents; and
- recent work to address issues at the unit as a result of WorkSafe ACT and media attention, has not been universally accepted by staff - some are optimistic and supportive of leadership in making the changes while others do not accept change is possible under the current governance and leadership.

A strong safety culture that prioritises prevention and risk minimisation, and learns from adverse events to drive good practice, is required. Systems review and change is needed at Dhulwa. This will ensure that Dhulwa is a best practice and safe environment for the workforce and consumers. A shared sense of purpose and the will to work towards individual and collective action by the workforce is required.

Organisational safety culture is made up of the values and behaviours that workers demonstrate and the shared attitudes and beliefs in the written and unwritten rules of the workplace. The Inquiry has identified that the disconnect between the attitudes and behaviours at various levels in the unit and a lack of a shared understanding of the purpose of the unit is resulting in, at times, isolated approaches to addressing WHS risks.

As noted in Recommendation 10, governance arrangements at the unit should be reaffirmed. This should encompass a review of the leadership roles to ensure they are credible and respected in their understanding of forensic mental health care (i.e., they have a strong working knowledge and experience in operational implementation of the contemporary empirical evidence base to manage the therapeutic needs of the consumers in a secure unit). There should be clarity of roles and responsibilities at all levels and the facilitation of communication with workers to drive a culture of proactive management of issues. The demonstration of positive leadership and management behaviours and the treatment of staff with fairness and respect through consistent management approaches, will drive continual improvement of the service and assist in removing the blame culture.

7.3 Consultation and communication on safety matters

Consultation with the workforce on WHS matters is a WHS legislative requirement. Consultation that is carefully planned is effective in engaging the workforce to design and contribute to work that is safe and productive. A workplace with a focus on continuous improvement and better practice routinely consults with the workforce on a variety of matters.

While the CHS WHS management system describes a comprehensive approach for consultation with workers, including the role and function of Health and Safety Representatives (HSRs), the submissions received from staff indicate that there is a perception of poor consultation at Dhulwa about health and safety matters.

The unit does not appear to have implemented the CHS guidance at a local level or have a clear and documented approach for consultation and communication with the workforce on WHS issues. This has led to poor role clarity for staff with a specific role in the consultation process, such as the HSRs.

In the absence of a clear process for staff to raise WHS concerns, staff are creating their own methods to raise issues and prompt management action. There is a strong perception amongst staff that their concerns are not being addressed or given sufficient attention by management and some staff have utilised engagement with the unions as a means of driving change when WHS issues arise. This is due to the absence of a clear approach to address WHS issues and a lack of trust in the

Dhulwa leadership team. When staff bypass the usual workplace channels for addressing issues, management is not provided a proper opportunity to address the issues in a timely manner before union involvement. This is further fuelling dysfunction within the unit.

Feedback received by the Inquiry has identified situations where confused, or misconstrued, communication has triggered incidents and led to poor outcomes for both staff and consumers. The mechanisms for staff to be consulted about WHS issues at Dhulwa should be improved. At a unit level this must start with clarity of representation on the WHS committee, including clarity of the workgroup that each HSRs represents, to ensure that all areas of the workforce have mechanisms to raise WHS matters. The HSRs also need to fully understand their role in supporting the health and safety arrangements at the unit. This requires that they be properly trained and have access to ongoing training and updates on their role and responsibilities.

CHS and the Dhulwa leadership team can embed a culture of consultation for continuous improvement by ensuring that consultation is planned for all aspects of the service. A continuous improvement approach would include ensuring that any policy or procedure change is discussed with staff and reviewed after a period of implementation to determine if any unintended impacts have resulted from the policy direction.

7.4 Effective change management

Poorly managed change is a significant issue within the unit. The Dhulwa leadership team should ensure there are proper processes to manage workplace change including full consultation and communication with staff and the alignment of any changes with the Model of Care. The approaches to manage any change in the unit need to be clearly documented so the staff are aware of their rights to active participation. Staff require clarity as to those aspects of change management that provide an opportunity for influencing, and those that are being communicated rather than consulted on. For example, while a decision may be taken, and communicated to staff, as to the appropriate Model of Care for the unit, staff should be consulted about the policies and procedures adopted to deliver that Model of Care.

The Inquiry found that CHS and Dhulwa had a range of policies and procedures available to support consultation on WHS arrangements in the unit. Unfortunately, due to confusion regarding the Model of Care, there has been a divergence from the policies and procedures due to practices adopted by individuals. As a result, some staff no longer have confidence that the policies and procedures are fit for purpose and believe that they are implemented inconsistently. The Dhulwa leadership team must address issues within the unit associated with poor change management to ensure the effective implementation of the Inquiry's recommendations.

Poor change management was also identified in submissions to the Inquiry regarding a previous attempt to implement the Safewards model at Dhulwa. Submissions noted the effective implementation of the Safewards model in other health care facilities in the ACT and other jurisdictions, with some indicating potential for its use at Dhulwa. The earlier attempt to implement the model within Dhulwa may not have gained support due to the dysfunction that existed within

the staff at the unit. The benefits that could be gained through the implementation of Safewards at Dhulwa have been described earlier in this report (see Chapter 4.2), however, it must be recognised that change management requirements to implement this model would be a significant challenge for the unit in its current state of functioning and would need to be carefully planned and managed to prevent additional risks being created by another poorly implemented change management action.

Recommendation 15: Consultation and communication arrangements

In order to establish a strong safety culture at Dhulwa existing consultation and communication arrangements should be reviewed, having regard to Canberra Health Services work health and safety management system requirements and working with staff to identify an approach that aligns with the organisational requirements and is fit for purpose for the unit.

Recommendation 16: Resources to manage change

Appropriate resources should be allocated to support change management at Dhulwa to ensure there are proper processes in place for communication, engagement and implementation of the Inquiry's recommendations, and to embed effective change management practice for the future.

Chapter 8: WHS integrated risk management

8.1 Risk identification

The organisational governance framework at Dhulwa does not take a best practice approach to integrated risk management. Risk management should be built into all operational processes and underpin clinical and WHS decision making. From the information provided, the Inquiry has identified situations, brought about by the failure to appropriately recognise, prevent, and manage risk, that have resulted in injury to staff and poor outcomes for consumers.

Under WHS legislation, a risk management approach must include:

- the identification of WHS risks associated with the work;
- the implementation of identified controls to eliminate or reduce the risks;
- consultation and engagement with the workforce about the health and safety risks and the actions in place to address the risks; and
- the review and monitoring of the effectiveness of the actions taken to eliminate or reduce the risks.

An integrated risk assessment and management approach is not evident at Dhulwa. The Inquiry has determined that a significant proportion of the WHS risks raised by staff were the direct result of the inability of staff to effectively manage behaviours of the consumers.

It appears that controls implemented tend to address either a WHS or a clinical risk but there is little or no consideration given to how one type of risk interacts with the other. This is compounded by inconsistencies in the application of the identified controls to address WHS risks. These inconsistencies arise from differences in the skills, knowledge and experience of staff.

Whilst WHS legislation requires the application of the hierarchy of controls to prevent harm, actions to eliminate or minimise the risk must be considered in conjunction with what is reasonably practicable for the requirements of the work. Effective WHS risk management needs to consider the clinical, situational and environmental risks of the functioning of the unit and include the risks of both physical and psychosocial health and safety.

While it is not possible to identify and eliminate risk entirely in a unit like Dhulwa where therapeutic care is provided to a consumer group with challenging behaviours, the objective of good clinical and WHS risk management is to minimise the likelihood of an adverse outcome for staff and consumers. To understand the risks posed by consumers who may exhibit violence, intentionally or unintentionally, towards others, a systematic approach to the identification, assessment and management of the risks is required. A staff member must have a good understanding of a consumer's individual care plan and have an aligned WHS plan in place to prevent foreseeable risks. WHS risk plans should be regularly reviewed and updated after an incident or as required.

The staff at Dhulwa have been trained in Violence Prevention and Management using the Health Education and Training Institute program developed for NSW Health. The program content is designed to equip staff with the knowledge and skills to prevent, manage and respond effectively to difficult, challenging and/or violent behaviours in the workplace. However, the written and verbal submissions received from staff have demonstrated a lack of confidence in applying that training. Staff have made requests for more training relating to the management of violent behaviours once they arise rather than training to enable them to recognise and prevent the occurrence or escalation of violent or aggressive behaviours. This request for greater emphasis on training in restraint rather than de-escalation techniques was reflected in at least one incident investigation report examined by the Inquiry.

While there are tools and resources available to support the identification and management of occupational violence risks at Dhulwa these do not appear to be well utilised.

The Inquiry noted while there is a risk register for the MHJHADS division, there is a demonstrated lack of an integrated approach to risk management at Dhulwa and the risk register at the divisional level does not seem to have adequately captured the risks that have been raised locally at the unit.

Recommendation 17: Documenting risk

Dhulwa should have a risk register that is monitored and reviewed and that captures work health and safety risks within the unit, including the psychosocial safety of workers.

8.2 Risk assessment

A violence risk prevention and reduction strategy that has an empirical evidence base uses validated risk assessment instruments to identify consumers who might be at risk of engaging in aggression, followed by the development of a plan and the implementation of the proposed strategies.[52]

Effective risk assessment for the consumer will reduce the likelihood of them engaging in violence and reduce the risks of work-related injury as a result. Risk management plans should provide a summary of all the risks identified, assessment of when the situations may occur and clearly describe the actions to be taken by clinicians, the consumer or other carers to mitigate the risk. Risk management strategies and their implementation should be incorporated into the consumer's care plan.

Any approach to risk assessment and intervention needs to be structured. This requires the provision of clinical instruments to underpin clinical expertise, training in their use and correct interpretation of the instruments, and a quality assurance cycle to review and monitor for continuous improvement. Such a structured and systematic approach is not currently apparent in the policies and procedures, or clinical practices being employed at Dhulwa. While Dhulwa is using an appropriate suite of validated evidence-based risk assessment instruments, it appears that there

has been a departure from the manner in which they should be administered and used in clinical practice. This applies in particular to the Dynamic Appraisal of Situational Aggression (DASA).

Risk assessment instruments are an important adjunct to clinical practice and should not be used as a standalone measure. The DASA assessment is a measure used consistently at Dhulwa, however it appears to have become a measure to inform risk in isolation of other considerations, and is creating additional risks for the propensity for violence.

The main purpose of the DASA assessment is to provide a systematic method to appraise a consumer's risk of imminent violence. From the DASA assessment, timely preventative interventions can follow.[53] The DASA assessment can also be used to generate information about consumers' clinical progress and generate more nuanced information about aggressive behaviour, and to identify consumers who are not at risk of imminent aggression so that consideration can be given to the relaxing of any restrictions and extension of liberty.[53] The risk state that is assessed by the DASA is best regarded as a state of irritability and disagreeableness, rather than purely a total risk score. Fluctuations in DASA scores over time can be interpreted as fluctuations in irritability and disagreeableness.[53] To this end the DASA scores should not be linked to automatic leave removal or loss of privileges, rather interventions need to be instigated to reduce the risk of aggression.

From review of the clinical files, interviews with consumers and some current and former staff, it was apparent that the DASA is being administered incorrectly and at worst, it is being used punitively. The phrase "you have been DASA-ed" appears to be used commonly where staff inform consumers, they have been scored an item or items on the DASA, which results in loss of privileges, such as leave. From documentation in the clinical file the DASA score is recorded however there is little to no information about the reasons for the score, and little evidence of any interventions following the assessment of risk.

The use of the DASA to remove privileges or leave arrangements, and the poor communication of these actions to the consumer, was a significant foreseeable and preventable trigger in a number of the recent incidents of violence at the unit.

A change in culture is required to move away from using the DASA in a reactive manner to using it to proactively support consumers who are at increased risk of violence by discussing and implementing appropriate strategies collaboratively. Increasing the knowledge, skills and training of the workforce to undertake their role would have a significant positive impact on the prevention and management of aggression on the unit. Staff who are informed, and appropriately trained will be confident and skilled in identifying and managing the changing risk situation and able to implement responses to prevent the escalation of risk and reduce the likelihood of injury.

To ensure correct administration of the instrument, consideration should be given to the provision of DASA assessment refresher training for nursing staff. It was noted the developers of the DASA tool were engaged to train staff when the facility opened, and it may be worthwhile re-engaging similarly qualified people to deliver the training again for staff. In addition, education also needs to be provided to the consumer group about the DASA. This will assist consumer understanding of its

intent and correct use. The current consumer group needs to be made aware that the DASA has previously been used incorrectly and, that following training for staff and consumers, the DASA will be administered correctly to inform practice and to instigate interventions to reduce aggression. Consistent monitoring will be required to ensure that the DASA risk assessment instrument is used appropriately.

Recommendation 18: Use of the DASA risk assessment instrument

Dhulwa staff should be retrained in the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument and its application should be continuously monitored to ensure appropriate use.

8.3 Nursing intervention following risk assessment

Risk assessment by itself is unlikely to reduce aggression, therefore risk assessment must be followed with strategies to prevent aggression.[53] While DASA risk assessment appears to be used on a regular basis at Dhulwa, the documentation of interventions designed to prevent aggression is lacking. Without a systematic framework for nursing intervention, attempts to intervene may be varying, or unsuitable,[53] and may result in a reliance on restrictive practices.[54]

A framework to guide nursing practice may enhance the use of risk assessment instruments such as the DASA, by providing structure for nursing interventions, so that nurses are guided with recommendations on how to mitigate risk after it has been identified.[55] There is also evidence that structuring nursing intervention following the assessment of risk can reduce aggression and the use of restrictive interventions.[56,57,58,59]

A recent program of research has developed an Aggression Prevention Protocol (APP) designed to structure intervention following the assessment of risk using the DASA.[56,59] The APP was designed to be used in conjunction with the DASA, to provide staff with guidance about how to intervene to prevent violence for consumers presenting with diverse levels of risk.

Two studies testing the DASA and the APP have demonstrated a reduction in use of medications administered to manage violent behaviours, aggression and the use of restrictive interventions when nurses have used the APP to structure interventions following assessment using the DASA.[56,59] While Dhulwa may not necessarily implement the APP, there needs to be consideration, implementation and documentation of suitable interventions designed to prevent and manage aggression.

Recommendation 19: Risk mitigations following risk assessment

Consideration should be given to the use of a framework such as the Aggression Prevention Protocol (APP) to ensure that appropriate risk mitigation interventions are put in place after risk is identified.

Chapter 9: Incident management

Review of the documentation provided to the Inquiry and discussions with staff highlighted that whilst incidents that occur at Dhulwa are reviewed, it is unclear if recommendations to improve practices are implemented following an incident review. Further, it is also unclear if outcomes are discussed with staff to test their understanding of the incident, to develop controls and to strengthen clinical or operational practice. Effective engagement and consultation with staff as part of the review process is important to develop productive workplace relationships, and to reshape the Dhulwa workplace culture from one of blame to continuous improvement.

The Inquiry has closely reviewed incident reports of occupational violence (relating to both physical and verbal assaults) covering the period since Dhulwa opened in 2016 until mid-August 2022. In the Inquiry's review, of the 403 incident reports lodged, there were multiple reports relating to the same incident. Whilst not negating the impact on staff, this in effect has inflated the number of incidents that have occurred at the unit. A small number of these incidents (fewer than 15 over the entire period) resulted in an injury necessitating more than one day of time off work for the staff member concerned. The majority of the incidents with more serious consequences have involved security staff.

Many of the incidents of occupational violence resulting in injury to staff have arisen while staff have been attempting to restrain and/or seclude consumers, and as a result of resistance from the consumer concerned rather than an unprovoked attack by a consumer on staff. A reduction in the instances of restraint and seclusion of consumers and the use of the methods described in earlier chapters to assess and manage aggression, should have a favourable effect on the incidence of staff injury.

Whilst all incidents of occupational violence should be taken seriously and every effort made to reduce the risk of violence occurring, it must be noted that, at Dhulwa, incidents of violence that have resulted in staff requiring time off work have, on average, numbered about two per year since 2019.

The inflated claims and exaggerated reporting of occupational violence at Dhulwa has damaged its reputation and had far-reaching consequences for both consumers and staff. This reputational damage impacts the attractiveness of Dhulwa as a prospective workplace for healthcare professionals, especially those with forensic mental health qualifications and expertise. In addition, given the stigma attached to the unit, it may also have had adverse consequences for Dhulwa consumers seeking to transition to less restrictive environments or to the community.

Effective investigation and review following incidents is essential to optimise continuous improvement and identify system actions to reduce the likelihood of further incidents occurring.

Whilst the findings for specific incidents are important, considering the incidents in totality assists in identifying areas of common issues and where implementation of controls may have unintended

consequences. Sharing the findings from incidents more broadly will have a greater safety impact over the longer term.

The incident management framework for Dhulwa needs to consider the clinical and therapeutic services provided by Dhulwa (as defined in the Model of Care) and include appropriate review of incidents to support the health and safety of consumers, staff and visitors to the unit. The incident management framework should include consultation and communication approaches to ensure that relevant staff and others are engaged in, and contribute to, the findings of the review. Involving staff in the identification of recommendations from the review, and communicating lessons learned in a timely and effective way will ensure that any recommendations do not create additional risk.

Review of incidents and the use of a root cause analysis methodology to take a broad look at the systems, processes (including consumer care plans and WHS risk assessments) and cultural factors contributing to the incident, rather than individuals or individual actions, are critical for a continuous improvement safety culture. A culture of reporting and information sharing is needed to drive improvements and enhance learning and improved practice.

Recommendation 20: Incident management process

An incident management process should be implemented at Dhulwa to ensure immediate review involving all relevant staff, and timely remedial action.

Chapter 10: Workforce

10.1 Building an effective workforce

The Inquiry found that a large part of the workforce at Dhulwa do not have sufficient knowledge, skills and training to manage the complexity of the consumers admitted to the unit.

Increasing the knowledge, skills and training of the workforce to undertake their role would have a significant positive impact on the management of WHS risks in the unit. Staff who are informed and appropriately trained will be confident and skilled in identifying and managing the clinical needs of the consumers and the changing risk situation at Dhulwa. Informed and trained staff will also be able to manage in a dynamic risk environment and effectively implement responses to prevent the escalation of risk and reduce the likelihood of injury.

The Inquiry noted that training and orientation provided to staff when the unit was opened in 2016 was based on best practice forensic mental health standards, however it appears that not only has this training changed substantially, but ongoing competency-based training has not been implemented.

A structured and continual approach to training needs, analysis and delivery at Dhulwa is required. The competencies required by all staff to perform their role must be clearly defined and communicated to staff. Training, aligned to those competencies, must be provided to all staff upon their commencement or appointment at the unit. Staff must also undergo an appropriate orientation to the unit to ensure they understand its purpose, policies and procedures and can appropriately identify and engage with risk.

Staff should be consulted on the risks they perceive, and the training they require, in undertaking their work. This will enable training to be tailored to meet both individual and workforce development needs and provide management with an understanding of the attitudes and the level of knowledge of staff. Adopting a proactive and collaborative approach to the training needs analysis will assist in changing the perceptions of the workforce about capability and assist in the development of a culture of continuous improvement and ongoing learning. This in turn will help to raise the clinical competency and capabilities of the workforce to deliver better outcomes for consumers, thus reducing risk.

The uncertainty regarding the Model of Care impacts on the identification of the training required by staff. As noted, staff have sought to ensure that they are trained to respond to situations of aggression in the unit but have not recognised or sought to ensure that they have, and continue to develop, the skills to prevent and manage aggression through effective clinical care. To address the WHS issues associated with occupational violence in the unit, training needs to be prioritised and have a focus on early intervention, de-escalation strategies, limit setting, self-awareness of behaviours, interpersonal communication skills (verbal, body stance, non-verbal), and restraint and

seclusion practices (such as allocation of staff in Emergency Response Team, who should lead, restrain, escort safely through doorways).

Staff would benefit from regular occupational violence scenario-based training. This would enable them to have the skills to identify clinical signs and symptoms that may result in escalating occupational violence actions by the consumer. Interventions that recognise and address clinical factors early benefit both clinical and WHS outcomes.

Recruitment of staff with the knowledge, skills, attitudes and capabilities to integrate within the team and deliver the services required competently and professionally, is critical for the ongoing functioning of the unit. Many of the submissions noted the academic qualifications of staff, however, during the consultations, it became apparent that some staff did not supplement these qualifications with ongoing professional development tailored to their role at the unit. Commitment to ongoing professional development must be undertaken at both the individual and organisational level.

Structured developmental pathways based on clinical competence such as the Mental Health Nursing Competence and Career Framework developed by the National Health Service, may be helpful when considering the career development and progression pathway for the Dhulwa nursing workforce.

Diversity in recruitment must also be considered alongside knowledge and skills. Whilst adhering to the principles of merit-based recruitment, it is important that, with every recruitment, the unit considers what skills, knowledge and attributes are important to complement the current skill-mix, or gaps, of the team.

Interviews with, and submissions from, current and former staff members raised concerns in relation to recruitment at Dhulwa. There was a perception expressed by some current nursing staff that recent recruitment processes were biased and did not adhere to the principles of merit-based selection. The Inquiry noted that the staff raising this issue in their submissions and interviews did not appear to have raised their concerns through the available appeal processes. While not dealing with the validity of these claims, the Inquiry noted that work needs to be undertaken to enhance workplace communication and consultation practices to improve the work culture at Dhulwa, and create more trusting and productive relationships between management and staff.

Attraction, recruitment and retention of appropriately skilled clinical staff in all disciplines was also raised as a challenge for Dhulwa and was a consistent theme of discussion particularly from former staff. There is a recognised shortage both domestically and internationally of skilled mental health clinicians, particularly those with specialist skills and experience in forensic mental health. Dhulwa's ability to attract staff to vacant clinical roles is further challenged by the reputational damage to the unit from the exaggerated reporting of occupational violence. The challenges in attracting specialist staff (medical, allied health and nursing) further impacts Dhulwa's ability to address the care needs of consumers and provide the full range of therapies required to support individual recovery plans.

The Inquiry notes the efforts CHS has undertaken to fill vacant roles, however more work is required to attract and retain staff in key therapeutic roles.

The Inquiry also noted that several former staff members advised at interview they would consider returning to Dhulwa should the changes needed in workplace culture and clinical practice be implemented.

Recommendation 21: Competencies and training

Clinical competencies should be mapped for all levels of staff at Dhulwa to ensure the effective delivery of the Model of Care, and training requirements should align with the clinical competencies and address any risks raised by the workforce.

10.2 Leadership role in managing and mitigating unhealthy team dynamics

Working in complex clinical settings like Dhulwa, with consumers who may present with a range of needs, risks and challenging behaviours, can test a clinical team's treatment approach. The Inquiry found evidence of unhealthy team dynamics, including communication breakdown, lack of decision making, cliques, and an absence of trust. Furthermore, there was also evidence to suggest the unhealthy team dynamics may have also contributed to clinical reasoning errors, where thinking may have been clouded by certain assumptions and preconceived ideas, which can result in failure to explore alternate courses of action.[60]

Secure settings require the workforce to have an additional range of knowledge, skills and attitudes. Clinicians working in these settings must be able to understand the socio-political and legal context of care. In addition, they must understand the clinical and ethical issues associated with working with consumers who have come into contact with the criminal justice system, and have sound assessment and intervention skills to address their complex needs.[61]

It is important to acknowledge that clinicians working in settings such as Dhulwa are also members of the community and may share opinions that do not condone offending and aggressive behaviour. However, it is important that the clinical practice of staff does not further reinforce stigma and discrimination.[62] All members of the team need to manage personal feelings relating to consumer offending, and the impact of challenging behaviour, to ensure clinical judgement is not affected.[62]

It has been suggested that when clinicians are made aware of their use of bias, accuracy and quality of assessment can improve. Clinicians must be attentive, reflect on decisions and think critically when reviewing the information collected, and the ideas and perspectives of others.[63]

After reviewing closed-circuit television footage and from discussions with various stakeholders, it appears that an element of Group Think has been occurring amongst the nursing team at Dhulwa.

Group Think is the practice of thinking or making decisions as a group, typically resulting in unchallenged, poor-quality decision-making.

According to Irving Janis, a psychologist and researcher well known for his theory of "Group Think", the drive for consensus in a group can come at any cost, and ultimately, supress dissent and the appraisal of alternatives in groups making decisions. [64]

When Group Think transpires, members of the group may attempt to minimise conflict and reach a consensus decision, without any critical appraisal of alternate thoughts or opinions or consideration of any external influences. Allegiance to the group manner of thinking can also place pressure on individuals to avoid either raising possible issues that might be considered contentious or to offer alternatives. Group Think can also result in loss of individual creativity and independent thinking and have a negative impact upon consumer care.

Clinicians working in forensic mental health need to ensure that a methodical approach is employed during decision-making processes to prevent Group Think from occurring.[64] Other considerations include choosing staff members who have the ability, and are confident, to introduce and present diverse views. Training on roles, responsibilities and the consequences associated with decision-making for all members of the team may also be helpful. Work also needs to be done to ensure that staff can engage in difficult conversations to enable and value the role of constructive feedback. The leadership team need to be able to guide team members during these discussions and promote new or alternate perspectives and conversation.[65]

In addition to Group Think, the Inquiry found examples of some particularly negative group dynamics among the team at Dhulwa including the presence of several different cliques. It is possible that some of these negative group dynamics together with the poor work environment may have contributed to, at times, poor standards of care delivery. The Inquiry is also concerned by allegations by numerous stakeholders concerning breaches of privacy and confidentiality relating to consumers which may have amounted to a breach of their human rights.

In health care settings, there may be situations present where it will seem tempting to bend the rules or make an exception to the rules where there is a rationale to justify making the deviation from expected or approved practice. While most clinicians whose practice is grounded by sound ethical principles will not make blatant ethical deviations from practice, ethical drift can occur over time, particularly when a person justifies the deviations as acceptable and when they believe themselves to be maintaining their ethical boundaries.[66]

To address some of the issues associated with poor standards of care, human rights issues and ethical drift, the Inquiry recommends training and education is provided to all staff on the importance of nursing values, boundaries (including staff to staff boundaries) and standards that guide care, including the Forensic Mental Health Nursing Standards of Practice.[49]

The Inquiry also suggests reinforcement of CHS's values (Reliable, Progressive, Respectful and Kind) at Dhulwa and that these values be linked to Dhulwa's mission and vision. Staff at Dhulwa would also

benefit from ethics education that includes a framework for decision-making when working through ethical dilemmas. The Inquiry recommends that ethical performance is also monitored, and feedback provided.

Recommendation 22: Ethics, human rights, confidentiality and privacy training

Training should be provided for existing Dhulwa staff and all new recruits on the legislative and other requirements and obligations relating to ethics, human rights and in particular, the rights of consumers to both confidentiality and privacy.

10.3 Developing forensic mental health capabilities

Secure inpatient units are a necessary component of a forensic mental health service. Consumers admitted to forensic mental health inpatient units will present with a range of mental health, psychological, emotional, physical, social, cultural and spiritual needs. The multidisciplinary team collaborates with consumers and their families/carers and supporters to provide assessment and treatment.

The Dhulwa nursing workforce would benefit from additional training focusing on the development and maintenance of the therapeutic relationship, structuring the treatment environment to integrate security with therapeutic goals, risk assessment and intervention, assessment and management of offence issues, and demonstrating professional integrity in response to challenging behaviour.

For consumers admitted to Dhulwa who have offending needs, there appears to be little attention to understanding the link between mental illness and offending, or to addressing criminogenic needs to reduce recidivism. The staff would benefit from training related to addressing offending behaviour, and the consumers would benefit from tailored intervention to address their offending behaviour, and other needs.

After consultation with stakeholders, review of the clinical documentation, and discussion with consumers and carers, it appears that nursing practice at Dhulwa is not orientated towards **forensic** mental health nursing. It appears there is a lack of understanding of the link between mental illness and offending, including the integration, assessment and management of offence issues into nursing care, and a lack of structure in the treatment environment to integrate security with therapeutic goals.

Forensic mental health nursing is a subspecialty of mental health nursing. Nurses working in forensic mental health settings apply the same codes of conduct and standards of mental health nursing practice. However, there is an additional set of practice standards that can assist nurses, the Forensic Mental Health Nursing Standards of Practice (the standards).[49] There are 16 standards of practice (see Table 2).

Table 2. Forensic Mental Health Nursing Standards of Practice[49]

Forensic Mental Health Nursing Standards of Practice
Standard 1: Structure the treatment environment to integrate security with therapeutic goals.
Standard 2: Apply knowledge of the legal framework to service delivery and individual care.
Standard 3: Conduct forensic mental health nursing practice ethically.
Standard 4: Practice within an interdisciplinary team that may include criminal justice staff.
Standard 5: Establish, maintain and terminate therapeutic relationships with forensic consumers.
Standard 6: Integrate assessment and management of offence issues into nursing care processes.
Standard 7: Assess for the impact of trauma and engage in strategies to minimise the effects of trauma.
Standard 8: Assess and manage risk potential of forensic consumers.
Standard 9: Manage the containment and transition process of forensic consumers.
Standard 10: Promote optimal physical health of forensic consumers.
Standard 11: Minimise potential harm from substance use by forensic consumers.
Standard 12: Practice respectfully with families/carers of forensic consumers.
Standard 13: Advocate for the mental health needs of forensic consumers in a prison or police custodial setting.
Standard 14: Support and encourage optimal functioning of forensic consumers in long term care.
Standard 15: Demonstrate professional integrity in response to challenging behaviours.
Standard 16: Engage in strategies that minimise the experience of stigma and discrimination for forensic consumers.

The standards can assist nurses to recognise the key features of forensic mental health nursing practice (that it is 'more' than just mental health nursing practice in a forensic context) and identify the nursing contribution to interdisciplinary assessment and treatment of forensic consumers. These standards can be used to guide nursing practice, teaching and education, as well as research in forensic mental health nursing.[49] All nursing staff at Dhulwa, including management, would benefit from recognising the standards and integrating them into their practice to assist in identifying the nursing contribution to care.

A way of enhancing forensic mental health nursing practice at Dhulwa would be to re-invigorate an education package that was developed specifically for Dhulwa prior to the unit opening. This education package is called Forensic Education for Registered Nurses (FERN). FERN is based on the forensic mental health nursing standards of practice, and includes a module for each standard of practice, which nurses should work through to ensure they have a comprehensive understanding of what underpins their practice in a forensic mental health setting. Many of the modules have been designed as self-directed learning packages, that can be completed and discussed in a session with a mentor, and others can be completed in small groups.

For successful implementation, FERN requires co-ordination and mentoring by a nurse who has forensic mental health expertise, knowledge and skills. Completion of additional education in forensic mental health nursing would be desirable. It would also be of benefit for the nurse who co-

ordinates the program to receive mentoring or clinical supervision from an experienced forensic mental health nurse, so they are able to reflect on their practice and support the other nurses in the FERN program.

Nursing staff at Dhulwa need experience of working in other mental health care settings within MHJHADS to further develop their clinical competencies. This experience will enhance their assessment and intervention skills, provide an understanding of other areas of the service and the consumer journey, and provide the opportunity to work with other teams and disciplines. Secondment to forensic mental health services in other jurisdictions could also be explored.

The Dhulwa leadership team would benefit from developing and maintaining links with other forensic mental health services across Australia. Given the small size of Dhulwa, the leadership team are professionally isolated, and regular contact with the opportunity for reflective practice/networking with other professionals who work in forensic mental health, would allow the leadership team to discuss practice issues and keep up to date with contemporary care.

Recommendation 23: Improve nursing staff capabilities

Nursing staff should be rotated through other mental health facilities, including forensic mental health facilities, to gain greater experience and to improve clinical capability.

Recommendation 24: Leadership external support

The leadership team at Dhulwa should develop contacts with forensic mental health professionals in other jurisdictions in order to assist in the maintenance of contemporary practice.

Chapter 11: Trauma informed approach

Exposure to trauma is a common experience for mental health consumers, including those who have come in contact with the criminal justice system. Exposure to trauma can have enduring and significant neurological, biological, psychological and social effects on the person.

The main areas related to forensic consumers and trauma are:

1. exposure to traumatic experiences (such as being a victim of, or witness to abuse or neglect);
2. trauma related to committing the index offence;
3. trauma related to detention in secure facilities (including isolation from supports, community role loss);
4. trauma related to experiencing coercion in secure settings; and
5. trauma related to the impact of the secure environment (such as locked doors and loss of privacy).

Appreciating the high prevalence of trauma and understanding the impact that trauma and violence can have on a consumer is necessary to be able to assess for the impact of trauma, implement appropriate treatment and avoid inadvertently re-traumatising consumers. [67]

In recent years there has been a growing recognition of the impact of trauma and an emphasis on Trauma Informed Care to respond to the needs of individuals exposed to trauma, mental health services, and prisons. Trauma Informed Care refers to a framework for providing services to people impacted by trauma in childhood and/or adulthood.

Trauma Informed Care involves staff understanding the myriad of biopsychosocial impacts of trauma, trauma triggers and the ways in which traditional service delivery can exacerbate the impact of trauma; [68] for example, the use of seclusion or physical restraint in mental health settings among consumers who have experienced interpersonal violence or abuse.

Services that adopt Trauma Informed Care are characterised by staff that are aware of how consumers' needs are moulded by their life experiences, and regard trauma as a defining experience that contributes to the individual's identity and sense of self, rather than as a discrete event that happened to the person.[68,69] In the absence of such a cultural or systematic framework, even "evidence-based" treatment approaches such as psychological or pharmacotherapy may be compromised.[70]

The introduction of Trauma Informed Care would enhance care and treatment at Dhulwa where some of the routine procedures could be reviewed with a trauma informed lens to see how improvements can be made to ensure consumers are not inadvertently traumatised or retraumatised. An example of such a procedure that requires review is the admission of consumers to Dhulwa. Currently, upon their admission consumers are placed into a stark room and surrounded by several staff wearing gloves.

As noted in Chapter 3: Model of Care, the physical environment at Dhulwa is stark and custodial and could be reviewed with a trauma informed lens to improve the consumer experience.

Some of the consumers spoke of experiencing trauma related to their index offence and expressed a need to be able to discuss this with staff, however felt that this was not encouraged. There were also reports from consumers that some of the unit procedures were 'triggering' reminders of previous traumatic experiences such as strip searches, the loud sound of keys, insensitive responses from some staff when talking about deeply personal and traumatic experiences, lack of gender safety and a lack of consumer focus.

A trauma informed approach is less likely to result in the consumer experiencing procedures and processes that unintentionally trigger trauma responses and other behavioural responses that can contribute to incidents where staff and consumer safety is at risk.

Recommendation 25: Trauma Informed Care

Dhulwa should adopt a Trauma Informed Care approach and all staff should be trained in Trauma Informed Care.

Appendix A: Abbreviations

ACAT	ACT Civil & Administrative Tribunal
ACT	Australian Capital Territory
ADoN	Assistant Director of Nursing
AIN	Assistant In Nursing
AMHU	Adult Mental Health Unit
APP	Aggression Prevention Protocol
CDN	Clinical Development Nurse
CHS	Canberra Health Services
CNC	Clinical Nurse Consultant
DASA	Dynamic Appraisal of Situational Aggression
DMHU	Dhulwa Mental Health Unit
FPTO	Forensic Psychiatric Treatment Order
HSR	Health and Safety Representative
MHJHADS	Mental Health, Justice Health and Alcohol & Drug Services
OV	Occupational violence
PTO	Psychiatric Treatment Order
SMHU	Secure Mental Health Unit
WHS	Work health and safety

Appendix B: Glossary

APP	The Aggression Prevention Protocol (APP) was designed to be used in conjunction with the DASA, to provide guidance on intervention to prevent aggression and the use of restrictive interventions.[71]
DASA	The Dynamic Appraisal of Situational Aggression (DASA) is a validated seven item observer rated instrument designed to appraise the risk of aggression in inpatient units.[53]
Safety Huddles	Safety Huddles are a brief, focused exchange of information about potential or existing safety risks which may affect patients, staff and any person accessing the healthcare environment. They are multidisciplinary, occur at the beginning of every shift and follow a three-point agenda.[72]
Safewards	Safewards is an evidence-based model that was developed in the United Kingdom (UK) specifically for mainstream acute mental health services. It is designed to reduce what is known in the model as conflict (events that threaten staff and consumer safety (such as aggression, self-harm absconding), and containment (restrictive practices used to manage conflict such as extra medication, restraint and seclusion).[41]
Trauma Informed Care	Trauma Informed Care involves staff understanding the impact of trauma, triggers, and the ways in which service delivery can aggravate the impacts of trauma.[70]

Appendix C: Implementation Program

Recommendation	Action	Timeline
Chapter 1: Introduction		
1: Independent oversight There should be independent oversight of the implementation of the recommendations to ensure that change occurs at Dhulwa, and that the change is effected as soon as reasonably practicable.	1: Appoint and establish an independent oversight mechanism.	**Immediately upon acceptance of Recommendations**
Chapter 3: Creating a sense of purpose for Dhulwa through a clear Model of Care		
2: Model of Care The Model of Care for Dhulwa should be clarified to confirm that its primary purpose is the provision of forensic mental health services, which in turn will inform the therapeutic and work health and safety management of the unit.	1: Endorse the 2016 Model of Care and: - ensure Dhulwa is operating according to the Model of Care (or mechanisms are in place to ensure that Dhulwa is operating in accordance with the Model of Care); and - Dhulwa returns to the Justice Health stream of MHJHADS.	**Within 3 months**
	2: Undertake a review of the 2016 Model of Care to ensure the unit is meeting the clinical service needs of the community.	**At 12 months**
	3: Ensure that all staff are aware of the Model of Care, and have the knowledge, understanding and skills for their role and responsibilities, to deliver the model of care.	**Within 3 months**

	4: Publish the confirmed Model of Care on the CHS website and advise all staff, consumers, carers and representatives of its availability.	**Within 3 months**
	5: Improve the physical environment of Dhulwa to make it more homely and conducive to social integration.	**6-12 months**
3: Information for consumers The Dhulwa Consumer and Visitor Handbooks should be updated and disseminated in order to clearly communicate the Model of Care for Dhulwa and operational procedures to all stakeholders.	1: Update the "Consumer Information Booklet" and "Visitor Welcome Handbook" to reflect the Model of Care and implement processes to ensure all consumers and their representative have access to, and are provided with, the information on their admission to Dhulwa.	**Within 3 months**
4: Policies and procedures Following confirmation of the Model of Care, to ensure consistency, the policies and procedures relating to clinical and work health and safety management at Dhulwa should be reviewed.	1: Review all clinical and operational policies and procedures to ensure alignment with the Model of Care, ensuring that, where a CHS organisational policy does not fully align with the Model of Care, a Dhulwa specific policy or procedure is developed to address any disconnect.	**Within 6 months**
	2: Ensure governance arrangements are in place so that all future policies and procedures are consistent with the Model of Care.	**Within 3 months**
	3: Implement processes to ensure staff are included in all policy and procedure reviews and, are advised of changes and how they affect them and the delivery of care at Dhulwa.	**Within 3 months**

	4: Implement arrangements to enable staff to provide feedback about the efficacy of policies and procedures throughout their implementation.	**Within 3 months**
5: Policies and procedures – Leave Management Where legally required, matters for external leave (leave from the unit) for consumers should be considered by ACT Civil & Administrative Tribunal (ACAT), and in all other cases leave should be a matter for clinical decision at an appropriately senior level on an individual consumer basis.	1: Implement a process to ensure that all relevant leave is a matter for clinical decision at a senior level.	**Immediately**
6: Staffing profile The staffing model for Dhulwa should be restructured to provide clear leadership and an appropriate skill-mix on every shift. Emphasis should be given to the provision of therapeutic, occupational, vocational, educational and social activities for consumers through the recruitment and retention of allied health staff.	1: Review the staffing profile and rostering arrangements to ensure there is an appropriate skill-mix on every shift. (See Recommendation 11)	**Within 3 months**
	2: Ensure the full complement of allied health positions are recruited to and actions in place to promote retention.	**Within 6 months**
	3: Update the program of activities to reflect the Model of Care providing consumers with access to at least 25 hours of activities, across seven days of the week.	**Within 3 months**

7: The inclusion of the lived experience workforce Dhulwa should ensure there is representation from the lived experience workforce in the multidisciplinary team.	1: Recruit staff with appropriate lived experience, where necessary.	**Within 6 months**
Chapter 4: Understanding preventing and managing aggression at Dhulwa		
8: Implementation of Safewards The Safewards model should be fully implemented at Dhulwa and, once embedded, consideration given to the implementation of the Safewards Secure model.	1: Develop an implementation plan to fully introduce the Safewards model and interventions into Dhulwa.	**Within 3 months**
	2: Fully introduce the Safewards model and interventions into Dhulwa.	**Within 12 months**
	3: Consider the implementation of the Safewards Secure model.	**12 months +**
9: Reducing the use of restrictive practices A framework to reduce the occurrence of restrictive practices at Dhulwa including seclusion and restraint should be implemented.	1: Review the use of restrictive practices at Dhulwa to identify an appropriate framework for reducing restrictive practice occurrence giving consideration to the Six Core Strategies framework.	**Within 3 months**
	2: Implement and integrate the framework into efforts to reduce restrictive interventions.	**Within 12 months**
Chapter 5: Governance and Leadership		
10: Governance arrangements The governance arrangements for management at Dhulwa should be re-affirmed to ensure	1: Review the organisational structure and governance arrangements of Dhulwa to identify the responsibilities of key roles, reporting requirements, and	**Within 3 months**

that those who have the ultimate responsibility for quality and safety at the unit have the appropriate delegations and reporting lines to be able to manage effectively.	mechanisms for information / communication up and down the governance structure.	
	2: Ensure that the leadership cohort defined in the organisational structure is appropriately supported, resourced, knowledgeable, skilled, and structured to implement the recommendations.	**Within 6 months**
	3: Define expectations for clinical and safety performance at Dhulwa and communicate these to staff.	**Within 3 months**
	4: Implement systems to manage, measure and monitor clinical and safety performance.	**Within 6 months**
11: Clinical oversight and leadership To improve accountability and consistency of clinical care at Dhulwa, enhanced clinical oversight arrangements should be established. These include: - a designated nursing team leader position for each shift; - an after-hours clinical support position; - the institution of a Primary Nurse model; and - the provision of specialist psychiatric support for Dhulwa at all times.	1: Restructure the staffing model to align it with the Model of Care to deliver the appropriate skill-mix for Dhulwa.	**Within 6 months**
	2: Revise rostering to appoint a clinical lead at the level of Team Leader for each shift at Dhulwa.	**Immediately**
	3: Establish a dedicated after-hours operational and clinical support position.	**Within 6 months**
	4: Institute a Primary Nurse Model to ensure continuity of care and accountability for patient care.	**Within 3 months**
	5: Ensure staff have access to responsive specialist psychiatric support when there is no psychiatrist on site at Dhulwa	**Immediately**

Chapter 6: Safety and security arrangements		
12: Integration of security into clinical and therapeutic practice Practices at Dhulwa should be revised to ensure that personal safety of staff is improved through relational security becoming an integral part of clinical and therapeutic practice, and that clinical care is not delivered in a custodial manner.	1: Provide training to all staff to reinforce the importance of relational security and the need for personal safety to be integrated into clinical and therapeutic practice.	**Within 3 months**
13: Role of security staff The role of the security staff at Dhulwa should be clarified to ensure that it is consistent with the Model of Care and that the role is limited to the provision of perimeter security.	1: Update security policies and procedures to clearly define the role of security guards at Dhulwa as limited to perimeter security.	**Within 3 months**
14: Best practice use of security cameras The use of security cameras at Dhulwa should be reviewed and best practice use of security cameras in a forensic mental health facility adopted.	1: Review and implement best practice approaches for the use of security cameras in forensic facilities.	**Within 12 months**
Chapter 7: Ensuring a safe environment for all		
15: Consultation and communication arrangements In order to establish a strong safety culture at Dhulwa	1: Review and document the role, scope, membership and reporting arrangements of the Dhulwa WHS committee.	**Within 3 months**

existing consultation and communication arrangements should be reviewed, having regard to Canberra Health Services work health and safety management system requirements and working with staff to identify an approach that aligns with the organisational requirements and is fit for purpose for the unit.	2: Review the WHS workgroups for Dhulwa, and either confirm or elect HSRs to represent the workgroup, and then ensure that HSRs have clarity on their role.	**Within 3 months**
	3: Clearly document: - how staff are consulted about WHS at the unit; - how staff can report or advise of a WHS issue; - how WHS arrangements will be reviewed and/or monitored; and - how a change to WHS arrangements will be communicated to staff. These processes should be inclusive of the timeframes for consultation or communication based on the level of urgency, the purpose for the consultation and how any feedback from the consultation will be addressed.	**Within 6 months**
	4: Develop a proactive engagement strategy with key stakeholders to ensure engagement is focussed on addressing issues in a timely manner and in accordance with a documented consultation approach.	**Within 3 months**
	5: Ensure communication channels for the unit, and clear standards for how they should be used, including methods for escalation.	**Within 3 months**

16: Resources to manage change Appropriate resources should be allocated to support change management at Dhulwa to ensure there are proper processes in place for communication, engagement and implementation of the Inquiry's recommendations, and to embed effective change management practice for the future.	1: Develop a change management plan to ensure transparency for the delivery of the recommendations in this report, and allocated resources for the various recommendations.	**Within 3 months**
	2: Measure unit atmosphere using EssenCES (or another validated unit atmosphere measure) to monitor the therapeutic climate of Dhulwa during the change process and ongoing.	**Within 12 months**
Chapter 8: WHS integrated risk management		
17: Documenting risk Dhulwa should have a risk register that is monitored and reviewed and that captures work health and safety risks within the unit, including the psychosocial safety of workers.	1: Consult with the workforce to develop a risk register that incorporates all risks that impact on health and safety at the facility eg clinical, staffing, WHS etc	**Within 3 months**
18: Use of the DASA risk assessment instrument Dhulwa staff should be retrained in the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument and its application should be continuously monitored to ensure appropriate use.	1: Retrain all nursing staff at Dhulwa on the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument.	**Within 3 months**
	2: Provide education to the consumer cohort at Dhulwa on the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument.	**Within 4 months**
	3: Establish processes within Dhulwa to audit the use of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment instrument	**Within 6 months**

	and incorporate audit findings into ongoing refresher training for staff.	
19: Risk mitigations following risk assessment Consideration should be given to the use of a framework such as the Aggression Prevention Protocol (APP) to ensure that appropriate risk mitigation interventions are put in place after risk is identified.	1: Engage the services of a specialist forensic mental health clinician to select an appropriate framework to assist intervention following risk assessment of violence and aggression.	**Within 3 months**
	2: Implement a framework to guide intervention following risk assessment giving consideration the Aggression Prevention Protocol (APP)	**Within 6 months**
Chapter 9: Incident Management		
20: Incident management process An incident management process should be implemented at Dhulwa to ensure immediate review involving all relevant staff, and timely remedial action.	1: Review the CHS incident management framework to ensure a best practice approach at a unite level, including: - reviewing and monitoring data; - incident review as part of the unit function; - seeking SME input where required; and - debriefing for consumers.	**Within 6 months**
Chapter 10: Workforce		
21: Competencies and training Clinical competencies should be mapped for all levels of staff at Dhulwa to ensure the effective delivery of the Model of Care, and training requirements should align with the clinical	1: In conjunction with mapping workforce competencies, review the training provided, consult with the workforce on their training needs and ensure that training is tailored for the unit and includes: - Risk specific training; - Role specific training; and	**Within 6 months**

competencies and address any risks raised by the workforce.	- Integrated WHS/clinical risk training proactive assessment, mitigation management of risk.	
	2: Re-launch the Forensic Education for Registered Nurses (FERN) training program including prioritisation of training for: - de-escalation; - limit setting; and - therapeutic relationships.	**Within 3 months**
22: Ethics, human rights, confidentiality and privacy training Training should be provided for existing Dhulwa staff and all new recruits on the legislative and other requirements and obligations relating to ethics, human rights and in particular, the rights of consumers to both confidentiality and privacy.	1: Deliver a training program for all staff at Dhulwa on ethics, human rights, confidentiality and privacy.	**Within 3 months**
23: Improve nursing staff capabilities Nursing staff should be rotated through other mental health facilities, including forensic mental health facilities, to gain greater experience and to improve clinical capability.	1: Aligned with the clinical competencies developed for nursing staff, implement a rotation through all areas of mental health service provision in CHS.	**Within 6 months**
24: Leadership external support The leadership team at Dhulwa should develop contacts with forensic mental health professionals in other	1: Establish links with other forensic mental health professionals to strengthen operational and clinical practice.	**Within 3 months**

jurisdictions in order to assist in the maintenance of contemporary practice.		
Chapter 11: Trauma informed approach		
25: Trauma Informed Care Dhulwa should adopt a Trauma Informed Care approach and all staff should be trained in Trauma Informed Care.	1: Adopt a Trauma Informed Care approach using supports such as the Forensic Mental Health Nursing standards of practice and use the Trauma Informed Care and Practice Organisational Toolkit[73] to audit, plan, implement and evaluate trauma informed care at Dhulwa.	**Within 12 months**

Appendix D: Submissions table (issues raised)

Table 3.

Submission Issues Themes	Number of Submissions mentioned
Safety: Workplace, Staff, Consumer, quality care improves safety, Health and Safety Notices, alleged breaches, WorkSafe ACT	44
Leadership and Management	40
Poor Leadership / Management	34
Positive Leadership / Management	6
Assault, injury, workplace trauma	34
Workplace Culture Issues (toxic, bulling, risk averse, fear, blame, need to improve)	34
Policy and Procedure (departure from existing, need to review)	33
Recruitment Issues (turnover, difficulties, allegations of unfair practice)	31
Seclusion / Restraint	29
Staff perceptions of management undermining their knowledge, skills and experience from working at Dhulwa, overturning decisions, not listening to nurse concerns causing staff to feel incompetent/loss of confidence	27
Violent or aggressive consumers	25
Clinical Care, therapeutic and least restrictive practice	24
Training and Development (including clinical leadership for development, initial training when open facility, occupational violence / violence prevention management)	23
Governance Frameworks Clarity (Model of Care, clinical/therapeutic operational)	22
Bullying in the workplace (managerial, staff, lateral)	21
Poor staff consultation, communication and multidisciplinary collaboration	20
Management favouritism	18
Staff lack skills required for the facility	18
Poor management plans/treatment plans, changes to plans	17

Submission Issues Themes	Number of Submissions mentioned
Changes to Patient leave arrangements	16
Security (including physical, procedural and relational) and Security Officers	16
Failure to act on reports / conduct timely incident reviews	14
Staff poor treatment of consumers/Punitive and restrictive practice towards consumers/ Lack of empathy for consumers	14
Legislative Framework (Human Rights Act, Mental Health Secure Facilities Act Update)	13
Improve communication with consumers, consumer advocates (care, complaints, decision making)	13
Racism/Discrimination/Cultural issues	12
Union involvement in the Workplace	11

Appendix E: Inquiry Comments on the Review of the Mental Health (Secure Facilities) Act 2016 (Angelene True on behalf of the ACT Health Directorate)

Table 4. Inquiry comments on the recommendations and observations

No.	Recommendation	Inquiry Support	Inquiry Comments
1	That consideration be given to the merits of separate secure mental health facility legislation and whether such provisions would best be incorporated into the Mental Health Act (i.e., primary legislation), which pays specific regard to section 40B of the Human Rights Act.	Yes	This would assist in altering the emphasis from custodial to therapeutic.
2	That the Act explicitly clarify the cohort of patients a secure mental health facility caters for.	Yes	See Chapter 3 and Recommendation 1
3	That safeguards for the treatment of children and young people in a designated secure mental health facility be strengthened by inclusion of criteria and thresholds for the decision-makers, explicit minimum standards of treatment and care, and oversight by the Public Advocate.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
4	That the Act make explicit reference to the rights, culture and protections of First Nations peoples, encompassing culture and cultural safety, and establish explicit standards of care for Aboriginal and Torres Strait Islander peoples while they are receiving treatment in a secure mental health facility.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
5	That the Act make explicit provisions for the rights and protections of vulnerable people including people from culturally or linguistically diverse communities, and people who identify as either lesbian, gay, bisexual, transgender, queer and intersex.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
6	That safeguards for the treatment and care, and protection of human rights, of people with cognitive and/or physical disability in a designated SMHF be strengthened, minimum standards of treatment and decision-making processes be clarified, and oversight by the Public Advocate be provided.	Yes	While supportive of this recommendation, the Inquiry did not consider this matter to be within the terms of reference.

7	That those directions contemplated by the Act or any other policies, procedures or guidelines that serve to limit the rights of patients be established via statutory instrument to protect the rights of consumers, and enhance transparency, oversight and governance.	Yes	The Inquiry considered any activity to promote transparency and protect consumer rights is a positive outcome.
8	That the Act and associated policy/procedures specify that any revisions to paper registers must be recorded additionally as a correction, without retroactive change to the record, and section 27(2) be amended to include a new subsection requiring the grounds for reasonable suspicion be included in the register of searched mail.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
9	That the Act confirm that limitations on contact (section 17(1)) be classified as a reviewable decision (Part 5 and Schedule 1) and provisions made for notification and review.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
10	That standards of care be positively framed and articulated within the Act.	Not considered	Standards of care should be positively framed however, the Inquiry did not give any consideration to establishing these in legislation.
11	That limitations on contact (Part 3) be established by direction as a disallowable instrument and all limitations on contact be designated a reviewable decision.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
12	That, given the current limitations on rights, the Act be amended to clearly define 'prohibited', 'restricted' and 'unapproved restricted items' in relation to distinct patient cohorts, together with the criteria used to determine when the director general believes on reasonable grounds that a declaration is necessary to ensure security or good order of a secure mental health facility.	Not considered	The Inquiry is supportive of differential treatment for consumers based upon their individual needs.
13	That, in relation to a strip search, Division 4.3 be updated to better reflect the intent of sections 10 and 19 of the Human Rights Act 2005.	Not considered	Whilst the Inquiry did not consider the legislative aspects, they are supportive of any additional emphasis on Human Rights in the

			unit, which is reflected in Recommendation 22.
14	That section 50(b) of the Act be amended to state that, 'the patient must be present, or if the patient chooses not to be present, a person named by the patient must be present, unless the patient consents to no-one being present', and that section 57 be amended to ensure that the Public Advocate is directly informed of the seizure of property to ensure patients receive appropriate recourse in the specified timescales.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
15	That all instruments that give effect to the operations of the Act with regard to searches, appropriately and consistently reflect requirements and processes for reviewable decisions as set out in Part 5 and Schedule 1 of the Act.	Yes	The Inquiry considers instruments of this type should be subject to review.
16	That provisions for the use of force, the use of involuntary seclusion and the forcible giving of medication be clarified, and that decision-making criteria and safeguards be established in primary legislation; that a register of all such activity be legislated and provision made to proactively inform the Public Advocate of the use of force.	Partially supported	The Inquiry is supportive of greater safeguards in relation to these matters.
No	**Observations**		
1	That the Chief Psychiatrist ensure that secure mental health facility related guidelines not established via notifiable instrument be accompanied by a statement clarifying how the guideline is consistent with primary legislation and human rights, and that these statements be published alongside guidelines.	Yes	The Inquiry is supportive of policy, procedure and guidelines being consistent with all legislation and with human rights.
2	That the CHS Secure Mental health Unit Operational Model of Care, 2016 and the consumer information handbook be reviewed and refreshed as appropriate, made available to all patients, carers and representatives, and published on the ACT Health website.	Yes	The Inquiry recommends a review of the Model of Care and that all categories of consumers have their needs considered and addressed as necessary (See Chapter 3 and Recommendations 2 and 3.

3	That specific Models of Care be developed for First Nations peoples; children and young people; people who identify as either lesbian, gay, bisexual, transgender, queer and intersex; people from culturally and linguistically diverse communities; and people with cognitive and/or physical disability.	Yes	The Inquiry recommends a review of the Model of Care and that all categories of consumers have their needs considered and addressed as necessary.
4	That a comprehensive set of minimum conditions and standards of care be established to safeguard rights and the provision of optimal care within a SMHF.	Yes	The Inquiry considers this matter will be addressed through the review of the Model of Care and corresponding policies and procedures.
5	That access to rehabilitation services be sustained as a matter of priority to ensure the provision of a therapeutic environment and recovery-focused approach to treatment and care.	Yes	As per Recommendation 1 of the Report
6	That consumers, carers, representatives and advocates be informed of policies and procedures on limitations of contact and the rationale for any exceptional restrictions on contact.	Yes	See Chapter 3 and Recommendation 3.
7	That criteria, standards, processes and provisions for leave be legislated via a direction under the Mental Health Act 2015, where decisions about leave are not specified in the patient's mental health order, and the refusal or withdrawal of leave be considered as reviewable decision and provisions made for external oversight.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
8	That all information on the rights of patients receiving mental health treatment and care be updated and published in accessible formats and that all Dhulwa staff be trained on human rights and be enabled to actively facilitate consumer access to accurate and timely information and community advocacy services and supports.	Yes	The Inquiry is supportive of any additional emphasis on human Rights in the unit, which is reflected in Recommendation 22.
9	That consistent terminology and reference to intersecting legislation, policies, procedures or guidelines be used when updating the Act, subordinate legislation and associated operational documents, and that all such documents be made available to consumers, carers, community and civil advocacy services and supports.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.

10	That consideration be given to the enhancement of clinical record functionality, to negate the need for paper records and support the creation of electronic registers, encompassing automated notification, as a by-product of the electronic clinical record.	Not considered	The Inquiry did not consider this matter to be within the terms of reference.
11	That all SMHF staff receive updated and compulsory training on the: • Human rights of patients (custodial, forensic and civil) • Legislative framework within which they operate • Appropriate and proportionate use of restrictive practices • Requirement to record and register all restrictive practices • Associated reviewable decision requirements and administrative processes.	Yes	The Inquiry is supportive of any additional emphasis on Human Rights in the unit, which is reflected in Recommendation 22.
12	That the Public Advocate be informed of any use of force or strip search and that independent review mechanisms be established to strengthen governance and oversight, and that a learning system approach in support of continuous quality improvement be adopted.	Yes	The Inquiry did not examine the matters covered in this observation in detail but is supportive of enhanced governance and transparency at Dhulwa. See Chapter 5 and Recommendations 10 and 11.
13	That explicit provisions be made to ensure that both consumers and staff are empowered to voice any issues or concerns within a broader framework of a learning system focused on enhancing safety and the consumer and staff experiences of care.	Yes	See Chapter 3, Chapter 7 and Appendix F.
14	That a summary of the roles and responsibilities of Canberra Health Services and ACT Health Directorate, including the Chief Psychiatrist and the Office for Mental Health and Wellbeing, with specific regard to secure mental health facility patients, be published to enhance system literacy.	Yes	The Inquiry supports transparency and the provision of clear information to consumer and consumer advocates as noted in Recommendation 1.

Appendix F: The Safewards Model

Safewards is an evidence-based model that was developed in the United Kingdom (UK) specifically for mainstream acute mental health services. It is designed to reduce what is known in the model as conflict (events that threaten staff and consumer safety (such as aggression, self-harm absconding), and containment (restrictive practices used to manage conflict such as extra medication, restraint and seclusion).[75,76] As can be seen from the definition of conflict, it is quite broad and does encompass a range of conflict events. The model also uses a generalised whole of unit approach to address conflict and reduce containment.

The Safewards model was largely derived from a literature review that included over 1,000 studies on conflict and containment, as well as research conducted on conflict and containment and consultation with clinicians and consumers.[74,76]

The Safewards model consists of six domains:

- the staff team
- physical environment
- outside hospital
- the consumer community
- consumer characteristics and
- the regulatory framework.

The model suggests that certain features that present in these domains can influence or trigger conflict events and identifies flashpoints, which are defined as social and psychological situations that stem from features of the six domains, with these flashpoints signalling and preceding imminent conflict behaviours.[75,76] The model also has a range of interventions and prevention strategies designed to correspond to the diverse flashpoints identified in the model.[75,76]

There are ten interventions which are commonly referred to (although there are a range of other interventions available on the Safewards website), see Table 5 for a list and description of the interventions.

Table 5. Safewards interventions[77]

Intervention	Description
Know each other	Providing and sharing information that can help staff and consumers know each other better and form positive relationships.
Mutual help meeting	A voluntary meeting with staff and consumers that has a structured agenda that support positive appreciation.
Clear Mutual Expectations	Clarification of the expectations of the unit, which allows staff to be consistent and everyone to understand their obligations on the unit.
Soft words	Provides ways of communicating to avoid confrontations and work more collaboratively with consumers.
Text Positive Words	Staff state something positive about each consumer at handover and, when difficult behaviour is described, staff offer potential psychological explanation.
Text Talk Down	Text A model for de-escalation.
Calm down Techniques	This intervention suggests a range of alternative distraction techniques to using PRN medication and provides the means to make these items available to people.
Bad News Mitigation	An intervention designed to help notice occasions when people may have received bad news (or identify potential occasions in advance) and act fast to mobilise psychological and social support for the person.
Reassurance	Following the occurrence of an anxiety providing incident on the unit staff work to allay the anxieties that occur in circumstances where consumer may react with fear or anger following certain events, by engaging them in conversation and being present.
Discharge messages	This intervention provides a method to imbue hope and convey authoritative messages about the purpose and benefit of an admission. Consumers leave a message describing a positive aspect of their own experience directed to other consumers.

Safewards was originally tested in a Randomised Controlled Trial (RCT).[75] The single blind cluster RCT was conducted in the UK to evaluate the impact of the introduction of the Safewards model and the associated interventions on reducing rates of conflict and containment. To conduct the RCT, 31 adult mental health acute inpatient units, in and around London were randomly selected.

The results demonstrated a significant reduction of conflict and containment (seclusion) as compared to the control intervention units.[75] Following on from the initial RCT been other trials of Safewards, and in 2015, a trial of Safewards commenced in Victoria, led by the Department of Health and Human Services, where seven services and 18 units across Victoria introduced Safewards. This trial was evaluated and the results suggested there was a reduction in seclusion events in the units involved in the trial, as compared to other Victorian unit not included in the Safewards trial.[77]

It is however important to highlight that the Safewards model was designed for acute mental health inpatient units that have brief, time-limited admissions for people experiencing acute mental ill health. While the efficacy use has been established in acute units, forensic mental health units were excluded from the initial RCT.[75] Safewards has been introduced across forensic mental health services internationally with mixed results.[78]

Price[79] conducted a study evaluating the implementation of Safewards at a medium secure forensic hospital in England. Results found no significant difference in conflict and containment in the implementing units, when compared to the control units, however there was issues reported with engaging staff in the implementation.

Cabral and Carthy[80] also conducted an evaluation of Safewards in a forensic mental health setting. This study did find some evidence of reduction of conflict and containment events, an improvement in unit atmosphere, positive changes in a recovery measure, and in addition responses from focus groups were positive about Safewards.

It is important to note that both studies reported a level of resistance to introducing Safewards, including insufficient training, negative staff attitudes (e.g., believing the interventions were already occurring in practice, when they were not) and resistance to change.[76,78]

There have however been other studies that have reported positive findings in forensic settings. A study conducted at the Thomas Embling Hospital in Melbourne Victoria, was designed to evaluate the introduction of the Safewards. Results showed a reduction in conflict events, however there were no changes in the already low rate of restrictive interventions use.[75] The fidelity checks which are used to measure how consistently interventions are implemented, indicated a high degree of staff and consumer adherence to implementing the interventions. The unit atmosphere was also measured using the Essen Climate Evaluation Schema,[81] where results showed a significant improvement in consumer cohesion, and the experience of safety on the unit following the introduction of Safewards.

There has also been some suggestion of a need to consider adapting the Safewards model of care to the forensic mental health setting, by including some of the key features present and enhancing some of the interventions to address forensic specific risk and offending issues, to ensure appropriate targeting of flashpoints not currently included in the model.[75]

There has since been the development of Safewards Secure.[41] Safewards secure is an adjunct to the original Safewards model. The secure version was developed in a Delphi study using a group of international Safewards and forensic mental health experts including input from people with lived experience of mental ill health.

The Safewards and forensic mental health experts identified the necessary components missing from the original model and reached consensus on key considerations for Safewards Secure interventions. To ensure the Safewards Secure model was also robust and developed on a program

of research, all items suggested by experts in the study were cross-referenced and dependent on empirical evidence in the literature.[41]

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