

National Consensus Statement:

Essential elements for recognising and responding to deterioration in a person's mental state

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Contents

Purpose	3
Scope and application	4
People	4
Settings	4
Contributing factors	5
Resources to support implementation	5
Values	5
Person-centred and holistic health care	5
Culturally competent health care	6
Recovery-oriented mental health care	6
Trauma-informed care	7
Integrating values into practice	7
Guiding principles	8
Essential elements	9
Part A. Processes of care	10
1. Recognising deterioration in a person's mental state	12
2. Escalating care	13
3. Responding to deterioration in a person's mental state	14
Part B. Therapeutic practice	15
4. Creating safety and minimising restrictive practices	17
5. Teamwork and shared decision making	18
6. Communicating for safety	19
Part C. Organisational supports	20
7. Leadership and governance	22
8. Workforce development	23
9. Standardised processes to support high-quality care	24
10. Evaluation and feedback	25
References	26
Appendices	28
Appendix A: Terms used in this document	28
Appendix B: Consultation participants	32
Appendix C: Typical signs of deterioration in a person's mental state	37

Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission), in collaboration with key stakeholders, has developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (the Consensus Statement). It provides guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to deterioration in a person's mental state.

People can experience deterioration in their mental state in all healthcare settings. An acute deterioration in a person's mental state is an adverse outcome in itself. It can also be associated with further adverse outcomes, including suicide, aggression, and the traumatic use of restrictive practices.

People experience and express deterioration in mental state in different ways, making recognition of the signs of deterioration a complex task. A person can experience deterioration in mental state due to internal factors, including exacerbation of mental illness, psychological distress, physical conditions including delirium, atypical responses to prescribed treatments, or intoxication with licit or illicit substances. People can also experience deterioration in mental state due to factors arising from their social context or their response to the environment.

There is currently marked variation in the effectiveness of responses to deterioration in a person's mental state, both within specialist mental health services and in the broader health system. Moreover, there is evidence that many people who experience deterioration in their mental state are further traumatised by interventions delivered by health services, even when these interventions are implemented within existing national and jurisdictional guidelines.

The Consensus Statement is an adaptation of the model described in the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*.¹ This model was based on the evidence that many people experienced preventable adverse outcomes after early signs of physiological deterioration were either not recognised, or not promptly responded to.

The success of the original model is related to the systematic approach to recognising signs of physiological deterioration, documenting these, and escalating care through agreed and available pathways. The standardised processes do not replace or dilute clinical judgement but support it, with the capacity to escalate care solely on the basis of clinical concern built into the system.

Purpose

The Consensus Statement outlines 10 essential elements, divided into three parts:

- Processes of care
- Therapeutic practice
- Organisational supports.

The three parts are interrelated: actions that members of the healthcare workforce take require organisational supports to implement them in a way that is consistent with recovery-oriented values. For instance, how a member of the healthcare workforce escalates care is described in 'processes of care'; the values enacted while escalating care are described in 'therapeutic practice', and the system-level components of the health service organisation's escalation protocol are described in 'organisational supports'.

The Consensus Statement also provides seven guiding principles that describe the philosophy of care underpinning the recognition and response approach to deterioration in mental state.

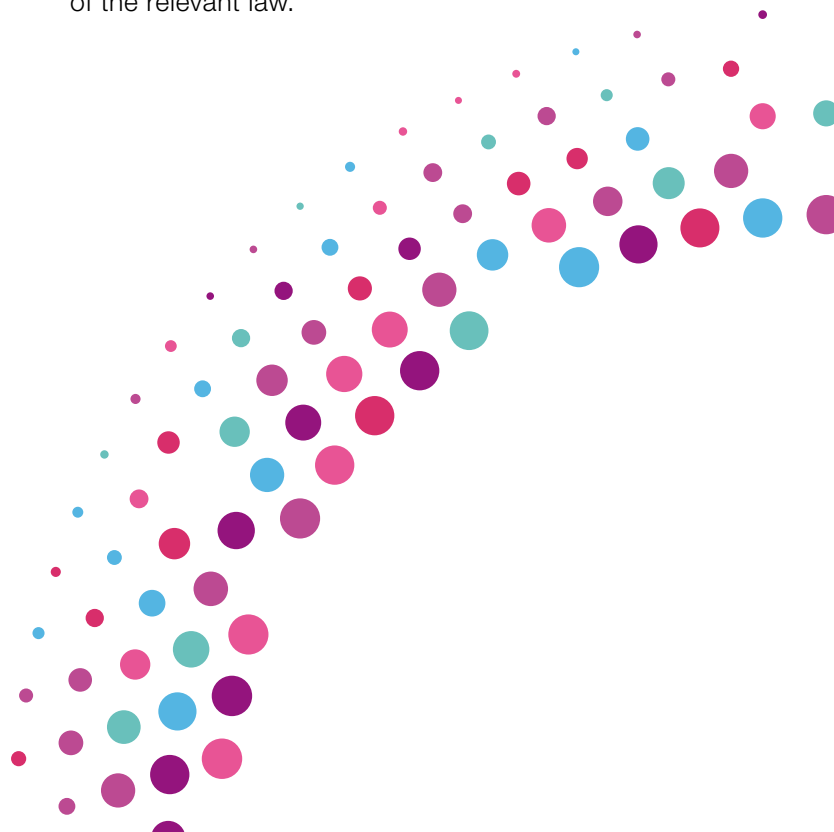
The Consensus Statement describes best practice. It aims to guide health services in developing their own recognition and response systems in a way that is tailored to their communities and the resources and personnel available, and in line with relevant state and territory or other programs. The Consensus Statement is not intended to replace existing systems designed to care for people experiencing deterioration in mental state, including the expertise practised by members of the healthcare workforce.

The Consensus Statement is also designed to support health service organisations to implement actions in the National Safety and Quality Health Service (NSQHS) Standards (second edition). The Consensus Statement aligns with actions in the:

- Recognising and Responding to Acute Deterioration Standard
- Comprehensive Care Standard
- Clinical Governance Standard
- Partnering with Consumers Standard
- Medication Safety Standard
- Communicating for Safety Standard.

The Commission will develop more detailed information about this alignment in a Mental Health User Guide to the NSQHS Standards (2nd ed.).

The Consensus Statement is not a legal document and clinicians must continue to be aware of, and abide by, the laws of the jurisdiction in which they practise. Any inconsistency between the Consensus Statement and a law of a state, territory or the Australian Government, will be resolved in favour of the relevant law.



Scope and application

The scope of the Consensus Statement is intentionally broad. People can experience deterioration in their mental state for a range of reasons and in all healthcare settings. Moreover, acute deterioration in a person's mental state is frequently preceded by early warning signs, and effective recognition and response improves the potential to prevent an adverse outcome.

People

The Consensus Statement applies to all people accessing health care. This includes:

- People receiving specialist mental health treatment
- People with a known mental health condition receiving health care for a physical health problem
- People receiving health care who have no prior history of mental health issues
- People of all ages.

Collaboration underpins the Consensus Statement. Health services need to develop and sustain partnerships with people who experience deterioration in mental state, their families and carers on the planning, delivery and evaluation of their recognition and response processes.

The actions set out in the Consensus Statement are to be implemented by:

- Members of the healthcare workforce
- Specialist mental health workers
- Health service executives and managers responsible for the development, implementation and review of systems for delivering health care, including mental health care
- Providers of clinical education and training, including universities and professional colleges
- Health professional registration, regulation and accreditation agencies
- Planners, program managers and policymakers responsible for the development of state, territory or other strategic programs dealing with the delivery of mental health care.

Settings

The Consensus Statement applies in:

- Specialist mental health settings
- Medical and surgical wards
- Maternity and paediatric units
- Emergency departments
- Multi-purpose services and remote clinics
- Justice health
- Ambulance services
- Community-managed organisations.

Application of the essential elements will necessarily be different in different contexts. The Consensus Statement is designed to align with existing systems for delivering mental health care, and provide a specific structure to help understand ways in which those systems can be improved to ensure safe and effective response from a health service when a person experiences deterioration in their mental state.

Contributing factors

The Consensus Statement has been developed primarily to address deterioration in mental state related to psychological distress and mental illness. People can also experience deterioration in their mental state due to other causes, the most prevalent of which is delirium. It is critical that members of the workforce are able to effectively screen for potential physical causes when a person experiences deterioration in their mental state.

The Commission has developed a *Delirium Clinical Care Standard*² which describes best practice in the detection and management of delirium. The Commission has also released *A better way to care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital*,^{3,4} reflecting acknowledgement that deterioration in a person's mental, cognitive and physical state is often closely connected. This Consensus Statement should be read in conjunction with these other documents.

Resources to support implementation

Implementation of the Consensus Statement will require local solutions, reflecting the different contexts in which people experience deterioration in their mental state. The Commission will work with stakeholders to identify which existing processes and tools support implementation of the Consensus Statement, and develop additional resources where these are needed.

Appendix A contains definitions for key terms and describes how they are used in this document.

Values

Experiencing deterioration in mental state can be distressing for a person, whether it is the first experience, or a recurrence. It is also distressing for their family members and carers. How members of the healthcare workforce respond to the person can be a critical factor, not just in the short-term resolution of the episode, but also in terms of the person's future willingness to engage with health services.

All members of the healthcare workforce enact values in their everyday practice. These values may not be explicitly articulated, and may inadvertently privilege views about the world that extend beyond the clinical context. Over the past two decades, consumers of health services, including people with lived experience of mental health issues, have challenged health services to develop frameworks that make values transparent.

Person-centred and holistic health care

Delivering health care that is holistic and person-centred is consistent with the principle of partnering with consumers, an approach that is now familiar across all health settings, both at an organisational and individual level.⁵ In the NSQHS Standards (2nd ed.), partnering with consumers is described as follows:

At the level of the individual, partnerships relate to the interaction between clinicians and patients when care is provided. At this level, a partnership involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients in their own care.

A critical aspect of delivering person-centred care involves recognition of the diversity of people who access health services. In terms of recognising and responding to deterioration in a person's mental state, this entails understanding that the experience, and the response to interventions, may be different for different people. Health services need to be tailored to meet people's specific mental health needs, including children and adolescents, people with intellectual disability, and people with chronic physical conditions.

Culturally competent health care

Cultural competence describes both the direct delivery of care, and an underpinning systemic approach. Cultural competence 'focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services'.⁶

Culturally competent health care is defined as:

A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.⁷

When a person experiences deterioration in their mental state, their cultural values and beliefs about health and illness can have an impact on their experience. Similarly, beliefs about the individual and their place in their family and community differ, and these can influence how people and their families and support networks experience health care. In addition, people can experience marginalisation, stigma and discrimination that contribute to mental ill health.

Many stakeholders have identified problems when they access 'one-size-fits-all' health care.⁸ These include people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islanders, and people from lesbian, gay, bisexual, transgender and intersex (LGBTI) communities. There are existing frameworks and other guides that support health services to deliver culturally competent care.⁹⁻¹¹

In addition to values familiar to all health services, mental health services, in collaboration with people who have experienced mental health issues, have developed frameworks describing the overarching values that should be used in recognising and responding to deterioration in a person's mental state. These interconnected values contribute to an approach to mental health care that is recovery-oriented and trauma-informed.

Recovery-oriented mental health care

In contemporary mental health practice, the word 'recovery' has meaning beyond the reduction of clinical symptoms. Clinical recovery is seen as distinct from personal recovery, which is defined as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.¹²

Delivery of recovery-oriented mental health services forms part of the *National Standards for Mental Health Services* 2010.¹³ In 2014, Australian Health Ministers endorsed *A national framework for recovery-oriented mental health services*^{12,14} (the framework). The framework states:

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.¹⁴

Members of the healthcare workforce can maintain a recovery-oriented approach when they are recognising and responding to deterioration in a person's mental state in any health setting, through forming partnerships and practising shared decision making.

Trauma-informed care

Trauma-informed care and practice acknowledges that many people who access mental health services have experienced trauma in their lives. Trauma can arise from physical, psychological and sexual abuse, as well as from protracted neglect.

Trauma-informed care is:

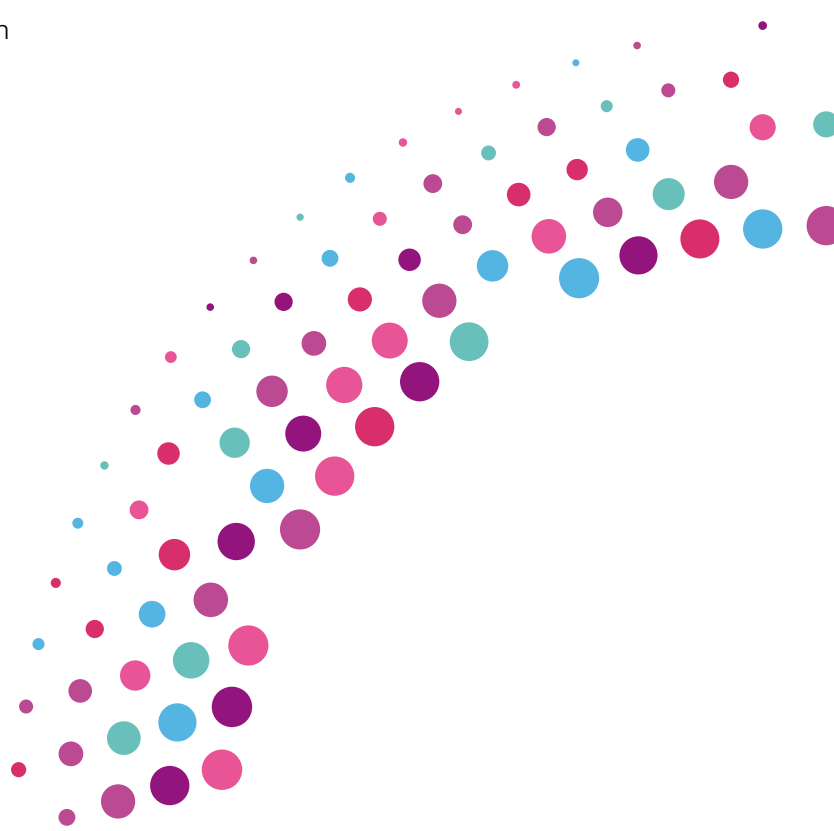
an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. It is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.¹⁵

Recurrent thoughts about past trauma can trigger deterioration in a person's mental state. The experience of deterioration in mental state itself can be traumatic, and recall past traumatic experiences. Further, responses by others, including members of the healthcare workforce, can contribute to re-traumatising people. It is therefore critical that members of the healthcare workforce are aware of trauma-informed approaches to recognising and responding to deterioration in a person's mental state.

Integrating values into practice

These values work together; care that is trauma-informed will also be culturally competent.¹⁶ Integrated into practice, these values will contribute to the goals of creating safety, supporting the person to resume control of their mental state and preventing adverse outcomes. These values have been embedded in the Guiding Principles and Essential Elements of the Consensus Statement.

The Commission acknowledges the contribution of stakeholders across Australia in the development of the Consensus Statement. Consultation participants are listed in Appendix B.



Guiding principles

1. Members of the healthcare workforce are alert to the risk of deterioration in mental state for all people accessing health care, in all healthcare settings, at all times.
2. Members of the healthcare workforce are able to recognise deterioration in a person's mental state, initiate response, and escalate care to clinicians with mental health or other relevant expertise, either within the organisation, or through established partnerships with other organisations.
3. Responding to deterioration in a person's mental state includes comprehensive assessment of potential causes.
4. Decision making is shared between the multidisciplinary team and the person. Family and carers are involved in accordance with the person's expressed wishes.
5. The response to deterioration in a person's mental state is person-centred, culturally competent and recovery-oriented.
6. The response to deterioration in a person's mental state should minimise trauma to the person, their family and carers, or members of the healthcare workforce.
7. The response to deterioration in a person's mental state is consistent with legislation.

Essential elements

Part A: Processes of care

Describes the actions that members of the healthcare workforce take, in partnership with the person, to safely and effectively recognise and respond to deterioration in mental state:

1. Recognising deterioration in a person's mental state
2. Escalating care
3. Responding to deterioration in a person's mental state.

Part B: Therapeutic practice

Describes the collaborative approach that members of the healthcare workforce adopt with consumers and carers and with each other:

4. Creating safety and minimising restrictive practices
5. Teamwork and shared decision making
6. Communicating for safety.

Part C: Organisational supports

Describes the structural and organisational factors that support the healthcare workforce to effectively recognise and respond to deterioration in a person's mental state:

7. Leadership and governance
 8. Workforce development
 9. Standardised processes to support high-quality care
 10. Evaluation and feedback.
-

Part A

Processes of care



Being alert

As part of best practice, all people accessing health care should be screened for physical, mental and cognitive health. Risk identification and categorisation can support effective care for people with known risk of deterioration in mental state. However, a level of alertness must be maintained for all people accessing care, as people with no identified history of risk may still experience deterioration in their mental state.

Recognising deterioration

The key factor in recognising deterioration in a person's mental state is noticing changes in a person's behaviour, cognitive function, perception, or emotional state. While there are a number of typical signs that can indicate deterioration, these can vary significantly and individual changes that are reported or observed are critical in recognising deterioration in a person's mental state.

If a person has previously experienced deterioration in mental state, they typically have good understanding of specific factors that can precipitate deterioration for them, as well as factors that contribute to maintaining wellbeing. They will also be likely to have knowledge about what responses are effective should they experience a deterioration in their mental state. This knowledge may be formalised in an advance care plan. Engagement with family and carers, where culturally and developmentally appropriate, will further support early recognition, as the people who know the person best are the most likely to recognise critical changes, which may not be discernible from a strictly clinical perspective.

The use of screening tools can support clinicians in assessing a person's mental state, through prompts to check for specific signs. However, tools do not replace the need for clinicians to use their clinical judgement to make a holistic assessment of the person's mental state, including contextual factors that may influence their mental state, and the person's own knowledge of their experience.

Escalating care

Escalating care can involve increasing the intensity of support delivered within the existing healthcare team, or it can involve referral to expertise external to the immediate team. An escalation protocol sets out the organisational response required to deal with different levels of deterioration in a person's mental state (see Essential Element 9: Standardised processes to support high-quality care).

In practice, recognising a need for intervention, escalating care and initiating response are not performed as separate actions by members of the healthcare workforce. However, separating them demonstrates the systematic and conceptual elements needed to effectively perform the actions.

Members of the healthcare workforce without mental health expertise should be aware of the referral criteria, processes and time lines for accessing specialist mental health services. Mental health clinicians should have a clear process to enable access to assistance from colleagues, including senior clinicians.

Responding to deterioration

All members of the clinical workforce should be able to initiate a response when they recognise the signs of deterioration in mental state in a person for whom they are providing health care. An empathic and calm response to a person's distress can immediately de-escalate a situation. Mobilising a person's existing supports will also contribute to effective response.

In responding to deterioration in a person's mental state, clinicians should consider if symptoms indicate the person is experiencing delirium, and manage the condition when it occurs.³

1. Recognising deterioration in a person's mental state

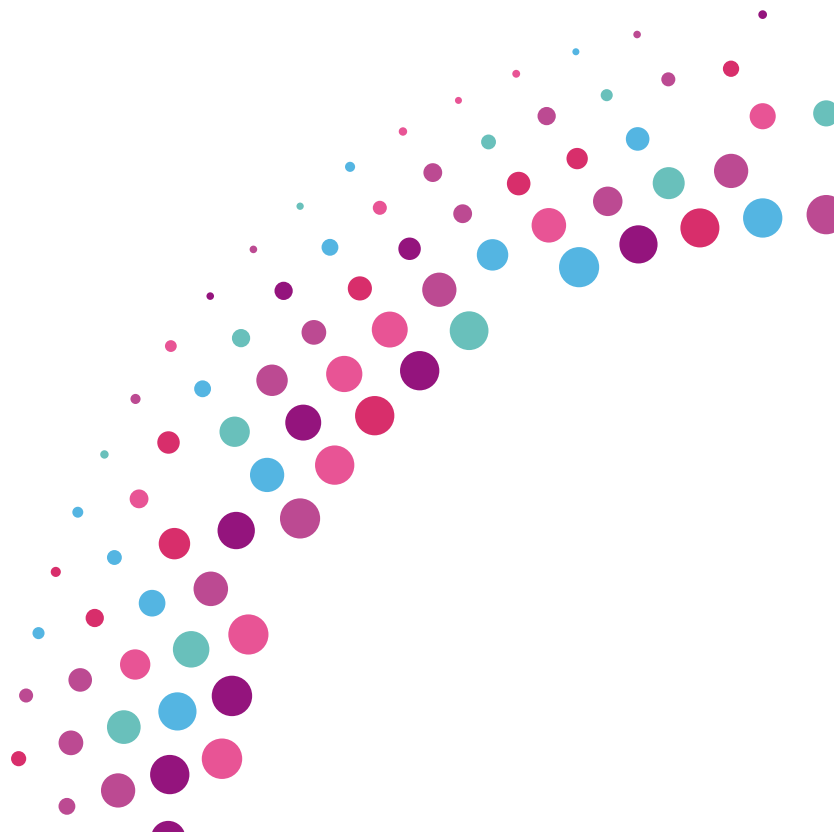
Actions

- 1.1** Members of the workforce in all healthcare settings are alert to the potential for deterioration in a person's mental state.
- 1.2** Members of the healthcare workforce use relevant screening processes at presentation, during clinical examination and history taking:
 - To identify cognitive, behavioural, mental and physical conditions, issues and risks of harm
 - To identify social and other circumstances that may compound these risks.
- 1.3** Members of the healthcare workforce comprehensively assess the conditions and risks identified through the screening process.
- 1.4** Members of the healthcare workforce in all healthcare settings reassess possible causes for acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported.
- 1.5** Members of the healthcare workforce anticipate factors that may contribute to deterioration in a person's mental state, and, where possible, modify these factors to prevent deterioration.
- 1.6** Members of the healthcare workforce communicate their observations of changes in a person's mental state to relevant senior clinical colleagues when they occur.
- 1.7** The person experiencing deterioration in mental state is consulted about what is happening for them.
- 1.8** The person's family and carers are consulted about their knowledge of the person's progress and specific signs of deterioration in the person's mental state.
- 1.9** Members of the healthcare workforce can use standardised tools or checklists to support recognition and communication of typical signs of deterioration in a person's mental state. A list of typical signs is included as Appendix C.
- 1.10** Members of the clinical workforce document their observations of changes in a person's mental state in the person's clinical record.

2. Escalating care

Actions

- 2.1 When early signs of deterioration in a person's mental state are observed or reported, members of the healthcare workforce determine the immediate actions to prevent further deterioration.
- 2.2 Members of the workforce escalate care in graded steps, consistent with the acuity of deterioration in the person's mental state.
- 2.3 Members of the healthcare workforce are aware of, and use, the escalation protocol in place in their healthcare setting.
- 2.4 The person experiencing deterioration in their mental state, their family and carers can directly escalate care if they recognise signs of deterioration.



3. Responding to deterioration in a person's mental state

Actions

- 3.1** Members of the healthcare workforce use processes for shared decision making to develop a comprehensive and individualised plan that:
- Addresses the significance and complexity of the person's health issues and risks of harm
 - Includes the person's known early warning signs of deterioration in mental state
 - Identifies agreed goals and actions for the person's treatment and care
 - Identifies any support people a person wants or does not want involved in communications and decision making about their care.
- 3.2** The person whose mental state is deteriorating and, with permission, their family and carers, are involved in the response as much as possible.
- 3.3** Information from a person's advance care plan is incorporated into the response.
- 3.4** Where available, peer workers can be involved in the response.
- 3.5** Responses to deterioration in mental state include, but are not restricted to:
- Listening to the person's current stated needs
 - Addressing practical needs (e.g. wellbeing of family members)
 - Verbal de-escalation techniques
 - Relocation to a calm environment
 - Sensory modulation techniques
 - Increasing the frequency and/or level of nursing observations
 - Support and encouragement for the person to manage their own mental state
 - Further assessment by specialist mental health clinician
 - Use of additional medication to treat symptoms (PRN, or as needed).
- 3.6** Members of the healthcare workforce respond to deterioration in a person's mental state within agreed time frames.
- 3.7** Where practical, response to deterioration in mental state is led by a team member known to the person.
- 3.8** Where practical, response to deterioration in a person's mental state is undertaken in supportive, low-stimulus, private environments.
- 3.9** The effectiveness of the response to deterioration in a person's mental state must be continuously assessed, and adapted to current need.
- 3.10** The person and their family or carer are engaged in evaluating the effectiveness of the response.
- 3.11** Members of the healthcare workforce document detailed and structured information about the interventions implemented as part of the comprehensive care plan, and the outcomes of the response in the healthcare record.
- 3.12** Strategies evaluated as effective are integrated into the person's individualised management plan, and can be incorporated into future advance care plans.

Part B

Therapeutic practice



Creating safety and minimising restrictive practices

Deterioration in mental state can be a distressing experience for a person and their family and carers. It can also result in people acting in ways that risk harm to themselves or others. Early recognition and response significantly mitigates these risks, and ideally detects deterioration at a time when the person can still participate in shared decision making.

There is strong impetus to minimise and, where possible, eliminate the use of restrictive practices, which have traditionally been strategies used in responding to deterioration in a person's mental state.^{17,18} Reducing the use of restrictive practices was identified as a key national safety priority in 2005,¹⁹ and significant effort has gone into implementing this strategy within and subsequent to the National Mental Health Seclusion and Restraint Project (2007–2009), resulting in continued reductions in the documented rates of seclusion in mental health inpatient facilities across Australia over the past 10 years.²⁰ Members of the healthcare workforce enacting values of recovery-oriented, culturally competent and trauma-informed care can contribute to minimising the use of restrictive practices.

Teamwork and shared decision making

Shared decision making is a critical part of making sure that people with deteriorating mental state are partners in their own care. Shared decision making is more than just providing information to people and their families or asking them questions to inform a clinically driven decision. It is a process that allows people, carers, families and multidisciplinary teams to work together to make decisions in the person's best interests based on the best scientific evidence available, the realities of the person's clinical condition and treatment options, and the person's choices, values and preferences.

Some people may have fluctuating or reduced capacity to participate in decision making, due to deterioration in their mental state, or for other developmental, cultural or physical reasons. Members of the multidisciplinary team should undertake assessment of decision-making capacity and maximise opportunities for participation by people with reduced capacity for decision making. Substitute decision makers, and advance care plans should be incorporated into decisions about care when they are available.

Communicating for safety

Communication is an integral part of teamwork and shared decision making, but stands as a discrete essential element because poor communication has been identified as a contributing factor to incidents where there has been an ineffective response to deterioration in a person's mental state. The person's goals of care, and the treatment plan, need to be clear to all members of the multidisciplinary team so that care can be effectively coordinated. This includes ensuring effective communication and liaison with care providers in the community, such as general practitioners, nurse practitioners, community nursing services, Aboriginal and Torres Strait Islander health services, home care workers, and managers of community and residential services.

Processes for structured clinical handover assist with effective communication about a person's health care.

4. Creating safety and minimising restrictive practices

Actions

- 4.1** Members of the healthcare workforce practise with empathy and use skills in developing rapport with people experiencing deterioration in their mental state.
- 4.2** Members of the healthcare workforce recognise that many people who experience deterioration in their mental state have previously experienced trauma, and deliver care in ways that acknowledge and respect this history, and minimise the risk of re-traumatising people.
- 4.3** Members of the healthcare workforce practise with cultural competence, acknowledging that cultural beliefs about mental health and mental illness may influence the way in which people express their experience of changes in mental state.
- 4.4** Members of the healthcare workforce working with people from Aboriginal and Torres Strait Islander communities recognise that broader issues related to social and emotional wellbeing have an impact on people's mental states.
- 4.5** Members of the healthcare workforce anticipate potential sources of conflict, and seek to mitigate these.
- 4.6** Members of the healthcare workforce recognise the influence of their own behaviour on others, and ensure that their behaviour does not contribute to escalating conflict.
- 4.7** Members of the healthcare workforce use restrictive practices as a last resort, after other methods to manage deterioration in mental state have been trialled and assessed as ineffective. Trialled strategies are documented in the person's clinical record.
- 4.8** Only members of the healthcare workforce who have been trained in safely implementing restrictive practices participate in the intervention.
- 4.9** Members of the healthcare workforce implement restrictive practices consistent with legislation.
- 4.10** Restrictive practices are used for the shortest duration, consistent with maintaining safety.
- 4.11** People who have experienced restrictive practices, their families and carers, members of the workforce, and others who witnessed the events are offered debriefing subsequent to the event, with a peer worker involved where available.
- 4.12** When restrictive practices have been implemented, the person's care plan is reviewed, to identify precursors to the incident and prevent recurrence.
- 4.13** Members of the healthcare workforce report incidents of restrictive practices to the highest level of governance in the health service organisation.

5. Teamwork and shared decision making

Actions

- 5.1 Members of the healthcare workforce seek to understand and respond to the individual healthcare preferences and needs of all people, families and carers.
- 5.2 Members of the healthcare workforce involve the person experiencing deterioration in mental state and, with permission, their families and carers, in shared decision making regarding treatment options.
- 5.3 If a person's mental state affects their capacity to participate in shared decision making and consent to treatment, members of the workforce engage substitute decision makers or nominated persons, in line with legislation.
- 5.4 The mutual roles and responsibilities of different multidisciplinary team members and the person and their family and carers are clearly defined and understood by all those involved in a person's care.
- 5.5 Members of the healthcare workforce recognise the scope of their expertise, and engage other multidisciplinary team members if a person is experiencing deterioration in mental, physical or cognitive state, which is outside their professional scope.
- 5.6 Peer workers, Aboriginal and Torres Strait Islander, and bilingual mental health workers are engaged in responses to deterioration in a person's mental state when appropriate and available.
- 5.7 Team members with expertise in mental health provide leadership to develop the skills and capacity of other members of the healthcare workforce in relation to deterioration in mental state.

6. Communicating for safety

Actions

- 6.1** Members of the healthcare workforce clearly communicate their assessment of deterioration in a person's mental state, what they consider to be appropriate and feasible options for response, and any risks or potential side effects related to proposed interventions to the person, their family and carers.
- 6.2** Members of the healthcare workforce communicate respectfully with the person experiencing deterioration in mental state, and their families and carers.
- 6.3** Members of the healthcare workforce communicate in a manner that is understandable and meets the needs of each person, their families and carers.
- 6.4** Members of the healthcare workforce use bilingual mental health workers or interpreters when providing care for people who experience deterioration in their mental state, who are not confident in speaking English.
- 6.5** Members of the healthcare workforce incorporate appropriate strategies and technologies to communicate with people with visual, auditory or other disabilities.
- 6.6** Clinical communication is consistent with privacy legislation and mental health and guardianship acts.
- 6.7** Members of the healthcare workforce check with people accessing care about consent before sharing information with carers and other family members, and work with them to review their choices about privacy as their mental state changes.
- 6.8** Members of the healthcare workforce use clinical communication processes to effectively communicate critical information, alerts and risks when they emerge or change.
- 6.9** Members of the healthcare workforce use processes for structured clinical handover to effectively communicate about a person's health care, particularly when care is being transferred:
- Between clinicians within the team
 - Between multidisciplinary teams
 - Between organisations
 - At discharge.

Part C

Organisational supports



Leadership and governance

Successful and sustainable systems for delivering safe, high-quality care when recognising and responding to deterioration in a person's mental state require a robust safety culture within health service organisations. Executive and clinical leaders at all levels of the organisation's clinical and corporate governance structures can provide proactive and practical support to the multidisciplinary teams and managers responsible for delivering recognition and response systems.

Workforce development

A suitably skilled and qualified healthcare workforce is integral to a health service organisation providing an appropriate response to deterioration in a person's mental state. Health service organisations use recruitment processes to ensure that the healthcare workforce has the appropriate skill mix to deliver safe, effective and culturally competent care. Where appropriate, this may include recruitment of peer workers, Aboriginal and Torres Strait Islander, and bilingual mental health workers.¹⁶

Members of the healthcare workforce benefit from ongoing professional development, accessed within the health service organisation, or through external training programs, to augment their skills.

Dealing with deterioration in mental state can be challenging for members of the multidisciplinary team, and for other healthcare workforce members such as ward clerks, porters and cleaners. It can add considerably to workplace stress. Chronic, unmanaged stress can erode empathy and potentially contribute to poorer experiences for people accessing health care. Members of the healthcare workforce should have access to peer support, mentoring and appropriate clinical supervision.

Standardised processes to support high-quality care

Many health services have escalation protocols to respond to specific aspects of deterioration in a person's mental state, including:

- A process for review by specialist mental health experts
- Support for people who have thoughts of self-harm, or who have harmed themselves
- Support for people who have suicidal thoughts
- Management of delirium
- Drug and alcohol intoxication or withdrawal
- Management of aggression or violence
- Discharge against medical advice, including an assessment of competency.

Technological systems such as My Health Record may also provide benefits to people, for example, by contributing to improved communication with external care providers and improved continuity and coordination of care as people are transferred in and out of acute health services.

Evaluation and feedback

Ongoing monitoring and evaluation of processes and systems for recognising and responding to deterioration in mental state is essential to establish their efficacy, track performance over time and determine priorities for improvement.

Evaluation should address the quality and safety of responses to deterioration in mental state, not just the potential preventability of adverse outcomes.

7. Leadership and governance

Actions

- 7.1** The health executive leads and sustains the development of a safety culture that incorporates recognition and response to deterioration in a person's mental state in all parts of the health service.
- 7.2** The organisation has a formal governance process in place to oversee the development, implementation and ongoing review of systems for recognising and responding to deterioration in a person's mental state.
- 7.3** People who use health services, and their families and carers, are partners in the development and governance of organisational systems for recognising and responding to deterioration in a person's mental state.
- 7.4** The organisational approach to recognising and responding to deterioration in a person's mental state is documented in a formal policy framework that operates together with recognition and response systems for people who experience deterioration in physical health and/or cognitive function.
- 7.5** The health service organisation communicates its policies and procedures to referring agencies, and their local communities.
- 7.6** The health service executive consider how best to allocate resources within the context of the organisation's strategic plan to support the delivery and effective functioning of the systems for recognising and responding to deterioration in a person's mental state.
- 7.7** Appropriate policies and documentation about advance care planning for mental health decision making are in place, to ensure that the care delivered in response to deterioration in a person's mental state is consistent with appropriate clinical practice, the person's expressed wishes and legislative requirements.
- 7.8** The health service organisation has processes to identify the capacity of a person to make decisions about their own care, and a substitute decision maker if the person does not have this capacity.

8. Workforce development

Actions

- 8.1** The health service organisation uses recruitment processes to maintain a healthcare workforce with the capacity to recognise and respond to deterioration in a person's mental state.
- 8.2** Peer workers, Aboriginal and Torres Strait Islander, and bilingual mental health workers are integrated into the mental health workforce where available.
- 8.3** All members of the multidisciplinary team receive education about their roles and responsibilities in relation to the local systems and processes in place for recognising and responding to deterioration in a person's mental state.
- 8.4** People who have experienced deterioration in mental state, their families and carers are invited to participate in providing education about mental health care.
- 8.5** Education covers medico-legal issues, including the relevant legislation in the state or territory of clinical practice.
- 8.6** The principles of delivering health care that is culturally competent, recovery-oriented and trauma-informed are included in education.
- 8.7** Education includes specific training for providing mental health care to people with limited capacity to participate in shared decision making.
- 8.8** All members of the multidisciplinary team receive education about how to recognise feelings of moral distress and burnout in themselves and their colleagues. They are supported to develop skills in self-care, reflective learning and providing peer support to colleagues, and are informed about how to seek help if required.
- 8.9** The health service organisation makes clinical and reflective supervision available to members of the healthcare workforce.

9. Standardised processes to support high-quality care

Actions

- 9.1** The health service organisation has a clear process for escalating care when deterioration in a person's mental state is recognised, which includes:
- Clear thresholds for graded escalation of care
 - Designation of roles and responsibilities for members of the healthcare workforce
 - Time frames for response.
- 9.2** The escalation protocol is tailored to the specific health setting, taking into account:
- The size, location and role of the setting
 - The available resources, including healthcare workforce skill mix
 - The capacity to engage specialist help.
- 9.3** The health service organisation develops and maintains partnerships with other organisations where they are required to provide safe and effective response to deterioration in a person's mental or physical state.
- 9.4** The health service organisation implements processes to improve communication between multidisciplinary teams within the organisation, and external health service partners at transitions of care.
- 9.5** Systems are in place to provide timely access to essential psychiatric medications.
- 9.6** The health service organisation provides members of the healthcare workforce with access to legal advice relating to delivery of treatment under mental health and other relevant legislation.
- 9.7** Systems are in place to facilitate appropriate documentation about mental health, and to reduce the burden of documentation and data collection when possible.
- 9.8** The health service organisation maximises safety and quality of care through the design and maintenance of the environment.
- 9.9** The health service organisation provides access to a calm and quiet environment when it is clinically required.

10. Evaluation and feedback

Actions

- 10.1** Data about the effectiveness of processes for recognising and responding to deterioration in mental state are collected, reviewed and reported to stakeholders.
- 10.2** Monitoring and evaluation strategies capture feedback about the quality of responses from multiple stakeholders, including people who have experienced deterioration in mental state, their families and carers, and members of the healthcare workforce from multiple disciplines.
- 10.3** Evaluation and monitoring are simple, inexpensive, feasible, and use routinely collected data, and data linkage, where possible.
- 10.4** Methods for collecting data include:
- Tracking rates of use of restrictive practices (restraint and seclusion)
 - Tracking rates of use of mental health legislation to treat people
 - Retrospective audit of case notes (for example, documentation of shared decision making discussions, comprehensive care planning, nursing and other observations, and referral to specialist care)
 - Medication chart safety review (for example, were appropriate psychiatric medications prescribed and administered appropriately)
 - Follow up with families, carers, clinicians and other members of the healthcare workforce involved in a person's mental health care
 - The use of tools developed for specific settings (for example, consumer and carer surveys)
 - Multidisciplinary mortality and morbidity review.
- 10.5** The local use of restrictive practices is routinely reviewed against local and national benchmarks and subject to continuous quality improvement.
- 10.6** All critical incidents are routinely reviewed to determine whether the quality and safety of the response to deterioration in a person's mental state was appropriate, and in what ways it could have been improved. People who have experienced deterioration in mental state are represented in review processes.

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Appendices

Appendix A: Terms used in this document

There is a lack of clarity and agreement about the meaning of many terms that are commonly used in relation to recognising and responding to deterioration in a person's mental state. It is important for all those involved in the provision of mental health care to have a common understanding about what such terms mean in practice. Some common terms, and descriptions of what they mean in the context of this document, are listed in this appendix.

Term	Description
acute healthcare facility	A hospital or other healthcare facility providing healthcare services to people for short periods of acute illness, injury or recovery. ²¹
advance care plan	A plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and should be prepared from the person's perspective to guide decisions about care. ²²
assessment/comprehensive assessment	A clinician's evaluation of the disease or condition based on the person's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings, including data obtained through laboratory tests, physical examination, medical history, and information reported by carers, family members and other members of the healthcare team. ³
carer	<p>A person who provides personal care, support and assistance to another individual who needs it because that other individual has a disability, medical condition (including a terminal or chronic illness), a mental illness, or is frail and aged.</p> <p>A person is not a carer for the purpose of the legislation if they only provide care, support or assistance either for payment, such as a care or support worker, or as a volunteer for an organisation, or as part of the requirements of a course of education or training.</p> <p>An individual is not a carer merely because he or she is the spouse, de facto partner, parent, child or other relative of an individual, or is the guardian of an individual, or lives with an individual who requires care.²³</p>
clinician	A healthcare provider, trained as a health practitioner, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements not specified here. They may include nurses, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

Term	Description
cultural competence	A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. ⁷ Cultural competence focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services. ⁶
de-escalation	De-escalation techniques consist of a variety of psychosocial techniques aimed at reducing violent and/or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, through the use of verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression. ²⁴
deterioration in mental state	Change in a person's perception, cognitive function or mood which negatively influences their capacity to function as they would typically choose.
escalation of care	The process whereby a member of the healthcare workforce, recognising that the person's current health status is beyond their scope to manage, engages additional support, either within the health service organisation or through partnership with other services.
goals of care	The aims for a person's medical treatment as agreed between the person, family, carers and healthcare team. Goals of care will change over time.
health service organisation	A separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit or service units providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.
mental health service	Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. ¹³

Term	Description
multidisciplinary team	A team including professionals from a range of disciplines who work together to deliver comprehensive care that addresses as many of the patient's health and other needs as possible. The professionals in the team may function under one organisational umbrella or may be from a range of organisations brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. ²⁵
observations/nursing observations	<p>In physical health care, 'observations' typically refer to a set of non-invasive investigative procedures, such as counting respiratory rate, and measuring blood pressure, that are routinely implemented, and used to track physical health status.</p> <p>In mental health care, 'nursing, or formal observations' typically refers to the practice of increased frequency or intensity of observation of a person who has been identified as at risk. This can be for the purpose of surveillance or therapy.²⁶</p>
peer workers	People who are employed in roles that require them to identify as being, or having been, a mental health consumer or carer. Peer support, which is one element of peer work, is based on the belief that people who have faced, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. ²⁷
person	The primary recipient of care.
person-centred care	Treating each person as an individual; protecting a person's dignity; respecting a person's rights and preferences; and developing a therapeutic relationship between the care provider and care recipient which is built on mutual trust and understanding. ²⁸
recovery	Recovery is understood to be more than reduction in clinical symptoms, and as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'. ¹²
recovery-oriented practice	Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. ¹⁴
screening	A process of identifying consumers who are at risk, or already have a disease or injury. Screening requires sufficient knowledge to make a clinical judgment. ²⁹

Term	Description
signs of deterioration	The signs that indicate deterioration in a person's mental state. They may be generally recognisable, or they may be specific to an individual. A person, and their family and carers, may have clear knowledge about their individual signs of deterioration, or 'relapse signature', and this knowledge can be incorporated into a plan to maintain wellness, and inform an advance statement.
supervision (clinical)	Clinical supervision is the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the clinician in their professional environment. ³⁰
team	See multidisciplinary team.
trauma-informed care	An approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. It is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. ¹⁵
trigger	In recognition and response system literature, the term 'trigger' is used to describe a sign of deterioration that 'triggers' the clinician to respond. However, in mental health literature, the term 'trigger' frequently refers to an event that potentially leads to deterioration in mental state. To avoid confusion, the term 'sign of deterioration' is used throughout this statement, rather than trigger.
workforce	All people working in a health service organisation, including clinicians (see above) and any other employed or contracted, locum, agency, student, volunteer or peer workers.

Appendix B: Consultation participants

The Commission acknowledges the contribution made to the Consensus Statement by the expert stakeholders listed in these tables.

ACSQHC Mental Health Advisory Group		
Name	Position	Organisation
Ms Christine Gee (Chair)	CEO Board member	Toowong Private Hospital ACSQHC
Ms Anna Love	Chief Mental Health Nurse	Department of Health (Vic)
Ms Anne Mortimer	Regional CEO, Ramsay Care	Australian Private Hospitals Association Psychiatric Committee
Ms Cecily Pollard	Safety and Quality Consultant	Tasmanian Health Service
Ms Clair Edwards	Director of Nursing and Deputy Director Mental Health	Sydney Local Health District (NSW)
Ms Eileen McDonald	Carer representative	National Mental Health Consumer and Carer Forum
Ms Heather Nowak	Consumer representative	National Mental Health Consumer and Carer Register
Ms Jane Moxon	Director, Projects	National Mental Health Commission
Ms Janne McMahon OAM	Independent Chair	Private Mental Health Consumer and Carer Network (SA)
Ms Karen Burns	Chair	Mental Health Coordinating Council (NSW)
Dr Marc Broadbent	Senior Lecturer, School of Nursing and Midwifery	University of the Sunshine Coast, (Qld)
Associate Professor Morton Rawlin	Chair, General practitioner	General Practice Mental Health Standards Collaboration (Royal Australian College of General Practitioners) (Vic)
Dr Nathan Gibson	Chief Psychiatrist, WA	Safety and Quality Partnership Standing Committee (SQPSC)
Dr Peter Jenkins	Director, Child and Youth Mental Health, Eastern Health	Royal Australian and New Zealand College of Psychiatrists
Ms Tanja Hirvonen	Team Leader, Social and Emotional Wellbeing	Danila Dilba Health Services (NT)
Mr Tom Brideson	Statewide Coordinator	NSW Aboriginal Mental Health Workforce Program

ACSQHC Recognising and responding to clinical deterioration Advisory Committee		
Name	Position	Organisation
A/Prof Alison McMillan (Chair)	Chief Nursing and Midwifery Officer	Department of Health and Human Services, Vic
Prof Tracey Bucknall	Professor of Nursing	Deakin University
Ms Julie Claessens	Consumer representative	Consumers Health Forum
Mr Malcolm Green	Program Leader	Clinical Excellence Commission
Ms Anne Hawkins	Clinical Nurse Consultant For Emergency/ Critical Care Services	Murrumbidgee Local Health District
Ms Robyn Hayes	Nursing Unit Manager, Acute Medical Unit	Launceston General Hospital
Prof Imogen Mitchell	Deputy Dean	Australian National University Medical School
Dr Kim Mullaley	Emergency Physician	Joondalup Health Campus
Ms Glenna Parker	Group Clinical Governance Manager	Ramsay Health Care

Participants in one-day workshop on draft Consensus Statement February 2016

Name	Position	Organisation
Ms Anna Love*	Chief Mental Health Nurse	Department of Health (Vic)
Ms Anne Barbara	Carer representative	National Mental Health Consumer and Carer Register
Ms Anne Mortimer*	Regional CEO, Ramsay Care	Australian Private Hospitals Association Psychiatric Committee
Mr Benjamin Yeh	Quality Manager	Ramsay Care
Ms Catherine Lourey	Deputy Commissioner	Mental Health Commission of NSW
Ms Cecily Pollard*	Safety and Quality Consultant	Tasmanian Health Service
Ms Christine Gee*	Board Member CEO	ACSQHC Toowong Private Hospital
Ms Clair Edwards*	Director of Nursing and Deputy Director Mental Health	Sydney Local Health District (NSW)
Ms De Backman-Hoyle	Victorian State Representative	Private Mental Health Consumer and Carer Network
Ms Deidre Widdall	Project Officer, Cognitive Care	Royal Darwin Hospital
Ms Eileen McDonald*	Carer representative	National Mental Health Consumer and Carer Forum
Ms Heather Nowak*	Consumer representative	National Mental Health Consumer and Carer Register
Ms Jane Moxon*	Director, Projects	National Mental Health Commission
Ms Janet Martin	A/Director, Clinical Governance	Office of the Chief Psychiatrist (Qld)
Ms Janne McMahon OAM*	Independent Chair	Private Mental Health Consumer and Carer Network (SA)
Ms Karen Burns*	Chair	Mental Health Coordinating Council (NSW)
Dr Kim Mullaley†	Emergency department consultant	Joondalup Health Campus
Ms Lily Wu	Consumer representative	National Mental Health Consumer and Carer Register
Mr Malcolm Green†	Program Lead, Between the Flags	Clinical Excellence Commission (NSW)
Dr Marc Broadbent*	Senior Lecturer, School of Nursing and Midwifery	University of the Sunshine Coast, (Qld)

Participants in one-day workshop on draft Consensus Statement February 2016 (continued)

Name	Position	Organisation
Associate Professor Morton Rawlin*	Chair, General practitioner	General Practice Mental Health Standards Collaboration (RACGP) (Vic)
Dr Nathan Gibson*	Chief Psychiatrist, WA	SQPSC
Dr Nick Kowalenko	Chair, Faculty of Child and Adolescent Psychiatry	Royal Australian and New Zealand College of Psychiatrists
Dr Peter Jenkins*	Director, Child and Youth Mental Health, Eastern Health	Royal Australian and New Zealand College of Psychiatrists
Associate Professor Richard Newton	Medical Director, Mental Health	Austin Health
Professor Tracey Bucknall†	Associate Head of School, Faculty of Health	Deakin University
Ms Wei Ting Ho	Clinical Nurse Consultant, Physical Health	Sydney Local Health District Mental Health Service

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Submissions to the national consultation August – September 2016

1	Australian College of Nurse Practitioners
2	Individual
3	Individual
4	Western Sydney Local Health District Mental Health Services, (NSW)
5	Chief Psychiatrist, NSW
6	Perth Clinic, (WA)
7	Individual
8	South Eastern Sydney Local Health District, (NSW)
9	Australian Government Department of Health
10	NSW Forensic Mental Health Service
11	Tasmanian Department of Health and Human Services
12	Eastern Health, (Vic)
13	Australian Medical Association
14	Clinical Excellence Commission, (NSW)
15	Queensland Mental Health Commission
16	Department of Health, (WA)
17	WA Country Health Service
18	ACT Health
19	SA Ambulance Service
20	Mental Health Commission, (WA)
21	National Mental Health Consumer and Carer Forum
22	Mental Health Commission of NSW
23	Royal Australian and New Zealand College of Psychiatrists
24	Schizophrenia Fellowship of NSW
25	NSW Nurses and Midwives' Association
26	Individual
27	Private Mental Health Consumer and Carer's Network
28	Department of Veterans' Affairs
29	Office of the Chief Psychiatrist, (Qld)
30	Safety and Quality Partnership Standing Committee
31	Carers Australia
32	Australian College of Mental Health Nurses

Appendix C: Typical signs of deterioration in a person's mental state*

Reported

- Verbal commands to do harm to self or others
- Suicidal ideation
- Attempt at self-harm
- Threat of harm to others
- Situational crisis
- Psychotic symptoms (hallucinations, delusions, paranoid ideas)
- Mood disturbance (depression, elevated or irritable mood)
- Unable to wait safely

Observed

- Agitation
- Restlessness
- Bizarre/disoriented behaviour
- Physical/verbal aggression
- Confusion
- Ambivalence about treatment
- Withdrawn/uncommunicative

* Adapted from Department of Health, Mental health triage tool.³¹



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