This evidence update focuses on recent research about the Six Core Strategies©, which is a whole-of-system approach used by many DHBs to guide the reduction of seclusion and restraints.

The update reflects recent New Zealand literature and information gathered from DHB case studies (see the reference list). Relevant findings from the United Kingdom’s adaptation of the Six Core Strategies©, known as REsTRAIN YOURSELF, are also included.

Current strengths and areas of innovative practice in DHBs are highlighted, including leadership, sensory modulation, use of data, and workforce development. Areas for improvement include peer workforce and debriefing.

LeaderShip toward organisational change

The importance of committed leadership was highlighted in DHB case studies as being central to least restrictive practice; it sets the scene for staff and supports a culture shift within mental health services. Leadership factors were highlighted in local research and in the UK.

The need for sustainability strategies was identified in the UK. Suggestions included long-term auditing processes, additional training days to re-group and reflect, and use of posters to reinforce a least restrictive culture.

“We based a lot of what we’ve done so far around Huckshorn’s Six Core Strategies [...] the thing that has made the most difference has been around leadership.”

(DHB Consumer Advisor)

Examples of leadership that have worked well in DHBs:

- **Committee and review groups** have enabled a coordinated response and encourage staff to take a proactive role.
  - Groups often include representation from peer and consumer leaders, cultural advisors, and family/whānau advisors.

- **Plans and policies based on Six Core Strategies©** have strengthened a whole-of-system approach. Policies requiring one-to-one observations have positively influenced staff attitudes and increased accountability for decision making.

- **Physical environment changes** through remodelling and refurbishments have supported least restrictive approaches.

Sensory modulation (use of reduction tools)

Sensory modulation is a key evidence-based approach utilised by DHBs to help reduce people’s distress. Some DHBs have celebrated the repurpose of seclusion rooms into sensory rooms and have used sensory modulation in culturally responsive ways.

Examples of strategies that have worked well in DHBs:

- **Personal safety forms or sensory preference forms** that enable clinical staff to assess and understand the responses required for individual people, such as early recognition of distress.

- **Broader professional groups inclusion** in the use of sensory modulation, such as nurses and allied health roles.

- **Integration within the continuity of care** provided between services, such as the utilisation of sensory modulation in community mental health services.
Workforce development

The introduction of Safe Practice Effective Communication (SPEC) training in 2016 has supported greater national consistency in effective communication and restraint training. DHBs have also highlighted a growing emphasis on the use of trauma-informed approaches.

Examples of workforce development strategies that have worked well in DHBs:

- Supporting translation of SPEC training into clinical practice, for example through identification of champions.
- Professional development plans that help identify future leaders and professional development needs.

In the UK, adequate and safe staffing levels were identified as critical for the implementation of least restrictive practices, particularly for supporting effective communication and building rapport with people accessing services.

Use of data to inform practice

Innovation around data transparency and identification of data trends have been a strong focus. DHBs have found it helpful to have “non-blaming” processes and attitudes around the use of data.

Examples of data use and transparency in DHBs:

- Displaying data on noticeboards, nurses’ stations or meeting rooms during clinical reviews.
- Real-time dashboards have helped inform real-time decision-making.
- Identification of trends has helped inform clinical practice and workforce development. For example, one DHB identified increasing use of seclusion in the evenings and addressed this with a new after-hours senior nurse position.

Peer workforce (service user inclusion)

Peer workforce development and inclusion of people accessing services and their whānau in decision making were highlighted as areas for improvement in DHB case studies and in the local literature.

Examples of strategies that have worked well in the UK:

- Recognition of formal and informal peer support and the introduction of community meetings provided opportunities for people accessing services to connect with each other, discuss concerns, and explore ways to improve services.
- Safety plans have been used as self-management tools that help people identify personal triggers and calming strategies. This person-centred approach helps staff understand and respond to individual people.

Debriefing

DHB case studies described debriefing as “underdeveloped” and a “work in progress”. The local literature also highlighted debriefing as an area for improvement. In the UK, services experienced positive cultural shifts around the use of debriefing. The shift towards trauma-informed approaches resulted in debriefing being viewed as an opportunity to learn more about people’s needs and strengthen collaborative practices.

For more information about least restrictive practices, visit the Te Pou website or contact our co-leads: Caro Swanson (Caro.Swanson@tepou.co.nz) and Gilbert Azuela (Gilbert.Azuela@tepou.co.nz).

References:

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