Survey of Seclusion and Restraint Reduction Initiatives in New Zealand Acute Mental Health Services

December 2008
ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

This report provides an overview of current District Health Board (DHB) work that supports the reduction of seclusion and restraint use in New Zealand’s acute mental health inpatient services.

The 20 DHBs that provide acute inpatient mental health services were surveyed to identify initiatives implemented to reduce use of seclusion and restraint. The survey concentrated on acute adult mental health inpatient units. A key focus was to identify any DHBs that had adopted one of the two US initiatives, either the National Association of State Mental Health Program Directors (NASMHPD) produced a ‘Training Curriculum for the Reduction of Restraint and Seclusion’ or the Substance Abuse and Mental Health Services Administration (SAMHSA) released ‘A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages’. The NAMSPHD six core strategies were used as a questioning framework, as they are potential areas that may target seclusion reduction efforts. Initiatives that either directly or indirectly contributed to a reduction in seclusion use were identified in the interviews. An assessment of the quality and accuracy of the initiatives was beyond the scope of this survey.

FINDINGS

Six DHBs have described being well underway with initiatives specifically targeting the reduction of seclusion. Four DHBs had introduced whole or parts of the NASMHPD package along with other seclusion reduction best practices, while two DHBs were implementing initiatives that closely modelled parts of the NASMHPD package. However, few DHBs had a comprehensive and systematic approach implemented in order to reduce seclusion and restraint use. Based on the information provided, it was evident that DHBs already have in place a large number of practices and interventions that would support the reduction of seclusion.

CONCLUSIONS

The findings provide an overview of DHB work to reduce seclusion use. All DHBs have in place initiatives that directly and indirectly reduce the use of seclusion. Few DHBs have a comprehensive and systematically implemented approach in place to reduce seclusion and restraint use. Further investigation is required to ascertain the impact of these initiatives on seclusion use.

Interviewees raised a number of organisational, resource and environmental factors at both a local and national level, which they believe need to be considered.

Promotion of the six core strategies (NASMHPD, 2006) may support DHBs to introduce initiatives in a systematic manner and refine their implementation to specifically target the reduction of seclusion use.

1 It did not specifically include forensic, child and adolescent or older persons services.
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1. INTRODUCTION

Seclusion has been used in New Zealand inpatient mental health services for many decades. Over the last five to ten years there has been growing national and international interest in reducing the use of seclusion. An emerging consensus recognises that seclusion has no therapeutic value and can result in negative consequences for both service users and staff (Department of Internal Affairs 2007, Mental Health Commission 2004-1). Furthermore, international efforts have documented that seclusion can be reduced, and even eliminated, without increasing the risk of harm (Donat, 2003, Gaskin, Retrieved 21.07.2008).

Up until 2001, the use of restraint and seclusion within mental health services was governed by procedural guidelines, issued by the Ministry of Health (MOH). The MOH was eager to see a reduction in all types of restraint and therefore, through Standards New Zealand, introduced the Restraint Minimisation and Safe Practice Standard (RMSP) in 2008. This standard superseded the procedural guidelines for physical restraint and the procedural guidelines for seclusion. Within the RMSP seclusion is classified as a type of restraint: “The intent of this standard is to reduce restraint in all its forms and to ensure that, when practised, it occurs in a safe and respectful manner. This standard covers all forms of restraint, that is, personal, physical, environmental (including seclusion), and enabler.”

A definition of seclusion is provided in the RMSP Standard – “seclusion is defined as the placing of a person, at any time and for any duration, alone in an area where he/she cannot freely exit.” The authorisation for the use of seclusion is provided for in section 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the development of standards and guidance on its use is provided for in section 130.

National seclusion statistics were reported for the first time in the Office of the Director of Mental Health Annual Report 2006. Between October and December 2006, 16.1 per cent (383) adult mental health service users were secluded. While most episodes of seclusion were less than three hours, time in seclusion varied from under one hour and up to 24 hours. Maori were disproportionately over-represented in both seclusion rates and number of seclusion events. Males were more likely to experience a seclusion event than females (Ministry of Health, 2007-2).

In recent times, there have been increasing efforts within New Zealand mental health services to reduce the use of seclusion and restraint. This report describes DHB work to reduce the use of seclusion within acute adult inpatient settings.

2. BACKGROUND

Internationally, particularly in the US, a range of initiatives which provide a ‘whole-of-system’ approach to reducing seclusion use have been developed and implemented (Donat, 2002; Gaskin, Retrieved 16 November 07). In the past ten years some states in the US have made dramatic reductions in their use of seclusion and restraint. The catalyst for this was the release of a series of damming articles on deaths that had occurred through the use of restraint in 50 states (Weiss et al, 2002).

The RMSP Standard will be superseded by NZS 8134.2:2008 - Health and disability services Standards - Health and disability services (restraint minimisation and safe practice) Standards on 21 December 2008.
There was a huge reaction from consumer groups and the public in response to these articles, which listed 140 plus deaths from restraint in 10 years, including many children. This led to significant change to Federal legislation.

A review of the literature has identified a number of best practice guidelines for reducing and eliminating the use of seclusion and restraint (O’Hagan, Divis & Long, 2008). Best practices identified included high level strategies such as having a national direction, ensuring organisational leadership and oversight of the reduction initiative, and workforce development. Best practice organisational strategies included use of practical prevention tools, service user development and participation, rigorous debriefing for service users and staff, collection and use of information to reduce seclusion practices. Two training curriculum that incorporate a range of these best practices are:

- the National Association of State Mental Health Program Directors’ (NASMHPD) *Training Curriculum for the Reduction of Seclusion and Restraint*

The NASMHPD *Training Curriculum for the Reduction of Seclusion and Restraint* is underpinned by a trauma-informed philosophy. It includes staff and service user perspectives, erroneous assumptions about seclusion and restraint and reduction experiences in three US states. It is framed around six core strategies to reduce the use of seclusion and restraint (see Appendix 1 for more details on each of the core strategies). Each module outlines a single core strategy and provides guidance for implementation (NASMHPD 2006). The six core strategies are:

1. Leadership toward organisation change
2. Use of data to inform practice
3. Workforce development
4. Use of seclusion and restraint prevention tools
5. Full inclusion of consumers and families

The SAMHSA *Roadmap to Seclusion and Restraint Free Mental Health* emphasises the importance of both service user and staff involvement in driving sustainable reduction and elimination of seclusion and restraint. It outlines tools that reduce seclusion and restraint such as wellness recovery action plans, psychiatric advance directives, use of comfort rooms and improving communication between staff and service users. It also provides guidance on development of personal and organisational action plans (SAMHSA, 2005).
3. METHOD

Twenty DHBs\(^3\) provide acute adult inpatient mental health services in New Zealand. All were surveyed to identify initiatives implemented to reduce the use of seclusion and restraint. Forensic, child, adolescent and older people’s services were excluded from the survey.

Clinical directors and general or service managers were asked to identify persons within their organisation who had extensive knowledge of practices and policies in the area of seclusion and restraint. This led to interviews with people in the following positions:

- operations, service, group and acute service managers
- clinical directors and DAMHS representatives
- associate directors of nursing, clinical nurse directors, clinical nurse advisors, professional nurse advisors, clinical nurse specialists, clinical nurse educators
- clinical nurse managers, charge nurse manager, charge nurses
- restraint coordinators
- a training coordinator and project manager.

A semi-structured interview schedule was developed comprising a mix of open ended and closed questions. Interview questions (see Appendix 2) were developed based on a review of literature which identified best practice methods for reduction in the use of seclusion (O’Hagan et al, 2008). Interviewees were first asked to describe a DHB initiative with an explicit goal of reducing seclusion and restraint use. Then they were asked about a range of other initiatives that have been identified as supporting the reduction of seclusion internationally.

The interviews were designed to take between 30 and 45 minutes; however, many lasted between one to one and a half hours. Most interviews (16) were conducted over the phone, with the remainder (4) being face to face meetings. Sixteen interviews were with individuals and four were with two or more people.

Summary profiles of each DHB were developed from the survey data. The profiles outline both specific seclusion reduction initiatives and practices that relate to the six core strategies. In addition, a summary of practices implemented by DHBs was drawn together and presented in the final report.

All descriptions regarding the comprehensiveness of initiatives or strategies in this area are based on interviewee descriptions. The report does not present any evaluation of the effectiveness of these initiatives in reducing the use of seclusion and restraint, how they were working in practice or experienced by different stakeholder groups within the DHB. This was outside the scope of this survey and would have required a different methodology. Furthermore, this report does not claim to have captured all initiatives. We were reliant on the knowledge of those people we interviewed.

\(^3\) Wairarapa DHB does not have an acute mental health inpatient unit. If people in Wairarapa require an admission they are transported to Hutt Valley or MidCentral DHB, and any seclusion statistics in relation to these patients appear on the corresponding DHB’s data.
4. FINDINGS

The results presented in this report describe initiatives implemented by DHBs specifically targeted at reducing use of seclusion and restraint in acute adult inpatient units. It also describes a range of practices that, while not implemented with the intention to reduce seclusion and restraint use, have the potential to contribute toward that development.

Seventeen DHBs indicated that they had seclusion reduction initiatives in place. In this section we briefly describe six of those initiatives that were specifically linked with the NASMHPD and/or had been comprehensively implemented. Many of the initiatives identified were relevant to reduction of seclusion, however, few DHBs identified that they were systematically using a ‘whole of system’ approach. The other eleven initiatives are described in relation to one of the six core strategies.

Four DHBs identified that they had introduced whole or parts of the NASMHPD ‘whole of system’ package along with other seclusion reduction best practices. They were Auckland, Waitemata, Counties Manukau and Waikato DHBs. Another two DHBs were implementing initiatives that closely modelled parts of the NASMHPD package. They were Northland and Otago DHBs. No interviewees reported using the SAMHSA training package.

There were six DHBs who described that they were well underway with specifically targeted seclusion reduction initiatives. These were distinguished by being comprehensive and proactively linked to seclusion reduction goals within acute mental health services.

Waitemata DHB had embedded trauma informed care philosophy into service delivery. They had employed trauma informed care coordinators to oversee and support application of trauma informed care philosophies into practice. In addition, they had many strategies in place to communicate the priority given to seclusion reduction including a focus on communicating their priority on seclusion reduction during orientation for new staff.

Capital and Coast DHB had developed and implemented a staff self directed competency programme to reduce use of seclusion in their acute units. The programme involved written and verbal self directed learning opportunities. It aimed to increase understanding of policy and practice about the use of seclusion and its impact on service users for nursing staff.

Otago DHB had focused on improving systems for collection, review and analysis of seclusion statistics. They explicitly used the information collected to monitor their seclusion practice and formulate recommendations to effect changes in service delivery practices. These changes were then reviewed for impact on seclusion use in the ward. They reported that the number of seclusion episodes had decreased from 30 episodes per month in August 2007 to just fewer than ten episodes per month in March 2008.

Northland DHB had created a sensory modulation room for service users to support their efforts to reduce seclusion. The sensory room included a massage chair, music, low lighting and activities.
South Canterbury and Otago DHBs focused on identifying areas for improvement during debriefing sessions with service users whom had experienced seclusion. The information was used to inform and effect changes to their service delivery.

West Coast DHB had also focused on formulating recommendations for changes to their systems or practices to reduce the use of seclusion from issues identified in the debriefing sessions. They also had a procedure in place to ensure that there was follow up and action based on these recommendations.

Only one interviewee described an initiative that had resulted in the reduction of seclusion use for Maori services users. It was not specifically aimed at reducing seclusion, but had been seen to have an impact on reducing seclusion for Maori. Tairawhiti DHB employed family/whanau and cultural supports who were reported to directly contribute to their seclusion reduction efforts. In this DHB Kaiawhina (helper, assistant) and Kiaarahi (guide, escort) worked alongside the crisis assessment and treatment (CAT) team. Their role included reassuring and supporting the service user and their family by sharing information and education. Unit staff reported that involving Kaiawhina and Kiaarahi diffused family tensions and calmed service users. This reduced the need to seclude people upon admission.

**SIX CORE STRATEGIES**

**4.1. Organisational leadership and oversight**

Active, committed, high-profile leadership has been identified as essential in any initiative to reduce seclusion and restraint. NASMPHD and others stress that leadership must emphasise the reduction of seclusion use as a priority in acute mental health services.

Overall, interviewees did confirm the integral role of leadership and commitment from senior staff to supporting the commitment to reducing the use of seclusion. Senior staff were identified as responsible for key strategies supporting seclusion reduction. Examples of these strategies included:

- organising regular in-service trainings and staff skill development in de-escalation, calming and restraint and debriefing
- reviewing individual seclusion and restraint cases and data on seclusion episodes
- providing feedback and support to other staff
- promoting therapeutic interventions and best practice.

As can be seen in table one, only one DHB had implemented a specific initiative to emphasise the organisation commitment to reducing seclusion and restraint use in staff orientation. The service manager at Waitemata DHB talked about their commitment to reducing the use of seclusion within their service at their staff orientation. The staff orientation also included compulsory reading of the report on the confidential forums (Department of Internal Affairs 2007).
Table 1 Organisational leadership and oversight initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>DHBs describing a comprehensive initiative aimed at reducing seclusion and restraint use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation of new staff</td>
<td>1</td>
</tr>
<tr>
<td>Job descriptions, recruitment interviews and performance appraisals</td>
<td>5</td>
</tr>
<tr>
<td>Communication of seclusion reduction as a priority</td>
<td>6</td>
</tr>
</tbody>
</table>

Five interviewees identified how their job descriptions and performance appraisal processes specified a commitment to reducing the use of seclusion. Two interviewees described how they very explicitly outlined their commitment to reducing seclusion during recruitment interviews with prospective employees.

Interviewees from seventeen DHBs described some strategies they had in place to communicate their commitment to the reduction of seclusion and restraint use. However, only one outlined an in-depth communication strategy. Waitemata DHB communicated their commitment to seclusion reduction within their service comprehensively. For example:

- the service manager talks about her commitment to reducing the use of seclusion within their service during orientation for new staff
- the staff receive education about trauma informed care
- seclusion and restraint trends are regularly published
- articles about the project to reduce seclusion have been published in the DHB newsletter.

Strategies used to communicate a commitment to seclusion reduction varied amongst DHBs. Six interviewees reported that the commitment to seclusion reduction was reflected in organisation documents including the vision, policies and procedures (for the unit) and/or communicated at trainings and during debriefings after seclusion events. Two interviewees reported they have very candid messages from leaders emphasising the ward/unit was committed to reducing seclusion with a vision to eliminating its use in the future. Others were more indirect in the focus and emphasised an increase in overall quality of care for the service user and service delivery.

4.2. USE OF DATA AND INFORMATION TO INFORM PRACTICE

Routine collection, analysis and use of data are essential to seclusion reduction efforts. All DHBs routinely collect data about seclusion and restraint episodes for Ministry of Health reporting. As part of Ministry of Health requirements each DHB sends seclusion information to the Directors of Area Mental Health Services (DAMHS) group who forward this to the Ministry of Health. Information collected about seclusion events was also sent to each DHB’s restraint quality groups.\(^4\) Interviewees reported how the information collected was fed-back to whole teams, or to

\(^4\) Also called restraint minimisation group, restraint review panel, restraint approval group, or quality improvement group
specific members of teams (for example nurse specialists, team leaders, family and consumer advisors).

Table two indicates how few DHBs had specific and comprehensive initiatives using seclusion data to inform practice improvements. Only one DHB interviewee from Otago DHB described a comprehensive and systematic programme for the analysis of seclusion data. This analysis was then used to implement changes to practice. These changes were then reviewed for impact on seclusion use in the ward.

Another 12 of the interviewees indicated their services analysed seclusion data on an ad hoc basis. In instances where seclusion data was analysed, four interviewees described how it was primarily used to examine trends surrounding seclusion events such as time of day, skill and experience mix of staff (for example the number of casual and permanent staff), number of staff and patients in the ward at the time of the event, environment, and duration of seclusion.

Table 2 Use of data and information to inform practice

| DHBs describing a comprehensive initiative aimed at reducing seclusion and restraint use |
|---------------------------------|-----------------|
| In-depth data collection        | 1               |
| Review and analysis             | 3               |
| Feedback and recommendations    | 3               |
| Action – changes to practice    | 2               |

Two interviewees (West Coast and Capital & Coast) described how they summarised and made recommendations based on these trends. These summaries and recommendations were distributed to clinicians. At West Coast DHB a quality team followed up with the team to ensure that these recommendations were actioned.

At Nelson Marlborough, the unit manager analysed the seclusion statistics, reviewed seclusion incidents and associated documentation with consumer and family advisors. This information was used to identify and give feedback to staff about areas for improvement.

In another service, deidentified case studies of actual seclusion events had been developed for use in restraint trainings. Trainees used the case studies explore how the use of seclusion could have been prevented.

Two DHBs monitored their reduction of seclusion and restraint against key performance indicators (KPI’s) which specified a target reduction for the service.
4.3. Workforce development and organisational culture

Effective staff education and training in reduction initiatives support the building of organisational cultures that successfully reduce the use of seclusion (American Psychiatric Association 2003, Huckshorn 2004-1, NASMHPD 2006, SAMHSA 2005).

Recovery training was provided by most DHBs, however training was diverse in terms of focus and delivery. Three DHBs contracted external agencies (for example, local consumer advisory groups) to provide this training, while others had in-house training with the assistance of consumer advisors and/or consumer educators. South Canterbury DHB delivered strengths focused training to their staff.

All DHBs surveyed provided training and skill development initiatives for de-escalation. However, as with the recovery training, de-escalation training was diverse in terms of delivery and focus. An interviewee from Tairawhiti DHB reported that their service provided de-escalation training as regularly as once every seven weeks with a focus on developing skills to prevent use of seclusion and focusing on the staff role as a healing/therapeutic change agent. A further, two interviewees stated they had modified and developed their “calming and restraint” and/or “challenging incidents” trainings to incorporate a greater focus on de-escalation and they had renamed these training packages to reflect the changes (for example, “safe practice, effective communication”, “safer practice”). Five interviewees reported they addressed de-escalation within their “calming and restraint” and/or “challenging incidents” training.

More uncommon was the use of trauma informed care in DHB mental health services. As already described earlier, only one service (Waitemata) had implemented trauma informed care training and employed trauma informed care coordinators to oversee and support application of trauma informed care philosophies into practice. Three DHBs incorporated trauma informed care philosophies within existing trainings (for example safe practice, effective communication, aggression management).

Another approach described earlier was the development of an in-depth competency programme for seclusion reduction by Capital and Coast DHB. The programme involved written and verbal self directed learning opportunities aimed to increase understanding of policy and practice of the use of seclusion and its impact on service users by nursing staff.

4.4. Use of practical seclusion and restraint prevention methods

Practical prevention methods involve managing the service environment, developing alternatives and utilising prevention or early intervention tools. Interviewees were asked about what types of spaces they had available, alternative therapies and tools to seclusion and restraint use.

Of the 20 DHBs, only three did not have designated quiet spaces for service users to use. The three DHBs identified poor ward design and lack of space as factors preventing them from having designated quiet spaces. The set up of quiet spaces ranged in the seventeen DHBs from service users having their own individual bedrooms to special spaces and rooms. An example of the latter was provided by Mid Central DHB, where they have a whanau room, male and female
lounges, courtyard and a “garden of tranquillity”. Quiet areas differed in focus among the DHBs with some being low stimulus environments and others having provision of sensory stimulation activities and equipment. Examples of sensory stimulation equipment and activities included bean bags, music, television, reading material, jigsaw puzzles, couches, lamps and weighted blankets.5

Interviewees from ten DHBs described the use of advance directives in their acute units. Abiding by advance directives and crisis plans has been suggested to help prevent agitation and to indicate ways to prevent escalation in situations when a person becomes agitated (SAMHSA 2007). However, interviewees indicated that these were not often implemented and had a low uptake from service users. One interviewee stated that low uptake of advance directives was due to services users being reluctant to engage in putting these in place. Whanganui DHB had policies and procedures in place to use advance directives if provided at admission. Three interviewees talked about the integral role that community teams play in developing advance directives and management plans with people during periods when they are well in the community.

Few services use violence and/or trauma assessments. In the three DHBs that do use trauma assessments, they were used informally or in other forms, for example, as part of risk assessments or family violence screening.6

Table 3 Use of practical prevention methods

<table>
<thead>
<tr>
<th>DHBs with initiatives in place with potential to reduce seclusion, but not specifically targeted to reduce seclusion and restraint use</th>
<th>DHBs describing a comprehensive initiative aimed at reducing seclusion and restraint use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of activities</td>
<td>19</td>
</tr>
<tr>
<td>Advance directives</td>
<td>10</td>
</tr>
<tr>
<td>Management plans</td>
<td>20</td>
</tr>
<tr>
<td>Sensory modulation techniques</td>
<td>9</td>
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</tbody>
</table>

5 All DHBs had provision for activities or activity groups. These included provision of activity equipment (e.g. board games, jigsaw puzzles and playing cards) and/or a gym or exercise equipment in mental health units. Interviewees in five DHBs had employed occupational therapists, diversional therapists, activities officers or assistants and recovery coordinators to facilitate day programmes and activities. Across DHBs there was wide variation in the types of activities provided. Examples included men’s and women’s groups, music groups (e.g. drumming, singing), art and craft groups (e.g. bead work, painting) exercise and relaxation groups (e.g. volley ball, power walking, swimming, Tai Chi, Yoga, massage) wellness groups (e.g. relapse prevention) and vocational and employment programmes. As well as providing in-house activities service users at Capital & Coast could attend an Art Centre in the community.

6 All DHBs used at least one type of management plan. Types of management plans included treatment plans, crisis and/or relapse prevention plans, community/personal triggers and/or early warning signs identification, early intervention and/or de-escalation planning and risk assessments. Five DHBs used Wellness Recovery Action Plans (WRAP) which included identifying triggers, early warning signs, and developing plans for maintaining wellness, preventing crisis and advance directives for crisis situations.
Sensory modulation techniques provided by nine DHBs included massage, weighted blankets, music therapy and aromatherapy. Northland DHB had created a sensory modulation area within their acute inpatient unit and at Auckland DHB, they had created a portable sensory modulation trolley. Equipment included provision for music, lava lamps, life size stuffed animals, fluffy blankets, a sensory trolley with rocks, pebbles, “prickly things” and bubble wrap.

4.5. Service user participation and development

The majority of DHBs had a broad range of initiatives in place to ensure service user participation in the development of mental health services. However, few of the interviewees directly linked these activities to the goal of reducing seclusion.

Eighteen of the 20 DHBs surveyed had mechanisms in place for getting feedback from service users in in-patient settings. These mechanisms range from providing a suggestion box in the ward to distributing the Ministry of Health consumer satisfaction survey.\(^7\)

Sixteen DHBs elicited service user feedback using existing delivery of care processes. For example, feedback is solicited during the process of developing treatment, relapse and crisis plans or during debriefing processes after an individual has been placed in seclusion.\(^8\)

**Table 4 Service user participation and development initiatives**

<table>
<thead>
<tr>
<th>DHBs with initiatives in place with potential to reduce seclusion, but not specifically targeted to reduce seclusion and restraint use</th>
<th>DHBs describing a comprehensive initiative aimed at reducing seclusion and restraint use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced directives</td>
<td>10</td>
</tr>
<tr>
<td>Development of service user coping skills</td>
<td>15</td>
</tr>
<tr>
<td>Feedback mechanisms</td>
<td>18</td>
</tr>
<tr>
<td>Those with experience of using mental health services are employed in the service</td>
<td>20</td>
</tr>
</tbody>
</table>

\(^7\) Eleven of these 18 DHBs had more than one feedback mechanism in place, including recording verbal feedback and posting or handing out feedback forms or surveys to either a random sample of services users or to all service users. Nine interviewees reported that consumer and family advisors play a role in gathering feedback from service user and family members (both from individuals and from forums) and feeding this back to staff. For example, Whanganui DHB distributes a discharge questionnaire to all service users as well as conducting a service user survey twice a year. They also involved service users in the annual audit of the team nursing model.

\(^8\) In total interviewees from fifteen DHBs reported that they provided coping and life skills development as part of their therapeutic interventions for service users (for example, communication, problem solving, assertiveness, anger management). Provision was usually linked to individual needs. Interviewees from eight of these DHBs reported that specialist professionals (e.g. occupational therapists) provided skill development programmes in these areas. Further research would be required to assess how these programmes are used within clinical services to reduce and/or prevent seclusion events.
People who have experienced mental illness are employed as advocates, advisors, peer support workers or educators in all DHBs. It was not clear from the interviews if this group of employees were systematically included in seclusion reduction initiatives or when seclusion/restraint events occurred. Only one DHB, Nelson Marlborough described how they included consumer advisors in analysis seclusion incidences in order to identify how it might have been prevented.

4.6. Debriefing

Debriefing after a seclusion or restraint event has been argued to be essential to seclusion reduction efforts (SAMHSA 2005). However, the practices in relation to debriefing are so varied, consequently, the evidence around utility is very mixed. Debriefing was the strategy most frequently implemented by DHBs as table six shows. There appears to be a large variation in how debriefing was carried out. Many interviewees noted debriefing procedures were an area where they could improve.

Eight DHBs usually offered debriefing to both staff and service users. These were usually conducted separately as the goals were perceived to be different for the two groups.

Debriefing for staff always occurred after a seclusion or restraint event in seven DHBs. Two DHBs differentiated between diffusion which was conducted after every seclusion event and debriefing which occurred less frequently, depending on staff levels and service user acuity levels within the ward. Another interviewee indicated that debriefing sessions were not always formal processes. In these situations, they were not documented.

Table 5 Debriefing practices

<table>
<thead>
<tr>
<th></th>
<th>DHBs using debriefing at times</th>
<th>DHBs describing consistent debriefing initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing for staff</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Debriefing for service users</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Analysis of the themes and outcomes</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>across debriefing sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using debriefing to inform practice</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

The other thirteen DHBs tended to use debriefing on an ad hoc basis depending on staff assessment of level of seriousness of the seclusion or restraint event. For example, one interviewee stated that debriefing occurred on an “as needed” basis and staff may choose not to debrief if the event was deemed to be minor by them. Another interviewee reported that debriefings occasionally occurred and usually only if staff had been assaulted. In situations where an event was deemed to have adverse effects on staff and service users, one interviewee described how they could request that a regional debrief facilitator undertake a formal debrief.

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9 Four interviewees stated that consumer advisors were involved in developing and delivering training and/or involved in policy development
DHBs varied in terms of who they involved in the staff debrief and whether or not it was compulsory for staff to attend. Two DHBs stated that debriefing was available to all staff who wanted to be involved and this sometimes included the whole team. Others reported that debriefing was available just to those directly involved or present during the incident. Some DHBs involved an independent facilitator in situations where there were adverse effects.

Comments about whether or not a debriefing took place raised some questions about when a seclusion event was defined as serious or not, who defined this, and what constituted adverse effects. This area requires more discussion with clinical staff.

Three interviewees reported their service always offered debriefing to service users after they had experienced seclusion or restraint events. An interviewee from one DHB reported the decision whether or not to offer service users debriefing was made following the staff debrief. In six DHBs, service user debriefings were attended by the staff members involved in the seclusion event and these DHBs offered the service user the option of having a family member or support person (including consumer advisors) present. Two interviewees stated that service user debriefing occurred one-on-one between the service user and with either the staff member who secluded them or with a person of their choice. Interviewees from two other DHBs reported that the consumer advisor for the service was available to support the service user, but was not usually involved in the debriefing. Another interviewee stated that debriefing for family members occurred if the family were present at the time of the seclusion event.

Staff commonly identified two key goals for debriefing; providing emotional support to staff and service users, and learning opportunities. Debriefing enabled staff to express and discuss their perspectives about the events surrounding the seclusion episode, to review their practice and learn from that experience. It was also an opportunity to acknowledge the psychological impact of seclusion episodes on staff and provide colleagues with emotional support to minimise distress caused by the experience.

Service user debriefing had similar goals. Debriefing aimed to give the person an opportunity to express how they felt, as well as provide feedback on how the situation could have been handled differently. Interviewees described how this was also an opportunity for staff to explain their perspective on the need for the seclusion event at the time and clarify understanding of what happened. A further goal was to identify the impact the seclusion event had on the person, “ensuring that their emotional health is okay,” and that the person could continue to work effectively with the staff.

The focus of debriefings with service users in five DHBs was to explore how the process could be managed differently and identifying actions which could be taken by both staff and service users to avoid or prevent a seclusion episode in the future.

One interviewee mentioned that debriefing was an opportunity for service users and staff to identify “what caused the level of distress and to inform relapse prevention planning, reducing triggers, identifying coping mechanisms and putting these in place and also used to inform and
put in place therapy plans (such as cognitive behavioural therapy or dialectical behaviour therapy) to address any specific issues”.

Interviewees identified common topics discussed during debriefing sessions including training needs, environmental factors (such as ward design) and events (such as the alarm going off) and low levels of staff in the ward. Other themes included serious assaults and physical injuries to staff and service users and/or that appropriate medications had not been prescribed or the service user had not been seen frequently enough.

Analysis of the themes and outcomes across debriefing sessions did not systematically occur in fifteen DHBs. This analysis did occur in five DHBs but tended to be informal or ad hoc. Two of the five DHBs who analysed the outcomes of debriefing stated a level of expertise was required to analyse this information and to date this analysis had not been very robust. Only three DHBs reported that recommendations were generated from the analysis of common themes and issues. For these three DHBs the recommendations were fed back to teams (or a quality council) for review and action. Implementation of actions was followed up in one DHB by the nurse educator and in another DHB by the quality team.

5. FACTORS TO CONSIDER IN IMPLEMENTATION OF SECLUSION REDUCTION EFFORTS

A number of factors were raised by interviewees which they felt needed to be taken into account when implementing seclusion reduction initiatives in their services. These factors include staffing levels and experience, organisational culture and commitment, the type of initiative introduced or implemented and organisational change and environmental factors.

Interviewees identified a number of staffing features that that could cause difficulty in implementing seclusion reduction efforts. These included high numbers of vacancies (one DHB had five FTEs vacant at the time of the survey), high ratio of less experienced staff, and lack of Maori and Pacific male nurses. An interviewee from one DHB identified there were troughs of staffing levels throughout the year and it was particularly difficult to recruit staff during the summer months and during mid year (May to August). One interviewee identified low staff levels put a strain on existing staff and limited creativity. Another interviewee noted less experienced nursing staff could lack confidence in their ability to de-escalate and identify warning signs effectively.

Interviewees from nine DHBs identified staff culture could be a barrier to introducing and implementing seclusion reduction initiatives. Two of these interviewees qualified this by stating the barriers included difficulties attaining staff commitment and addressing people’s willingness to accept change. One interviewee quantified this, stating there were just one or two staff members who had difficulty taking on board change. Two interviewees identified leaders were integral to any change initiative and the mindset needed to shift from improving quality to
reducing seclusion before any movement could occur. Another interviewee stated there was apprehension from staff about eliminating seclusion outright.

Three interviewees reported their service was undergoing development and expansion or they were currently working on a number of projects which required significant commitment of resources and staff time. The services would need to assess availability of resources and extra capacity to implement further efforts to reduce seclusion use. One interviewee stated their current information technology infrastructure capacity would limit further information collection and use if these were required in implementation of seclusion reduction initiatives.

Interviewees from eight DHBs stated environmental factors such as poor ward design were a factor that required consideration for implementing seclusion reduction initiatives. Environmental factors identified included the layout and size of the ward, lack of quiet space and lack of access to intensive psychiatric care and forensic service options. Two interviewees mentioned overcrowding was a factor that hindered implementation of seclusion reduction initiatives in their service. Finally, three interviewees stated high violence and acuity levels would potentially impede implementation of seclusion reduction efforts.

Three interviewees expressed any seclusion reduction initiative implemented by their service had to be relevant, practical and realistic. One elaborated that the initiative must offer alternatives to the use of seclusion and take into consideration the health and safety of staff and service users.

6. NATIONAL SUPPORT

Two key areas requiring national support and direction were identified by interviewees. These were information dissemination and research, along with the development and organisation of training sessions and forums.

6.1 INFORMATION DISSEMINATION AND RESEARCH

Interviewees stated information dissemination and sharing was a key area requiring national support. This included requests to support access to international and New Zealand literature focusing on the use of seclusion, interest in hearing about and sharing ideas, resources (for example practical surveys and training), and initiatives with others across New Zealand.

Interviewees identified areas that warrant further research. These included exploring:
- cultural perspectives on the use of seclusion
- views of nurses at the “coal face”
- the role of acute units and how these settings might be improved
- the seclusion reduction and service delivery approaches used in different communities with consideration of population need.

There was also interest from a few DHBs wanting assistance in developing projects to evaluate and improve their seclusion reduction initiatives.
6.2 TRAINING
Many interviewees requested national training and support for developing and organising trainings and resources. This included a request that any training or workshops developed or organised be either short versions of existing training programmes or newly developed training programmes that do not require staff be out of the ward for long periods.

There was a demand for training and resources for improving debriefing practices, to ensure these are rigorous, and the outcomes are used to inform improved practice.

There was also a demand for training and resources that focus on information collection and use, including identification about information to collect, how to use statistics to inform improvements and reduce use of seclusion.

There was interest in trauma informed care training and interviewees from DHBs in relatively isolated areas would like these to be facilitated regionally on a regular basis.

6.3 OTHER
Some interviewees identified having regular regional forums was important in order for key people from DHBs to have an opportunity to share ideas and resources more effectively.

One interviewee stated they would be interested in a pilot to improve the quality of practices around the use of seclusion rather than focus on work to reduce the number of seclusion hours.

7. CONCLUSIONS
This survey identified examples of comprehensive and systematic practices focused on reducing seclusion and restraint use in New Zealand DHBs. The survey established which DHBs were utilising the NASMHPD guidelines and other tools to reduce the use of seclusion and restraint.

Twenty of the 21 DHBs provide acute inpatient mental health services for adults. Every effort was made to interview the person(s) best placed to provide information, however some key initiatives may not have been identified.

The findings provide an overview of current DHB work to reduce the use of seclusion as identified by those surveyed. Every effort was made to interview the person(s) best placed to provide information about seclusion reduction initiatives in each DHB. General managers and clinical directors in all DHBs were contacted with a request to identify the person(s) most knowledgeable about seclusion reduction efforts in their service. However, it may be that some key initiatives were not identified or were missed. Although, the survey asked interviewees to describe initiatives being implemented, it did not assess the quality or impact of those efforts. A further limitation of this survey is that service users, consumer advisors/advocates/educators/peer
support workers and frontline staff were not surveyed, thus these perspectives are not represented in the findings. The survey aimed to identify potential examples of comprehensive and systematic practice targeting the reduction of seclusion and restraint use in DHBs.

Six DHBs identified comprehensive initiatives proactively linked to seclusion reduction goals, four of which were utilising the NASMHPD curriculum or parts of it. No DHBs were using the SAMHSA tool.

All 20 DHBs indicated they had initiatives that directly or indirectly supported the reduced use of restraint and seclusion. The majority of these initiatives have been implemented in an ad hoc way and most were not specifically targeting the reduction of seclusion and restraint use. Some closely link to one or other of the NASMHPD ‘six core strategies’ and could be the foundation of further advances in seclusion reduction. Initiatives specifically introduced to cut down the use of seclusion were limited in number. There are very few comprehensive ‘whole system’ initiatives.

Many DHBs acknowledged there was room for improvement in implementing activities to reduce the use of seclusion and restraint. A number of practices were identified as useful in assisting DHBs to further reduce their use of seclusion. These included:

- better information dissemination
- access to international and New Zealand best practice literature
- national support for developing and organising training
- resources to improve current practices such as debriefing
- information collection and use
- trauma informed care
- low staff levels
- high ratios of less experienced staff
- environmental factors such as poor ward design
- high acuity levels
- organisational change or expansion
- difficulty retaining staff commitment
- allaying staff apprehension about eliminating seclusion.

Promotion of the six core strategies (NASMHPD, 2006) may support DHBs to initiate ‘whole system’ approaches targeted at assisting services in their seclusion reduction efforts.

Interviewees in many DHBs acknowledged there was room for improvement in the implementation of the initiatives they had in place and indicated various areas that require national support and direction. These included information dissemination and access to international and New Zealand best practice literature. National support for developing and organising training and resources to improve current practices such as debriefing, information collection and use and trauma informed care were also requested.

Although interviewees acknowledged there was room for improvement in current practice, they also identified a number of factors to take into account of in efforts to reduce seclusion in their services. Interviewees identified that the type of initiative(s) introduced or implemented must be
relevant and realistic, offer alternatives to the use of seclusion and take into consideration the health and safety of staff and service users.

All DHBs have in place initiatives that directly and indirectly reduce the use of seclusion. These initiatives need to be implemented in a systematic manner and the implementation processes refined and specifically targeted to reduce seclusion use.
REFERENCES


Huckshorn, K. (2004-2). *Six core strategies to reduce the use of seclusion and restraint planning tool (draft): Kevin Huckshorn.*


APPENDIX ONE: THE NASMHPD ‘TRAINING CURRICULUM FOR THE REDUCTION OF SECLUSION AND RESTRAINT’

SIX CORE STRATEGIES TO REDUCE THE USE OF SECLUSION AND RESTRAINT

1. **Leadership toward Organisation change**
   Active, committed, high-profile leadership is essential in any initiative to reduce seclusion and restraint. NASMPHD and others stress that leadership must emphasise the reduction of seclusion use as a priority in acute mental health services. To be effective, messages from leaders about the benefits of reduction, modelling of recovery language and supportive environments, rewarding and celebrating successful reductions had to be consistent and frequent (American Psychiatric Association 2003, Huckshorn 2004-1, NASMHPD 2006, Smith et al 2005). Messages about the importance of seclusion reduction need to be embedded consistently in staff supervision, job descriptions, orientation, and performance review processes (American Psychiatric Association 2003, Donat 2002, Huckshorn 2005).

2. **Use of data to inform practice**
   Routine collection, analysis and use of data are essential to seclusion reduction efforts. Useful data to inform practice includes the total seclusion events, hours secluded, service users secluded, time of occurrence, age, gender, ethnicity of those secluded, the themes and outcomes of debriefings, trends in injuries to staff and service users and the use of alternative practices (Huckshorn 2004-1, Huckshorn 2004-2, Schreiner et al 2004, Smith et al 2005, Sullivan et al 2005). Summarised data can be used:
   - to support goal setting
   - to review seclusion and restraint use against targets
   - as a basis for reflection, discussion and decision making amongst staff
   - identification and implementation of local strategies to prevent the use of seclusion and restraint.

3. **Workforce development**
   Effective staff education and training in reduction initiatives support the building of organisational cultures that successfully reduce the use of seclusion (American Psychiatric Association 2003, Huckshorn 2004-1, NASMHPD 2006, SAMHSA 2005). An organisation culture that promotes hope, empathy, personal resourcefulness, participation, mutual respect and trust is necessary for the reduction of seclusion and restraint. Various philosophies and related trainings that inform the development of this type of organisation culture include recovery, trauma informed care, human rights and the public health prevention model (Curie 2005, NASMHPD 2006, SAMHSA 2005).

4. **Use of seclusion and restraint prevention tools**
   Practical prevention methods involve managing the service environment or setting and utilising prevention and early intervention tools. Examples of prevention and early intervention tools include advance directives and crisis plans, violence and trauma assessments, behavioural
coaching and therapy, de-escalation, sensory modulation (such as therapeutic brushing and limb compression, weighted blankets or vests, massage, meditation, exercise). Medication and dispute resolution mediation also support seclusion reduction. Many of these tools rely on staff ability to build rapport with service users and working alongside each service user during crisis prevention planning to identify which prevention and early intervention tools will be most acceptable to them (Chabora, Judge-Gorney, Grogan 2003, Champagne et al 2004, Fisher 2003, NASMHPD 2006, SAMHSA 2005, Schreiner et al 2004, Smith et al 2005, Sullivan et al 2005). Managing the service environment or setting by providing quiet spaces for people to use and creating opportunities to engage in meaningful activities also contributes to efforts to reduce seclusion (American Psychiatric Association 2003, Champagne & Stromberg 2004, SAMHSA 2005, Schreiner et al 2004).

5. **Full inclusion of consumers and families**

The service user participation and development core strategy has three key areas that contribute to the development of service user centred organisational cultures. These can potentially support the systematic reduction of seclusion use. Firstly, the systematic inclusion of service user feedback mechanisms and their use to inform changes to policy and systems and/or practice with individuals (American Psychiatric Association 2003; NASMHPD 2006, SAMHSA 2005, Sullivan et al 2005; Visalli 2000). Secondly, the employment of people who have experienced being service users – as advocates, advisors, peer support workers and educators (Huckshorn 2005, NASMHPD 2006). Thirdly, the provision of therapeutic interventions aimed at developing service user coping skills and stress reduction.

6. **Making debriefing rigorous**

Debriefing after a seclusion or restraint event is essential to seclusion reduction efforts (SAMHSA 2005). The goals of debriefing are to reverse or minimise the negative effects of the episode on the staff and service users involved, to address organisational problems and make improvements that will reduce use of seclusion and restraint in future (NASMHPD 2006). Ideally, immediate debriefings (sometimes called diffusing) are followed by formal debriefings that consider what systematic changes may be needed across the whole service (American Psychiatric Association 2003, Huckshorn 2004-1, Huckshorn 2005, NASMHPD 2006).
APPENDIX TWO: INTERVIEW QUESTIONS

1. What, if any, specific initiatives do you have underway that focus on reducing use of seclusion and restraint?

Questions about leadership and commitment
2. How is this commitment communicated to staff?
3. What supports the commitment to reducing seclusion in your inpatient team? e.g. do job descriptions, orientation and performance appraisals reflect the priority given to reduction? Please specify?

Questions about debriefing
4. On the scale always, sometimes, occasionally or never: Is debriefing used after a seclusion or restraint event?
5. From memory, what are the most common issues in debriefing sessions?
6. What are the goals of these debriefings?
7. Who is involved in the debriefings?
8a. Is there any analysis of the themes and outcomes of debriefings?
8b. How is this information used?

Questions about information collection and use
9. How is information that is collected about seclusion and restraint episodes used? (e.g. analysed for trends, reviewed at staff meetings, sent to MoH, etc)
10. Through a review of literature we have come to know that there are many strategies that indirectly contribute to reduction of seclusion and restraint. I’ll run through a list of these and can you let me know whether these are implemented or used in your unit?
   a. Training on trauma informed care
   b. Training on recovery
   c. Training and skill development in de-escalation
   d. Quiet spaces for service users to go
   e. Development of service user coping skills e.g. behaviour management plans, communication skills, anger management, problem solving and assertiveness?
   f. Use of sensory modulation techniques (such as therapeutic brushing and limb compression, weighted blankets or vests, massage, meditation, exercise, or a hot shower, used?) Please specify?
   g. Use of advance directives, crisis prevention plans, violence and trauma and/or assessments. Please specify?
   h. Activity groups or provision for activities e.g. painting, exercise etc
   i. Mechanisms for getting feedback from service users about what they found helpful and unhelpful
   j. People who have experienced mental illness are employed as advocates, advisors, peer support workers or educators? Please specify?
Final Questions
11. Is there anyway that we (Te Pou) could help you to develop your collection or use of information?
12. Can you think of any difficulties or barriers to introducing and implementing seclusion reduction initiatives in your service?