Towards restraint-free mental health practice

Supporting the reduction and prevention of personal restraint in mental health inpatient settings

Te Pou
o Te Whakaaro Nui

Acknowledgements

Many organisations and individuals have contributed to this publication and we would like to sincerely thank you all for taking the time and so generously sharing your perspectives on this work.

We wish to acknowledge the National Directors of Mental Health Nursing for their professional leadership and consistent support of a wide range of workplace-based initiatives to reduce and prevent the use of personal restraint.

We also acknowledge the assistance of the New Zealand Health and Disability Commission and Standards New Zealand in permitting the re-publication of relevant sections of key documents, as appendices to this publication.

The project reference group for this publication were:

- John Ankcorn, representing Te Ao Māramatanga New Zealand College of Mental Health Nurses
- Julie Young, representing Mental Health District Inspectors
- Louise Windleborn, representing the National Association of Mental Health Consumer Advisors
- Jane Earl, representing the National Directors of Mental Health Nursing
- Tio Sewell, representing Te Rau Matatini
- Suzy Morrison, representing Matua Raki
- Emma Quealey, representing the Ministry of Health.

Published in May 2015 by Te Pou o Te Whakaaro Nui
PO Box 108-244, Symonds Street, Auckland, New Zealand

Evidence based workforce development

ISBN 978-1-877537-12-7

www.tepou.co.nz
info@tepou.co.nz

Contents

Preface

Least restrictive practice is a term increasingly used to describe a wide range of approaches, practices and at times interventions that place the person at the centre of care and strive to eliminate the personal restraint experience in inpatient settings. This guidance is underpinned by the belief that the use of personal restraint is an adverse event in mental health inpatient settings and that national consistency and support of best practice approaches is key to a continued positive practice direction.

This document is part of a larger shared work programme that focuses on reducing both restraint and seclusion. This work is mandated by *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (Ministry of Health, 2012).

This practice based guidance supports the reduction and prevention of personal restraint in mental health inpatient settings. It aligns to further work being done on the Ministry of Health 2010 Seclusion Guideline.

Personal restraint is a practice that has an impact on everyone in the inpatient space. There are multiple opportunities to reduce and prevent restraint from occurring and some of these are relatively easy to implement while others can be more complex and challenging. This publication will assist services to plan and identify best practice approaches that support and advance a considered and focused least restrictive practice approach to service delivery.

Robyn Shearer, Chief Executive, Te Pou o Te Whakaaro Nui

Introduction

Nationally and internationally there are ongoing efforts to reduce and prevent the use of restraint in mental health environments. The most successful practice innovations are those that employ multi-perspective strategies (Wieman, Camacho-Gonsalves, Huckshorn, & Leff, 2014; O'Hagan, Divis, & Long, 2008), a range of practice-based strategies (Bowers, 2014) and pain-free techniques (Social Care, Local Government and Care Partnership Directorate, 2014), and that include service user leaders and workers at all levels of healthcare organisations (Davidson, Bellamy, Guy, & Miller, 2012; Wieman et al., 2014).

This document provides guidance on ways to reduce and prevent restraint in two parts.

- Part 1 is a restraint prevention framework, which summarises available prevention strategies, including the rationale for and timing of their use.
- Part 2 outlines principles and objectives that will help services to plan for reducing and preventing the use of personal restraint.

This document draws on the best available research, policy and practice developments, and the perspectives and experiences of a wide range of key stakeholder groups.

Many organisations are actively using the Six Core Strategy© approach (Huckshorn, 2006), and the New Zealand adaptation of this checklist published by Te Pou (Te Pou o Te Whakaaro Nui, 2013), to reduce the use of seclusion in inpatient mental health settings. Early indications are that the use of these strategies is producing positive results in New Zealand practice settings (Webster, 2013).

The framework and checklist in this document are designed to be used alongside, and with reference to, the Six Core Strategy© approach.

No single perspective, circumstance or approach will sufficiently influence the use of personal restraint in mental health inpatient settings. Models that are successfully reducing and preventing personal restraint use a range of approaches and consider a variety of perspectives. Key attributes of successful strategies are:

- organisational leadership
- service user leadership and active involvement
- the active involvement of frontline staff
- inclusion of cultural perspectives
- an emphasis on teamwork
- appropriate staffing levels and skill mix (Huckshorn, 2006; Scanlan, 2010).

Consultation in developing this document has incorporated a wide range of perspectives from key stakeholders. Almost every comment and submission has identified the need for: mutual respect, individual or person-centred care, trauma-informed approaches, cultural competence and a commitment to providing environments that are effectively staffed to provide optimal care and consideration.

A positive and encouraging feature of submissions from frontline mental health staff, and their organisations, has been a strong emphasis on the importance of service user involvement at all levels of this work.

Equally, submissions from service user organisations and individuals have emphasised the importance of staff members being appropriately supported and resourced to contribute to changes in practice and to provide the best possible care in optimal environments.

Key definitions

The following key definitions have been used in this document. See Appendix 9 and 10 for further definitions.

Least restrictive practice

Least restrictive practice refers to practice in mental health settings that is mindful of the need to maximise both the autonomy and safety of service users, and to reduce or prevent practices that restrict personal freedoms and are known to cause harm, such as restraint and seclusion.

Least restrictive practice is also informed by the need to promote an inpatient environment that is optimal for supporting recovery for all service users, while meeting the quality, safety and security requirements expected of an inpatient mental health setting and the professionals that work within it.

Personal restraint

Personal restraint is defined by *NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* as: "Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider." (Standards New Zealand, 2008).

Part 1: Personal restraint prevention framework

This framework provides an overview of strategies aimed at preventing personal restraint.

The framework has three levels of prevention strategies: primary, secondary and tertiary. It also has strong links with the Six Core Strategies© approach, as indicated by the placement of the six hexagons on the diagram below.

- Primary – strategic and environmental measures that are known to have an impact on reducing restrictive practices. The first five of the Six Core Strategies© underpin and inform this level.
  - 1 Leadership towards organisational change
  - 2 Using data to inform practice
  - 3 Workforce development
  - 4 Use of seclusion and restraint reduction tools
  - 5 Service user/consumer roles in inpatient units
- Secondary – individual or circumstance-specific measures.
- Tertiary – this level acknowledges that restraint may still occur. These measures focus on providing care and treatment after a restraint to prevent trauma, as well as on preventing reoccurrence of restraint. The sixth of the Six Core Strategies© 6 Debriefing techniques fits here.

The strategies in more detail

Primary prevention strategies are the early strategic and environmental measures that have been shown by evidence to successfully reduce the need for restrictive practices within an inpatient unit.

These strategies are carefully planned, led and evaluated, in recognition that these actions reduce the potential for, or assist in resolving, circumstances and conditions that may compromise safety. Examples of primary prevention strategies include conducting an environmental assessment of the ward and making necessary changes, such as providing sensory rooms and quiet areas, increasing the involvement of peer workers and cultural workers; using consistently professional and courteous communication and processes, such as the orientation and welcome people and families and whānau receive when entering the ward environment; and developing, from the outset, a therapeutic relationship with people using services.

Secondary prevention strategies tend to be individual or circumstance specific. They are the actions that should be immediately considered when a concern, frustration or conflict is developing or is likely to develop.

Examples of secondary prevention strategies include communication and engagement, de-escalation techniques, conflict and anger management, collaborative problem-solving, sensory modulation, relaxation, mindfulness, and using the person's agreed supports and plans.

Tertiary prevention strategies focus on providing care and treatment after an episode of restraint to reduce trauma. These strategies also focus on what can be learned from an adverse event to prevent it reoccurring, and how person-centred care strategies, such as advance directives, crisis plans and early warning sign plans can assist in achieving this goal.

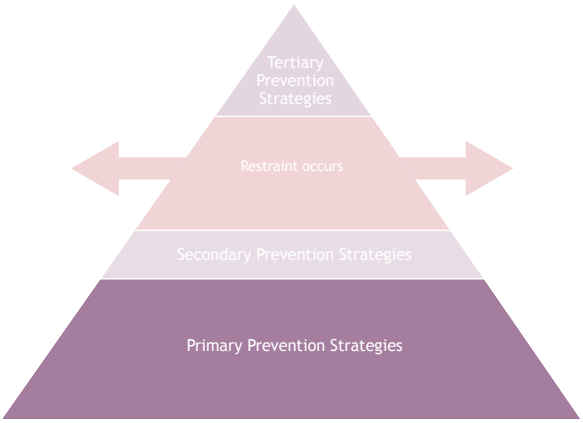
Debriefing is an essential component of these strategies both for people using services and for staff members, as is the need to review the restraint episode from multi-disciplinary team and systems perspectives.

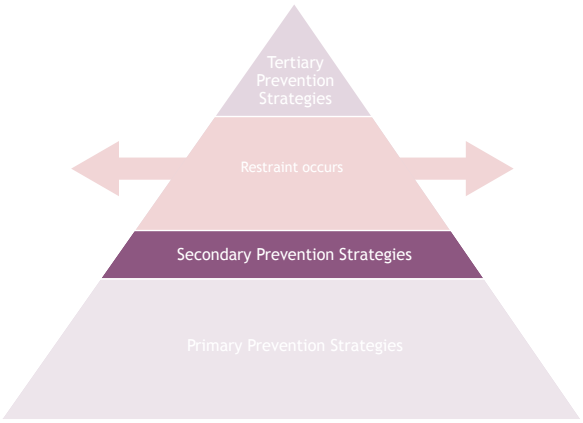
The diagram below shows the same personal restraint prevention framework, with an overview of the strategies that apply at each prevention level.

For examples of situations where these strategies have been used in practice, in ways that support prevention, see Appendix 2.

Primary Prevention

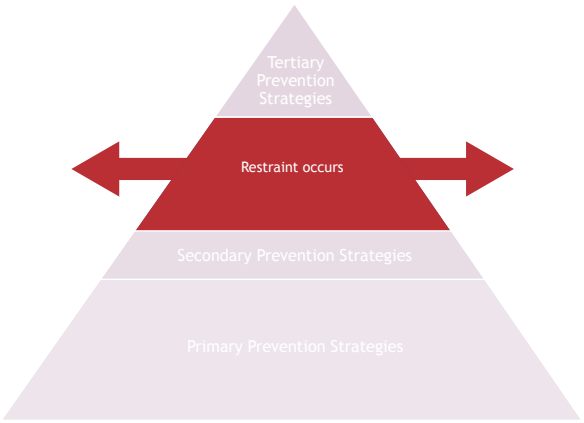
- Strategic environmental enhancements and measures, including:
  - » rooms in the ward for sensory modulation and quiet time
  - » cultural and peer worker expertise on the ward
  - » consistently professional and courteous communication
  - » developing a therapeutic relationship with people from the outset





Secondary Prevention

- Communication and engagement
- Initiating agreed supports and plans, including:
  - » de-escalation techniques
  - » conflict and anger management
  - » collaborative problem solving
  - » sensory modulation, relaxation and mindfulness

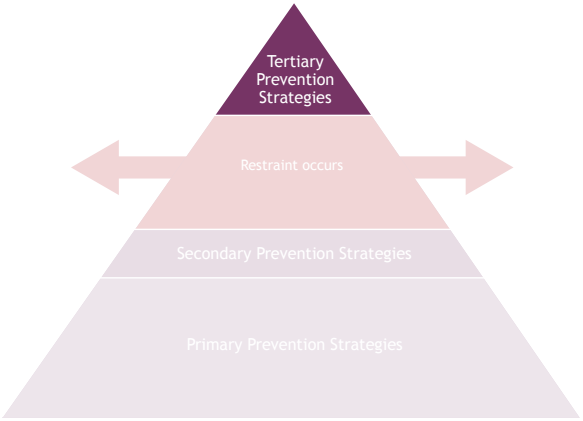


Restraint

- Nationally consistent physical restraint techniques that emphasise safety and least restrictive care practices

Tertiary Prevention

- Debriefing
- Person-centred care strategies, including:
  - » advanced directives
  - » crisis plans
  - » early warning signs
- Reviewing episode from multiple perspectives
- Initiating changes as required at primary or secondary prevention levels



Part 2: Planning for personal restraint prevention – key principles

Overview

The eight key principles summarised in this part, along with their associated objectives and indicators, focus on the prevention of restrictive practices. They will support organisations to complete a stocktake of their current situation and practices, and plan to make ongoing improvements.

Service user experiences, staff and workplace perspectives, ethics and human rights, legislation, organisational risk, structural and employer perspectives, and professional scopes and ethos of practice can all contribute to innovative practice solutions.

The eight key principles outlined below are designed to be used alongside the Six Core Strategies© checklist, to help services identify opportunities for safest practice, prevention and remedial action while they work to eliminate restraint.

"If you only have a hammer, you tend to see every problem as a nail."

Abraham Maslow

Summary of the eight key principles

The following key principles, and their associated objectives, have proven effective in helping services move towards least restrictive practice, as they describe personal restraint reduction and prevention activities. Each also has a number of associated indicators, which are described in more depth later in this section.

1. **Clear organisational goal of prevention**

A clear organisational goal of preventing personal restraint in mental health inpatient settings that is consistently led, communicated and evidenced.

2. **Implementation of a personal restraint prevention strategy and plan**

Mental health inpatient settings actively implement a personal restraint prevention strategy and plan.

3. **Person-centred care models, principles and strategies**

Person-centred care models, principles and strategies are a key focus of mental health inpatient teams (see Appendix 2).

4. **Best practice alternatives**

Best practice alternatives are thoroughly considered and implemented.

5. **Personal restraint techniques only used as safety intervention of last resort**

When personal restraint techniques are used, it is in accordance with all applicable legal obligations and approved team training and only as a safety intervention of last resort.

6. **If personal restraint techniques are used, the focus is on safely ending restraint as soon as possible**

If personal restraint techniques are used, once immediate safety is established, there is a focus on safely ending a restraint as soon as possible.

7. **Follow-up clinical interventions, reporting mechanisms and systems for review and prevention**

After a personal restraint has occurred, follow-up clinical interventions, event reporting mechanisms and systems are in place to review with the service user, family and whānau, frontline staff members, bystanders and clinical leaders, what occurred and how future episodes might be prevented.

8. **The use of personal restraint is considered an adverse event and organisational quality improvement processes aim for prevention and reduction**

The use of personal restraint is considered an adverse event. The organisation's strategic goal of personal restraint elimination is supported and evidenced by a quality improvement pathway that implements and supports practices known to prevent and reduce restriction.

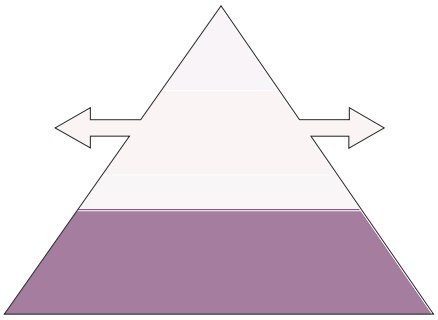
Making the links

Each of the eight principles relates to a level of the personal restraint prevention framework. In the following tables, the level it links to is indicated by a pyramid symbol beside the heading (see Appendix 1).

The eight principles each have a number of indicators. These indicators may align with one or more of the Six Core Strategies©. In the following tables, where there is a relevant strategy, this is shown by a number in the left-hand column beside each indicator (see Appendix 1).

The eight key principles

1. Clear organisational goal of prevention



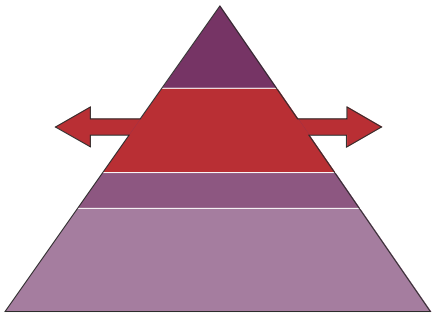
Rationale

There is a clearly mandated national and international practice direction towards the reduction, prevention and, ultimately, the elimination of seclusion and restraint in mental health services. Evidence shows that carefully planned, communicated and sustained efforts at a leadership level are critical to successful seclusion and restraint reduction outcomes.

Objective: A clear organisational goal of preventing personal restraint in mental health inpatient settings that is consistently led, communicated and evidenced.			
Related core strategy	**Indicators**	**How the indicators are currently being met**	**Plans to meet the indicator**
1 4 5	1.1 Prevention of occurrences of personal restraint using best practice-based strategies and interventions are an area of focus in the organisation's annual work and training plan.		
1 3 4	1.2 The organisation commits to implementing recommendations and strategies that address the high rates of restraint used for Māori and Pasifika service users.		
1 3 5	1.3 The organisation makes available to staff and service users a clear local policy and related accessible information on the use of personal restraint in local inpatient settings. Service user leaders and frontline staff are equitable participants in policy development and review.		
1	1.4 Visible leadership activities, such as those recommended by the Six Core Strategies© approach, are undertaken by both executive-level and workplace-based leadership and management.		
1 3	1.5 Organisational support for inpatient mental health staff to engage in best practice restraint prevention training is a key priority.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
1 3 4 5	1.6 The organisation's annual service development, workforce and financial planning, reflect an ongoing commitment to: • safe staffing principles • best practice training • train-the-trainer opportunities • frontline staff member participation in national networks.		
1 2 5	1.7 The organisation's restraint review group has a standard item on its agenda to monitor and review personal restraint activity in inpatient mental health settings.		
1 3 5	1.8 The organisation's restraint review group has membership from the organisation's mental health service that includes a mental health leader, a consumer advisor or leader, frontline staff member, lead trainer or instructor, and tangata whenua representative.		

2. Implementation of a personal restraint prevention strategy and plan

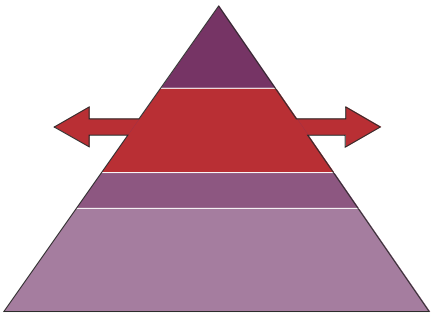


Rationale

Effective approaches towards preventing the occurrence of personal restraint involve assessing and implementing new or improved workplace-based strategies. This needs to include the active engagement of service users and frontline staff.

Objective: Mental health inpatient settings actively implement a personal restraint prevention strategy and plan.			
Related core strategy	**Indicators**	**How the indicators are currently being met**	**Plans to meet the indicator**
1 3	2.1 A workplace-based strategy and plan, using the Six Core Strategies© and the restraint prevention framework, is developed to meet the local need, environment and skill set.		
1 3 5	2.2 Mental health inpatient staff members and consumer advisors and leaders are actively engaged in the leadership, practice development, implementation and ongoing evaluation of restraint review and reduction strategies and plans.		
1 3	2.3 Executive and workplace-based leaders are actively engaged in leading and monitoring this plan and its progress.		
1 3	2.4 Effective Māori and Pasifika participation and leadership is a priority.		
1 2	2.5 The developed plan is widely and transparently communicated, demonstrably implemented, and regularly reviewed, updated and evaluated to achieve positive prevention results.		

3. Person-centred care models, principles and strategies



Rationale

Working collaboratively with service users and family and whānau is best practice towards maintaining a person-centred focus. This is achievable where clinical teams work collaboratively towards identified, agreed and shared best practice outcomes.

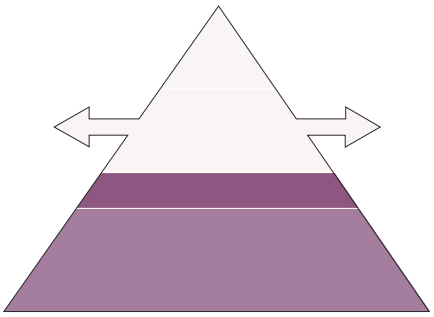
Objective: Person-centred care models, principles and strategies are a key focus of mental health inpatient teams.			
Related core strategy	**Indicators**	**How the indicators are currently being met**	**Plans to meet the indicator**
4	3.1 On admission to an inpatient mental health setting, service users and their family and whānau are welcomed and orientated to the environment.		
4 5	3.2 Staff members work to establish a therapeutic relationship with service users and their family and whānau and negotiate agreed goals and expectations of the admission. Staff recognise that an admission to a mental health inpatient unit is likely to be of significant concern to service users and their family and whānau.		
3 5	3.3 The inpatient environment and culture facilitates service user choice, connections with others and collaborative relationships.		
3 4 5	3.4 Staff members work cohesively as a team on agreed practice priorities that prevent the use of personal restraint.		
4 5	3.5 Service users are actively involved in their treatment plans and choices. Frontline staff members, which may include peer and culture specific workers, support identification and inclusion of personal strengths, priorities, preferences and concerns.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
4	3.6 Individualised plans relevant to the goals of the service user are developed collaboratively and followed as agreed. Examples of such plans include: • advance directives • culturally specific plans • wellness plans • crisis plans • relapse prevention plans • sensory plans.		
3 4 5	3.7 Clinical teams receive training in culturally competent best practice approaches and implement these approaches to prevent personal restraint of Māori and Pasifika service users.		
3 4	3.8 Access to cultural healing practices and activities that represent a Māori approach to sensory modulation, such as karakia, mirimiri and kapa haka, is encouraged and supported.		
3 4	3.9 Clinical teams receive training in, and use, trauma-informed care approaches to provide a safe service for all service users.		

4. Best practice alternatives

Rationale

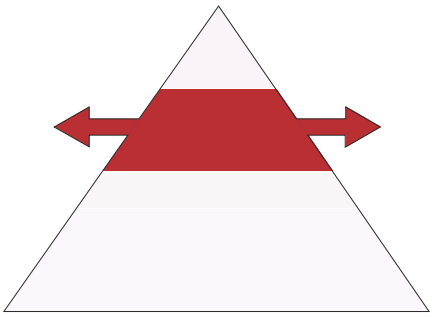
A wide range of best practice strategies are available to use when working with a service user who is showing signs of escalating distress or disturbance. The only rationale for the use of approved personal restraint techniques in a mental health setting is a serious risk to the safety of a service user or others within the inpatient environment.



Objective: Best practice alternatives to the use of personal restraint are thoroughly considered and implemented.			
Related core strategy	**Indicators**	**How the indicators are currently being met**	**Plans to meet the indicator**
4	4.1 Where the presenting situation permits, secondary prevention strategies (see Appendix 2) are actively employed by the lead clinician, service user and team, with the dual aims of averting the occurrence of personal restraint and keeping the service user and others safe.		
4 5	4.2 Every effort is made to proactively engage and communicate with service users in ways that minimise the need for restraint and promote self-management skills and resilience building.		
3 4 5	4.3 Ensure the use and availability of tikanga Māori approaches to working with tāngata whai ora in the inpatient setting.		
3 4 5	4.4 Establish a clear and effective line of communication with the service user as a priority once a situation of concern is identified. The lead clinician can be temporarily relieved of his/her other duties, by the team, in order to work to resolve the situation safely.		
4	4.5 Where an escalating situation cannot be averted, there is clear communication with both the service user and the clinical team by the lead clinician to maintain safety and reduce, where possible, trauma relating to the use of personal restraint.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
4	4.6 In assessing the use of personal restraint, the service user's health status, personal history, risk history and the risks associated with the use of personal restraint, are assessed in line with the requirements of NZS 8314.2.2008, Standard 2.2 (see Appendix 3).		

5. Personal restraint techniques are used only as a safety intervention of last resort and in accordance with all legal obligations



Rationale

Staff members in mental health inpatient environments are trained in personal restraint techniques that are designed to safely contain a person for the purpose of addressing immediate safety issues.

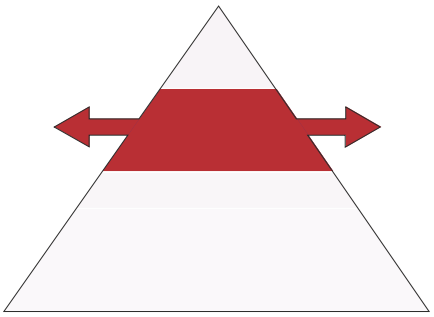
Personal restraint training includes a wide range of prevention strategies and does not solely focus on the physical action of personal restraint. Trained frontline staff are only approved to use those techniques that have been authorised and regularly reviewed by the organisation, in accordance with national guidance and the provisions of *NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (Standards New Zealand, 2008).

Objective: When personal restraint techniques are used, it is in accordance with all applicable legal obligations, approved team training and as a safety intervention of last resort.

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
3	5.1 Staff members who work in mental health inpatient settings attend organisation approved training in personal restraint and demonstrate competence, prior to any participation in an actual personal restraint.		
2 3	5.2 The decision to restrain a service user must be based on a clinically justifiable safety concern for the service user, or the need to maintain the safety of other people at risk of harm.		
	5.3 Staff members only use approved strategies and techniques, as authorised and trained by the organisation's restraint review group and organisation approved instructors.		
	5.4 Where the use of personal restraint occurs, the physical and psychological state of the service user, while subject to personal restraint, is continually assessed and monitored by a nominated suitably qualified clinician.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
	5.5 Where the use of personal restraint occurs, the lead clinician is responsible for maintaining ongoing communication with, and providing information to, the service user.		
	5.6 The use of personal restraint techniques must not include the deliberate application of pain.		
	5.7 Staff members must not deliberately restrain service users in ways that impact on their airway, breathing or circulation. This includes not deliberately using face-down (prone) restraint, and monitoring for the full range of risks that relate to positional asphyxia, potential for injury and sudden death during personal restraint.		
	5.8 If personal restraint is used, the indicators described in Principle 4 are still considered and actioned by the clinical team, as risk is addressed.		

6. If personal restraint techniques are used there is a focus on safely ending the restraint as soon as possible



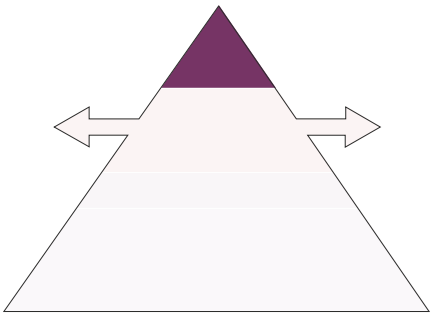
Rationale

While personal restraint may address a person's physical safety when other measures have failed, personal restraint has its own inherent physical, psychological and cultural risks to all people involved in it.

Objective: If personal restraint techniques are used, once immediate safety is established, there is a focus on safely ending an episode of personal restraint as soon as possible.			
Related core strategy	**Indicators**	**How the indicators are currently being met**	**Plans to meet the indicator**
	6.1 Once safety is established, every effort is made to ensure the least restrictive alternative to personal restraint is used, and that the comfort, dignity and privacy of the service user is upheld. This may include strategies identified in the service user's treatment plan, such as sensory approaches, medication, time with a staff member, kaumatua support, time alone, or support from family and whānau or friends.		
	6.2 The team member who is communicating with the service user is responsible for directing the other team members involved towards facilitating a safe transition and timely end to the restraint episode.		
	6.3 Staff recognise the risks of prolonged personal restraint to service users and work as a team to reduce these risks.		
	6.4 Team members understand and are alert to signs of psychological and physical distress, and actively work to alleviate these.		
	6.5 If person-centred measures to reduce distress are not effective, and personal restraint is prolonged, medical assistance to review the plan of care is sought.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
	6.6 Team members recognise and respond to signs that restraint is no longer required, and where appropriate transition to safe holds and strategies. This is followed by transitioning personal control back to the service user.		
	6.7 All team members work towards ending the restraint episode and reintegrating the service user back into the wider inpatient environment as soon as it is safe to do so. Staff use established best practice options.		

7. Follow-up clinical interventions, reporting mechanisms and systems for review and prevention



Rationale

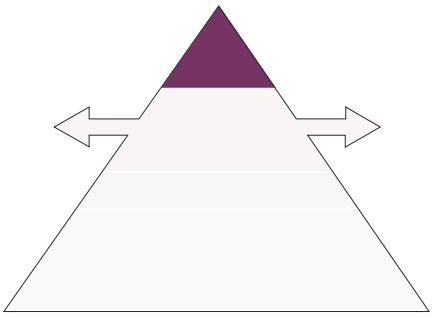
Following an episode of personal restraint, it is essential that all parties involved are included in the review process. Robust review, reflection and the planning of potential future options with the service user is a vital tertiary prevention strategy, known to significantly prevent future restraint episodes.

Objective: After a personal restraint has occurred, follow-up clinical interventions, event reporting mechanisms and systems are in place to review what occurred and how future episodes might be prevented. Follow-up involves the service user, their family and whānau, frontline staff members, bystanders and clinical leaders.

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
2 6	7.1 Immediate attention to the physical and psychological health of all people involved in a restraint episode is the initial priority. Any issues arising from this, such as injury or complaints, are formally reported.		
6	7.2 Personal debriefing of the service user, frontline staff members and bystanders occurs as soon as possible, using debriefing best practice principles appropriate to the practice context.		
6	7.3 Where team or individual personal debriefing is not immediately possible, the restraint review documentation is not considered complete until all involved have been offered a debriefing opportunity.		
5 6	7.4 Service users are offered an opportunity to debrief with a staff member or, if they prefer and if available a peer worker, kaumatua or advocate.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
2	7.5 An episode of personal restraint is recorded in accordance with the requirements of *NZS 8134.2.2 – Safe Restraint Practice*, Standard 2.3, criteria 2.3.4 (see Appendix 4).		
1 2 5	7.6 An episode of personal restraint is reviewed in accordance with the requirements of *NZS 8134.2.2 – Safe Restraint Practice*, Standard 2.4: Services evaluate all episodes of restraint (see Appendix 5).		
1 2 5	7.7 The organisation conducts regular and comprehensive multidisciplinary reviews of restraint use, for each inpatient setting, with a clear focus on preventing future personal restraint episodes.		
1 2 5	7.8 Summaries of restraint activity data are used transparently, with both inpatient teams and service users, to highlight successful reduction and inform further improvements and changes in approach that may prevent personal restraints.		
2 5	7.9 Information is communicated and made available to service users in ways that encourage collaboration and engagement in the goal of the service of being restraint free.		

8. The use of personal restraint is considered an adverse event and organisational quality improvement processes aim for prevention and reduction



Rationale

The interventions that have been reported in the research literature to have the highest success in reducing the use of restraint:

a) involve organisations and their staff members, service users, family and whānau and the wider community in genuinely collaborative and inclusive ways of working and developing practice

b) offer a range of strategies to reduce restraint and seclusion that assist both service users and clinical teams.

With a variety of strategies available it is important to consider how each team implements, measures and reports on change and improvement.

Objective: The use of personal restraint is considered an adverse event. The organisation's strategic goal of eliminating personal restraint is supported and evidenced by a quality improvement pathway that implements and supports practices known to prevent and reduce restriction.

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
	8.1 The organisation uses available tools, such as the Six Core Strategies© checklist (NZ adaption) and the restraint prevention framework (see part 1) to assess current activity and establish areas of practice development.		
1 2	8.2 The organisation uses established means of implementing and measuring change from a quality perspective, for example, using quality planning tools and improvement indicators, establishing targets, and reporting on progress for restraint reduction initiatives.		
1 2 3 4	8.3 Research activity that measures, evidences and describes initiatives that reduce the use of personal restraint in wards or units is supported and encouraged.		

Related core strategy	Indicators	How the indicators are currently being met	Plans to meet the indicator
	8.4 Leaders and staff participate in national initiatives, such as training, forums and networks, that share and support practice innovation towards the objective.		
	8.5 The organisation establishes ongoing contact with other mental health inpatient services to compare and support practice development and innovation.		

Appendix 1: Symbol key

Symbol	Indicates
	Six Core Strategies© approach; all sections applicable to the principle or indicator
	Leadership towards organisational change
	Using data to inform practice
	Workforce development
	Use of seclusion and restraint reduction tools
	Service user/consumer roles in inpatient units
	Debriefing techniques
	Personal Restraint Prevention Framework triangle; all sections applicable to the principle
	Primary prevention
	Secondary prevention
	Tertiary prevention
	Restraint occurs

Appendix 2: Practice that supports prevention

Primary prevention strategies	Reference or link
Welcoming and safe environment – conducting orientation, managing expectations, making introductions, establishing a therapeutic relationship	Beckett, P., Field, J. et al (2013) Social Care, Local Government and Care Partnership Directorate (2014) – www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions Nakarada-Kordic & McKenna (2011)
Visible and accessible leadership	Scanlan (2010)
Sensory modulation	http://www.tepou.co.nz/initiatives/sensory-modulation/103
Use of data and transparent reporting	Huckshorn (2006)
Peer workers and advisors leading practice initiatives	Davidson et al. (2012)
Engaging with and involving families and whānau and supporters	Boyd & Sigglekow (2012)
Appropriate staff skill mix and staffing levels	www.dhbsharedservices.health.nz/site/future_workforce/sshwu/overview
Appropriate response where English is the service user's second language	Culturally and Linguistically Diverse website – www.caldresources.org.nz
Providing trauma-informed care to all	Chandler (2012)
Providing information about and orientation to the ward environment that emphasises safety and respect for all	Bowers (2014)
Cultural considerations are developed in the environment and workforce	Wharewerea-Mika et al. (2013)

Secondary Prevention Strategies	Reference or link
Therapeutic relationship – taking time to listen, discuss and problem-solve issues or concerns collaboratively	Gilburt, Rose & Slade (2008)
Individual service user's plan of care – reviewing, reminding and encouraging recognition of triggers, and facilitating effective strategies to de-escalate	O'Hagan et al. (2008) http://www.tepou.co.nz/outcomes-and-information/knowing-the-people-planning/31
Making an early assessment when there are concerns expressed by or about the service user in the inpatient setting	Scanlan (2010)

Providing cultural and peer workers – accommodating service user preference	National Institute for Health and Clinical Excellence (2011)
Establishing and addressing the cause of a service user's distress, frustration or conflict, if it is known	Bowers (2006)
Assessing and communicating safety, risk and triggers for individual service users, and working as a team	Chandler (2012) Mollon (2014)
Having plans and approaches for communicating difficult or distressing information	Rosenzweig (2012)
Using advanced communication and de-escalation models, skills and techniques to resolve situations collaboratively and without coercion	Muskett (2014) Mollon (2014) (O'Brien & Golding, 2003)
Offering activity, distraction and occupation where it is useful to do so	Stickley & Hui (2012)
Maintaining and developing a healthy workforce and workplace culture	Chandler (2012)

Tertiary Prevention Strategies	Reference or link
Service user and staff team debriefing	Te Pou o Te Whakaaro Nui, 2014b
Follow-up systems debrief to inform quality improvement	Te Pou o Te Whakaaro Nui, 2014b
Documentation and reporting	Standards New Zealand (2008) (see Appendix 4)
Review and evaluation	Standards New Zealand (2008) (see Appendix 5)
Implement identified quality improvements	Standards New Zealand (2008) (see Appendix 6)
Review of plan of care, conduct a risk review (if required) and develop future prevention strategies in collaboration with the service user and their family and whānau	http://www.tepou.co.nz/outcomes-and-information/knowing-the-people-planning/31 Standards New Zealand (2008) (Appendix 5 and 6)
Have in place advance directives	www.hdc.org.nz/publications (leaflet)
Environmental analysis of adverse events and the impact of environment	Nakarada-Kordic & McKenna (2011)

Appendix 3: Restraint minimisation and safe practice standards 2008 – Standard 2.2: Assessment/Te aromatawai

Standard 2.2
Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

Criteria
The criteria required to achieve this outcome shall include the organisation ensuring:

2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

a. Any risks related to the use of restraint;
b. Any underlying causes for the relevant behaviour or condition if known;
c. Existing advance directives the consumer may have made;
d. Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
e. Any history of trauma or abuse, which may have involved the consumer being held against their will;
f. Maintaining culturally safe practice;
g. Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
h. Possible alternative intervention/strategies.

2.2.2 In assessing whether restraint will be used, the consumer and/or the family/whānau is informed and their input sought as practical.

Appendix 4: Restraint minimisation and safe practice standards 2008 – Criteria 2.3.4

(Excerpt from Standard 2.3: Services use restraint safely)

Criteria
The criteria required to achieve this outcome shall include the organisation ensuring:

2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

a. Details of the reasons for initiating the restraint, including the desired outcome;
b. Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
c. Details of any advocacy/support offered, provided, or facilitated;
d. The outcome of the restraint;
e. Any injury to any person as a result of the use of restraint;
f. Observations and monitoring of the consumer during the restraint;
g. Comments resulting from the evaluation of the restraint.

Appendix 5: Restraint minimisation and safe practice standards 2008 – Standard 2.4: Evaluation/Arotakenga

Standard 2.4
Services evaluate all episodes of restraint.

Criteria
The criteria required to achieve this outcome shall include the organisation ensuring:

2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

a. Future options to avoid the use of restraint;

b. Whether the consumer's service delivery plan (or crisis plan) was followed;

c. Any review or modification required to the consumer's service delivery plan (or crisis plan);

d. Whether the desired outcome was achieved;

e. Whether the restraint was the least restrictive option to achieve the desired outcome;

f. The duration of the restraint episode and whether this was for the least amount of time required;

g. The impact the restraint had on the consumer;

h. Whether appropriate advocacy/support was provided or facilitated;

i. Whether the observations and monitoring were adequate and maintained the safety of the consumer;

j. Whether the service's policies and procedures were followed;

k. Any suggested changes or additions required to the restraint education for service providers.

2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

2.4.3 Following each episode of restraint or at defined intervals, the consumer and where appropriate their family/whānau, receives support to discuss their views on the restraint episode.

Appendix 6: Restraint minimisation and safe practice standards 2008 - Standard 2.5: Restraint monitoring and quality review/ Arotake kounga me te aroturuki whakaita

Standard 2.5
Services demonstrate the monitoring and quality review of their use of restraint.

Criterion
The criterion required to achieve this outcome shall include the organization ensuring:

2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

a. The extent of restraint use and any trends;

b. The organisation's progress in reducing restraint;

c. Adverse outcomes;

d. Service provider compliance with policies and procedures;

e. Whether the approved restraint is necessary, safe, of an appropriate duration and appropriate in light of consumer and service provider feedback, and current accepted practice;

f. If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

g. Whether changes to policy, procedures, or guidelines are required;

h. Whether there are additional education or training needs or changes required to existing education.

Appendix 7: The Code of Health and Disability Services Consumers' Rights

Knowledge of, and adherence to, all requirements of the Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, 1996) is fundamental to all health and disability service delivery in New Zealand, including mental health and addiction services.

The table below sets out the rights in the code that have particular relevance to the objectives and indicators in this guidance.

Objective or indicator	Right in the Code of Health and Disability Services Consumers' Rights 1996
Objective 3: Person-centred care models, principles and strategies are a key focus of mental health inpatient teams.	**Right 4(5):** Every consumer has the right to co-operation among providers to ensure quality and continuity of services.
Indicator 4.3: Ensure the use and availability of tikanga Māori approaches to working with tāngata whai ora in the inpatient setting.	**Right 1(3):** Every consumer has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Māori.
Indicator 6.1: Once safety is established, every effort is made to ensure the least restrictive alternative to personal restraint is used, and that the comfort, dignity and privacy of the service user is upheld. This may include strategies identified in the service user's treatment plan, such as sensory approaches, medication, time with a staff member, kaumatua support, time alone, or support from family and whānau or friends.	**Right 1(1):** Every consumer has the right to be treated with respect. **Right 1(2)**: Every consumer has the right to have his or her privacy respected. **Right 1(3):** Every consumer has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values and beliefs of Māori. **Right 3**: Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.
Indicator 6.5: If person-centred measures to reduce distress are not effective, and personal restraint is prolonged, medical assistance to review the plan of care is sought.	**Right 4(4):** Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer. **Right 4 (5):** Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

A full copy of the code is available on the Health and Disability Commissioners website: www.hdc.org.nz.

Reprinted with permission of Health and Disability Commission.

Appendix 8: Excerpt from *Rising to the Challenge*

Excerpt from *Rising to the Challenge: The mental health and addiction service development plan 2012–2017* (Ministry of Health, 2012, p. 60).

Workforce development priorities for specialist DHB and NGO services.

Key workforce development priorities for the workforce in specialist mental health and addiction services (within DHBs and NGOs) that will support implementation of this Plan are:

- enhancing understanding of the service user perspective through the use of training for staff led by service users
- better leveraging the limited specialist resource by developing the consultation liaison component from the specialist service workforce to general health (primary and specialist)
- improving the capability of mental health and addiction specialists to address co- existing conditions
- building capability for addressing physical health issues and for collaborating with general health services to address people's physical health needs
- enhancing the understanding of needs of people with co-existing mental health or addiction issues and intellectual disability and developing skills to address these
- developing capability to minimise use of seclusion and restraint in inpatient settings
- ensuring the workforce supports self-management and recovery
- re-focusing service delivery where evidence suggests existing practices are no longer the most effective.

Appendix 9: Peer role definitions

Definitions and roles

(Sourced from *Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce* (Te Pou o Te Whakaaro Nui, 2014a)

A peer is a person who has had similar experience to another person or people, such as lived experience of mental distress or addiction that has had a significant impact on a person's life.

The peer workforce includes all people with openly identified lived experience of mental distress or addiction and recovery, who are in paid or unpaid employment to use that experience to benefit others with mental distress or addiction in the work they do. Most work in mainstream agencies in the mental health and addiction sector but some work in peer-led networks or in agencies outside the sector that have a broader client base, such as primary health organisations or social services.

Peer workforce roles include but are not limited to:

- **Peer support workers** work alongside individuals and groups with addiction or mental distress to help restore hope and personal power and to inspire them to move forward with their lives. Peer support worker is used in this paper as an umbrella term for several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist.
- **Peer advocates** work independently of the systems they advocate in with individuals to resolve their experiences of unfairness or injustice, or at a systemic level to resolve collective injustices.
- **Consumer advisors** work mainly within mental health and addiction organisations to provide operational and strategic advice based on peer values and recovery principles, and to ensure the voices of people with mental distress and addiction influences the direction of the service.
- **Peer educators** who provide education from a lived experience perspective for other peers, mental health and addiction workers or community members.
- **Peer researchers and evaluators** who do research and evaluation from a lived experience perspective using methodologies that work in partnership with their peers.
- **Peer auditors** provide a service user perspective in teams that audit mental health and addiction services and lead the auditing of service user participation and leadership in the service.
- **Peer supervisors** provide coaching, mentoring or supervision to other peer workers or to clinicians using their lived experience perspective and peer expertise.

Appendix 10: Definitions

Advance directive	A written or oral directive by which a service user makes clear their choice or choices regarding their future health treatment and the procedures to be used, only when the service user is assessed by an authorised and qualified clinician as not competent. Advance directives are prepared by the service user at a time when they are well, to ensure their preferences and choices are clearly and formally identified and understood.
Bystanders	In the context of a mental health inpatient setting, this refers to anyone who is in the area and may witness behaviour or incidents of concern. This includes other service users, family and whānau, staff members and visitors.
Event reporting	Includes the recording and reporting of accidents, incidents, adverse events, complaints, compliments, suggestions and other events, as indicated by statute, regulation or professional scope or standards.
Frontline staff members	Staff members who work in mental health inpatient settings and have contact with service users and their families and whānau as a part of their role.
Lead clinician	Refers to the staff member leading the efforts to de-escalate, calm and collaborate with the service user to provide a best practice response.
Least restrictive practice	Refers to practice in mental health settings that is mindful of the need to maximise both the autonomy and safety of service users, and reduce or prevent practices that restrict personal freedoms and are known to cause harm such as restraint and seclusion. Least restrictive practice is also informed by the need to promote an inpatient environment that is optimal for supporting recovery for all service users, while meeting the quality, safety and security requirements expected of an inpatient mental health setting and the professionals that work within it.
Organisation	District health boards and non-government organisations that provide mental health inpatient care.
Peer support	Social or emotional support that is mutually offered or provided by persons who have used health and disability services themselves. A peer is a person who has had similar experience to another person or people, such as lived experience of mental distress or addiction, which has had a significant impact on that person's life.
Personal restraint	Where a service provider uses their own body to intentionally limit the movement of a consumer, for example, where a consumer is held by a service provider (from Standards New Zealand, 2008).

Personal Restraint Prevention Framework triangle	Based on a health and safety prevention framework (Wigmore, 2011), this model recognises the importance of: • primary prevention – highly effective, systems-based approaches that support best practice person-centred care, such as the Six Core Strategies©, components of the Safe Wards model, recovery approaches, wellness, support and recovery plans, citizenship frameworks and coercion-free models • secondary prevention – recognised strategies that prevent the need for restraint, when a person is recognised as becoming distressed, frustrated or angry, or a concerning situation is escalating or likely to escalate. For example: active engagement and listening, collaborative problem-solving, sensory approaches, following a crisis or advanced directive plan, seeking input from staff members, family and whānau members, and using support people to de-escalate the situation and address the presenting issues or concerns of the service user • tertiary prevention – where a personal restraint occurs, every effort is made to learn why it occurred and if it could be prevented, and plans put in place to both reduce the impact of the restraint on the individual and prevent a reoccurrence in the future. Strategies that support effective tertiary prevention include: post-incident debriefing, follow-up, review, event reporting and reflection that will assist in preventing further restraint episodes; review and rework of crisis and relapse prevention plans; documenting personal triggers; changes to the environment and staff approaches; and ongoing professional development.
Personal restraint techniques	Refers to the physical techniques that frontline mental health service staff are trained in to restrain a service user.
Restraint	The use of any intervention by a service provider that limits a consumer's normal freedom of movement (from Standards New Zealand, 2008).
Restraint review group	A group representative of the organisation's staff who are involved in preventing personal restraint and its use, who meet regularly to monitor and review the use of personal restraint within the organisation, and approve training and practice innovation designed to prevent the use of personal restraint.
Restraint episode	For the purposes of restraint documentation and evaluation, a restraint episode refers to a single restraint event.
Service user	A person who accesses a health or disability service.
Suitably qualified clinician	Either a registered nurse or a medical practitioner (from Ministry of Health (2010) seclusion guidelines).

References

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D., & Pile, E.(2013). Practice what you preach: Developing person-centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing, 601*(8), 595-601.

Bowers, L. (2006). On conflict, containment and the relationship between them. *Nursing Inquiry, 13*(3), 172-180. doi: 10.1111/j.1440-1800.2006.00319.x

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing.* 21(6),499-508. doi: 10.1111/jpm.12129

Boyd, L., & Sigglekow, L. (2012). *Navigating through mental health services: Perspectives and priorities of family members and mental health services staff.* Wellington: Families Commission.

Chandler, G. E. (2012). Reducing use of restraints and seclusion to create a culture of safety. *Journal of Psychosocial Nursing Mental Health Service, 50*(10), 29-36. doi: 10.3928/02793695-20120906-97

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11,* 123-128.

Gilburt, H., Rose, D., & Slade, M.(2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *British Medical Council Health Services Research, 8,* 92.

Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Retrieved from http://www.hdc.org.nz/the-act--code/the-code-of-rights

Huckshorn, K. A. (2006). Re-designing state mental health policy to prevent the use of seclusion and restraint. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), 482-491. doi: 10.1007/s10488-005-0011-5

Ministry of Health. (2010). *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Wellington: Ministry of Health.

Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012–2017.* Wellington: Ministry of Health.

Ministry of Health. (2013). *Office of the Director of Mental Health: Annual report 2012.* Wellington: Ministry of Health.

Mollon, D. (2014). Feeling safe during an inpatient hospitalization: A concept analysis. *Journal of Advanced Nursing, 70*(8), 1727-1737. doi: 10.1111/jan.12348

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*, 51–59. doi: 10.1111/inm.12012

Nakarada-Kordic, I., & McKenna, B. G. (2011). *Environmental factors and outcomes in mental health clinical settings: A review of the literature.* Auckland: Te Pou o te Whakaaro Nui.

National Institute for Health and Clinical Excellence. (2011). *Service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services* (NICE clinical guidelines 136). London: National Institute for Health and Clinical Excellence

O'Brien, A. J., & Golding, C. G. (2003). Coercion in mental healthcare: The principle of least coercive care. *Journal of Psychiatric Mental Health Nursing, 10*(2), 167-173.

O'Hagan, M., Divis, M., & Long, J. (2008). *Best practice in the reduction and elimination of seclusion and restraint: Seclusion: time for change.* Auckland: Te Pou Te Whakaaro Nui.

Rosenzweig, M. Q. (2012) Breaking bad news: A guide for effective and empathetic communication. *The Nurse Practitioner*. Retrieved from: http://www.nursingcenter.com/lnc/journalarticle?Article_ID=1292421

Salias, E. E. S., & Fenton, M. (2012), Seclusion and restraint for people with serious mental illnesses (Review). *The Cochrane Library, 6.*

Scanlan, J.N. (2010) Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far a review of the literature. *International Journal of Social Psychiatry.* 56(4), 412-423.

Social Care, Local Government and Care Partnership Directorate. (2014). *Positive and proactive care: Reducing the need for restrictive interventions.* London: Department of Health. Retrieved from https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

Standards New Zealand. (2008). *NZS 8134.2:2008: Health and disability services (restraint minimisation and safe practice) standards.* Wellington: Standards New Zealand.

Stickley, T., & Hui, A. (2012). Arts in-reach: Taking 'bricks off shoulders' in adult mental health inpatient care. *Journal of Psychiatric Mental Health Nursing, 19*(5), 402-409. doi: 10.1111/j.1365-2850.2011.01811.x

Te Pou o Te Whakaaro Nui. (2008). *Survey of seclusion and restraint reduction initiatives in New Zealand acute mental health services.* Auckland: Te Pou o te Whakaaro Nui.

Te Pou o Te Whakaaro Nui. (2013). *Six core strategies for reducing restraint and seclusion checklist – New Zealand version.* Retrieved from http://www.tepou.co.nz/resources/six-core-strategies-for-reducing-seclusion-and-restraint-checklist/464

Te Pou o Te Whakaaro Nui. (2014a). *Competencies for the mental health and addictions service user, consumer and peer workforce.* Auckland: Te Pou o te Whakaaro Nui.

Te Pou o Te Whakaaro Nui. (2014b). *Debriefing following seclusion and restraint: A summary of relevant literature.* Auckland: Te Pou o te Whakaaro Nui.

Webster, S. (2013). *Health professional's experiences of implementing seclusion and restraint reduction strategies in an acute mental health unit.* Dissertation.

Wharewerea-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., … Edwards, E. (2013). *Strategies to reduce the use of seclusion and restraint with tangata whai i te ora.* Auckland: Te Pou o Te Wakaaro Nui.

Wieman, D. A., Camacho-Gonsalves, T., Huckshorn, K. A., & Leff, S. (2014). Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatric services, 65*(3), 345-351.

Wigmore, D. (2008). *Seeing the workplace through new eyes.* Canada: Manitoba Workplace Safety and Health Division.

Te Pou
o Te Whakaaro Nui