

Health professional's experiences of implementing seclusion and restraint reduction
strategies in an acute mental health unit

Sharon Webster
BHSc (Hons)

2013

Health professional's experiences of implementing seclusion and restraint strategies
in an acute mental health unit

A dissertation presented in partial fulfillment of the requirements for the Honours
degree of Bachelor of Health Science

Faculty of Health and Environmental Science

Auckland University of Technology

Sharon Webster
Student Number 0316521
December 2013

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Sharon Webster

Dated: 09 July 2013

ACKNOWLEDGEMENTS

I am blessed to live with many members of my extended family and their ongoing support and encouragement during this year has been invaluable. All my love and thanks to Gladys, Anthony, Kimi-Rose, Billie, and Luna for providing laughter and song, running the household, and coming for walks when I needed a break. Much love to Alex and Arahi for long chats that fed my soul and to Trish for proof reading and editing. Thanks to my friends who kept me in touch with the outside world providing encouragement, and advice when I needed it. This study would certainly not have been possible without the generous gift of time and commitment given by the mental health unit staff participants. I sincerely thank them for sharing their experiences and personal stories with me.

I am very grateful to Te Pou for awarding the financial scholarship which allowed me to complete this year of study. It has provided a welcome opportunity to work with my delightful colleagues in the Occupational Therapy Department at Auckland University of Technology (AUT).

Finally to my wonderful supervisor Daniel Sutton for unwavering guidance, encouragement, wise counsel, and always magically answering his phone for impromptu phone discussions, my especial thanks. I could not have done this without you.

ABSTRACT

Reduction of coercive practices known as seclusion (solitary confinement) and restraint (physical control of inpatients) are important priorities of mental health services. Seclusion and restraint are reported to be highly traumatic for service users and organizations are expected and encouraged to find alternatives to their use. A programme that contains six strategies to reduce seclusion and restraint has been successfully utilized internationally; however there is little research on the efficacy of the six strategies when implemented within New Zealand contexts. The purpose of this study was to explore the experiences of key clinicians from one New Zealand acute mental health facility who implemented the strategies to reduce the unit's use of seclusion and restraint.

A qualitative descriptive methodology was chosen for this study as it allowed participants to describe their experiences including factors that helped or hindered implementation of the strategies. Six participants, both clinical leaders and staff took part in the study and provided the data. Semi-structured focus group discussions were audio taped then transcribed verbatim. Transcribed data was analyzed and themes were generated using an inductive thematic analytical process. Three themes surfaced: 'Rethinking power and control', 'Into the unknown' and 'Getting staff on board'.

The findings suggested that the change involved two separate but interlinked processes. Clinical leaders introduced practical policy changes to reduce seclusion which in turn allowed staff to interpret and respond to the changes in ways meaningful to them. Ultimately these dual processes influenced staff's daily interactions with service users resulting in reduced use of both seclusion and restraint. Equal consideration needs to be given to clinical leaders' implementation of the strategies and staff contributions in ensuring their success. The findings in this study may provide useful insights for organizations that intend to use the seclusion and restraint reduction strategies.

CHAPTER ONE

INTRODUCTION AND STUDY CONTEXT

Introduction

There is an international push to reduce seclusion and restraint practices motivated by the realization they are detrimental to service user's recovery (O'Hagan, 2001; Office of Mental Health & Substance Abuse Services, 2005). The World Health Organization recommends that mental health services provide recovery-oriented care that offers alternatives to the use of seclusion and restraint (World Health Organization, 2013). In New Zealand the recovery philosophy is endorsed within strategic documents developed by the Mental Health Commission (2012) and Ministry of Health (2005). National health policy also calls attention to the urgent need for developing tools and strategies as alternatives to seclusion, which should only be used as a last resort (O'Hagan, Davis, & Long, 2008). Recent studies have raised concerns regarding the use of seclusion within New Zealand. Service users remain in seclusion for long periods of time and Maori and Pacific peoples are secluded more frequently than people of European or Pakeha ethnicity (El-Badri & Mellso, 2002; Ministry of Health, 2007). Te Pou, New Zealand's organisation for mental health research and workforce development, has recommended that the seclusion and restraint reduction programme known as the 'Six Core Strategies' (National Association of State Mental Health Program Directors [NASMHPD], 2006) be utilized at a national level to address this issue (O'Hagan et al., 2008). In 2010 the challenge to reduce seclusion rates using the Six Core Strategies was successfully undertaken within an adult inpatient mental health unit. The aim of this qualitative descriptive study was to explore the experience of implementing seclusion and restraint reduction strategies from the perspective of the unit's clinical leaders and frontline staff. It is anticipated that the findings might provide insights to assist other services who undertake seclusion and restraint reduction programmes.

Definitions of Terms

Seclusion

Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 seclusion is defined as a practice where “a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit” (Ministry of Health, 2010, p. 1). This definition contains the three elements that are seen to constitute seclusion i.e. a low stimulus environment, containment, and isolation (Canterbury Action on Mental Health and Addictions, 2013). The seclusion room in the ICU was bare of furniture and furnishings containing only a mattress on the floor.

Restraint

Restraint is legally defined in New Zealand as “the use of any intervention, by a service provider, that limits a patients/consumers normal freedom of movement” (Standards New Zealand, 2008, p. 30). Knox and Holloman (2012) describe the three main methods of restraint as physical (use of force), chemical (forcibly given medication), or mechanical (use of restraining devices). Restraint is used to prevent harm to an individual or limit an individual’s ability to harm someone else (Strout, 2010). Participants in this study described only the use of team restraints or wrist holds both physical restraints.

Consumer/Service user

Many terms are used within the literature to describe people who use mental health services. Terms include, client, consumer patient, service user, and unique to New Zealand, tangata whaiora (meaning ‘people seeking wellness’) (Moeke-Maxwell, Wells, & Mellso, 2008). The terms *consumer* and *service user* are used interchangeably within this dissertation when referring to people accessing mental health services.

Description of the Inpatient Mental Health Unit

This study focuses on the implementation of seclusion and restraint reduction strategies in one adult acute mental health service. The unit is situated within a public hospital, managed by a District Health Board (DHB). It provides acute psychiatric care for a largely low socio-economic population and consists of an intensive care

unit (ICU) and an adjoining open ward. Originally the whole unit contained two small purpose-built seclusion rooms; one has since been converted into a sensory room where service users are encouraged to self-regulate emotions and behaviors by engaging in sensory-based activities. Over a two year period the incidences of seclusion were successfully reduced by 90% which included a 10 month period of no seclusions. Restraint and PRN use were also reduced, although after a year rates of these practices began increasing again. Overall, the unit provides a strong example of successful application of seclusion reduction strategies, with a lesser but positive impact on restraint use.

Six Core Strategies

The six core seclusion and restraint reduction strategies developed by America's National Association of State Mental Health Program Directors (NASMHPD) (2005) have been widely applied across the United States of America and in other westernized countries. They are now recognized as evidence based practices within the USA (National Registry of Evidence-based Programs and Practices, 2013). These strategies are:

- 1) Leadership towards Organizational Change
- 2) Using Data to Inform Practice
- 3) Workforce Development
- 4) Use of Seclusion and Restraint Reduction Tools
- 5) Consumer Roles in Inpatient Settings
- 6) Debriefing Techniques (Huckshorn, 2005).

Further information about each strategy is provided in the following chapter.

Theoretical and Philosophical Background of the Strategies

Particular theoretical and philosophical frameworks, including humanistic psychology, the recovery philosophy, and trauma informed care underpin the six core strategies. The strategies are also positioned within the organizational change paradigm. When organizations implement the strategies staff are encouraged to create an organizational culture change by integrating the inherent principles within their own clinical practice. Systems theory recognizes that interconnected and interdependent factors contribute to organizational change (Amagoh, 2008) and this

along with the following practice frameworks are considerations in the study of seclusion and restraint reduction processes.

Humanistic Psychology

The six core strategies provide a programme of service delivery that is aligned with a humanist theoretical approach. Benjamin (2011) notes staff who hold a humanistic perspective actively support human rights and equality. They achieve this by taking a holistic view of consumers that promotes understanding of their mental health problems and avoids the use of seclusion and restraint. The humanistic perspective influenced the development of the person-centered approach to care (Sheldon, Joiner Jr, Pettit, & Williams, 2003).

Recovery Philosophy

New Zealand has made a commitment to use guiding principles found within the recovery approach to inform mental health care policy, guidelines, and training programmes (Ministry of Health, 2005; O'Hagan, 2001; O'Hagan et al., 2008). The recovery approach is based on tenets of humanistic psychology whereby service users are encouraged to maintain hope and reach their full potential irrespective of mental illness (Levin, Hennessy, & Petrila, 2010). Amering and Schmolke (2009) describe the recovery approach as one that highlights person-centered care, collaborative decision-making and increased service user participation and involvement. Implementation of these processes within services has also meant the ethics and practice of coercive interventions have come to be questioned. This move has been welcomed by organizations that support changing involuntary treatment legislation and human rights (Méndez, 2013).

Trauma Informed Care

In line with much of the literature, NASMHPD (2005) promotes an understanding that a high percentage of service users with mental health issues are likely to have experienced trauma (Chandler, 2008; Muskett, 2013). Trauma is regarded as any interpersonal violence or abuse and also includes traumatic events or disasters such as earthquakes and wars (Muskett, 2013). NASMHPD (2005) believe the psychological effects of trauma are largely ignored and unaddressed within health care organizations. They assert the fundamental principle underpinning the six strategies is

to prevent service users from experiencing further trauma. Harris and Fallot (2001) believe staff provide trauma-informed care when they are cognizant of the underlying trauma, directly address the trauma, and facilitate effective recovery for service users.

Why Study the Six Core Strategies?

A changed understanding about the role of seclusion and restraint within mental health services has highlighted the urgent need to reduce these coercive practices. Internationally concerns have been raised as seclusion and restraint are known to directly cause consumer deaths and potentially breach human rights (NASMHPD, 2005). Organizations are encouraged to reduce their dependency on seclusion and restraint and create more collaborative environments that empower service users in their recovery (O'Hagan et al., 2008). This change is often achieved by services when they implement the six core strategies to reduce coercive practices. While a few New Zealand District Health Boards have implemented the strategies, to date no studies have been undertaken as to the impact and acceptability of the strategies within a New Zealand context. Organizations and clinical leaders that wish to reduce their facilities' use of seclusion and restraint may benefit from the shared knowledge and experience of participants within this study.

Personal and Professional Interest

My interest in this study has arisen from my experience with a family member who experienced mental health issues and my interactions with service users while on clinical placement during my Bachelor of Health Science (Occupational Therapy) degree.

I had a family member whose unique quirks and personality were, according to medical accounts, schizophrenic symptoms. We treated this family member no differently from anyone else and this attitude of acceptance helped our family member maintain wellness for as long as he did. Sadly, not long after being formally diagnosed with schizophrenia, he took his own life. I believe he lost hope in a future that was not dominated by his illness. This experience convinced me of the importance of maintaining hope when living with mental illness. Holistic approaches

such as the recovery approach support humanistic perspectives and offer hope to people with mental illnesses that they will not merely survive, but thrive and prosper.

During my undergraduate training I had clinical placements at an older adult's acute mental health unit. At the unit, I observed seclusion being used on an almost daily basis by nursing staff with agitated service users who appeared traumatized by the experience. An occupational therapist and I offered hand massages and manicures as alternatives to service users who were becoming distressed or agitated. This enabled us to interact on a one to one basis and allowed them time to regain their dignity, self-control, and re-engage with the ward environment. This simple interaction with service users introduced me to sensory interventions. I gained insight from this experience into the potential that sensory interventions have in enabling people to gain self-control within acute mental health settings.

Overview of the Dissertation

This chapter has introduced the dissertation and provided a rationale for conducting the study outlining the context, background, and definition of relevant terms. Chapter Two contains a review of the published literature concerning the Six Core Strategies and how they are utilized to reduce seclusion and restraint practices within acute mental health organizations. The third chapter provides a comprehensive description of the study's methodology, methods, ethical considerations, and participant recruitment processes. Chapter Four presents the findings, themes and sub-themes that arose from data analysis and includes participant quotes that capture the essence of the data. The final chapter discusses the themes that arose from the study and provides an explanation of the findings in relation to the literature. Recommendations are made for future research; a reference list and appendices complete the document.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The following literature review examines the Six Core Strategies recommended by Te Pou in their 'Seclusion, Time for Change' report (O'Hagan et al., 2008). Each of the Six Core Strategies will be examined, the research evidence related to their effectiveness will be synthesized and conclusions about the evidence drawn.

Searching and Selecting the Literature

An extensive database search using a variety of key words was undertaken to source national and international literature related to seclusion and restraint reduction in acute mental health settings. In addition to database searches, government websites, academic theses and health care strategy documents relating to seclusion and restraint reduction were also found in Auckland University of Technology databases. Issues arose in the searching and selection of the literature as the terms used and implementation of the strategies varied greatly across studies. Although some studies directly referred to using the six strategies, the majority utilized an array of key terms, as there is no internationally shared consensus in the terminology used for individual strategies. Variations in the implementation of the strategies and the fact that each strategy contains multiple components within it also compounded the difficulty of sourcing relevant literature. This diversity in terminology and implementation of strategies was a consideration in the searching and selection of literature.

Despite the challenges faced in the search process, a combination of the following search terms were used to source literature within PsycINFO, EBSCO Health, PUBMED and SUMMONS databases:

seclusion and restraint reduction

seclusion and restraint reduction, organizational change

seclusion and restraint reduction, acute mental health, organizational change,
six core strategies, innovative interventions

occupational therapy, sensory modulation

The search included studies from the year 2000 onwards with a focus on the most current research from 2005 to 2013. Many studies had to be excluded from the review as they were not reporting findings from acute mental health settings and/or contained special population's i.e. young children, elderly adults, populations with physical or intellectual disabilities, and service users in forensic facilities, schools or living in the community and residential care facilities. However, some articles were included if they used all six core strategies within other types of service, but added relevant insights. Reference lists of highly relevant articles were checked to source additional studies and eventually 55 articles were found which were included in the review.

The 55 studies contain predominantly qualitative descriptive interviews and surveys of service users and staff including retrospective and statistical analyses of facility-specific data, position papers, and expert commentary. Two articles were sourced that reported seclusion and restraint reduction from an organizational systems level perspective (LeBel et al., 2004; Smith et al., 2005). Six literature reviews are included (Gaskin, Elsom, & Happell, 2007; Happell & Harrow, 2010; Johnson, 2010; Sailas & Fenton, 2012; Scanlan, 2010; Van Der Merwe, Muir-Cochrane, Jones, Tziggili, & Bowers, 2012). These studies provide a valuable platform, from which to understand how implementation of the strategies and reduction in seclusion and restraint practices impacted on both staff and service users. They also provide insight into how health professionals may improve service delivery for consumers when the organizational aim is to reduce seclusion and restraint practices. The abbreviation S/R for the terms *seclusion* and *restraint* is used extensively throughout the review.

Strategy One: Leadership towards Organizational Change

NASMHPD's (2006) first core strategy holds leaders accountable for implementing an organization's S/R reduction project. Leaders are seen to meet this requirement when they formulate a comprehensive plan for S/R reduction, preferably containing a recovery and trauma-informed care approach to service change (Huckshorn, 2004). Although leaders employed many strategies to achieve organizational change within the literature, the three main strategies that were consistently used by leaders to achieve successful S/R reduction included; visible leadership, facilitating a recovery and trauma-informed focus, and addressing safety concerns.

Visible leadership

The recognition of leadership as a driving force behind successful organizational change to reduce S/R practice was a significant theme within the literature (Allen, de Nesnera, & Souther, 2009; Gaskin et al., 2007; Johnson, 2010; Scanlan, 2010). The importance of strong and committed leaders should not be underestimated. In a review of interventions that reduced seclusion and restraint, Scanlan (2010) noted that studies, which had identified poor levels of seclusion reduction, also identified poor leadership levels within the organization. Strong leaders were identified within the literature as leaders who led through their actions including being personally involved in S/R reduction and role modeling new approaches to staff (Allen et al., 2009; Goetz & Taylor-Trujillo, 2012; Wale, Belkin, & Moon, 2011). Staff also consistently reported they highly valued leaders that rewarded best practices and celebrated individual successes (Allen et al., 2009; Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Lewis, Taylor, & Parks, 2009). Staff credited visible leaders with being more evidently committed to the seclusion and restraint reduction vision, which in turn helped motivate and inspire staff.

Facilitating Recovery and Trauma-informed Approaches

Recovery and trauma informed systems of care were commonly adopted by organizations when their approach to reducing S/R was broad and informed by all six of the core strategies (Ashcraft & Anthony, 2008; Azeem et al., 2011; Barton, Johnson, & Price, 2009). Three studies from the USA reported they eliminated the use of S/R practices using recovery and trauma informed care approaches (Ashcraft & Anthony, 2008; Barton et al., 2009; Smith et al., 2005). These studies emphasized the importance of validating service users within staff training programmes, which was not a common finding within the literature. Staff training in all three studies centered on improving staff attitudes towards service users by increasing their understanding of service user's perspectives of living with mental illness (Ashcraft & Anthony, 2008; Barton et al., 2009; Smith et al., 2005). Ashcraft and Anthony (2008) reported that providing a forum for staff to explore how they felt about service users resulted in an open discussion of staff prejudices regarding services user's ability to recover from mental illness. As a result, service users' stories of recovery were added to staff training programmes and this led to staff assimilation of recovery values. The change

in staff attitudes and values was credited with playing a pivotal role in the organizations complete elimination of S/R practices (Ashcraft & Anthony, 2008).

Managing Safety Concerns

Many studies within the literature reported that staff voiced fears and concerns for personal safety when S/R reduction plans were announced. Interestingly, when examining successful seclusion and restraint reduction initiatives, Scanlan (2010) found only one out of 46 studies reported an increase in staff injuries. The most commonly reported finding within the literature was that organizations which implemented S/R reduction projects also reported a decrease in staff and service user injury rates, contradicting staff fears of violence and injury rates increasing (Allen et al., 2009; Ashcraft & Anthony, 2008; Azeem et al., 2011; Barton et al., 2009; Goetz & Taylor-Trujillo, 2012; Johnson, 2010; Lewis et al., 2009; Schreiner, Crafton, & Sevin, 2004; Smith et al., 2005; Wale et al., 2011). Effective leaders were seen to take proactive stances when managing staff concerns for safety. They encouraged staff to share their fears through organizing staff meetings to discuss safety issues (Goetz & Taylor-Trujillo, 2012; Lewis et al., 2009) and implemented specific safety plans solely aimed at maintaining staff and service user safety (Azeem et al., 2011; Wale et al., 2011).

In summary, the literature suggests that the most important considerations for leaders in S/R reduction are to 1) publically champion S/R reduction and reward progress 2) ensure that staff understand and enact recovery-focused and trauma-informed care, and 3) proactively address staff concerns about safety.

Strategy Two: Using Data to Inform Practice

Within the literature, studies that implemented all of the six strategies tended to provide more in-depth descriptions of collected data than studies that implemented fewer strategies. A specific, frequently reported example, of how data was used to improve practice was by studies that reviewed how often individual consumers were secluded or restrained. They reported targeting interventions for frequently secluded or restrained service users (Barton et al., 2009; Fisher, 2003; Smith et al., 2005; Wale et al., 2011; Ward, Keeley, & Warr, 2012).

Sharing data within organizations was also stated to be a helpful strategy. Smith et al. (2005) directly attributed the successful elimination of S/R practices to improved data collection systems and the subsequent sharing of data between inpatient facilities. Similarly, Wale et al. (2011) credited transparent sharing of data as a crucial factor in driving the successful S/R reduction campaign, attributing it to creating healthy competition within the organisation. While the majority of studies reported the collection of data, several did not provide details of the type of data collected (Cummings, Grandfield, & Coldwell, 2010; Dorman et al., 2009) or how the data were being used to inform practice (Sanders, 2009; Sivakumaran, George, & Pfukwa, 2011; Swadi & Bobier, 2012; Tyrer, Beckley, Goel, Dennis, & Martin, 2012). Some studies combined seclusion and restraint reduction data, obscuring the impact of the strategies on each of the coercive practices (Donat, 2003; Fisher, 2003; LeBel et al., 2004).

Overall the literature suggested that organizations that identified high rates of S/R for specific individuals were able to implement targeted interventions to reduce seclusion incidences. Collected data was analyzed and organizations credited the analysis with assisting in performance improvement and clinical reviews of seclusion and restraint events. Additionally, transparent sharing of data was credited with creating healthy competition within organizations to reduce S/R practices. While data collection was universally acknowledged to take place, how the data was used to inform practice was less well reported.

Strategy Three: Workforce Development

The recognition that staff needed further training in order to embrace organizational change was identified as an important component of successful S/R reduction initiatives (Scanlan, 2010). Although few studies stated they pre-emptively examined organizational practice in order to identify specific barriers to change, those that did reported the successful implementation of targeted change programmes to reduce coercive practices (Ashcraft & Anthony, 2008; Fisher, 2003). Organizations generally reported using more than one staff training approach. For example; Schreiner et al. (2004) identified crisis de-escalation and extensive staff re-education programmes. Cummings et al., (2010) reported that the use of creative problem solving forums and

executive level reviews of seclusion and restraint events were valuable training for staff. Some studies reported training involved staff learning sensory modulation techniques and setting up sensory rooms within the service (Martin & Suane, 2012; Novak, Scanlan, McCaul, MacDonald, & Clarke, 2012). Studies also reported the use of recovery and trauma-informed care training programmes (Azeem et al., 2011; Barton et al., 2009; Goetz & Taylor-Trujillo, 2012). Other organizations took a different approach to workforce training and focused on strengthening staff safety programmes (Chalmers, Harrison, Mollison, Molloy, & Gray, 2012; Lewis et al., 2009).

It became apparent that many diverse training programmes were implemented; however few organizations reported training that specifically addressed staff attitudes and beliefs towards seclusion and restraint. Some studies found that staff attitudes and beliefs influenced the probability of particular service users being secluded over others. These studies reported staff were more likely to seclude consumers from indigenous or ethnic minority groups (El-Badri & Mellsop, 2002; Happell & Koehn, 2011; Irwin, 2006; Wharewera-Mika et al., 2013).

Current research also indicates that staff who continue to use S/R practices, find them more acceptable and validate their use as interventions more readily than staff that infrequently use seclusion or restraint (Van Der Merwe et al., 2012; Van Doeselaar, Slegers, & Hutschemaekers, 2008; Whittington, Bowers, Nolan, Simpson, & Neil, 2009). A common perception reported by some studies was that staff regarded service users as the instigators of aggressive encounters (Lakeman, 2012; Mann-Poll, Smit, Van Doeselaar, & Hutschemaekers, 2013; Steinert et al., 2010). However other studies that gained both service user and staff perspectives contradicted that view reporting that aggressive incidents leading to seclusion on psychiatric wards were often significantly precipitated by staff-service user interactions prior to the event (Duxbury, 2002; Duxbury & Whittington, 2005; Irwin, 2006). Several studies that examined incidences of aggression on acute inpatient units, determined that individual staff member's responses to emotional situations, level of experience, age, and gender were equally important factors that contributed towards whether staff used S/R or not (Irwin, 2006; Laiho et al., 2013; Papadopoulos, Bowers, Quirk, & Khanom, 2012).

The literature suggests that workforce training is valuable and specific training can be provided by organizations to increase staff knowledge and skills in reducing S/R practices. However, the literature also indicates that unacknowledged or unaddressed staff attitudes may be a barrier to S/R reduction.

Strategy Four: Use of S/R Reduction Tools

While a range of different interventions were implemented by organizations to reduce S/R, the most commonly utilized tools within the literature were changes to the physical environment, the provision of sensory rooms and the use of specific assessment and planning tools (Ashcraft & Anthony, 2008; Barton et al., 2009; Champagne & Stromberg, 2004; LeBel & Champagne, 2010; Lee, Cox, Whitecross, Williams, & Hollander, 2010).

Staff reported assessment and planning tools were valuable and described using them to construct crisis de-escalation and personal safety plans with service users (Fisher, 2003; Goetz & Taylor-Trujillo, 2012; Lewis et al., 2009). It was noted that these studies did not include service users perspectives of the value or otherwise of this strategy. Some studies that had included service user perspectives reported service users did not find the plans helpful as staff failed to involve them in decision-making prior to the use of seclusion or restraint (Mayers, Keet, Winkler, & Flisher, 2010; Soininen et al., 2013; Van Der Merwe et al., 2012).

The use of sensory rooms and sensory interventions were widely referred to within the literature as emerging practices for S/R reduction (Chalmers, Harrison, Mollison, Molloy, & Gray, 2012; LeBel & Champagne, 2010; Sutton & Nicholson, 2011). Sensory interventions and rooms were viewed as valuable preventative tools by staff. These tools reduced the need for S/R by providing service users with access to sensory items such as weighted blankets, rocking chairs and music enabling them to self-regulate emotions and behaviors. (Champagne, Koomar, & Olson, 2010; Lee et al., 2010; Novak et al., 2012). Many studies reported therapeutic outcomes for service users who used sensory interventions, including decreased distress levels, (Barton et al., 2009; Cummings et al., 2010; Lee et al., 2010) and improved self-management (Dorman et al., 2009; Martin & Suane, 2012; Sutton, Wilson, Van Kessel, &

Vanderpyl, 2013). While some qualitative studies based on staff and service user perceptions reported a decrease in S/R episodes after the introduction of sensory interventions (Champagne & Stromberg, 2004; Lee et al., 2010; Loukas, 2011; Wale et al., 2011) four experimental studies found that no significant changes in seclusion or restraint rates occurred (Chalmers et al., 2012; Cummings et al., 2010; Martin & Suane, 2012; Novak et al., 2012).

An interesting finding within the literature was that although sensory rooms were specifically implemented as preventative tools to decrease S/R rates, other studies described similar effects when creating welcoming and homely environments (Azeem et al., 2011; Champagne & Stromberg, 2004; Harris & Fallot, 2001; Muskett, 2013; Taxis, 2002). Although these studies anecdotally linked environmental refurbishment to a decrease in S/R rates, one recent experimental study conducted by Borckardt et al. (2011) supported the anecdotal findings. The study examined the effect on S/R rates when warm colors, plants, and comfortable furniture were introduced to the facility. A significant decrease in S/R rates was associated with the positive environmental changes (Borckardt et al., 2011).

In summary, the literature provides an emerging evidence base for the use of three specific S/R reduction practices. These are 1) use of assessment tools to create individualized crisis or safety plans, 2) introduction of preventative tools such as sensory interventions or comfort rooms and 3) changing the physical environment to be more welcoming, comfortable and homely.

Strategy Five: Consumer Roles in Inpatient Settings

Strategy five endorses the inclusion of service user input, often referred to as peer support, within the development and provision of inpatient services. However, most of the studies examined for this review did not identify what roles, if any, peer workers held within inpatient services. While few studies identified specific peer worker roles within inpatient services, those that did described paid roles of peer mentoring, counseling and advocacy work. Staff in these studies reported peer roles were valued as the increased interactions between staff and peer support workers were instrumental in reducing the organizations use of seclusion (Ashcraft & Anthony,

2008; Fisher, 2003; Lucock et al., 2011). More commonly however, negative staff attitudes towards the provision of peer support are reported within the literature. Staff bias and negative attitudes are reported by some studies as the main barrier to implementing peer support programs and service user workforce roles (Cleary, Horsfall, Hunt, Escott, & Happell, 2011; Davidson, Bellamy, Guy, & Miller, 2012; Happell, 2008).

It is well established within the peer support literature that service users regard the provision of peers within mental health services as integral to their recovery. Service users value the input from 'experts by experience' as much as professional support (Amering & Schmolke, 2009; Davidson et al., 2012; Georgieva, Mulder, & Wierdsma, 2012; Kemp & Henderson, 2012; Repper & Carter, 2011). While few studies stated that formal peer support programmes were in place, Bouchard, Montreuil, and Gros (2010) sought to find out whether informal peer support took place between service users. In one of the first studies to examine how service users provided peer support to each other while hospitalized, Bouchard et al. (2010) found that service users encouraged each other through providing emotional, informational, and social support. This support, such as service users sharing soft drinks was reported as often being disregarded or discouraged by nursing staff.

The literature suggests that service users highly value the provision of peer support within services that includes peer mentoring, advocacy and counseling. However, the literature also indicates that peer support roles are underdeveloped within acute mental health services and a concerted effort to increase service user input at all levels of service delivery is required (Kemp & Henderson, 2012; Resnick & Rosenheck, 2008; Schrank, Bird, Rudnick, & Slade, 2012).

Strategy Six: Debriefing Techniques

Debriefing is a technique used to gather information about each S/R episode and support staff and service users to deal with any trauma arising from the use of S/R (Azeem et al., 2011; Barton et al., 2009; Fisher, 2003; Huckshorn, 2004; Smith et al., 2005). It was noted within the literature that some studies referred to the technique of debriefing, as 'witnessing'. Witnessing meant leaders were on-call over a 24-hour

period in order to be present and elevate the visibility of each S/R incident (Allen et al., 2009; Lewis et al., 2009).

Debriefing procedures were typically reported as happening in two stages. The first stage occurred immediately after an S/R event where senior staff documented the S/R episode and a second debrief took place within the week with leaders, staff, and/or service users depending on the organization (Ashcraft & Anthony, 2008; Azeem et al., 2011; Goetz & Taylor-Trujillo, 2012; Lewis et al., 2009; Needham & Sands, 2010). While debriefing was identified within many studies, no two studies described using debriefing the same way. While some studies reported using the two-stage debriefing process (Fisher, 2003; Lewis et al., 2009), other studies used either one of the two stages as their debriefing practice (Schreiner et al., 2004; Smith et al., 2005).

The most commonly reported outcome from debriefing was the use to which the information gained was utilized within the service. Lewis et al. (2009) reported data gathered from debriefing was used to gain insights into events to avoid future repetitions, Smith et al. (2005) reported data assisted policy changes, Fisher et al. (2003) utilized data to review consumer's treatment program and Ashcraft and Anthony (2008) reported developing a de-escalation training manual. While studies did not indicate the impact of debriefing from a staff or service user perspective they often described how they made an effort to mitigate any trauma that staff may have experienced. They did this through establishing non-threatening or non-punitive environments to undertake debriefing in (Azeem et al., 2011; LeBel, Huckshorn, & Caldwell, 2010; Lewis et al., 2009). However, information pertaining to the role of service users in debriefing was limited or absent in many studies (Azeem et al., 2011; Goetz & Taylor-Trujillo, 2012; Lee et al., 2010; Sanders, 2009). Needham and Sands (2010) review of the post seclusion debriefing literature supports that this aspect of debriefing is not well reported. They found studies failed to provide any insight into service users experiences of seclusion and that often service users preferred a more practical approach after an S/R episode, for example, the offer of a cup of tea, a walk or a shower (Needham & Sands, 2010).

The literature describes debriefing techniques as typically occurring immediately after an S/R event with a follow up review within the week. However, the varied use and

reporting of debriefing practices makes drawing general conclusions about its efficacy difficult.

Implications for Practice and Research

Several key points arise from the S/R reduction literature reviewed, with implications for further research and practice. While two of the six-core strategies deliberately direct attention to the importance of including service users within S/R reduction plans, service users were more often conspicuous by their absence rather than their presence within the literature. Studies that actually described peer support roles were rare in comparison to the number of studies that identified a need for peer support within services.

The possibility that unacknowledged staff attitudes may contribute to seclusion and restraint use, makes increasing service user input within services even more important. Input may be through service user workforce roles and in helping staff understand the importance of trauma-informed approaches and ways of supporting recovery. The service user's role within debriefing was not well described and this was highly disconcerting, as numerous studies report service user's experience S/R practices as highly traumatic. Perhaps a new direction for debriefing with service users would be worth exploring, that of taking a more sensory and practical approach to mitigating effects of trauma. Staff should be encouraged to support service users in using the sensory room, or other coping strategies such as having a shower or going for a walk after an S/R event. The use of practical strategies may also open up opportunities for service users to verbally process the experience.

Further research is indicated concerning the use of sensory interventions within services. While most experimental and qualitative studies that implemented sensory rooms reported decreases in service user agitation, arousal and distress levels, the evidence is not so compelling when examining whether the implementation of sensory rooms equates to a decrease in S/R rates. Although many studies reported a decrease in S/R rates, it appeared equally as many studies reported no significant changes occurred.

Drawing conclusions about the impact and efficacy of any one of the six core strategies in isolation is difficult as all of the strategies interact and influence each other. Adding to this complexity is the diversity in the use and reporting of the strategies within the literature. It would be useful for future studies to be clear in reporting which of the six strategies was used and to justify any omissions. Clarity in the reporting of how the strategies were used and the perceived impact would also help comparisons across the literature, as would reports of strategies that did not work.

Quality of the evidence

While a large body of literature related to reducing and/or eliminating seclusion and restraint was found most studies included within this review are primarily qualitative in nature. Qualitative studies are on the whole deemed to lack scientific rigour in comparison to experimental research and particularly the ‘gold standard’ of randomized controlled trials. However it is difficult if not insurmountable for traditional randomized controlled clinical trials (RCT) to be conducted in acute health care settings. This is due to the complexity of different organizational, cultural, service user, and staff factors and consideration of ethical and practical issues for service users requiring acute mental health care. The absence of a randomized control group limits internal validity and therefore causation cannot be attributed to particular strategies for reducing seclusion and restraint practices. Due to the lack of RCT’s, some authors have stated there is little evidence to support currently used strategies for seclusion and restraint reduction (Borckardt et al., 2011; Muralidharan & Fenton, 2006). However, rather ironically, recent Cochrane reviews found there are no RCT’s that support the widespread use of seclusion and restraint either (Sailas & Fenton, 2012; Van Der Merwe et al., 2012).

Although no controlled experimental studies were found to include within this review, the sheer volume of qualitative and quasi-experimental studies using the six strategies within the literature points to a strong body of evidence (Gaskin et al., 2007; Johnson, 2010). A growing body of literature now exists that supports the implementation of multiple strategies to reduce seclusion and restraint practices (Bowers et al., 2010; Gaskin et al., 2007; Scanlan, 2010). The fact that several studies using the Six Core

Strategies were able to completely eliminate seclusion and restraint practices over sustained periods of time is also further evidence of their effectiveness (Ashcraft & Anthony, 2008; Barton et al., 2009; LeBel et al., 2010; Singh, Subhashini, Davis, Latham, & Ayers, 1999; Smith et al., 2005). However a clear gap exists within the literature in that no studies have been undertaken that examine the acceptability and impact of the strategies when implemented within uniquely New Zealand contexts. Therefore, the primary question asked in this study is; *What is the experience of implementing seclusion and restraint reduction strategies for the clinical leaders and frontline staff within a New Zealand inpatient mental health unit?*

Conclusion

Changing an organization's use of seclusion and restraint is seen to be a complex and dynamic undertaking involving interrelated personal and organizational factors. The literature supports the use of multiple strategies as most studies implemented more than one strategy and credited each one with contributing to the reduction of seclusion and/or restraint. This review has highlighted some of the complexities inherent within each strategy as well as drawing attention to aspects of the strategies that are not well reported such as peer support and debriefing for consumers. Gaps in the evidence were identified and further justification for this study was provided.

CHAPTER THREE

METHODOLOGY

Introduction

The primary aim of this study was to explore the experiences of clinical leaders and staff in using the six core strategies to reduce seclusion and restraint in a New Zealand inpatient mental health unit. A secondary objective was to gain an understanding of the factors that participants felt were either barriers or facilitators to the implementation of the strategies. To achieve these aims a qualitative descriptive methodology situated within the post positivist paradigm was used. Studies that use a qualitative descriptive approach within a post positivist perspective seek to report the “experiences, meanings and the realities of participants” (Braun & Clarke, 2006, p.81). A post positivist paradigm holds that it is possible to capture reality, although not with any certainty as the world is complex, constructed and open to interpretation by individuals (Pope & Mays, 2006). The following discussion further outlines the methodology and describes the methods used to achieve the study aim.

Methodology

A qualitative descriptive approach was chosen for this study, as it is congruent with the primary aim of gaining a clear description of the participants’ experiences of implementing the seclusion and restraint reduction strategies. It also allows for the interpretation of findings in a practical and straightforward manner. Other interpretive and philosophically driven methodologies such as hermeneutic phenomenology or grounded theory could also have been considered in exploring the participants’ experiences and change processes. However, the relatively concrete nature of qualitative descriptive methodology means it is highly appropriate for communicating the findings to a multidisciplinary audience in an easily understood fashion and it is also suitable for an honours project that is limited in size and scope.

In this approach analysis stays close to the data and to the participant’s point of view, rather than applying a particular interpretive lens (Pope, Ziebland, & Maysournal, 2000). The framework underpinning qualitative descriptive research is “founded in

existing knowledge, thoughtful linkages to the work of others in the field and based on the clinical experience of the research-group” (Neergaard, Olesen, Andersen, & Sondergaard, 2009, p. 2). Undertaking a comprehensive literature review therefore forms part of the qualitative descriptive methodology as it assists the process of inductive analysis and provides a solid basis from which the inductive reasoning and interpretation of meanings could be considered alongside other studies (Thorne, 1997).

Research Methods

Cultural considerations

In accordance with the principles of the Treaty of Waitangi, cultural consultation was sought by the researcher with a representative of the Maori cultural team and the Maori Research Advisor from the District Health Board (DHB). The appropriateness of the study design was discussed as it is hoped that the research may improve conditions for a particular cultural/social group of mental health inpatient service users. These service users are Maori and Pacific men who are over-represented in seclusion and restraint incidences. Both advisors expressed support for this study and no major alterations were required to the initial proposal. Approval for the study was given by the Maori Research Committee on the 28th June 2013 (Appendix A).

Ethical considerations

Ethics approval for this study was given on the 22 July 2013 by the Auckland University of Technology Ethics Committee (AUTEC), reference number 13/116 (Appendix B). A Letter of Agreement was signed between AUT and the DHB in which the acute unit was located, to ensure confidentiality and intellectual property rights were established and any findings of a sensitive nature would be reported in a manner acceptable to the DHB.

Two clinical leads acted as liaisons for the project and potential participants were recruited through a suitable non-managerial intermediary to avoid coercion and ensure voluntary participation of participants. Care was taken to reduce any risk or discomfort for participants and they were reassured that they would be neither

advantaged nor disadvantaged by taking part in the study. This was in acknowledgment that they may have felt a conflict of interest as they are employees discussing potentially negative aspects of an organizational change process related to their place of employment. There was also a small risk that the researcher, due to previous employment within the same DHB, may have been known to the participants. This fact was acknowledged on the participant information sheet allowing participants to decide if this was a risk they were willing to accept by taking part in the study.

A further ethical issue arose concerning the inability of the researcher to guarantee participant anonymity and confidentiality. Full confidentiality could not be guaranteed as data was being collected from two small focus groups at one DHB unit. The small sample number in each group increased the risk that colleagues could identify published participants' perspectives. There was also a risk that focus group members could reveal the source of particular data. Making participants aware of this risk was ethically important as it meant their autonomy was protected. Acknowledgement of limited confidentiality was added to the participant information sheet and explicitly stated on the consent form.

Recruitment and Sampling

The small sample size of six participants was pragmatically fixed prior to the commencement of the study in order to contain the amount of data to be analyzed. This was necessary due to the small scope of this honours project, which had to be completed in a five-month timeframe. After ethics approval was gained, a meeting was held with liaison staff at the unit to explain the study and this provided an opportunity for them ask any questions and familiarise themselves with the participant information sheets (Appendix C) and consent forms. The inclusion criteria required participants to be either clinical leaders or frontline staff (either qualified health professionals or health care assistants) who were currently working at the unit and had significant involvement in implementing the seclusion and restraint reduction strategies. Participants were also required to be articulate in English as both focus groups were conducted in English.

Six volunteers were purposively recruited via the intermediary to participate in two focus groups. The pool of potential participants who had been involved in the implementation of change from the beginning was limited which restricted the diversity of cultural and discipline representation. However, the inclusion of nurses, an occupational therapist and a health care assistant, as well as some variation in ethnicity within the sample allowed different perspectives to be obtained which contributed to the richness of the data (Patton, 1990). Overall, the greater number of females of European descent with nursing training in the sample is reflective of the demographic makeup of the unit staff (see Tables 1 and 2).

Informed consent

Potential participants were able to ask the intermediary questions regarding the details and aims of the study and researcher and supervisors' contact details were also provided. Participants were given three weeks to consider whether to take part and they were assured they could withdraw from the study at any time. Signed consent forms collected from participants at each focus group constituted the gathering of informed consent (see Appendix D).

Table 1. Participant profiles: Clinical leaders

Pseudonym	Gender/ethnicity	Age	Role
Jill	Female/European	30-40	Charge nurse manager
Sheryl	Female/European	25-35	Lead occupational therapist
Melissa	Female/European	40-50	Clinical nurse Specialist

Table 2. Participant profiles: Staff

Pseudonym	Gender/Ethnicity	Age	Role
Pita	Male/Samoan	35-45	Health care assistant
Barry	Male/European	50-60	Registered nurse
Rose	Female/Maori: European	25-35	Registered nurse

Data gathering

Focus groups or interviews are deemed to be the appropriate methods of choice for undertaking qualitative descriptive studies (Peters, 2010). Both methods are viewed as suitable tools for health research where data is required about interpersonal aspects of care (Hancock et al., 2007). Focus groups were considered a more feasible option than individual interviews in this study, as they are time efficient and provide opportunities to discuss differing perspectives which would potentially reveal factors that influenced opinions or behaviors (Curry, Nembhard, & Bradley, 2009). Separate focus groups were conducted for clinical leaders and frontline staff to facilitate the confidential sharing of negative as well as positive experiences, without undermining the working relationships between the two groups.

Research taking place outside of AUT requires the researcher to provide evidence of safe practice such as informing a colleague when the research premises are entered and exited, therefore a Researcher Safety Protocol is attached (Appendix E). An outline of the format of the focus group and ground rules were established at the start of each group session following a focus group protocol guide (Appendix F). The questions were structured around the six core strategies and the process of implementing these. The researcher's knowledge of the strategies from within the literature helped shape and influence the types of questions within the topic guide (Appendix G). However, it was important that as the researcher, I was not overly influenced by pre-determined ideas from the literature during the focus groups. Therefore a naïve approach to facilitation was adopted, whereby participants were viewed as the experts and clarification was sought on viewpoints rather than assumptions made. The use of open ended questions such as; "Tell me how you came to be involved in the seclusion reduction project?" allowed participants to lead the discussions and share their experiences and opinions. Careful listening was required when participants were speaking in order to probe further and 'unpack' initial responses. The duration of each focus group was two hours with a break for afternoon tea, which was provided by the researcher.

Data Analysis

The audio-recorded data from both focus groups were transcribed verbatim by the researcher, which allowed thorough immersion in the participants' responses. Braun and Clarke's (2006) inductive thematic approach was used to guide the analysis of the transcripts. Although the six core strategies provided an initial framework for the focus group questions, the analysis was largely inductive. The use of an inductive approach involves allowing themes to emerge from the participant accounts as opposed to a deductive approach where participant accounts are fitted into themes from predetermined theoretical knowledge (Braun & Clarke, 2006). Detailed readings of the transcripts were made to highlight manifest content, that is, the accounts were interpreted as presented, without assumptions or philosophical meanings being placed on the text. Participant responses were analyzed line by line and coded using relevant words or phrases. Then all similar codes were grouped together into potential themes and subthemes.

Once preliminary themes had been established they were reviewed to see if there was congruence in the coded extracts across the entire data set and a thematic 'map' was created. According to Sandelowski (1986) qualitative descriptive studies are "unavoidably interpretive" and a level of latent (interpretive) analysis ensured that the final three themes accurately captured the most significant sub-themes and codes. In acknowledgment that interpretations are shaped by the researcher's personal biases, values and ideas, a reflective diary was kept throughout the analytic process to record modifications and interpretations of collected data. These ideas were reflected upon and shared within fortnightly supervision sessions, which provided a level of guidance that deepened understanding of analysis and emerging themes.

Trustworthiness

Lincoln and Guba (1985) propose that in order to evaluate the merit or rigour of qualitative studies that a framework containing four evaluative criteria of credibility, transferability, dependability, and confirmability are used. Accordingly, this qualitative descriptive study was based on the above four concepts, referred to within the literature as trustworthiness (Sandelowski, 1986).

Credibility

Credibility is achieved when a study provides readers with confidence in the reported strategies used for data collection. This confidence develops trust in the findings and study outcomes. The focus group strategies used for data collection are described within the methodology section and participant quotes have been included within the findings that support the thematic interpretations. This allows the reader to draw their own conclusions as to the credibility of the study (Hancock et al., 2007).

Transferability

The benefit of qualitative research is in being able to determine if the findings may apply in similar contexts or with a similar group of participants rather than in the generalization of findings across populations (Lincoln & Guba, 1985). Thorough descriptions of the context and the use of detailed and clear descriptions within the findings assists with the transferability of this study (Jeanfreau & Jack, 2010).

Dependability

Sandelowski (1986) proposes dependability is evident within a study, through the researcher leaving a clear auditable trail about decisions made from the beginning to the end of the study. This enables a reader to understand and follow the events and logic used. My personal viewpoints and the sampling, data collection, and analytic processes have been described within relevant sections of the dissertation. In this way transparency and integrity are demonstrated increasing dependability in the findings (Curtin & Fossey, 2007).

Confirmability

Confirmability is achieved when the participants and the context of inquiry determine the findings. Reflexive practice by the researcher ensures their influence on data analysis and findings are minimized (Barusch et al., 2011). For this reason self-monitoring and reflection by the researcher continued throughout the study and concerns and issues were shared within supervision. This enabled the authentic voices of participants to be more easily heard strengthening confirmability of findings within this study.

Conclusion

A qualitative descriptive methodology supported the aim of this study as it enabled participant's to describe their experiences of implementing seclusion and restraint reduction strategies and factors that helped or hindered this process. The methodology underpinning the study has been described in detail and the factors that allow readers to determine the trustworthiness of this study have been outlined. Researcher reflexivity continued throughout this study in order that the findings in the following chapter reflect the authentic voices of participants.

CHAPTER FOUR

FINDINGS

This chapter captures the participants' experiences of implementing the seclusion and restraint reduction strategies and the changes that occurred within the unit as a result. It quickly became apparent from the two focus groups that different aspects of the change process were being described in each group. Clinical leads described the strategies that were implemented and the impact they believed those strategies then had on practice. Frontline staff explained how they experienced the strategies and described the influence they had on daily routines and their interactions with service users within the unit. Three themes were drawn from participant experiences; 'Rethinking power and control', 'Entering into the unknown', and 'Getting staff on board'. These and the associated sub-themes are presented in this chapter (see Table 3). The three themes describe how the participants' perceptions of their roles changed once the strategies were implemented and the resultant culture changes that had occurred.

The first theme 'Rethinking power and control' explores concepts of power and control that exist within the unit. This theme became evident in the participant accounts of the historical use of seclusion and the changed thinking and practices that now accompany the unit's use of seclusion. 'Entering into the unknown' provides accounts of the clinical leaders' practical implementation of the change strategies plus staff accounts of the impact that the strategies had on them. 'Getting staff on board' describes how staff interpreted the strategies, the skills and attitudes that were developed and the impact this had on their relationships with service users.

Table 3: Overview of themes

<u>Themes</u>	<u>Sub-themes</u>
Theme 1: Rethinking power and control (Views of seclusion and restraint)	Seclusion: negotiating safety, harm and autonomy Keeping an eye on restraint

Theme 2: Into the unknown
(Perspectives of implementing change)

Strategy one: leadership for organizational change
Strategy two: using data to inform practice
Strategy three: workforce development
Strategy four: use of (S/R) prevention tools
Strategy five: consumer roles in inpatient settings
Strategy six: debriefing techniques

Theme 3: Getting staff on board
(Changes in the unit culture)

Negotiating resistance
Developing new skills and attitudes
Creating a welcoming environment
Collaborative relationships: 'let's have a cup of tea'

Rethinking Power & Control: Views of Seclusion and Restraint

This first theme describes the negotiating that participants had to undertake in order to manage the tension between safety, and supporting service user rights and recovery. Clinical leads and staff discovered that in order to reduce their use of seclusion and restraint, they needed to reconsider the underlying dynamics of power and control and change their thinking and actions accordingly.

Participants recognized the power differential between staff and service users and discussed ways in which power and control were traditionally demonstrated: *"It's so easy, you know, we've got the swipe cards, we've got the keys and that is often lorded, lorded's not the right word, in the past, you know, people jangled their keys"* (Jill). Service users who were non-compliant were seen as a challenge to the power of staff members: *"In the old days ... [as] soon as they refuse - bang, that nurse will take that as personal and they'll form up the team and they'll gather"* (Pita). The participant accounts suggest that previously the ward culture was custodial, wherein staff power was made explicit to service users and challenges to this power were seen as personal.

Seclusion: negotiating safety, harm and autonomy

This subtheme presents the participants' perspectives on seclusion use. Clinical leaders and staff recognized the negative impact of seclusion on service users and described looking towards a new way of working. Staff reported that the primary

reason for using seclusion was maintaining the safety of staff and service users as the following excerpts show:

There's reasons why we do it and safety issues and things like that. (Jill)

It [seclusion] was an accepted best practice for staff that didn't like large aggressive men or aggressive females. (Barry)

When describing seclusion use, staff frequently alluded to awareness of the custodial nature of the unit. Seclusion was typically referred to as locking people up and the terms *prison* and *cells* were used to describe the unit and seclusion rooms when staff narrated service user's perspectives: "*They all have fears of coming into these places; it's like prison really to them*" (Barry). The accounts of seclusion generally reflected a sense of discomfort with past practices involving power imbalances, such as the following excerpt: "*If you don't toe the line, if you don't do what we want you to do, then we're going to lock you up because we've got all the control*" (Melissa). This particular quote also alludes to the punitive use of seclusion, as a punishment for service users not following unit norms or expectations, and not necessarily related to maintaining safety.

The clinical leaders and staff were unanimous in the view that they personally did not like using seclusion, as the following accounts illustrate:

I didn't like doing it; I've done it many times, I didn't enjoy it, it was not something I felt comfortable with. (Jill)

It's something I sort of dreaded, was having to get involved in that [seclusion]. (Sheryl)

The view was frequently expressed that there had to be a better intervention, as staff expressed doubts as to the validity of seclusion, for example, Rose stated: "*I couldn't really understand the rationale behind locking someone in a room*". Participants felt compassion for service users who underwent seclusion and acknowledged it was traumatic for them:

You know there's some kind of inhumane aspect of locking up people on their own. (Jill)

Clients would talk about their experience and it was incredibly distressing and frightening for them. (Sheryl)

Importantly, what these quotes highlight is that participants felt the desire as human beings to do things differently, not just because they received directives from hospital funders or management.

Participants described new perspectives and attitudes towards seclusion. One of the clinical leaders defined the new power dynamics: *“I think that’s probably, that power imbalance has changed and it’s more about, ‘I don’t have to win this argument”* (Melissa). Staff described the thinking that now underpins their practice which reflects a culture shift towards providing more person-centered care:

There was people who would be ‘why do you put up with that, why don’t you lock him up’ I would go, ‘I’m putting up with it because I’m not locking him up, why should we lock him up’? He didn’t need to lose his freedom because of that, what more stress do you need, you’re not at home, you’re in a hospital, cultural reasons, many different reasons, language barriers, all sorts of things happening, you’re not thinking straight and someone wants to lock you up as well, no! (Pita)

Staff were willing to relinquish some of their power over service users and recognised the complexity of factors that contributed to service user distress. This allowed them to look beyond reactive and punitive responses to consider a range of potential interventions for managing service user distress and aggression.

Keeping an eye on Restraint

Although the participants’ goals for reducing seclusion were frequently alluded to, similar goals for reducing restraint were not as clearly articulated. Clinical leaders described taking more of a monitoring approach to restraint use: *“We needed to keep an eye on restraint because we didn’t want to have none of one and a heap of the other...”* (Jill). This monitoring was achieved through collecting restraint data and graphing the results. Jill also identified a hierarchy of importance associated with reducing restraint use within the unit. She described mechanical restraint as the most severe form of restraint, which clinical leads would not allow to be used within the unit, followed by seclusion and then physical restraint.

A tension became apparent in the participant accounts between reducing restraint use and perceiving restraint as a necessary intervention. In contrast to participant accounts that suggested discomfort with seclusion, participants appeared to be comfortable using restraint, and described it as an intervention that worked well: *“you know what*

you're doing and you know they [staff involved in the restraint] trust you and they do because it's worked many times" (Barry).

Restraint was viewed as being a more supportive and potentially therapeutic intervention for service users when compared to seclusion as the following two excerpts demonstrate:

So he can see that people are around him, so basically we are there for that period of time supporting him, we are not shutting the door behind him. It is more support. (Pita)

The sooner we can restrain someone get that medication in, sooner we can start to stabilize and start to work and get that person home to people who love them and where they want to be. (Rose)

Participant accounts also suggested restraint was viewed as a necessary and acceptable component of ICU nursing practice. Rose spoke about the need to use restraint on the unit when describing that it was “*very different nursing up there*” and added that she would always seclude someone if she felt they needed it. Barry linked the use of seclusion and restraint to keeping staff safe and protecting them from “*very very dangerous or armed*” service users although admitted that neither of those situations had ever arisen. Therefore, while staff saw a need to reduce seclusion and restraint, they felt that having the option of using these practices with acutely unwell service users was necessary for safety reasons.

Participants described two types of restraint use. Planned restraints were viewed as normal daily practice: “*I mean if it's a procedural restraint around giving medication against somebody's wishes that is often, well most of the time planned*” (Melissa). Unplanned restraints were less desirable. These were described as non-procedural and more traumatic for consumers as a team of staff restrained the consumer on the floor. Staff described their focus during these restraints was on following a well-planned procedure:

If you've done it well and you've got the right medication, the doctors are part of the team and they charted the right medication etcetera, the staff back you up...generally it flows through beautifully, you have an outcome... (Barry)

One account suggested that staff's emotional state was a factor in whether restraint was used: *"If we're on edge, the patients will see it, we'll be jumpy, we'll use restraint more"* (Barry).

These participant quotes suggest that the use of restraint is a dynamic process and often used based on how clinical staff feel as well as service user behaviour and therefore not always used solely to maintain service user or staff safety. The view that restraint had some therapeutic benefit as it allowed medical treatment to be administered made participants feel more comfortable with the practice. This is important as it shows there is a need to understand these dynamics if the use of restraint is to be minimised.

Into the Unknown: Perspectives of Implementing Change

This theme describes the five of the Six Core Strategies that clinical leaders implemented and the impact of these strategies on frontline staff. The theme 'into the unknown' arose from frequently voiced comments by clinical leaders as they acknowledged uncertainties with starting a brand new change process. They often described feeling as though they were heading into unknown territory with each new strategy implemented.

Strategy one: Leadership towards organizational change

After careful consideration and consultation the clinical leaders decided their first step would be to examine the existing seclusion policy and make changes to seclusion procedures. One policy change required staff to sit continuously outside the seclusion room door, instead of making ten-minute checks on secluded service users. Clinical leaders attributed the effectiveness of this strategy to making seclusion a boring and unattractive option for staff. Clinical leads outline their reasoning in the following excerpts:

Basically if somebody was having to sit outside a seclusion room it meant there would be one less [staff] to help on the floor [ICU]. (Sheryl)

They [staff] also had to document justification for ongoing use of seclusion every hour and they had to review it and give a rationale. (Jill)

Clinical leaders also initiated a new seclusion review panel at the same time to reinforce the preventative changes: “...once a week all seclusions within that week would be reviewed by a specific panel of people” (Melissa). Over time, staff accepted the new policy and eventually supported it although described feeling fearful and unsupported while they adjusted to the changes in policy:

There was also an underlying fear from a lot of staff that should you seclude somebody, you're in trouble, you'll have to answer to it, this comes about by the paper work you have to do. (Barry)

It didn't help to think that you could be in disciplinary proceedings if you seclude a patient. That was never stated, but it was an underlying threat. (Pita)

Clinical leaders met frequently and supported each other to achieve the unit's goal of reducing seclusion and restraint: “All of us, were very committed, and believed that we could make a difference and that we could change it” (Sheryl). In order to make the vision a reality, clinical leaders involved the multidisciplinary team in the project, including the use of the on-call cultural team. This was due to their perception that a ward wide culture change was needed, not just within the ICU or particular disciplines. Clinical leaders also felt they strongly influenced and supported staff by demonstrating new approaches with service users to staff: “I don't think that without the role modeling, without the support that staff got from both Sheryl and Melissa that it would have been as successful as it has been” (Jill). It was apparent in the participant accounts that the creation of a vision and facilitating the engagement of the whole team to reduce seclusion and restraint use through role modelling and encouragement was an essential task of the unit leaders.

Strategy two: Using data to inform practice

Clinical leaders introduced seclusion and restraint registers for staff to use and felt they were highly beneficial as they helped prove or disprove staff assumptions about seclusion and restraint use: “When you look at the hard data, it can sometimes tell you otherwise, or it can confirm what you're thinking, you've actually got facts to back it up” (Sheryl). The analysed seclusion data was used to identify and reduce problematic seclusion patterns and shared during staff training days to demonstrate that successful reduction of seclusion and restraint was achievable.

Clinical leaders highlighted the unit's success in reducing seclusion rates by displaying seclusion and restraint graphs in public areas of the hospital. The data was shared with other services and these were seen as positive strategies by clinical leads:

We shared it with our colleagues in the North to try and support them to develop the same kind of process and we've shared it to a whole lot of people, a whole heap of DHB's [District Health Boards] out there as well. (Jill)

In contrast, staff felt exposed by the public display of the graphs. While they acknowledged feeling pleased about reducing their use of seclusion, they were not always comfortable having the figures on display:

All through there was charts drawn up, which is supposedly part of a positive aspect of it, we had charts up to show how much we'd used compared to [other units]. It was like a competition. I'm sure they had them up too, I don't know, I doubt they would have because we did shine. (Barry)

Staff also described the pressure they felt as a result of being under intense scrutiny:

We found out Te Pou was on board watching us, they were very interested, they started sending people up to see us, the ombudsman he came up to see us at one stage and we thought Jesus we can't fail now so extra pressure was brought to bear [Rose and Pita- yes, yes], again unsaid unwritten, but 'you guys, Te Pou's watching us now, we're shining in New Zealand', suddenly we're shining in Australasia as well and that was a lot of pressure there. (Barry)

The following excerpt supports the consideration that staff accounts of seclusion and restraint may not be well represented within the literature. Staff described feeling unappreciated when published articles had not acknowledged their contribution to the units' successful reduction of coercive practices:

I was really disappointed when all the staff saw that [published article] as they were the ones that participated, they were the ones that did the work [Barry – gutted] yes they were gutted, everybody was. (Pita)

Gutted, they worked really hard and they gave it [credit] all to the OT's [occupational therapists] and I was really quite hurt. (Barry)

While clinical leaders viewed the gathering of data to identify and reinforce progress as beneficial, staff participants' responses suggest that creating too much competition and external pressure may be counterproductive for staff morale. When reporting the data to others, the acknowledgement of all the staff involved in the process is also highlighted as being important.

Strategy three: Workforce development

Clinical leaders designed a comprehensive training day for staff, which included trauma-informed care, sensory modulation, de-escalation techniques, and pharmacology. Melissa described how she thought staff interpreted the trauma-informed care training:

I think they take it on board in their own way. If you asked them they wouldn't necessarily say this is trauma informed care but I think they get the message about being empathetic, responsive and not locking people up and restraining them. (Melissa)

The training was positively viewed by participants although staff acknowledged the real work would begin when they integrated new skills into practice: *"I think that gave everybody some base skills to work on, still you can't learn it in a book, you have to go out there and do it". (Barry)*

The training day was also viewed by clinical leads as an opportunity for staff to discuss fears around maintaining personal safety if seclusion was reduced. Clinical leads described staff fears and attitudes as potential barriers to change illustrated within the following excerpt: *"People looked at worse case scenarios, i.e. a staff member saying, 'are you going to ring my wife and tell her I've been killed at work', kind of thing"* (Jill). Overall, participant accounts of the training day suggest the combination of modules was designed to equip staff with alternatives to seclusion and create a more responsive and empathetic workforce, while addressing concerns about the changes being made.

Strategy four: Use of seclusion and restraint prevention tools

The clinical leaders decided to set up and equip sensory and comfort rooms on the open ward as alternatives to seclusion. They also developed the use of early intervention techniques, such as responding quickly to service user needs and distraction with activities as a key aspect of reducing seclusion. Their role in this was twofold, they supported staff in gaining confidence in learning the new techniques, and role modeled how to do things differently: *"just working on the floor and ICU, clients we might have usually put into seclusion, working with nurses around 'let's look at how else we can manage this'"* (Sheryl). The clinical leaders reported a significant change in this aspect of practice: *"We've had people sitting in the high*

care area supporting a client for over an hour to prevent them going in. That wouldn't have happened before, that just wouldn't have happened" (Melissa).

The sensory and comfort rooms and the related sensory tools were viewed by the clinical leads as valuable alternatives for staff to use when confronted with agitated or upset service users:

When people asked the question, 'what else are we going to do'? This was one intervention that you could use to support people, to not have to seclude them. It's not the only one, but it gave people something to focus on, something to see, something concrete. (Melissa)

While staff agreed that sensory interventions were valuable they reported that sensory tools were used very differently within ICU to the open ward. Staff felt service users were often brought in by police and angry on arrival at the ICU and did not necessarily want to use the sensory room to calm down under those circumstances. They acknowledged the expression of anger was a legitimate method for decreasing service users' heightened arousal levels:

A person who's in ICU who's angry doesn't want to be calmed straight away, they want to be heard straight away, they want to be angry, they want to kick that wall, they want to throw something across the room... if we haven't seen the signs that they're building to that, then it's our miss, they don't want to be told, come with me to a sensory room. (Barry)

Staff responses indicate that it was necessary to take a proactive and broad approach in implementing sensory strategies. This involved recognizing signs of agitation early and understanding the significance of relationships and human interaction as sensory input: *"the input they [service users] are receiving, that tells them whether you're friendly or not, whether you care or not or whether you give a damn, sensory modulation doesn't happen in a vacuum"* (Barry). This also involved the input of whanau [family] who had a role to play in implementing sensory modulation within the unit:

We [staff] weren't cutting it, she didn't want us, she didn't want anyone to do with mental health near her you know, but this cousin managed to rock her to sleep in there and just get the people on board. (Rose)

While sensory interventions such as bubble blowing were used frequently within the unit, staff acknowledged the powerful impact that music had on maintaining service users' wellbeing, as illustrated by Pita's description of playing his guitar:

I bring it out and play you know, we have a little... [Barry - Pita he's the one, he's god when he's got the guitar], [Rose - he makes me cry in there some mornings]. We're a mixture of old and young so it's based on who's interested in coming. I just sit in the room and they just walk in, people just walk in, [Barry - staff as well] I start playing, it draws them in you know, and I ask them what their favorite song is and some of them are very good guitar players, they're really talented so you know... (Pita)

The clinical leaders felt the introduction of sensory and comfort rooms, role modelling, early intervention and sensory techniques were valuable tools that supported staff to not rely on seclusion as a routine practice. Staff participants suggested ICU service users' needs were different to those of consumers on the open ward. They described the deliberate creation of a broader sensory environment that communicated safety and calm, and the tolerance of expressions of anger by service users as important strategies for reducing seclusion use.

Strategy five: Consumer roles in inpatient settings

Service user roles within the unit were limited. Clinical leaders reported the unit had two part time DHB service user advisors that provided peer support and limited input from one peer advisor attached to a non-governmental organisation. Clinical leads had not implemented any interventions under this strategy although they thought more input could be beneficial for service users. They described the barriers to having more peer support workers within the unit as multi-factorial: *“so you'd need to put a whole lot of different supports in place to have peer support workers working in these environments”* (Jill). Jill's concerns were that busy frontline staff would not have enough time to provide the necessary support for peer workers within the unit. She also had concerns whether peer support workers would have the capacity to safely manage the dynamics of working with acutely unwell service users.

Similarly frontline staff didn't see a need for formal peer support roles as they believed once service users had left the unit it was detrimental for their recovery to return as peer support workers: *“They've moved on, their recovery is in the community”* (Rose). However, staff did see a positive role for informal peer support among service users and described actively fostering service user's relationships with peers:

If you [staff member] walk around and show them [a new service user] to people, often somebody will target them in a friendly way, like I'll support you

and talk to you. Sometimes I'll look up and think 'wow that person's doing so much good'. I see it mostly on the open ward out the back, a lot of healing just two peers talking about their experiences you know... the older women will mother the younger ones, they'll tell them off too, like aunties. (Rose)

Pita felt that the use of informal peer support within the unit also helped decrease the stigma consumers felt and normalized their experiences of having a mental illness: "...that's how they interact out there. Being mental illness, there's a lot of stigma, so they work together to help each other - they can share their experience with each other" (Pita).

While benefits of peer support were recognised and informal peer support was encouraged, perceived barriers to effectively using more consumer advisors within the unit prevented the full implementation of this strategy.

Strategy six: Debriefing techniques

Participants described how the new policy required two debriefing sessions to take place after each seclusion incident; one with staff and one with service users. Clinical leaders took a proactive approach to staff debriefing by holding an initial debrief immediately after each seclusion incident and further reviewed the event at the weekly seclusion panel review. Staff and clinical leaders valued the debriefing process and both groups stated it enhanced clinical learning through close analysis of the seclusion event. Participants described staff debriefing as a technique whereby staff were able to process the emotional fallout and through team input gain better understanding of how to approach a similar scenario in the future. Clinical leaders very clearly explained debriefing was primarily for the staff's benefit:

It's about what happened to the staff at the time, rather than the experience of the client. (Melissa)

You should be able to go home and leave work at work for the most part; sometimes people just need the opportunity to vent, to express their frustration, their anger, whatever it is with no judgment. (Jill)

Consumer debriefs were described differently. Clinical leads described the focus of the consumer debrief was to gather information that would enable staff to avoid a repeat of the seclusion incident: "*what could we do to help you, for this not to occur again*" (Melissa). Staff stated service users were given the option of deciding whom they wanted to debrief with and when this would occur. An informal approach to debriefing with service users was preferred by staff:

I like having the formal one with the staff but I find it [formal debrief] awkward with the patients. I feel then like a doctor sitting there going, now how does that feel for you, and it puts up that barrier, it's a big barrier and I don't think it works. (Rose)

We usually give them the space after every incident and we usually do it the following day when it's fresh, and we usually talk with the registered nurse and sit down and spend an hour with that patient and have a cup of coffee and recall was there anything in his part, what does he think now about what went on, what is his point of view. (Pita)

While staff debriefing was credited by participants with offering both emotional and informational support, participant accounts suggest service user debriefs were more likely to be informational gathering debriefs, rather than directly addressing the potential trauma of the seclusion experience.

Getting Staff on Board: Changes in the Unit Culture

Four subthemes emerged from the staff accounts that summed up the culture shift within the unit as a result of implementing the strategies. These included having to negotiate resistance, create a welcoming environment, the development of new skills and attitudes, and the importance of collaborative relationships. The word 'battle' was frequently used to describe the challenges they faced in changing other staff attitudes, practices and unit norms. Staff referred to the necessity for other unit staff to 'get on board' whenever they were describing a new attitude, skill, or practice that they believed needed to be adopted by all staff within the unit.

Negotiating resistance

Participants described the first part of getting staff on board involved negotiating the resistance of other staff especially those with more experience and who held entrenched beliefs:

You listen to the more experienced nurses too and you know some of the staff just aren't going to get on board with things. (Rose)

From the beginning to change this we have had to battle with the other staff that are totally against this. (Pita)

There was a battle and I think [Pita- we won (laughter) we went face to face] we used a process, didn't we Pita. (Barry)

Having to engage in 'battle' was viewed as an inevitable outcome as they were challenging the established norms and practices in order to create a new seclusion free

culture. Staff felt able to challenge the established norms as they had been invited by clinical leads to be ‘change champions’: *“The manager at the time asked me to be her champion in the unit, to set this thing in process before any meetings and planning were implemented”* (Barry). Barry and Pita had both been asked to take on this role and they were clearly willing to help in getting others on board with the changes. Identifying key frontline staff as change champions appeared to broaden the sense of responsibility or ownership for implementing the seclusion reduction vision.

Developing new skills and attitudes

Winning the battle of culture change required champions to role model the desired change to other staff. This involved using and developing key skills and practices including de-escalation techniques, relationship building, knowing the person (service user) and finding out what the problem was in order to help:

We’re relying on using our skills, not to prevent it because I don’t even consider seclusion as part of my process; we’re using our skills at every stage to support a patient through a process. (Rose)

This is where that change was, was to look at their, you know they must get up and utilize their skills of de-escalation, you know all this therapy, one to one with the patient and find out what exactly is the problem. (Pita)

In addition to developing staff skills, another integral aspect of becoming seclusion free was to change staff attitudes: *“If you want to change this, you need good staff on board and that was the key, ... the staffs’ attitude, this must be changed and you start to change it”* (Pita). Changing attitudes was linked to staff perceptions that they were now allowed to bring more of themselves into the therapeutic relationship. This involved broadening the scope of their interactions with clients to allow greater connection at a human level: *“The door opens out to staff to utilize their professional and their normal life skills [Rose & Barry, yes]. You know, the skills of being human [laughter] so normalize the environment”* (Pita). This more humane approach reduced the power imbalance and helped to create a less alien or hostile environment for people in distress.

Creating a welcoming environment

The new approach to practice involved what participants described as: *“being with a service user throughout a process”* (Barry). They identified this involved the

managing of any situation without needing to resort to seclusion. For staff this process began with working consciously and diligently towards creating a unit environment that was welcoming and culturally responsive:

We make them feel comfortable I guess as possible, so that they can feel like, oh this is a hospital not a, you know, once they sit down and get their breath back after riding in the police car. (Pita)

Staff were aware that newly admitted service users had many fears about being on the unit and sought to draw a clear distinction between themselves and custodial police care. They achieved this by offering clear signals of hospitality right from the beginning as illustrated in Barry's quote: "*Officer would you like to take the cuffs off, would you like a cup of tea mate*" (Barry). The offer of a cup of tea and reference to the newly arrived person as 'mate' is welcoming and signifies acceptance.

When welcoming service users to the unit, staff identified the importance of assessing cultural needs and of not making assumptions. Participants described a range of strategies they used to meet cultural needs. These included the use of staff from the same cultural background as a tool for gaining rapport, offering to arrange for Kaumatua or Kuia [Maori Elders] to sit with new service users, and using culturally safe practices illustrated by Rose in the following excerpt:

You can't even predict someone's ethnicity, you know if they're Maori and you want to go up and give them a hongiri because they might be totally anti their..., you know everyone's got their own story. (Rose)

If it's a Māori, you know, somebody I have good rapport with because the majority of our patients are Maori really [Barry, that's where Pita comes in really, beautifully], I will go up to that nurse and say 'excuse me I'll sit here' and they'll just say 'what'? And I'll say 'no, no leave it to me, I'll sit here with them' and just quickly ask them for a cuppa or something and then it just, everything just dissolves [Barry, he doesn't even say it now, just gives us a look]. (Pita)

Staff not only met cultural needs they also displayed an understanding of Maori cultural perspectives as Barry's account demonstrates:

If you don't understand the culture you can still check with the patient, 'your uncle was here last night, are you saying you saw your uncle or you heard your uncle' which would be a technical question and a new nurse might think 'ohh they're really mad, that's psychotic' but if you say 'is that usual for to know

your uncle or aunty around the house keeping you comfortable' and they say 'yes, this has happened all my life since I was six years old' that might be very different and that's spiritual and that's cultural. (Barry)

Participants stated that everyone that came into the unit was part of the team and this included whanau, [family] visitors, and the domestic staff. Staff described one shared goal, that of supporting service users in their recovery and all non-clinical team members were valued for their contribution towards that goal:

Anybody new starts, and I say 'staff, learn the domestic's names first' and they go 'why'? and I go 'because they're the ones that will tell you when something is happening with your patients' and when we get someone who goes 'nah', I think, 'you're not going to make it here'. (Barry)

Relationships with whanau were highly important and very reciprocal. Staff believed as much as 80 percent of their daily work involved interactions with whanau. The interactions included supporting family and clarifying processes for them or conversely whanau actively supported staff by helping them with a family member.

Staff worked hard to create a welcoming, culturally responsive environment for service users as they understood them and their whanau feel more at home. This approach underlined their commitment to forging collaborative partnerships.

Collaborative Relationships: 'Let's have a cup of tea'

Having a cup of tea together was symbolic of the new relationships that were developed within the unit. The environment had shifted from one of control to one of collaboration where potential issues were discussed with service users and they were allowed input into decision-making. Barry described that in the past staff would have forcibly restrained service users to give them unwanted injections. This excerpt describes the new approach to the same situation:

...now I would be saying, 'I've got a problem; I need to do this' [give unwanted medication]. [The Service user says...] 'I don't fucking want that medication, who do you think you are putting that in me'? [I say...] ok let's have a cup of tea and talk about it. (Barry)

As well as taking a problem solving and partnership approach to care, staff described wanting to normalize the environment and that meant treating service users as they themselves would want to be treated. The following accounts detail some of the attributes staff thought contributed to more collaborative relationships:

Pita's skill is he's just a human being with a massive heart, whatever our patients need, Pita does it, whether it's 'can you fetch me a can of drink from the machine in the open ward' he'll just go and pay for it and give it to them.
(Barry)

Rose mentioned how she liked watching Barry with the older ladies; she described how he would escort them to the dining room by holding his arm out using an old-fashioned courtly gesture. Barry and Pita described how they worked hard at appearing gentle and calm to reduce service user fears of being restrained by large male staff. Participants felt they often called on their life experience and roles as parents, grandparents, or aunties when interacting with service users.

The main barrier to collaborative relationships was identified as miscommunication with whanau and service users. Staff worked hard to alleviate miscommunication at all levels within the unit. This included sorting out confusion for whanau caused by the specialized ward environment: *"they're confused; they don't understand our processes, what's 1560, what is this lingo that we speak"* (Rose). Staff identified that difficulties between consumers and doctors occurred when doctors failed to make allowances for the consumer's inability to understand ICU terminology: *"somebody's who's on the street; you know their English is sort of broken, and I have to break it down for them because the doctor just talks straightforward to them"* (Pita).

This more collaborative approach appeared to change staff perceptions regarding safety needs. Pita explained that staff's fears about an individual were often more about the staff member not really knowing that person, rather than the service user actually posing a risk or threat:

If they don't use their safety net thing, I'm going to get harmed, you know that sort of fear, so instead of that, you've got to spend some time with this patient and all sorts of knowing that person, you've got to have rapport. (Pita)

Staff perceptions of best practice now include taking shared responsibility with service users for seclusion use, valuing collaborative relationships and continuing to act as unit champions to encourage reduction of seclusion and restraint. This final quote captures the primary elements of the culture change that occurred within the unit and emphasizes the new staff relationships with service users:

If somebody ends up in seclusion, I feel I've failed a bit, [Rose – yes] not always, but sometimes I think I missed something there and I start again... So if I don't have to seclude somebody, I don't want to. I want a cup of tea [with the service user] and if somebody wants to grab them and put them in the side room, they're obviously in the wrong. Best practice is to work with people to achieve an end. (Barry)

This theme suggests that staff took responsibility for maintaining person centered and collaborative relationships with service users and their families. Staff valued effective communication and developed skills in managing distress and problem solving. Participants felt the use of seclusion now signified a breakdown in the therapeutic relationship rather than being purely a result of the secluded person's behavior.

Conclusion

The focus group data presented within this chapter provides an interwoven account of the clinical leaders and frontline staff experiences of using strategies to reduce seclusion and restraint and the resultant culture change. The subjective accounts revealed the three main themes that underpinned the change process, “Rethinking power and control”, “Entering into the unknown”, and “Getting staff on board”. The following chapter explores and discusses the findings and situates the themes within the literature.

CHAPTER FIVE

DISCUSSION

Introduction

The primary aim of this qualitative descriptive study was to explore and understand the experience of clinical leaders and staff in using the six core strategies to reduce seclusion and restraint. A secondary objective was to gain an understanding of the factors that participants felt were either barriers or facilitators to the implementation of the strategies. This chapter builds on the previous chapters and summarizes the findings into a coherent whole that aims to accurately reflect participant accounts. The three themes and sub-themes that arose from analysis of the data reveal the complex interwoven factors that participants identified contributed to the units' organizational change. The findings are discussed and related to relevant research and theoretical literature. The strengths and limitations of the study are acknowledged and conclusions drawn about the implications of this study for practice and future areas of study are identified.

Alignment with the Literature

Overall the clinical leaders' experiences and accounts of implementing the strategies were closely aligned with findings from other studies where seclusion and restraint were successfully reduced or eliminated (Barton et al., 2009; Scanlan, 2010; Smith et al., 2005). Unit leaders incorporated all but one of the six strategies into their seclusion reduction minimization plan. Similarly to studies that implemented multiple strategies, clinical leads believed that each strategy effectively contributed to the desired organizational change (Ashcraft & Anthony, 2008; Azeem et al., 2011).

An unanticipated discovery was that many of the staff views of using the strategies were not reflected within the existing literature. This finding led to the consideration that possibly management or clinical leader's perspectives are more often reflected within the seclusion and restraint literature than the perspectives of frontline staff and service users. This consideration is supported by Papadopoulos et al. (2012) who acknowledged a limitation of their study was that only manager level perspectives

were sought and therefore it was not surprising that strategies such as poor leadership did not emerge as a theme within their data. The value of the staff perspectives was highlighted in the findings of the present study, particularly related to the day to day culture change that occurred on the unit. Notable aspects of the findings will now be discussed in relation to the three main themes.

Rethinking Power & Control: Perceptions of Seclusion & Restraint

For the participants the renegotiation and sharing of power and control was the foundation for seclusion and restraint reduction. However, this process was complex because of deeply held beliefs about the need for seclusion and restraint for ensuring safety and medical treatment. In spite of the complexities that staff had to negotiate, their genuine desire to reduce the use of seclusion enabled them to share power and control with service users and create highly collaborative relationships. Collaborative relationships are an important component of the recovery process and according to Amering and Schmolke (2009) occur when staff reshape their clinical responsibilities towards service user. The findings in the present study indicate that unit staff developed an earlier and greater responsiveness to service users' subjective needs, which aligns with the findings of Ashcraft and Anthony (2008) who reported staff responded rather than reacted to service user behavior after implementation of the six core strategies.

This theme emphasized the tension that staff felt as they strived to integrate the principles underlying the six core strategies into daily practice. Although the aim of the unit was to reduce both seclusion and restraint practices, a dissonance between the reduction of and use of restraint became apparent within participant accounts. Participants were torn between the genuine desire to reduce seclusion and minimise restraint use, and perceived need for the option of forced confinement and treatment.

Both staff and clinical leads sanctioned the use of restraint to give medication which was not perceived as problematic. A recent study by Wilson (2012) found there is an over-reliance and over-emphasis on pharmaceutical treatments within New Zealand mental health services. This suggests that a gap exists between restraint reduction aims, attitudes and unit/health care policy and shows the incompatibility of seclusion and restraint reduction with a strongly custodial and medically based practice culture.

Staff ambivalence towards reducing restraint is supported by a study that examined professionals' attitudes towards seclusion and restraint use. Van Doeselaar et al. (2008) observed that seclusion and restraint reduction programmes in the Netherlands had not led to a reduction in restraint. Through further inquiry they found staff were not really opposed to restraint (Van Doeselaar et al., 2008), a finding which parallels the attitudes of participants within the present study. Similarly Happell and Harrow (2010) conducted a review of the literature examining the influence of staff attitudes on seclusion and restraint and found that nurses continued to use both practices as they believed they were necessary interventions.

The finding that participants within this study held different values and beliefs regarding the use and reduction of restraint as opposed to seclusion is an important consideration. The six core strategy guidelines developed by NASMPHD (2006) and subsequent studies (Allen et al., 2009; Ashcraft & Anthony, 2008; Azeem et al., 2011; Borckardt et al., 2011; Caldwell & LeBel, 2010; Pollard, Yanasak, Rogers, & Tapp, 2007; Sivakumaran et al., 2011) refer to both practices as S/R [seclusion and restraint] which are assumed to equally reduce when the six core strategies are implemented. However, the findings from this study indicate that examining the practices separately may be beneficial, as different staff attitudes towards each practice can impact on how successfully each one is reduced.

Although staff in the present study reported using seclusion and restraint to maintain unit safety, in contrast the literature universally supports that the implementation of the six core strategies leads to a decrease in staff and consumer injuries (Scanlan, 2010). This finding shows the need for a complex and dynamic response to people's distress and agitation, where staff understand that safety and recovery are more likely to be determined by relationships and multiple factors within the individual and the broader system rather than the availability of coercive practices.

Into the Unknown: Perspectives of Implementing Change

The second theme 'into the unknown' outlined the experiences of the participants as they implemented and integrated five of the six core strategies within the unit. The clinical leads acknowledged that the implementation of new strategies meant they did

not always have the answers to questions asked by staff. In spite of uncertainties generated by changing unit policy and procedures, they were willing to journey into the unknown. This willingness and commitment by the clinical leaders to change the units' practices and norms was a key factor in the unit's successful reduction of seclusion and restraint.

However, frontline staff found the process daunting at times as they had to adopt new practices often without fully understanding the reasons and philosophy behind the changes. The fears that staff experienced during implementation of the strategies contrasted with the clinical leaders' positive experience. This could be explained by organisational change theory, as Duck (2001) describes two aspects of culture change; 1) operational strategies that leaders implement to create change and 2) change at a second level that consists of people's shared experiences of emotions and human dynamics related to change. It was at this second level that staff experienced barriers to change that were largely unacknowledged and unaddressed.

Examples of this two-tiered process were highlighted within strategies one and two. Clinical leaders rewrote seclusion policy guided by strategy one in an effort to reduce staff use of seclusion. While this policy change led to a reduction in seclusion practices, it did not necessarily equate to staff positively changing their attitudes towards seclusion use. Staff reported refraining from using seclusion as they felt the new procedures were punitive towards staff and engendered fear if seclusion were used. Significantly, this finding suggests the strategies themselves do not create the deep culture change that Huckshorn (2005) deemed necessary for sustained seclusion and restraint reduction. Huckshorn described a deep culture change as one where staff are required to change their attitudes towards seclusion and restraint.

While the literature suggests that staff attitudes have an impact on decision making regarding seclusion and restraint, this is an area that is not widely examined within workforce training programmes. Two recent studies suggest more research is needed in this area. Mann-Poll et al. (2013) state there is little evidence for knowing how to achieve the deep culture change in mental health professionals' attitudes towards seclusion. Similarly, Laiho et al. (2013) after reviewing thirty-two studies found there

is little research that describes the influence of organizational and staff values and attitudes on decisions to seclude service users.

A second example of the two-tiered change process outlined by Duck (2001) was also evident within strategy two, when staff described feeling uncomfortable and pressurized by the public display and continual sharing of data. While the clinical leads understood the purpose behind this strategy, staff did not appreciate the creation of a competitive environment. This suggests competitive environments are more reflective of American culture where the strategies originated, rather than a reflection of New Zealand culture. This finding also supports the notion of staff perspectives being minimal within the literature, as this issue was not reported in any of the previous research.

While the strategies implemented by the clinical leads were successful, staff accounts suggest leaders need to consider the impact of the strategies on staff and provide regular opportunities for maintaining staff morale and engagement in the process. This may help staff 'own' the strategies and reduce workplace stress for frontline staff.

The most significant strategies that contributed to the successful reduction of seclusion and restraint appeared to be strong leadership by both clinical leads and staff champions, and the use of sensory tools. While the literature supports the importance of strong leadership, leaders are generally referred to as those holding hierarchical positions within an organization (Azeem et al., 2011; Scanlan, 2010; Smith et al., 2005). However, Colton (2007) identified successful leaders in seclusion reduction initiatives at both management and staff levels. Leaders were described as those that ensured the reduction process was well planned, purposeful and focused, as well as being undertaken by staff who had taken on a championship role and contributed to a 'rethinking of the treatment philosophy' (p. 36). This was reflected in the descriptions and actions of both participant groups in the present study.

The sensory room and tools were valued as practical interventions by participants as they provided alternatives to seclusion for aroused or agitated consumers. However, staff in the ICU did not use sensory interventions in the same way as staff in the open wards. While ICU staff valued the sensory room they did not perceive that it initially

had a lot to offer newly arrived service users who were angry and upset. Staff felt new arrivals at the unit who were angry more often benefited from being able to express their anger. Chandler (2012) reported similar findings that staff took a more positive trauma-informed approach when they simply gave angry service user's space to yell and throw things and stayed with them during angry outbursts instead of placing them in seclusion. Although staff found that highly agitated service users often did not want to use the sensory room, they went to great lengths to provide a broader sensory environment and recognised the importance of the sensory aspects of interpersonal interaction. Tina Champagne, a leader in the field of sensory modulation, supports the provision of meaningful and sensory rich environments for service users and suggested this also allows service users to better manage emotional states (Champagne & Stromberg, 2004).

In their report on sensory modulation within four New Zealand inpatient services, Sutton and Nicholson (2011) stated that there was little evidence supporting the application of sensory modulation with highly aroused service users within the ICU units. They cautioned this may largely be due to environmental design as sensory rooms and equipment were typically placed in the open wards which acute service user admissions do not always have access to. They concluded this is an important area for future practice development (Sutton & Nicholson, 2011).

Getting Staff on Board

The importance of getting all staff on board was perceived by staff participants as crucial in creating the collaborative culture they believed was necessary to reduce seclusion and restraint. Establishing collaborative relationships with other staff, service users and whanau signified a change of attitude had occurred. This change of attitude was articulated by participants as the key to reducing seclusion and restraint within the unit. Although the strategies provided impetus for staff to manage interactions with service users without using seclusion and restraint, staff took an additional step when they interpreted the strategies as an opportunity to bring themselves more fully into relationships with service users. They perceived their primary role was to develop their personal and professional skills which would support therapeutic person-centered relationships, eliminating the need for seclusion.

A significant factor that enhanced collaborative relationships became apparent when staff demonstrated advanced awareness and understanding of cultural practices. This supported engagement and connection at a meaningful level with service users and their families. In alignment with other studies (Clark et al., 2008), staff recognized these partnerships helped maintain low seclusion rates.

These new relationships allowed staff to interact with service users on a more informal basis and engage in shared recreational activities such as playing music. In this way they themselves became the main therapeutic tools that supported reduction of seclusion and restraint. Stokowski (2007) describes this type of practice as true client-centered care and the main intervention that assists service users in their recovery.

Staff displayed a recovery-oriented approach during these interactions and Borge and Fagermoen (2008) suggest self-worth is increased for service users when staff display a combination of professionalism and kind hearts during interactions. The value of kind staff interactions with service users was also reported by Grant and Briscoe (2002) who found that service users felt their relationships with nurses crucially impacted on the effectiveness of care they received within acute facilities. Although these studies support the finding that staff perceived they could be a powerful tool to reduce seclusion and restraint rates, this staff perspective is not highlighted within the seclusion and restraint reduction literature. The literature more frequently reports that staff are barriers towards reducing seclusion and restraint practices when citing staff fears and concerns for their own and service user safety (Fisher, 2003; Irwin, 2006).

As well as becoming more skilful in their interactions with service users, staff were committed to their role as champions of the unit to reduce seclusion practices. Champions were comfortable with challenging established unit norms and role modelled different attitudes and approaches to other staff in order to decrease seclusion use on the unit. These staff actions are supported by studies such as Lewis et al. (2009) who stressed the importance of having several nurse 'champions' within units to reduce seclusion and restraint. Similarly Petti, Mohr, Somers and Sims (2001) found it was important to identify and build on staff willing to take responsibility in handling situations differently to reduce seclusion. This finding suggests that staff

champions are able to support the changing of staff attitudes, thereby contributing to a deeper culture change in reducing seclusion and restraint practices.

Strengths and Limitations of the Study

Strengths

The strength of the study is located within the candidness of the six participants in telling their stories, which provided rich data, as well as the realistic interpretation of the stories using acknowledged methods. The principles and philosophies underlying the qualitative descriptive methodology were scrupulously adhered to which maintained the integrity of the study. The clear examples and illustrations using participant quotes within the findings may strengthen the transferability of the findings to similar settings and contexts. Collaboration occurred frequently throughout this study with a supervisor and partnerships were formed with unit staff where the focus groups took place. Consultation was undertaken with two cultural advisors and all steps were taken to ensure client confidentiality and cultural safety were protected and respected.

Limitations

This study was structured to meet the final requirements of a dissertation within a Bachelor of Health Science (Honours) degree. This meant that the timeframe and scope of the study needed to be contained. This included only having a small participant sample which may contribute to a narrow or biased range of views within this study. Additionally, participants were approached by an intermediary attached to the unit and this process may have influenced who volunteered. While the findings are relevant to the study question, they are not totally representative of the participants' lived experience of implementing strategies to reduce coercive practices. Only the data most relevant to the three themes was prioritized and presented in order to contain the scope of the project. Finally, as a researcher I bring my own worldview and perspective to this study and acknowledge they may have influenced the analysis of participant accounts through determining what was important to highlight and which data was considered less important.

Implications for Practice

The study findings and existing literature indicate that seclusion and restraint use can be seen as a failure of three complex interwoven factors; relationships, service systems and staff skills. Failure should not lead to blame, but instead should draw attention to the shared responsibility that exists between family, service users and staff to manage distress and reduce or eliminate seclusion and restraint use.

The use of restraint was seen to be a dynamic and complex process and this study highlights that staff may view seclusion and restraint as separate practices. Therefore organizations may wish to have clear strategies for reducing each practice independently. It became apparent that clinical leaders and staff had separate experiences of implementing the six core strategies. Organizations need to positively engage staff in the process and this could be achieved by sharing the rationale for each strategy more clearly with frontline staff. This would potentially alleviate staff fears around such issues as changing seclusion policy and displaying data. Providing staff with an opportunity to give feedback on these strategies within organizations would go some way in alleviating the ‘invisibility’ of staff perspectives within the literature and also ensure strategies were implemented at a level that was cognizant of New Zealand cultural practices.

The clinical leaders in this study implemented the strategies thoughtfully and well. However, it is also important to recognize the important contribution of staff, whose perspective has been neglected in other studies. Staff were able to change attitudes within the ICU by deliberately creating a welcoming and broad sensory environment. Within this environment they created collaborative relationships with service users and reciprocal relationships with whanau. These relationships were sustained through staff providing comprehensive cultural support and clear communication. This study also highlights the importance of developing champions of change amongst frontline staff as this appeared to affect staff attitudes significantly.

Organizations may wish to increase or add workforce training programmes that allow leaders and frontline staff to explore attitudes, values and beliefs relating to the use of seclusion and restraint. Although implementation of the strategies can reduce

seclusion and restraint, the literature suggests staff attitudes are vital to creating ‘deep’ and lasting organizational change.

An important finding was that leaders and frontline staff did not implement or actively support formal peer support, but staff encouraged the use of informal peer support within the ICU unit. This distinction between formal and informal peer support is not well reported within the literature. The finding that staff valued and supported informal peer support suggests services could actively encourage staff to recognize and support service users in engaging in these processes.

Finally, although participants valued debriefing as a tool for emotional and informational support for staff, it appeared little recognition was given to mitigating the trauma of seclusion or restraint for service users. Perhaps this strategy needs to be implemented differently within organizations with staff taking a more informal and sensory approach to debriefing with service users.

Implications for Future Research

Future studies should ensure a broad range of staff as well as service user perspectives are included and should address seclusion and restraint as different practices, which may in turn require different strategies to change them. The findings suggest that ingrained staff attitudes and beliefs continue to influence decision making regarding seclusion and restraint suggesting the need for further research into the impact of staff attitudes on seclusion and restraint use. Further research into the role and value of informal peer support would also be beneficial as would studies that more clearly identify barriers to formal peer support processes being implemented. The creation of a broad sensory environment within the ICU was an important finding and more research is needed within this specialized environment. Larger studies situated within New Zealand would be beneficial to gain further understanding of how best to implement the strategies within uniquely New Zealand contexts.

Conclusion

Three themes were identified in this study, ‘Rethinking power and control’, ‘Into the unknown’ and ‘Getting staff on board’. Each theme is directly derived from the six

participants' experiences of using five of the six core strategies to reduce seclusion and restraint practices. The six participants who took part in this study clearly took key roles in the unit's successful reduction of seclusion and restraint minimization project. They were proud of their achievements and worked hard in achieving a change in culture based on policy and practice changes. While clinical leads sometimes felt uncertainties in implementing the strategies, they felt each one contributed to the units' reduction of seclusion and restraint. Frontline staff had not experienced all the strategies positively but had taken a proactive approach in developing skills to enable the forging of collaborative relationships between themselves and service users. The work that both clinical leads and staff undertook contributed to the successful reduction of coercive practices at the unit and their accounts provide useful insights for other services looking to apply seclusion and restraint reduction strategies.

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Appendix A
Maori Research Review Committee

28 June 2013

Daniel Sutton, PhD, NZROT
Senior Lecturer
Dept Occ Science and Therapy
AUT University

Re: Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting

By way of introduction the Maori research review forms part of the locality assessment. The Maori research review process across the Auckland and Waitematā District Health Boards is overseen by the Auckland and Waitematā Maori Research Committee. The Maori Research Advisor represents the Maori Research Committee and has primary responsibility for reviewing research applications across the Auckland and Waitematā District Health Board.

Within this context the Maori Research Review critiques research proposals for responsiveness to Maori. Ethical, scientific and clinical rigour is reviewed by the respective bodies at each District Health Board.

Thank you for providing the ethics application and research proposal. The research is part of an academic pursuit exploring the implementation of strategies to reduce seclusion and restraint practices in a mental health unit.

The investigator identifies that Māori (and Pacific) men are more likely to be restrained and secluded. Therefore, the research has the potential to benefit Māori. A consultation process is required to ensure Māori voice and perspectives are addressed as researchers develop their research proposals. The investigator identifies consultation has taken place with the mental health team at Waitamata. Could the primary investigator please identify if consultation has taken place with Māori. Finally the research findings will be of interest to Māori therefore would the investigator identify those Māori, individuals, whānau, hapū, iwi or organisations that the findings will be disseminated to.

I look forward to hearing from you.

Heio ano

H.A Wihongi

Dr Helen Wihongi

Maori Research Advisor

He Kamaka Waiora (Maori Health)

Auckland and Waitematā DHB,

Private Bag 93 503,

Takapuna, Auckland

Ph + 64 9 4868920 ext 3204

Cell 021 0203 1167

Email helen.wihongi@waitematadhb.govt.nz

Tereki Stewart

Chairperson

Auckland and Waitematā DHB

Maori Research Committee

PO Box 108040

Symond Street

Ph +64 09 366 1993

email tstewart@tihiora.co.nz

28 June 2013

Daniel Sutton, PhD, NZROT

Senior Lecturer

Dept Occ Science and Therapy

AUT University

Re: Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting

Following on from the letter dated 28 June 2013. I received an email dated 1/7/13 clarifying the consultation process that has occurred. Given this please take this letter as approval for the study to continue.

Heio ano

H.A Wihongi

Appendix B

Ethics Approval

A U T E C
S E C R E T A R I A T

22 July 2013

Daniel Sutton
Faculty of Health and Environmental Sciences

Dear Daniel

Re Ethics Application: **13/116 Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTE C).

Your ethics application has been approved for three years until 15 July 2016.

As part of the ethics approval process, you are required to submit the following to AUTE C:

A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 15 July 2016;

A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 15 July 2016 or on completion of the project.

It is a condition of approval that AUTEK is notified of any adverse events or if the research does not commence. AUTEK approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application. AUTEK grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Sharon Webster westwahine@hotmail.com

Appendix C

Participant Information Sheet



Date Information Sheet Produced: 30 April, 2013

Project Title:

Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting.

An invitation

Hello my name is Sharon Webster and I am a mature student doing an honours year in occupational therapy at AUT. I have always been interested in mental health, especially concerning the potential of sensory modulation as an intervention to reduce seclusion practices. As you will know, the Waiatarau seclusion rate decreased after the instigation of a change in organisational practices through introducing the 6 Core Strategies and sensory modulation intervention. The strategies are briefly known as: 1) strong leadership to support organisational change, 2) the use for data to inform practice, 3) workforce development, 4) the use of seclusion prevention tools (including introducing sensory modulation intervention), 5) the inclusion of consumers and 6) rigorous debriefing.

I was delighted to be offered the opportunity of working on this project, which is a small study, focused on gaining staff perspectives on the introduction of the organisational changes into your unit. I would therefore like to invite you to take part in this research project which would involve taking part in a focus group with a couple of colleagues. The focus of this research is centred on identifying what constituted barriers to implementation and what factors helped you introduce the organisational change. Your time and participation will be deeply appreciated.

Participation is voluntary and you may choose to not answer any particular question and/or withdraw at any time prior to the completion of data collection. While there may be some conflict of interest in that you are employees discussing the

organisational change process of your place of employment, taking part in this study will neither advantage nor disadvantage you.

Undertaking this research is a requirement of my honours degree and results in a written dissertation. It is also anticipated that a journal article will be written from the study. There will be an academic presentation at the end of the year, to which you are invited to attend, at the Auckland University of Technology for interested staff and post-graduate students.

What is the purpose of this research?

This study primarily focuses on your experiences (i.e. what worked and what did not work so well) when you implemented the 6 Core Strategies and sensory modulation intervention into the Waiatarau unit in 2010 as part of the seclusion and restraint reduction plan. It is anticipated that the findings may assist other clinical staff within mental health inpatient units to implement these strategies successfully and thus reduce the need for seclusion and restraint practices, which are experienced as traumatising by the majority of acute mental health service users.

How was I identified and why am I being invited to participate in this research?

You were identified by Waiatarau's management team as having played a part in implementing the 6 Core Strategies. You have been invited to participate in this study because you bring a particular perspective (either management or clinically focused) that is seen as important to our understanding of staff views of the change process. You will be asked for a contact address so that a research report can be sent to you.

What will happen in this research?

You will be invited to take part in a small focus group involving 2 other participants, sharing your views and perspectives on the organisational change process of implementing seclusion and restraint reduction practices. The focus group is envisioned to take no more than an hour and a half to two hours. The focus group will be audio recorded and I may take brief notes during this process.

What are the discomforts and risks?

There is some risk that colleagues may identify your perspectives from the written research findings due to the small numbers of participating staff and the fact that the research is based only within Waiatarau. Therefore, complete anonymity and/or privacy cannot be guaranteed. There is a slight possibility that you may feel some discomfort when answering questions regarding negative experiences with implementing organisational change as you are employees of Waitemata DHB and depend on the DHB for financial employment. However you do not need to answer any question that you feel will cause discomfort. There is also a small risk that the interviewer may know you and if this is uncomfortable for you, you are free not to participate in the study.

How will these discomforts and risks be alleviated?

In order to minimise risk, all identifying details within the interview data will be removed or altered to protect your anonymity and pseudonyms will be used if necessary to individuate an individual's response although preferably generic terms will be employed e.g. staff members. You will be invited to view the transcripts from the focus group and approve, remove or alter any of your own statements in order to protect your privacy and ensure your views are represented accurately.

The following examples of the types of questions likely to be asked may alleviate potential concerns about the nature of responses/disclosure sought.

1. Tell me about your role in implementing the 6 core strategies/sensory modulation interventions
2. What challenges or difficulties did you face during the initial stages? What factors helped the set-up process?
3. What impact has implementing the 6-core strategies/sensory modulation had on the unit?

If you wish to discuss any issues/concerns that arise for you as a consequence of taking part in the research AUT provides free counselling for participants and appointments may be booked through the Health and Wellness Centre: City Campus 09 921-9992 or North Shore Campus 921-9998.

What are the benefits?

It is hoped you will benefit from participating in this research through gaining an enhanced sense of professional achievement as you reflect on and share your experiences of implementing successful organisational change. It is hoped that you will enjoy participating and gain positive feelings of empowerment as you share your stories and gain a deeper understanding and consolidation of your knowledge of the organisational change process.

How will my privacy be protected?

While the researcher and the study intermediary will be aware of your personal and professional details, which mean you do not have full anonymity, full confidentiality of all information used within the presentation of findings is guaranteed. Conversely, you have every right to share with colleagues that you took part in this research project if you so wish.

What are the costs of participating in this research?

It is anticipated that participating in the focus group will take between one and a half to two hours of your time. You will also need to find time to review the focus group transcripts in order to approve or change your statements as needed.

What opportunity do I have to consider this invitation?

A response to this invitation would be appreciated by July 30th, 2013.

How do I agree to participate in this research?

Consent is given when you sign the consent form. The consent form addresses the specific confidentiality requirement and agreement to be audiotaped that is necessary when you participate in a focus group.

Will I receive feedback on the results of this research?

Yes you will receive feedback on the results of this research both during the progress of the study and once it is completed. All correspondence related to the study will be mailed to an address of your choosing (either private or workplace) as you will have the option to review, alter, delete or change any information from the transcribed interviews and receive a research summary. I will also extend a written invitation to a verbal presentation of the research findings closer to the end of the year. Your contact details on the consent form will be the address used for all correspondence.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Daniel Sutton: Occupational Science and Therapy Department, AUT University

Email: dsutton@aut.ac.nz Phone: 9219999 ext. 7732

Concerns regarding the conduct of the research should be notified to the Acting Executive Secretary of AUTEK, Madeline Banda, *ethics@aut.ac.nz*, 921 9999 ext. 8316.

Whom do I contact for further information about this research?

Sharon Webster: westwahine@hotmail.com

Project Supervisor Contact Details:

Daniel Sutton: dsutton@aut.ac.nz 9219999 ext. 7732

Or

Kirsten Van Kessel kvankessel@aut.ac.nz 9219999 ext. 7691

Appendix D

Consent Form



Project title: Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting.

Project Supervisor: **Daniel Sutton**

Researcher: **Sharon Webster**

I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.

I have had an opportunity to ask questions and to have them answered.

I understand that the identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

- I agree to take part in this research
- I wish to receive a copy of the report from the research (please tick one):
Yes No

- I understand that only limited confidentiality can be guaranteed by the researcher.

Participant's signature:

.....

.....

Participant's name:

.....

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 22 July

2013. AUTEK Reference number 13/116

Note: The Participant should retain a copy of this form.

Appendix E

Researcher Safety Protocol

RESEARCHER SAFETY PROTOCOL



Project title: **Staff perspectives of implementing organisational change strategies to reduce seclusion and restraint in an acute mental health setting.**

Project Supervisor: Daniel Sutton

Researcher: Sharon Webster

Researcher safety protocol for interviewing participants at their workplace:

- Sharon Webster will advise Daniel Sutton in writing in advance of the dates, and times of each focus group, and public transport route taken.
- As soon as is practicable after the focus group Sharon will phone Daniel to advise the focus group is successfully completed.

Approved by the Auckland University of Technology Ethics Committee on 22 July 2013. AUTEK Reference number 13/116

Appendix F

Focus Group Protocol

Task	Tick list
Pre-focus group	
Check in with recruiter that date and time has been arranged	
Check refreshments for participants have been organised	
Book digital audio recorder with batteries and spare batteries/tapes	
Focus group	
Ensure I have working digital audio recorders x2, with batteries and spare batteries/tapes	
Arrive at venue half an hour early and ensure that everything is ready	
Ensure I have information sheets and consent forms with me	
Introduce myself as facilitator. Begin with welcome and explain that I am going to go through some “housekeeping”. Then introductions - then they will be asked to respond to some questions.	
Explain that I will ask participants to introduce themselves on tape later	
Check everyone has an information sheet and consent form	
Go through the information sheet to explain the purpose of the research	
Explain that participant’s contributions will be anonymous in terms of name (I only want first names)	
Remind participants that they can withdraw at any stage with no penalty and that audiotapes will be destroyed at the end of the study	
Invite questions about the research process.	
Ask people to sign the consent form and make sure they hand one copy to me and they keep one	
Explain the process for the focus group and expected timeframe. Set guidelines for the group as follows: Discuss ground rules (including confidentiality and only using first names) There are no right or wrong answers and I am interested in what everyone	

has to say Participants are encouraged not to criticise or argue with what other people have to say Issues might come up that you didn't expect, please discuss with me after the group and I can refer you to the Health and wellness centre	
Turn on the tape recorders x2	
Facilitator and participants introduce themselves use an icebreaker (name and why they decided to be mental health nurses)	
Facilitate discussion on the research topic, note areas of consensus and any outlying points of view	
Monitor the participants for any signs of distress. If needed check in with the participants and provide them with the option of leaving the group if necessary	
During discussion some of the discussion points may merge or be discussed spontaneously without prompting. As much as possible I will allow a natural flow of the discussion, prompting if necessary to have all the points covered	
Thank participants for their time, energy and ideas and tell them that they will be mailed a summary report of the focus group results if they wish	
Leave venue tidy and clean	
After the group	
Following each focus group meeting, I will record overall impressions, key ideas and insights from the interview (keep the tape on and record)	
Notify recruiter when focus group has been completed	
If any unexpected issues arise I will discuss/debrief with Daniel if necessary	

Appendix G

Focus Group Question Guide

You have told me a little about your role in implementing the 6 core strategies; can you tell me how it began for you, becoming involved in the seclusion reduction project?

What stood out as being a major challenge or challenges?

What would you say helped?

Why do you think your seclusion reduction rates were so successful so quickly?

It was interesting to note you had a seventh strategy, a cultural intervention. Can you tell me more about the purpose of this strategy?

I was wondering if you had challenges or issues with collecting your seclusion data

Which workforce training would you say had the most impact on your seclusion and restraint reduction project?

Which of the prevention tools did you think worked well?

- Or was challenging?

Do you have service users employed or working voluntarily on the unit and if so how is it going?

- What would you describe as the benefits
- challenges

How do you find the debriefing process?

Encourage participants to give examples and share stories

(Can you give me an example of how you may have worked in the past and what you now do differently)?

