




BEST PRACTICE IN THE REDUCTION AND ELIMINATION OF SECLUSION AND RESTRAINT

SECLUSION: TIME FOR CHANGE





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EXECUTIVE SUMMARY

Reducing use of seclusion and restraint in mental health service inpatient settings has gained wide national and international interest. A review of the literature has identified a number of best practices for reducing and eliminating use of seclusion and restraint. This document outlines these best practices and discusses the new draft Health and Disability Sector Standards that govern use of seclusion and restraint in New Zealand. Specific advice on best practice for working with Maori and other ethnic groups is required to support change in this area.

Best Practice Initiatives that Reduce and/or Eliminate Use of Seclusion

Researchers have consistently reported a number of best practices based on analyses of successful seclusion and restraint minimisation efforts. Best practices that contribute to seclusion and restraint reduction include; a national direction that supports seclusion and restraint reduction and elimination efforts, active, committed and high profile organisational leadership and oversight, and an organisational culture that embodies recovery oriented approaches such as trauma informed care. Workforce development is another crucial aspect of successful reduction efforts and includes recruitment, education, supervision and staff involvement initiatives. Further best practice methods that support reduction include service user development and participation, for example, through provision for feedback and employment in advisory, educator, peer support and advocate roles. Milieu management and use of practical tools, such as; provision of meaningful activities, an atmosphere of listening and respect, crisis prevention planning, violence and trauma assessments, behavioural coaching, de-escalation and sensory modulation also support reduction in use of seclusion and restraint. Effective debriefing and collection and use of information are also essential for seclusion and restraint reduction.

Seclusion Reduction Training Packages

Two training curriculum developed in the United States incorporate a range of these best-practice methods. The two packages are:

- **NASMHPD** (National Association of State Mental Health Program Directors - Training Curriculum for the Reduction of Seclusion and Restraint) or
- **SAMHSA** (Substance Abuse and Mental Health Services Administration - Roadmap to Seclusion and Restraint Free Mental Health Services)

(SAMHSA 2007; NASMHPD 2006)

It is recommended that these curricula are adapted for use in New Zealand.



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7. PURPOSE AND METHOD

The purpose of this paper is to identify, through a review of literature, best practices in the reduction and elimination of seclusion and restraint in mental health inpatient settings. This paper includes a review of the current NZ context and analyses the literature on best practices and its relevance to New Zealand. Recommendations for adopting and adapting US training packages for the New Zealand environment follow the analysis. Finally the paper outlines the ‘Seclusion: Time for Change’ project.

Te Pou carried out a literature search on the reduction and elimination of seclusion and restraint in mental health services. We are confident that the major literature was identified. However, we were unable to access some articles and there may be other relevant literature that was not traced.

2. DEFINITIONS OF SECLUSION AND RESTRAINT

2.1 Restraint

The Health and Disability Restraint Standard defines restraint as “the use of any intervention by a service provider that intentionally removes the normal right to freedom” for the service user (Standards NZ, 2007).

The actions of a service user are controlled either through bodily force (physical restraint), with the assistance of an object (mechanical restraint) or by limiting their normal access to an environment (environmental restraint).

2.2 Seclusion

Seclusion practices are a particular type of restraint. In a seclusion episode the service user is placed by themselves in a room or area from which they cannot freely exit (Standards NZ, 2007, p.28).


“Seclusion involves:

- Containment – a person is contained within a room where the door is shut and the freedom to exit is decided by staff.
- Isolation – the person is in the room alone.
- Reduction of sensory input – the room is reasonably bare, often containing no more than a bed and sometimes a toilet” (Mental Health Commission 2004).

3. NZ CONTEXT OF SECLUSION AND RESTRAINT

3.1 National Direction and Actions

National steps to reduce the use of seclusion and restraint have included a discussion



document, data collection, workshops, and the revision of practice standards for the use of seclusion and restraint.

The Mental Health Commission put seclusion on the agenda when it stated in 2004 that it would “like to see a significant reduction in seclusion use and its eventual eradication” (MHC 2004-1, p13).

The Commission based its conclusion on:

- the emerging consensus that seclusion is not therapeutic
- the negative consequences of seclusion on service users and to a lesser degree on staff
- human rights concerns
- evidence that seclusion can be reduced, and even eliminated, without increasing the risk of harm


The Ministry of Health also holds the view that seclusion practices need to be reduced without increasing negative outcomes for patients or service providers. The Mental Health Director for the Ministry of Health, Dr David Chaplow, says “Seclusion is a worry for us, we want it to start trending down and we want to really minimise, possibly even extinguish, the use of seclusion” (Barton, 2007).

The ministry has begun to collect statistics on the use of seclusion in New Zealand (Ministry of Health, 2007). Preliminary analysis of these statistics reveals clear differences in the amount and duration of seclusion used when different DHBs are compared. The ministry report showed that between October and December 2006, 16.1% (383) adult mental health service users were secluded and a further 94 service users were secluded in youth and forensic services. While most episodes of seclusion lasted less than three hours, time varied from under one hour and up to 24 hours. The majority of people secluded in mental health units fall within the age bracket of 14 to 49 years. Maori are disproportionately over-represented in both seclusion rates and number of seclusion events.

There have been no studies investigating why seclusion rates vary across New Zealand DHBs; however, overseas studies suggest key reasons for seclusion rate variations include; differences in seclusion practice, geographical variations in prevalence and acuity of mental illness, ward design factors (such as availability of intensive care and low stimulus facilities), staff factors (such as numbers and experience of staff), use of sedating psychotropic medication, distortion of statistics by outliers over relatively short data collection time, and data collection or analysis errors (Livingstone, 2007).

In 2006, a survey of the actions taken by 10 DHBs to reduce seclusion practices revealed cases of successful reduction in the use of seclusion by some DHBs (Harrison, 2006). The publication of this seclusion data in 2007 was intended as a first step to developing and monitoring strategies to reduce the use of seclusion.

Training workshops have been held in NZ in 2006 by the National Association of State Mental Health Program Directors (NASMHPD) who developed and implemented a training



curriculum for the reduction of seclusion and restraint in the US. These workshops were sponsored by Mental Health Workforce Development Programme, the Ministry of Health, the International Initiative for Mental Health Leaders and the Mental Health Commission and were held in Auckland and Wellington. The workshops were attended by Managers and senior staff of New Zealand's DHBs.

3.2 Health and Disability Services (Restraint) Standards

A restraint minimisation and safe practice standard was produced in 2001 to reduce the use of all forms of restraint and ensure that remaining practices are safe and respectful. This standard is a legal requirement for all facilities which are certified by HealthCert, Ministry of Health. An update of this standard is currently being drafted. According to the draft Standard service providers should ideally observe secluded service users continuously. Any breaks in observation must be no longer than 10 minutes. Every 10 minutes there should be physical inspection and interaction with the patient to check their general condition, breathing, position, activity and behaviour. Every two hours providers must attempt to enter the room to conduct an assessment of the service user's mental state and physical state as appropriate. Local protocols should specify how many service providers are required to safely enter the seclusion room. A psychiatric assessment must be conducted every 8 hours.


The draft standard would require that a case management conference and the development of a management plan occur when a patient has experienced more than 24 hours of seclusion within a four week period. Decisions to end seclusion would require the approval of two qualified nurses, or a qualified nurse and doctor. A seclusion event would officially end when the person has been out of seclusion for more than one hour. The draft standard requires that forms must be used to record the use of seclusion and to support the 10 minute and 2 hourly observations. These forms are then to be used for review and auditing purposes.

Design specifications for seclusion rooms are also outlined in the draft Standard. The draft Standard specifies that services must

- “Demonstrate that the use of restraint is actively and strategically avoided”
- Monitor and provide education in restraint type and procedures
- Ensure consumers are thoroughly assessed with regard to restraint
- Maintain accurate records of restraint use are maintained and demonstrate attempts to reduce risk associated with restraint
- Evaluate all episodes of restraint
- Monitor and review the use of restraint
- Demonstrate that every instance of “seclusion is clinically justified and clinical practice is clearly defined”
- Demonstrate that “seclusion only occurs in an approved and designated seclusion room (Standards NZ, 2007)

3.3 Preventing Harm to Service Users and Others

Commonly cited reasons for the use of seclusion and restraint in mental health inpatient



settings are the prevention of violence or agitation due to sensory stimulation (Fisher, 2004; Livingstone, 2007). The DRAFT NZ Restraint Standard specifies that seclusion use may be appropriate where violent behaviour cannot be controlled through behavioural techniques or medication, where the service user is displaying disturbed behaviour as a result of psychological disturbance, or as a means to reduce the disruptive effects of external stimuli and to prevent violent or disruptive behaviour when specific indicators are identified.

The standards do not encourage the use of seclusion and restraint, but lay down the minimum requirements for safe practice, if and when these interventions are used.


The New Zealand Nurses Organisation supports the principles of reducing the use of restraint within Health settings. However, the organisation has concerns that doing so may have implications for the safety of healthcare workers and highlights the need for extra training and resources for staff and consumers in order to reduce seclusion use (Sangster, 2007). The NZ nurses organisation has enquired as to whether there are plans for a national approach to training in de-escalation and restraint minimisation techniques (Sangster, 2007).

Nonetheless there is international evidence of effective ways to prevent violence or agitation without the use of seclusion and restraint. Seclusion and restraint practices have been reduced in a number of overseas settings without a corresponding increase in physical injury to patients and staff (Evans et al., 2002, Smith, Davis, Bixler, Lin, Altenor, Altenor, Hardentine, & Kopchick., 2005; as cited in Livingstone 2007). In Pennsylvania where the number of seclusion and restraint incidents in state hospitals was reduced by 74% there was no associated increase in either the frequency or the severity of staff injuries (Smith et al., 2005). Educational training supported by expert consultation was effective at reducing the use of restraint within an American aged care setting, with no corresponding increase in physical injury (Evans, Strumpf, Allen Taylor, Capezuti, Maislin, & Jacobsen, 1997).

4. SUMMARY OF THE LITERATURE

Virtually all of the known attempts to reduce or eliminate seclusion and restraint, and the associated literature, have come out of the United States in the last ten years. There is much consensus in the literature about best practices in this area which include:

- national direction
- independent advocacy
- organisational leadership and oversight
- organisational culture change
- workforce development
- service user development and participation
- using practical tools
- debriefing
- information collection and use
- funding
- timeframes



(American Psychiatric Association 2003, Curie 2005, Huckshorn 2004-1, Huckshorn 2005, NASMHPD 2006, SAMHSA 2007).

These practices have proven successful in reducing seclusion and restraint in a range of child, youth and adult inpatient settings. For instance, a training curriculum (NASMHPD 2006) that covers most of these best practice areas was piloted and evaluated in 2003 on 26 teams from 25 states in the United States. Eight states provided data from before and after the staff seclusion and restraint training. A large majority of these hospitals significantly reduced the number of seclusion events, the number of service users put into seclusion, and the total seclusion hours (Huckshorn 2004-1).

In addition to this, all the literature that analyses successful reduction efforts mentions some or all of the above best practice areas (Fisher 2003, NASMHPD 2006, Schreiner et al 2004, Smith et al 2005, Sullivan et al 2005). The best practice areas mentioned least are those which fall outside the responsibilities of frontline workers and their managers – such as national direction, advocacy and organisational leadership.

There is a consensus of opinion in the literature that the reduction of seclusion and restraint, at the very least, should not create an increase in injuries or the use of alternative restraints, such as involuntary PRN medication and special observation. In fact, the reduction of seclusion and restraint has been associated with a decrease in injuries to staff and service users (Curie 2005, NASMHPD 2006, Smith et al 2005) and a decrease in the use of other restraints (Donat 2002, Smith et al 2005).


Reading between the lines, the literature appears to span a philosophical continuum. At one end, seclusion and restraint must be reduced to comply with regulations, minimise harm and to ensure they are used when appropriate (Donat 2002, Fisher 2003, Schreiner et al 2004). At the other end of the continuum, seclusion and restraint must eventually be eliminated because they are inconsistent with a recovery approach (Curie 2005, Huckshorn 2004-1, Sullivan et al 2005, NASMHPD 2006, SAMHSA, 2007). The recovery values of hope, autonomy, social inclusion and a broad range of responses for a broad range of people, provides a more supportive platform for reduction than traditional institutional values.

5. PRACTICES THAT REDUCE AND ELIMINATE SECLUSION AND RESTRAINT

5.1 National Direction

National leadership and direction is well recognised in the literature as an important contributor to the overall efforts to reduce seclusion and restraint in the United States (Curie 2005, Huckshorn 2004-1). At present the United States is the only country that is making a concerted effort to reduce the use of seclusion and restraint. Several national and federal developments have supported the case for reduction. The earliest cited attempt to reduce seclusion and restraint started in the Pennsylvania state hospitals in 1990 (Smith et al 2005).

In October 1998 a series of newspaper articles on seclusion and restraint in the Hartford



Courier prompted a legislative inquiry into their use. Following this, federal regulations became tighter with mandatory debriefing for staff and service users as well as restrictions on the time people could be restrained or secluded (Bazelon Center, undated). Some facilities faced non-reimbursement for healthcare costs for an individual if they restrained or secluded the person beyond the federal time restrictions.

In 2003 a federal report with (policy recommendations) included a goal to ‘reduce the use of seclusion and restraint’ (President’s New Freedom Commission, 2003). In the same year, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a definitive statement on the need to reduce seclusion and restraint (SAMHSA 2003). SAMHSA backed its statement with funding for pilot reduction projects, curriculum development and technical assistance to be provided by the National Association of State Mental Health Program Directors.

5.2 Advocacy

The user-survivor movement has advocated for the elimination of seclusion and restraint since its beginnings in North America and Europe in the early 1970s (Chamberlin 1990). They have been joined by some journalists, lawyers and families, who have exerted pressure, at both the local and national levels, to reduce and eliminate seclusion and restraint in the United States. Advocacy has been directed at public opinion, politicians, bureaucrats or service providers (Curie 2005, NASMHPD 2006, Smith et al 2005).

5.3 Organisational Leadership and Oversight

Active, committed, high-profile leadership is essential in any process to reduce seclusion and restraint. Leadership must be present at all phases from beginning to end to:

- carry the vision
- develop the policies
- develop the action plan
- ensure the collection and use of data
- ensure training
- provide personal oversight of seclusion and restraint practices (American Psychiatric Association 2002, Huckshorn 2004-2, NASMHPD 2006).

The style of leadership must:

- champion reduction and make it a clear priority
- include all major stakeholders in the process: staff, service users, families and advocates
- keep up constant dialogue with staff and other stakeholders
- entice staff with reasons reduction will benefit them, such as a more pleasant work environment and evidence of increased safety
- create a supportive, respectful, non-coercive milieu for staff that models the milieu they need to create for service users
- use language that models recovery values

- reward and celebrate successes in reduction with staff (American Psychiatric Association 2003, Huckshorn 2004-1, NASMHPD 2006, Smith et al 2005).

General evidence on change shows that leadership, backed up by a dedicated change management team of key stakeholders is important for success (Fixsen 2005, Iles and Sutherland 1999).

5.4 Organisational Culture

Culture change tends to be slow and has been defined as ‘lasting changes to the organisation’s shared ways of thinking, beliefs, values, procedures and relationships’ (NASMHPD 2006).

Leaders have a major influence on organisational culture. The reduction of seclusion and restraint must be accompanied by culture change - from an organisation that accepts violence and coercion to a recovery based culture that promotes hope, empathy, personal resourcefulness, participation, mutual respect and trust. There needs to be a shift from viewing seclusion and restraint as ‘treatment’ to viewing them as consequences of ‘treatment failure’. Though reduction itself helps to create culture change, culture change is also necessary to achieve and sustain reduction. (Curie 2005, NASMHPD 2006, SAMHSA 2007).

Various philosophies underpin the more recovery oriented approaches to reducing seclusion and restraint. These include recovery, trauma informed care, human rights and the public health prevention model.


Recovery; from a New Zealand perspective, is an approach to the delivery of mental health services that places high value on hope, autonomy and choice, social inclusion, and a broad range of responses to meet diverse cultural and individual needs (MHC 2004-2).

Trauma informed care recognises the high prevalence of trauma in service users and addresses the profound neurological, biological, psychological and social effects of trauma using collaborative, supportive and skill-based methods/practices (NASMHPD 2006, National Executive Training Institute 2004).

International human rights is traditionally ambiguous about the use of seclusion and restraint. However, the latest relevant treaty, the ‘Convention of the Rights of Persons with Disabilities’ (United Nations 2006) states in Article 14 that ‘the existence of a disability shall in no case justify a deprivation of liberty’. Article 15 states that ‘No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment’, and Article 16 calls on States to “protect persons with disabilities, both within and outside the home, from all forms of ... violence and abuse”. The new Convention is more discouraging of all forms of psychiatric coercion than any United Nations treaty that has gone before it.

The public health model applied to the reduction of seclusion and restraint emphasises the following approaches, in order of priority:

- primary prevention – anticipating risk factors so agitation and aggression don’t occur.
- secondary prevention – early intervention so conflict is minimised and resolved quickly.

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- tertiary prevention – debriefing after a seclusion or restraint event to minimise the chances of it happening again (NASMHPD 2006).

5.5 Workforce Development

The reduction of seclusion and restraint requires action on several workforce development fronts – recruitment, education, supervision, performance appraisal and staff involvement.

Recruitment and staffing

Reduction tends to be more achievable when:


- there is a high ratio of staff to service users
- staffing is stable
- staff are mature and well trained
- untrained temporary staff are not heavily relied upon
- job descriptions, orientation and performance appraisals reflect the priority given to reduction (American Psychiatric Association 2003, Donat 2002, Huckshorn 2005).

Education

Staff education needs to be well planned and ongoing with clear objectives. It is best conducted jointly by service users and staff.

Literature suggests the curriculum needs to include:

- *Experiences of seclusion* among service users and staff.
- *Erroneous assumptions* about seclusion and restraint such as claims of safety, therapeutic value and staff ability to predict violence.
- *Effects of trauma* – psychological, social and neurobiological.
- *The requirements of leadership* such as vision, policies, action planning, oversight, support for staff, use of data.
- *Service user and staff participation* – peer support, personal crisis planning, debriefing, planning a reduction initiative, monitoring progress, leadership and championing reduction.
- *Creating culture change* such as recovery, trauma informed care, public health model for reduction, power issues, use of language, social justice and human rights.
- *Understanding resilience and recovery* – definitions, historical development, values and assumptions.
- *Identifying and managing risk factors* – individual risk, environmental triggers, safe use of seclusion and restraint.
- *Case studies* of reduction initiatives elsewhere.
- *Prevention tools* – crisis assessment, trauma history assessment, identifying risk factors, de-escalation, sensory modulation, advance directives, crisis planning, active listening, dispute resolution, mediation, changes to physical environment, meaningful activities for service users, WRAP, and peer support.
- *Debriefing* for service users and staff involved.

- 
- *Elevating visibility of seclusion and restraint reduction* at all levels in organisational changes including importance of leadership oversight and on-call responsibilities, the on-site supervisor role and frontline staff attributes (American Psychiatric Association 2003, Huckshorn 2004-1, NASMHPD 2006, SAMHSA 2007).

Supervision and performance appraisal

Staff need to demonstrate competence on an ongoing basis and become very familiar with policies and procedures. Education should be reinforced by mentoring or supervision and linked to performance appraisal. Supervision needs to be increased if a staff member goes over a certain threshold of initiating seclusion or restraint. (American Psychiatric Association, 2003).

Staff involvement

All staff need to be involved in reduction initiatives. Management, clinical staff, support staff and security staff should receive relevant training (American Psychiatric Association 2003). Key staff should be involved in the design, implementation and evaluation of reduction initiatives. Staff involvement needs to model service user involvement.

5.6 Service User Development and Participation

People using inpatient services can have a significant role in the reduction of seclusion and restraint through their own learning and participation.

Developing service user coping skills is considered an important contributor to the reduction of seclusion and restraint (Visalli 2000). Staff can help people with this through promoting autonomy, providing choices and working with people on behaviour management plans. A Louisiana facility has a recovery centre where people using the inpatient service learn communication skills, anger management, problem solving and assertiveness (Schreiner, Crafton, Sevin 2004). Dialectical behaviour therapy has also been used to reduce aggression (Fisher 2003).

Asking people what they find helpful or unhelpful and getting their feedback about the service is another approach to reducing seclusion and restraint (American Psychiatric Association 2003, NASMHPD 2006, SAMHSA 2007, Sullivan et al 2005). If people are happy with the service, they are less likely to get agitated or aggressive.

Service users who are not currently using the inpatient unit can also have a major impact on the reduction of seclusion. They provide a fresh perspective, help change the culture and understand the point of view of the people staying in the inpatient unit. These service users can be employed in various roles – as advocates, advisors, peer support workers and educators. They may also occupy clinical and support roles. Self-identified service users need to be involved in every phase of the reduction initiative and at every level (Huckshorn 2005, NASMHPD 2006).

5.7 Practical Prevention Methods




Milieu management

- *Physical environment.* Research suggests that the level of agitation and aggression will decrease in an environment where there is no overcrowding and there are quiet spaces for people to go to. (American Psychiatric Association 2003, Champagne & Stromberg 2004).
- *Meaningful activities.* Violence is reduced when service users are occupied in rewarding activities that enhance recovery, such as creative expression, exercise and recovery education. Some of these activities can help develop people's skills in dealing with anger (American Psychiatric Association 2003, SAMHSA 2007, Schreiner et al 2004).
- *Atmosphere of listening and respect.* Violence is also reduced in an atmosphere where people feel respected, acknowledged, supported and listened to. Staff need to model this kind of behaviour and understand how power and control issues impact on service users and themselves (SAMHSA 2007).

Prevention and early intervention tools

No prevention and early intervention tool is likely to suit everyone. Staff and service users need to negotiate tools during the crisis prevention planning process (Sullivan et al 2005, NASMHPD 2006, SAMHSA 2007).

- *Advance directives and crisis plans.* These are instructions, completed while people are well, that indicate the treatment and support they want in a crisis. Following advance directives and crisis plans may help prevent agitation. They may also contain directions on what to do when a person gets agitated (SAMHSA 2007).
- *Violence and trauma assessments.* Everyone who is admitted to a facility should be assessed, as soon as practicable, for violence risk and trauma history. The violence assessment asks questions relating to the risk factors for violence such as a history of violence and substance abuse. The trauma assessment asks about the nature of the trauma, the perpetrator, when it happened, and the impact on the person's life (American Psychiatric Association 2003, Sullivan et al 2005).
- *Crisis prevention plans (for preventing agitation and aggression).* Drawing on the assessments, some people will benefit from working on a crisis prevention plan with a staff member. This process needs to identify the triggers and early warning signs and include a discussion and negotiation of strategies the staff and the service user can apply to prevent and de-escalate agitation or aggression (NASMHPD 2006, SAMHSA 2007).
- *Behavioural coaching and therapy.* Following a crisis prevention plan or an episode of agitation or aggression, staff may work with the service user to assist them to learn and rehearse strategies for dealing with triggers and responding to early warning signs. Dialectical behaviour therapy has been used in at least one inpatient service to reduce aggression and the use of seclusion and restraint (Fisher 2003).
- *De-escalation.* This is a set of skills to 'bring down' aggressive behaviour through keeping calm, showing support for the person, acknowledging their feelings, active listening and helping to find a non-violent solution to the current situation (American Psychiatric Association 2003, Chabora, Judge-Gorney, Grogan 2003, Schreiner et al 2004). In some facilities staff volunteer to go on a special roster for a Psychiatric Emergency Response



Team. When alerted, they drop what they are doing as soon as they are alerted, so they can assist with de-escalation (Smith et al 2005).

- *Sensory modulation.* This is a set of trauma-sensitive tools that induce calming by changing a person's sensory experience. Sensory modulation can include therapeutic brushing and limb compression, weighted blankets or vests, massage, holding, meditation, exercise, or a hot shower. An increasing number of facilities in the United States are installing multi-sensory or comfort rooms that are attractively decorated with calming colours, low lighting, soft music, pot plants and rocking chairs (Champagne et al 2004, NASMHPD 2006, SAMHSA 2007).
- *Medication.* Sometimes optimal amounts of medication, such as anti-psychotics, can be prescribed on a voluntary basis as a tool to prevent or reduce agitation and aggression (Fisher 2003, Smith et al 2005).
- *Dispute resolution – mediation.* Mediation is a process whereby a neutral third party assists participants to reach a voluntary and informed settlement. This can be useful in episodic or prolonged disputes (SAMHSA 2007).

5.8 Debriefing

The use of debriefing after a seclusion or restraint event is essential and needs to: consider the facts, acknowledge feelings, aim to be a learning opportunity and focus on planning for prevention of further episodes (SAMHSA 2007). Debriefing requires courage, honesty and safety for everyone involved (Huckshorn 2005).

The goals of debriefing are to:

- prevent future use of seclusion and restraint
- reverse or minimise the negative effects of the episode
- address organisational problems and make improvements (NASMHPD 2006)

Immediate debriefing (Acute debriefing)

Immediate debriefing is essential to any seclusion reduction initiative. It needs to be a safe learning opportunity immediately after the event, where both the service user and the staff members involved in a seclusion episode can:

- share feelings and perceptions
- review clinical data and revise the treatment plan
- revise the person's crisis prevention plan
- identify areas for performance improvement

Critical incident review (Formal debriefing)

According to literature immediate debriefing should be followed by a meeting with the involved staff, service user, service leaders, and employed service user leaders. The review needs to consider the incident from a more systemic point of view, to consider whether improvements are needed across the whole service (American Psychiatric Association 2003, Huckshorn 2004-1, Huckshorn 2005, NASMHPD 2006).



5.9 Information Collection and Use

The routine collection and use of data is essential for a seclusion reduction initiative. Realistic goals need to be set for reduction and baseline data need to be established. Information on the following should be collected regularly:


- total seclusion events
- total seclusion hours
- total number of service users secluded, including demographics
- total number of seclusion events and total hours for each service user secluded
- the use of alternative restraints to replace seclusion e.g. medication or one to one time with staff
- the use of non-restraining methods to replace seclusion
- the number of injuries sustained by service users and staff
- the days and shifts the seclusion events occurred
- the staff member-s involved in each seclusion event
- analysis of both the themes and outcomes of debriefings
- analysis of trends in use of seclusion, and of non-restraining methods.

Staff should be provided with up to date data on a monthly basis. Data need to be used to create healthy competition and celebration of those staff that are reducing their use of seclusion and restraint. Data should not be used in a punitive way (Huckshorn 2004-1, Huckshorn 2004-2, Schreiner et al 2004, Smith et al 2005, Sullivan et al 2005).

5.10 Timeframes

Experience in the United States shows significant reduction usually takes two or three years:

- *Pennsylvania State Hospitals*. It took from 1991 to 2000 to get from 7.2 seclusion episodes per 1,000 patient days to 0.3 seclusion episodes per 1,000 patient days. The average duration of a seclusion event went down from 11.6 hours per 1,000 patient days to 1.3 hours in this time (Smith et al 2005).
- *Elmhurst Hospital, New York*. It took from 1998 to 2001 to get from 5.8 episodes per 1,000 patient days to 1.9 episodes. The average duration of seclusion events went from 36.6 hours per 1,000 patient days to 8.3 hours. (Sullivan et al 2005).
- *Creedmore Psychiatric Center, New York*. It took from 1999 to 2001 to get 67% reduction in seclusion and restraint events and a 92% reduction in total hours of seclusion and restraint (Fisher 2003).
- *Developmental Neuropsychiatry Program, South East Louisiana Hospital* – It took from September 2000 to March 2001 to get a 35% reduction in seclusion events (Schreiner et al 2004).
- *Massachusetts*. It took from 1999 to 2004 to get 78.8% reduction in seclusion and restraint episodes per 1000 patient days (NASMHPD 2006).
- *South Florida State Hospital*. One seclusion episode of more than one hour, and 5



restraints occurred between May 2002 and March 2006 (NASMHPD 2006).

5.11 Funding

Because of the different funding mechanisms in the United States, and the mixed messages on the need for additional funding in the literature, it is difficult to draw any conclusions about whether New Zealand mental health services require additional funding to implement seclusion reduction initiatives.

South Florida, Pennsylvania and Massachusetts reduced seclusion and restraint with no additional funding (NASMHPD 2006). However, the information on other reduction initiatives referred to in this paper did not mention funding.

In 2004 SAMHSA awarded State Incentive Grants totalling \$5.3 million (US) to eight states to support efforts to reduce seclusion and restraint using best practice methods. SAMHSA also funds a coordinating centre to support the funded initiatives, evaluate their impact, and promote good practice in this area (Curie 2005).

6. TRAINING PACKAGES

There is no single comprehensive package that adequately covers every area of best practice; however, the two US national training curricula developed by NASMHPD and SAMHSA address many of the best practices.


The SAMHSA curriculum is designed for frontline staff and administration while the NASMHPD is “appropriate for use by systems that are currently in the initial stages of addressing the reduction of seclusion and restraint within their operations” (NASMHPD, 2006).

There are some much briefer materials that are reasonably comprehensive in coverage, such as checklists for team leaders or managers, case studies and summaries. Most of the remaining literature deals with specific aspects of reduction (See Appendix 1 for a categorised list of references).

6.1 NASMHPD

The NASMHPD curriculum focuses on six core strategies for reducing the use of seclusion and restraint it identified from reviews of the research literature. The six core interventions or strategies are: 1. Leadership toward Organisation Change, 2. Use of Data to inform practice, 3. Workforce Development, 4. Use of Seclusion and restraint prevention tools, 5. Full inclusion of consumers and families, 6. Making debriefing rigorous. The curriculum outlines the importance of these six strategies and provides guidance around implementing the strategies. The training also covers consumer and staff perspectives, erroneous assumptions about seclusion and restraint, the impact of trauma-experiences, staff and service user perspectives on seclusion and restraint, as well as case studies of the reduction experiences in three US states.

The NASMHPD training curriculum is underpinned by a trauma-informed philosophy. Each



module covers a single aspect of a restraint reduction project, which may allow some flexibility in the delivery of the training. The training programme also includes a template plan to reduce seclusion and restraint. The curriculum has both intellectual and emotive appeal. The NASMHPD curriculum is a work in progress; there are plans to incorporate further recommendations, improvements and best practices as these are identified.

6.2 SAMHSA

The SAMHSA training explores sustainable solutions and strategies for supporting elimination of seclusion and restraint. The curriculum explores the perspectives of consumers and staff, the concepts of resiliency and recovery, the impact of trauma on consumers and direct care staff, and changes which may be needed to drive cultural change.

The SAMHSA curriculum emphasises the importance of both consumer and staff involvement in driving sustainable change and takes students through the development of personal and organisational action plans to reduce and eliminate seclusion and restraint.


The SAMHSA training is written with the underlying premise that the role of direct care staff is critical to meaningful system change and addresses strategies identified to reduce seclusion and restraint. These strategies include developing a wellness recovery action plan, developing a psychiatric advance directive, establishing drop-in centres, using comfort rooms and improving communication between staff and service users. The strategies identified differ from those covered in the NASMHPD curriculum.

All components of the course must be completed but there is flexibility to complete the 6 modules in separate sessions. The complete training will take 21-24 hours and is designed to be applicable for a variety of settings. The facilitators do not need prior training however the authors advise that at least one facilitator or co-facilitator should be a consumer, family member or direct-care worker. The first training module includes facilitating a discussion with a consumer panel. Many other interactive tasks, such as group discussion and worksheet activities, are incorporated into the training package.

7. RECOMMENDATIONS

Although no New Zealand literature has been identified that deals directly with methods to reduce of seclusion and restraint, the current literature coming out of the United States should be regarded as largely relevant to New Zealand, given the similarities in culture and in mental health service development.

There is however, a significant gap in the literature that needs to be addressed when adapting a seclusion reduction package for New Zealand. There is no consideration of best practice for people from indigenous populations or ethnic minorities, apart from a passing mention of cultural differences in the expression of anger (Sullivan et al 2005). This is especially important, because New Zealand like other western countries uses seclusion more frequently on indigenous people and people from ethnic minorities, than on people of European descent (Ministry of Health 2007, Mental Health Commission 2004-1). Malcolm Robson, service leader



for trans-cultural mental health services in Capital and Coast DHB, is working on a paper on seclusion and Maori which will be available in early 2008.

Some minor differences in the United States literature need to be taken into account when adapting a package for New Zealand. These include:

- Differences in language
- Differences in health structures, funding mechanisms, regulations and laws
- Some of the prevention and early intervention tools take time to use and are designed for people in medium to long stay hospitals
- Mechanical restraints are rarely used in New Zealand inpatient services
- New Zealand may have less sophisticated information systems than many of the US sites

Further recommendations include:

- Sustained national direction and independent advocacy that promotes and supports reduction efforts
- Adapt the best practice methods outlined in this paper, and develop best practice advice relating to Maori as well as to Pacific and Asian people
- DHBs opting to pilot or test seclusion reduction initiatives will be most likely to succeed if they have, or are developing, the following characteristics:
 - Recovery values are embraced and embedded
 - Committed, high-profile, hands-on, inclusive leaders
 - Dedicated change management team made up of stakeholders
 - Mature stable staff
 - Service users who are encouraged to be active agents
 - Sound information systems
 - Any pilot initiatives should allow at least two years to halve use of seclusion

8. SUMMARY AND WHERE TO FROM HERE: THE 'SECLUSION: TIME FOR CHANGE' PROJECT

This paper outlined the New Zealand context of seclusion and restraint in mental health services and reviewed the international literature for practices that support seclusion and restraint reduction and elimination. The NASMHPD and SAMHSA training curricula were identified as incorporating a range of best practices to reduce and eliminate use of seclusion and restraint. A number of recommendations were outlined to adapt and pilot these training curricula and best practices for the New Zealand context.

A number of actions are planned to build on past activities and the work that is already being undertaken in the sector. The "Seclusion – Time for Change" project supports the national goal of reducing and eventually eliminating seclusion in mental health services in New Zealand. It reinforces the goal that people receive services in the least restrictive settings.




Te Pou, working closely with others (such as DHBs and Ministry of Health), will be taking the following actions to support these goals:

1. Showcase current DHB initiatives that aim to reduce seclusion use
 - a. Identify DHBs currently implementing the NASMHPD or SAMHSA best practice training packages and gather information on implementation learnings
 - b. Identify other DHB initiatives implemented to reduce the use of seclusion & restraint including barriers to introducing and implementing initiatives
2. Establish and implement a method for critiquing and adapting the NASMHPD and SAMHSA training packages for the New Zealand context
3. Pilot/test ideas and practices that will reduce use of seclusion in New Zealand's DHBs, and:
4. Disseminate information about practices and packages that will support mental health services to reduce use of seclusion



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APPENDIX: LITERATURE CATEGORIES

GENERAL

Overviews:

Huckshorn, K. (2004-1). Reducing seclusion & restraint use in mental health settings. *Journal of Psychosocial Nursing & Mental Health Services*, 42(9), 22-33.

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Experiences and case studies:

American Psychiatric Association. (2003). *Learning from each other: success stories and ideas*.



Arlington: American Psychiatric Association.

Fisher, W. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.

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Sullivan, A., Bezmen, J., Barron, C., Rivera, J., Curley-Casey, L., Marino, D. (2005). Reducing restraints: Alternatives to restraints on an inpatient psychiatric service – utilizing safe and effective methods to evaluate and treat the violent patient. *Psychiatric Quarterly*, 76(1), 51-65.

Most of the general literature also addresses some or all of the following specific issues.

SPECIFIC

Sensory modulation:

Champagne, T., Stromberg, N. (2004). Sensory approaches in inpatient psychiatric settings: innovative alternatives. *Journal of Psychosocial Nursing & Mental Health Services*, 42(9), 34-44.

Staffing ratios:

Donat, D. (2002). Impact of improved staffing on seclusion/restraint reliance in a public psychiatric hospital. *Psychiatric Rehabilitation Journal*, 25(4), 413-416.


Individualised treatment:

Fisher, W. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.

Medication:

Fisher, W. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.

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Behavioural approaches:

Fisher, W. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice*, 9(1), 7-15.

De-escalation:

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